

INQUEST

into the death of

GAIA INIGO YOUNG

held at

Poplar Coroner's Court
127 Poplar Highstreet
London
E14 0AE

before

MS MARY HASSELL

(His Majesty's Senior Coroner for Inner North London)

on

Friday, 28 January 2022

Family members appeared In Person.

MS C ROBERTSHAW appeared on behalf of University College Hospital NHS Trust.

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P R E - I N Q U E S T H E A R I N G

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2
3 THE CORONER'S OFFICER: Okay. Before I get the Coroner into Court, I'm just going to
4 run through a brief introduction. My name is David Brereton. I'm a coroner's officer
5 here at Poplar Coroner's Court for Inner North London. I'll just go through the names
6 of people who we've got present, so that everybody knows who everybody is.

7
8 First of all, we have Lady Dorit Young of Dartington, who is the Honourable Gaia
9 Young's mother. She's accompanied by three friends: Annabelle Silver(?); Penelope
10 Elphinstone(?); and David Brooke(?), who are all present in Court. Online, we have Ms
11 Clementine Robertshaw of Hempsons representing University College London
12 Hospitals NHS Foundation Trust. Is there anybody else online at the moment? No?
13 Okay, thank you.

14
15 I'll just run through how this is going to work. I've started the court recording
16 equipment. This hearing will be recorded for sound only. Nobody else is allowed to
17 make any recording either of sound or video. No photographs or screenshots may be
18 taken. If you have started recording, please stop now or you may be held in contempt
19 of the Court. If you would like a recording of the proceedings then, after the hearing is
20 over, please email me and I will email you the form for completion and return.

21
22 When the Coroner comes into Court, the hearing will begin. I want to remind you all
23 that this will be a formal pre-inquest review hearing, and not a meeting. Coroner
24 Hassell will speak and then she will invite each of you to speak in turn. Please wait to
25 be invited to speak. Is there anything anybody wishes to ask before we start?

26 LADY YOUNG: How much time -- How long will this hearing actually be?

27 THE CORONER'S OFFICER: As long as it needs.

28 LADY YOUNG: Okay.

29 THE CORONER'S OFFICER: So, to avoid problems with feedback, Ms Robertshaw, if you
30 could mute your mic and keep it on mute until you're actually going to speak, and set
31 phones to silent, I shall now invite the Coroner into Court. Thank you.

32 UNKNOWN SPEAKER: Is the practice to stand when the Coroner comes into Court?

33 THE CORONER'S OFFICER: I'll ask you to rise when the Coroner comes in. Rise, please,
34 for the (inaudible) Coroner.

1 THE SENIOR CORONER: We are here today to resume the inquest touching the death of
2 Gaia Young. The Honourable Gaia Young died on 21 July 2021 at University College
3 Hospital. Her investigation was begun on 28 July 2021, and her inquest was opened on
4 11 November 2021 by one of my assistant coroners, Jonathan Stevens. Today is not a
5 substantive hearing but is a pre-inquest review only and I understand that I have Lady
6 Young with me and also family friends.

7 LADY YOUNG: Yes.

8 THE SENIOR CORONER: You're all very welcome to Court today. Before we go any
9 further, I can see that I have another interested person online. Perhaps you'd be kind
10 enough to introduce yourself.

11 MS ROBERTSHAW: Good afternoon, ma'am. Clementine Robertshaw, solicitor for the
12 University College London Hospitals NHS Foundation Trust.

13 THE SENIOR CORONER: Ms Robertshaw, you're also welcome to Court. So, I have called
14 this pre-inquest review in order to consider various applications made by Lady Young
15 in respect of the inquest that has been listed for 10 a.m. on Monday, 14 February 2022
16 at St Pancras Coroner's Court, not here at Poplar. Lady Young, this is not a particularly
17 formal court, so I'm just going to invite you to take me through the applications that
18 you have one by one and I'll consider those, and then we'll see where we are. So, tell
19 me what it is that you ask of me in respect of the inquest.

20 LADY YOUNG: Ma'am, I have a list of requests, and I'll just go through them according to
21 priority.

22 THE SENIOR CORONER: Yes, as I say, just one by one, if you would. Thank you.

23 LADY YOUNG: So, the first, and I think the most crucial, request is for you to commission
24 two neurological expert reviews and request their attendance as witnesses. Gaia died of
25 a condition exclusively limited to the brain, so I see it as crucial that a neuroradiologist
26 expert reviews the CT scans, in particular, consider the extent of cerebral oedema in
27 first and second CT scans, to review the choroid plexus, and to review the CTA and
28 CTV scan on the same day at nine o'clock in the evening as to when Gaia's brain death
29 was actually manifest by the time of the second CT scan or later at the time of the CTA
30 and CTV scan. Also, a neurologist expert review of metabolic encephalopathy
31 mechanisms of disease in the context of this case --

32 THE SENIOR CORONER: I'm so sorry, I just -- there was a noise and I just missed that. I
33 heard "a neuroradiologist", and I didn't catch what was after that.

1 LADY YOUNG: A neurologist's expert review. Number one, metabolic encephalopathy
2 mechanisms of disease in the context of this case. Number two, the mechanism of
3 raised, acute, catastrophic, idiopathic intracranial hypertension. Also, his view of the
4 role of acute hyponatremia in this case. Could the fluid overload accelerated the brain
5 oedema? Gaia received three litres of Hartmann's solution in nine hours. Despite, her
6 sodium fell from 129 to 123 over those nine hours, which was not monitored.

7
8 Also, to consider the role of fundoscopy in the context of this case, and I'd like to hear,
9 from this neurologist, the role of neurological observations like Gaia's altered mental
10 state, her photophobia and changing pupil sizes with initial mydriasis.

11
12 I further request to consider my four submissions to respond and, if deciding to
13 disregard them, to give reasons for doing so. There are four submissions and they give
14 detailed background information why those two neuroradiologists are absolutely
15 crucial, and that means why the inquest on the 14th should be delayed. There is number
16 one; the memorandum dated 13 December, and that has detailed considerations of the
17 aetiology of Gaia's death and the apparent contradiction between the two postmortems
18 regarding tonsillar herniation. My second submission was a review of the serious
19 incident report from the UCLH, basically stating that it was completely lacking
20 consideration of clinical data regarding the aetiology of Gaia's condition.

21
22 I further wrote a letter to the Coroner dated 12 January basically regarding procedural
23 irregularities of your original file review and the insufficiency of the review, and then
24 my address to the Court dated 26 January which is containing my personal emotional
25 statement as Gaia's mother and my request to the Court, which I am now basically
26 going through.

27
28 I would like you to reject the serious incident report by the UCLH, dated 9 December,
29 for the following reasons, and admit and update the report into evidence. I received an
30 email on 20 January that the Trust is considering revising their serious incident report.
31 Reasons being, it contains no consideration of the aetiology of Gaia's condition.
32 Antemortem findings were not reviewed in detail to explore the above. It lacks an
33 explanation of the correlation between the radiology, the first CT scan, was reported as

1 normal, then the clinical events of herniation shortly afterwards, and the underlying
2 pathology may be very crucial to investigating the cause of Gaia's death.

3
4 I also want to say that the report ends very abruptly at 16.53 after the second CT scan,
5 and there's no mentioning of the CTA and CTV scan at about nine o'clock, and no
6 mentioning of what happened in those crucial hours in between. When were the
7 neurosurgeons consulted? Why and when did they come to the conclusion that
8 neurosurgical intervention was not indicated and that there was no hope of recovery?

9
10 I also like to request you to call relevant and impartial clinicians as witnesses to assess
11 the care Gaia received. So far, you proposed to call Dr Gregson and Dr Polhill. Dr
12 Gregson is the co-author of that serious incident report. Dr Polhill took over Gaia's
13 care on 20 July, about one and a half days after her respiratory arrest. It is difficult to
14 see the purpose of her attendance. I suggest --

15 THE SENIOR CORONER: I beg your pardon for interrupting.

16 LADY YOUNG: Yes?

17 THE SENIOR CORONER: In terms of those who were looking after your daughter, Lady
18 Young, who would you prefer rather than Dr Polhill?

19 LADY YOUNG: I come to it now. Yes. I suggest to call the duty neuro special registrar. His
20 involvement started at about 12.30, and also the acute medical consultant. He was on
21 the ward round from 10.26 of Sunday morning to give a detailed and chronological
22 account of the communication between the two care teams, the neuro team and the
23 acute medical team, and to state, actually, who was in charge of Gaia's care during
24 those crucial hours. I'd like to be called to give evidence, and I'd like that the crucial
25 contradiction between the two post-mortems gets resolved by requesting an addition
26 from Professor Schiff because he says there was tonsillar herniation whereas the
27 neurological pathologist, Al-Sarraj, says there was no visible tonsillar herniation.

28
29 I am now following a list of additional statements to be obtained from the following
30 clinicians. Dr Zoe Veary, she was the emergency department doctor one, the first doctor
31 who encountered Gaia. I'd like to know, how did she reach the diagnosis of
32 intoxication?

33
34 Gaia came straight from home. She was fully conscious; she was fully co-operating

1 with the ambulance. They said she was fully alerted, spoke to them immediately. Her
2 conscious level deteriorated whilst in hospital. I want to know what tests were
3 undertaken to prove or disprove the diagnosis of intoxication. I also would like to
4 know if Dr Zoe Veary was aware of altered mental states in connection with cerebral
5 hypoxia. Did she receive any training for confirmation bias? Because the diagnosis of
6 intoxication stuck for 10 hours.

7
8 A very personal request is she called me on Sunday morning at 1.17 from a withheld
9 number, not leaving any message, nor a contact number for me to call. She never called
10 again. Her statement also does not address the omission to perform fundoscopy,
11 whether it was attempted or even considered. Her statement refers to the assessment of
12 Gaia by registrar, acute medical doctor one, when she was much more alert, but her
13 alertness seems to change. Was fundoscopy then considered or attempted?

14
15 I also would like to know from this doctor why he was convinced that there was no
16 evidence of photophobia, although Gaia was seriously photophobic at home already. I
17 had to close our blackout curtains on a July evening. She was repeatedly found with the
18 sheet pulled over her face by nurses and doctors. She was also found with her hands
19 covering her eyes. She was rolling away. She was trying, in a way, almost to defend
20 herself against bright lights. This doctor says that, because Gaia looked into the light,
21 there is no evidence of photophobia. It's pretty ridiculous.

22
23 The next person I would like additional statements from is Dr Tom Samuels, acute
24 medical doctor two, regarding the two failed LP attempts -- lumbar puncture attempts.
25 Number one, why did he let a junior doctor perform the procedure on a "fidgety and
26 restless patient", like Gaia, a very difficult patient? She was repeatedly described as
27 restless, rolling around, fidgety. Why did he allow someone who had less experience
28 than himself to do the first lumbar puncture?

29
30 Number two, her condition then worsened during the first LP. She became agitated and
31 expressed pain. At the same time, the neuro SpR expressed her doubts at 2.30, whether
32 there was generalised brain oedema to be seen on the first CT scan. There was no
33 urgency documented anywhere for the second attempt or generally for the LP to be
34 done at the time when it was done. Why did Dr Tom Samuels then rush into the next

1 attempt at 15.25 rather than waiting for the neuro SpR's result of a further consultation
2 with neurologists at the National Hospital for Neurology and Neurosurgery?

3
4 Number three, did he attain the patient's or the next of kin's consent to undertake this
5 invasive and potentially fatal procedure? Can he explain why it took him five days to
6 log these events? I would also like statements from the student nurse and from acute
7 medical doctor three, they assisted and witnessed Dr Samuel's second LP attempt. I,
8 therefore, request their statements to corroborate, shed light on this crucial event which
9 caused Gaia's respiratory arrest and effective death.

10
11 Also, very important, the duty neuro SpR can shed light on these crucial moments
12 before the second LP when she consulted the neuroradiologist and the consultant
13 neurologist on call at the National Hospital for Neurology and Neurosurgery regarding
14 the safety of the lumbar puncture in Gaia's case. Did she communicate her doubts to
15 the acute medical team and if, when? Was Dr Samuels actually aware of her doubts?
16 Why did she and the other neurologists from the National Hospital for Neurology and
17 Neurosurgery think the LP was ill-advised?

18
19 Finally, I request a statement by one of the neurosurgeons who advised that
20 neurosurgical intervention was not indicated. When were they consulted? Why was
21 there no craniotomy considered or attempted immediately after the second CT scan at
22 16.53? What happened to Gaia in those hours between 1653 and 2100 hours when the
23 CTA and CTV was performed?

24
25 I am grateful for the Court's consideration. I earnestly hope you will accede my
26 request, which I believe to be correct by law, and postpone the proposed inquest on 14
27 February. These are certainly heartfelt requests of a grieving mother who needs to
28 know the truth; why and how her much loved child came to die. Thank you.

29 THE SENIOR CORONER: Thank you very much. Ms Robertshaw.

30 MS ROBERTSHAW: Thank you, ma'am. I think probably the first point I needed to convey
31 is that the Trust is in need of (inaudible) post-mortem findings and we hope that an
32 amended report will be available by next Monday, 7 February, which might --
33 appreciate that is sufficient time (inaudible) to consider it before being met on the 14th,

1 but I don't anticipate that, due to the complexity of it and the number of different
2 specialists involved, it would be possible to provide any more information.

3
4 In terms of the further evidence sought and the applications made on behalf of the
5 family, firstly, obviously the written submissions are very detailed and include various
6 medical points which I would have to say that would require support by evidence, and
7 to be potentially dealt with in the hearing. In terms of the requirement for further
8 evidence, obviously a number of different items have been highlighted as potentially of
9 assistance to you, ma'am, the first question is for you to consider to what degree you
10 view the present evidence as indicating a natural cause of death.

11
12 It may be, ma'am, that you're unable to conclude that until you have sight of the
13 amended SI report but, of course, you're required by law to consider the evidence that
14 you have, consider the definition of a natural death in this context and particularly
15 consider how the parameters of the inquest process are often somewhat different to the
16 questions that the family very understandably have, particularly in circumstances like
17 this where we appear to have a potentially natural death but in deeply unexpected
18 circumstances.

19
20 In terms of the legal definition of a "natural death", ma'am will be familiar with the
21 case law that we have, effectively, defines "natural" by omission. The primary case
22 being that of *Regina (Touche) v Inner London North Coroner* [2001] EWCA Civ 383,
23 which defines a "natural death" and becoming unnatural if clinical steps had been taken,
24 the death would probably have been voided.

25
26 On the present evidence, I suggest, ma'am, there isn't evidence which would indicate
27 there's a specific intervention which could probably, or even possibly, have averted the
28 death and, in particular, the evidence that we have -- particularly including two post-
29 mortem analyses -- hasn't been able to identify a specific cause and therefore, ma'am, it
30 might be difficult for you to conclude that clinicians at the time between the
31 presentation of the patient and her deterioration, whether it would have been possible
32 for them to identify and then reverse the cause of the ultimate cause of death, the
33 oedema.

1
2 Ma'am, there was a review of the current evidence and the view of whether or not you
3 have sufficient evidence to conclude the death was natural is a question for you and, as
4 I know, the case law (inaudible) is of limited assistance in defining the terms. Other
5 cases which -- (inaudible) which you will already be familiar is that of *R (Canning) v*
6 *HM Coroner for Northamptonshire* [2006] EWCA Civ 1225, where a death which is
7 natural is unnatural if wholly unexpected and would not have occurred without some
8 culpable human failure. In the case of *R (Thomas) v Poplar Coroner* [1993] QB 610, it
9 found that whether a death is natural or unnatural is a practical question based on the
10 ordinary meaning of those words.

11
12 I think, ma'am, the other point that I make in terms of the scope of the inquest, you are,
13 of course, limited to the questions of who died, where, when and how, which leaves,
14 unfortunately, the family with the discomfort of not having an answer to the question of
15 why death has occurred, and I would suggest that this is potentially a quite complicated
16 case, a very medically complicated case, and it's a question for your discretion to what
17 degree you feel it's necessary to go through the process of causation on that balance
18 between what evidence there might be to how the death has occurred and where it
19 ventures into why the death has occurred.

20
21 It may be, ma'am, that an appropriate next step would be to ask the pathologist to
22 clarify (inaudible) inconsistency which the family highlight, but also to review if there
23 is more evidence which could elucidate the cause of death. The matters that the family
24 raise -- for instance, corroborating entries in medical records -- ma'am, these largely go
25 beyond the scope of an inquest and so I would suggest the first question is whether
26 further evidence is going to assist you in answering the statutory questions. From my
27 side of the evidence, the pathologist would be best placed to say whether furtherance is
28 achievable which can take you any closer to answering the structural questions.

29
30 That, in my submission, will be a proportionate first step, as well as obtaining the
31 amended SI report from the Trust, and that may then give indication of whether you're
32 able to conclude that the death was a natural death, and it may well be that there are
33 further questions which the family would like to discuss with the Trust and with the

1 inquest context, which can provide some further reassurance or answers to the degree
2 that that is possible.

3
4 This appears, ma'am, to be one of the very difficult cases where, as is often the way that
5 there are some unanswered questions even after an inquest process, that there may be
6 significant questions for the family which are simply not answerable, and that is no
7 doubt a matter of deep distress to them but that doesn't necessarily mean that there's a
8 step that could be taken within the inquest which would get to those answers. Ma'am,
9 would it assist you to address the points more specifically, or perhaps you can give me
10 an indication of your views at this point?

11 THE SENIOR CORONER: Thank you, Ms Robertshaw. Thank you. Let me first try to put
12 this in the context of what an inquest is seeking to achieve and how it goes about that,
13 and I shall try to address -- I have read a great deal of material very helpfully sent by
14 Lady Young, which, of course, I've had forwarded to the Trust and is a great assistance
15 in preparing for the inquest because it enables the Trust to be aware of questions that
16 will be posed at the inquest. So that's very helpful indeed, thank you.

17
18 To put this in context, the purpose of an inquest is to attempt to answer four questions:
19 who the deceased was, where she died, when she died and how she came by her death.
20 In answering the question of how she came by her death, clearly integral to that is a
21 medical cause of death, and that's what I'm focused on first and foremost. So, in
22 making a decision about which witnesses to call to give evidence, that is the first
23 question that I seek to answer because, without that, it's extremely difficult to answer
24 the question of how a person came by their death.

25
26 Now, in doing so, let me just set out some of the case law to put this in context. *R v*
27 *North Humberside and Scunthorpe Coroner, ex parte Jamieson* [1994] EWCA Civ
28 J0425-3. In this case, the Court set out that:

29
30 "It's the duty of the coroner to ensure that the relevant facts are fully,
31 fairly and fearlessly investigated. He must ensure that the relevant facts
32 are exposed to public scrutiny. He fails in his duty if his investigation is
33 superficial, slipshod or perfunctory."

34
35 Now, that doesn't mean that the investigation is limitless. Sir Thomas Bingham, as he
36 was then, was clear that the responsibility is the coroner's. He must set the bounds of

1 the inquiry. In the case of the *R (Mack) v HM Coroner for Birmingham and Solihull*
2 *and Ors* [2011] EWCA Civ 712, the coroner has:

3
4 “... a wide discretion – or perhaps more appropriately a wide area of
5 judgment – whom it is expedient to call.”
6

7 In the case of *R v Inner West London Coroner, ex parte Dallaglio* [1994] 4 All ER 139,
8 it’s for the coroner to decide, on the facts of the given case, at what point the chain of
9 causation becomes too remote to form a proper part of the investigation. In *R (Allen) v*
10 *HM Coroner for Inner North London* [2009] EWCA Civ 623, the coroner is not obliged
11 to investigate or give conclusions in relation to every issue raised by the family.
12

13 I also have in my mind the very firm guidance given by the present Chief Coroner of
14 England and Wales, his Honour Judge Thomas Teague QC, who has impressed upon
15 coroners that, in the inquisitorial process, the views and submissions of interested
16 persons are important but are not determinative. He has reminded coroners that an
17 inquest is not a species of litigation so this is not a clinical negligence trial. It’s not a
18 civil trial in any way, shape or form. He has told coroners that there has to be a
19 complete inquest, but that does not mean it has to be exhaustive. It must be sufficient,
20 but “sufficient” does not equal a public inquiry.
21

22 (After a pause) In *R (Maguire) v The Assistant Coroner for West Yorkshire (Eastern*
23 *Area)* [2018] EWCA Civ 6, the Court noted that ruling an issue in scope does not carry
24 with it a duty for a coroner to ask, or to permit an interested person to ask, every
25 conceivable question relating to that issue. In the case of *R (Takoushis) v HM Coroner*
26 *for Inner North London* [2005] EWCA Civ 1440, the court noted that the coroner must
27 make all necessary inquiries as to whether he needs an expert witness, but that does not
28 mean that he has to call an expert witness.
29

30 (After a pause) In the case of *Shaw v Leigh Day (a firm)* [2018] EWHC 2034 (QB), the
31 Court noted as follows:

32
33 “Mrs Shaw failed to obtain answers to all the questions that she wanted
34 answered, and is unhappy with those answers that she did obtain.
35 Having in consequence failed to achieve the closure that she sought,
36 Mrs Shaw has convinced herself that someone must be to blame. She
37 cannot accept that an Inquest will not always succeed in laying to rest

1 all the concerns of the family of the deceased, and that this situation
2 may not be anyone's fault. Although, like other judges before me, I
3 have great sympathy for Mrs Shaw's desire to get to the truth of what
4 happened to her father, that is the position here."

5
6 Finally, in the case of *Goodson v HM Coroner for Bedfordshire and Luton* [2004]
7 EWHC 2931, the Court was firm that the independence of the inquest is derived from
8 the independence of the coroner, not of the independence of any of the witnesses, be
9 they expert or other.

10
11 (After a pause) So, having reminded myself and those present of some of the law which
12 contextualises this application, I now go to more detail. As I've indicated, first and
13 foremost, I want to understand the medical cause of death. Now, at present, in dealing
14 with that aspect of the evidence, I have Professor Sheaff, the pathologist who conducted
15 the majority of the post-mortem examination. I shall give consideration as to whether it
16 is necessary to call Professor Al-Sarraj, but my preliminary view is that what will be of
17 most assistance is if my Coroner's Officer were to write to Professor Al-Sarraj and to
18 Professor Sheaff and simply ask for a resolution to the question that Lady Young has
19 put regarding the tonsillar herniation. So it's simply about whether there was or was
20 not herniation.

21
22 (After a pause) In answering the question of the medical cause of death, I appreciate
23 that, of course, I have a very clear cause of death as far as it goes but I am very
24 interested to understand, if that's possible, how it was that particularly such a young
25 woman should develop the level of cerebral oedema so as to cause her death. Now, that
26 was my intention in calling Dr Polhill.

27
28 Ms Robertshaw, it seems to me that I would be very assisted by a treating consultant in
29 attempting to understand the cause of the cerebral oedema. Obviously, I shall have
30 Professor Sheaff, potentially Professor Al-Sarraj, although that's probably less likely,
31 but one or the other in any event. My preliminary view was that one of the intensive
32 care consultants would be best placed to assist me in answering that question but, given
33 that Lady Young does not have any questions for Dr Polhill, I would like to put that
34 back to the Trust and to ask you to assist me in providing a witness, who must be a
35 consultant, who is most likely to assist me in the question -- one of the treating

1 consultants, I should say, who is most likely to assist me in the question of the cause of
2 the cerebral oedema.

3
4 It may be that you're not able to help me with that today. Let me not make any
5 assumptions. Let me ask you, are you able to help me with that today or is that
6 something that you would like to take away and to come back to me about?

7 MS ROBERTSHAW: Ma'am, I would like to hear -- to take instructions on it. I would
8 probably (inaudible) the work the Trust is doing on the medical side of the Court, which
9 obviously is trying to look at the question of the cause of the cerebral oedema, and it
10 may be a general medical consultant who is involved, it may not, and it might be that
11 we suggest a combination of someone involved in treating and someone who wasn't but
12 with other relevant clinical expertise to explain causation as much as possible. But
13 preferably a medical consultant would probably be my suggestion. I will come back to
14 you as soon as I can.

15 THE SENIOR CORONER: Thank you, Ms Robertshaw. Well, for the avoidance of doubt,
16 unless that person is Dr Polhill, Dr Polhill is discharged. So that was the sole reason for
17 calling her to give evidence and, if she's not the best person to assist me with that, then
18 I am very happy to proceed with the witness or witnesses volunteered by the Trust, but
19 my officer does need to know the identity of that person, and let's say by twelve noon
20 on Monday, the 7th.

21 MS ROBERTSHAW: Ma'am, thank you. I will be happy to oblige with that and thank you for
22 the indication (inaudible).

23 THE SENIOR CORONER: Thank you. In terms of expert witnesses to answer that question,
24 at present, I'm not convinced that a non-treating expert witness is going to be any more
25 likely to be able to assist me with that, but I'm going to hold over a final decision about
26 that until after I've heard evidence from the Trust witnesses about the medical cause of
27 death.

28
29 There are three options available to me in terms of the application to adjourn the
30 inquest: the first is that I adjourn and that the inquest is resumed at a later date; the
31 second is that I proceed with the inquest on the 14th; and the third is that I proceed with
32 the inquest on the 14th and then, at the conclusion of that evidence on that day, I look at
33 the matter afresh and decide whether I have sufficient evidence to allow me to conclude
34 the inquest or whether I need to adjourn, part-heard.

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I favour that third alternative for several reasons. I'll just record my decision first.
(After a pause) So, the first reason is because I am keen to hear from any witness who has factual evidence before that evidence goes cold because it is my experience that, if there is a delay in hearing an inquest, there is a degradation of first-hand witness evidence. It may be that memories fade or that witnesses move away or even pass away themselves. That's a situation that I've encountered on several occasions and, once that happens, that evidence is lost. The factual evidence is lost, so I want to hear that evidence as quickly as possible.

I'm also conscious that I have a very, very busy court list and it will not be easy to find another date, and it seems to me that adjourning generally is unsatisfactory and, as I say, brings with it a very great risk of degradation of the evidence, so I'm keen not to do that. Expert evidence will not degrade in the same way because it's simply looking at the notes and records, and in a sense, it doesn't matter when that's done. Lady Young.

LADY YOUNG: Ma'am, but you then have to insist that some neurological clinician becomes a witness because, so far, we have no neurologists as witnesses, and Gaia's condition was a brain -- affected exclusively the brain. All her other organs were fine, and the statements in the serious incident reports -- None of the participating clinicians is looking beyond hyponatraemia, generalised oedema. Nobody has been trying to answer the question what actually happened in Gaia's brain. We do need some neurological expert review.

THE CORONER'S OFFICER: Well, I do have a neuropathologist, so I do have Professor Al-Sarraj.

LADY YOUNG: But that's the end point. This is not the aetiology, it's the end point what happened to Gaia. It doesn't give us any information what Gaia went through, what happened inside her. The clinicians obviously have the data, but they didn't use the data so far.

THE SENIOR CORONER: Well, Ms Robertshaw has heard your point there. Ms Robertshaw, obviously, I don't want to get to inquest and find that the witnesses offered by the Trust are unable to explore fully that aspect of the evidence, and you've heard Lady Young's very firm view about the necessity for neurological evidence. I'm going to leave that with you. Thank you.

1 (After a pause) Next -- So, I have, of course -- Or I should have said at the outset,
2 Lady Young, of course I'm delighted to hear oral evidence from you. I'm very, very
3 happy to do that.

4 LADY YOUNG: Okay, thank you.

5 MS ROBERTSHAW: Sorry, my Lady, the audio briefly went out. I heard the beginning and
6 end of that point but not the substance.

7 THE SENIOR CORONER: So, another of the applications was that I should hear oral
8 evidence from Lady Young, and I've said that I'm delighted to do that.

9

10 So, I have so far oral evidence from Lady Young, evidence from the pathologist,
11 evidence from a clinician or clinicians to assist in the medical cause of death and
12 evidence from the serious incident report author, and let me include within my
13 directions the updated SI report to be served simultaneously on the Court and on the
14 family by twelve noon on Monday, 7 February 2022. You indicated, Ms Robertshaw,
15 that the Trust is able to do that.

16 MS ROBERTSHAW: Ma'am (inaudible) I don't believe myself and my colleagues have been
17 directly in contact with the family via email. I don't know if they're happy for me to do
18 that or for your officer to pass on the SI report when it's disclosed to me.

19 THE SENIOR CORONER: I do think that, unless there's any objection to that, it would be
20 greatly preferable for you to provide that direct, and I'm getting a nod here. So Mr
21 Brereton will furnish you with the correct email address.

22 MS ROBERTSHAW: Understood, ma'am.

23 THE SENIOR CORONER: So, thus far, we have evidence from family, pathologist, clinician
24 regarding cause of death, and SI report author. I now come to look at the factual
25 sequence of events.

26 MS ROBERTSHAW: Ma'am, apologies, if I can make one further point. In terms of the
27 witnesses, you are expected to hear from Dr Gregson, one of the SI authors. She is due
28 to go on maternity leave the week of the inquest, and I wonder -- I doubt she'll be able
29 to cope with those childcare challenges, so obviously, there's potential question marks
30 around her availability should her maternity leave (inaudible), but also in view of the
31 potential part-hearing and it being -- So, that was the same people involved. If we go
32 part-heard only to resume at a later date, would it be helpful if I can review, if I can ask
33 the most helpful person to (inaudible) in that role of SI author, or a different SI author,

1 or someone who's contributed to the amendment to ensure we get that breadth of
2 evidence about the SI and the action plan and the medical cause of death?

3 THE SENIOR CORONER: Ms Robertshaw, I don't have any strong feelings about the identity
4 of the person who talks about the SI report. I need somebody who can talk about it
5 meaningfully. So I am very happy to leave that with you.

6
7 (After a pause) So, next, the factual evidence. Now, one of the things I would say here
8 is -- I'm sure this will sound very odd. Let me explain what I mean. One of the
9 elements of an inquest that is urged upon coroners, again by the chief coroner, is that
10 inquests must be proportionate, and the chief coroner and the former chief coroners
11 have been emphatic about that.

12
13 Now, I know that will seem odd because how could anything be "disproportionate" in
14 terms of investigating the loss of your daughter, the loss of such a young woman? I
15 appreciate that. It will seem a very, very odd word to use. But it is nevertheless part of
16 the coroner's role to exercise judgment about which witnesses are brought to court,
17 even if they're brought online.

18
19 I'm very conscious -- particularly in these pandemic times, but I'm always very
20 conscious -- that witnesses giving evidence in court are not treating patients. I mean
21 medical witnesses. Medical witnesses giving evidence in court are not treating patients.
22 I have that in my mind always, and so I must undertake a balancing exercise between
23 those witnesses I'm of the view are vital and those who are not. Sometimes that means
24 that one witness will talk about some events for which they were not necessarily
25 present.

26
27 So, for example, sometimes, rather than a junior doctor giving evidence about what they
28 did or didn't do, their consultant may say, "I instructed that this should happen," and if
29 the instruction is coming from a consultant and the consultant is the decision-maker,
30 then it seems to me entirely reasonable that the consultant should give the evidence
31 because then they will also be able to give the thinking behind the decision-making,
32 rather than the junior who says, "Well, I did what my consultant told me to do."

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So, in terms of the factual witnesses for the sequence of events, Dr Samuels, I think, is very important to you, Lady Young. Is that right?

LADY YOUNG: Yes.

THE SENIOR CORONER: I think we'll have Dr Samuels, Ms Robertshaw. The diagnosis of intoxication, I wonder whether we could -- and also the issue about the photophobia. I think the issue about the photophobia, given that we have a clear note of that -- I think another doctor could talk usefully about what is the definition of photophobia, and given the factual evidence that's going to be presented about what was happening at home and what was happening in hospital rather than just the light being shined in the eyes, it would not trouble me if that were given by another doctor.

The diagnosis of intoxication, I think that we could usefully deal with that by way of an additional statement, Dr Robertshaw(sic), dealing with that point. So, in fact, two points: (1) how was the diagnosis of intoxication reached; and (2) how was the conclusion of no photophobia reached? And I think that should come from the relevant emergency department doctor. Is there anything -- Yes, Lady Young?

LADY YOUNG: I just wondered, ma'am -- I think the question of the diagnosis of intoxication is very important, but how was it actually then clinically proven? What tests were undertaken to say, "Yes, this woman is intoxicated"? It's one thing, yes, saying she's intoxicated because it was Saturday night and she was a young woman and then going off with the diagnosis, another point to checking it actually out.

THE SENIOR CORONER: Well, I think what's important is what the consequences of that suspicion of intoxication were, so how did that affect management?

LADY YOUNG: Good, that's -- Yes, absolutely, absolutely, yes.

THE SENIOR CORONER: So, how was the diagnosis of intoxication made? How did that diagnosis affect management?

LADY YOUNG: I just want to make one point in that context. What really upset me enormously was the fact that because of the diagnosis of intoxication, my daughter was basically seen as not collaborating with possible neurological testings, whilst from my point of view she had found herself without warning in a situation realising that she was losing her mind. A hellish situation for a young woman to find herself in without warning. Covering her face, rolling around, being fidgety, all these, from my point of view -- obviously, it's easy to say it retrospectively -- are neurological symptoms,

1 observations which were seen in a way as -- My daughter was blamed for something
2 she had no control over.

3 THE SENIOR CORONER: Well, I would certainly expect the clinical evidence to deal with
4 that in any event because it's a very well-worn path that neurological compromise may
5 be confused with non-cooperation. That's a very well-worn path, so I would most
6 certainly expect that to be dealt with, yes.

7 LADY YOUNG: Thank you.

8 THE SENIOR CORONER: And just going back to that written statement, also the diagnosis of
9 photophobia.

10 LADY YOUNG: Yes. (After a pause) Gaia couldn't bear any light when she was at home. At
11 seven o'clock, I had to close blackout curtains. And, of course, she couldn't escape the
12 light but that's a different story.

13 THE SENIOR CORONER: We'll have that in that statement.

14 LADY YOUNG: Okay. Okay.

15 THE SENIOR CORONER: And finally, I think we could have, Ms Robertshaw -- Again, it
16 seems to me a straightforward matter for one of the neurosurgeons to give a short
17 statement saying why no neurosurgery was advised. That, it seems to me, will be a very
18 straightforward task to undertake. Again, it should be a consultant, but whichever
19 consultant is able to do that.

20 LADY YOUNG: And when was this question actually put towards a neurosurgeon? The
21 chronological --

22 THE SENIOR CORONER: The timing of that.

23 LADY YOUNG: Yes, timing is very important.

24 UNKNOWN SPEAKER: Madam, I wonder if I could just make one very small observation as
25 a friend. I happen to be a retired judge and a member of the Bar, so I'll keep it short,
26 but you've not mentioned here why -- I'm losing my thread here slightly. Yes, there
27 was a question as to why it was that the people who investigated the CT scan eventually
28 concluded that the lumbar puncture was not advised but, unfortunately, that message
29 came too late. Have we dealt with that? I may have lost track of it. Because that, too,
30 would be important evidence, it seems to me.

31

32 You may take a different view, but we know that the neurologist who revisited the CT
33 scan came to the conclusion that a lumbar puncture procedure should not be embarked

1 upon. Unfortunately, it was, but we don't know why they concluded that it should not
2 be embarked upon.

3 THE SENIOR CORONER: I don't think we have dealt with that. Thank you very much for
4 that intervention.

5 UNKNOWN SPEAKER: Thank you.

6 THE SENIOR CORONER: Ms Robertshaw, I don't mind whether that's dealt with by a
7 separate statement or it's included in one of the other statements or by one of the oral
8 witnesses, but the question of when and why the LP decision was changed.

9 UNKNOWN SPEAKER: Thank you, madam.

10 MS ROBERTSHAW: Yes, although experts' reports (inaudible) it may be that there are
11 questions which are actually fairly straightforward (inaudible) and it's just the
12 explanation you seek put forward (inaudible) that's addressed and (inaudible).

13 THE SENIOR CORONER: I think that deals with all the matters that I have for today. Is there
14 anything else with which I may assist?

15 LADY YOUNG: I'm still disappointed that you're not commissioning neurological expert
16 reviews because the SI report did not shed any light on the aetiology, so -- Because it is
17 obviously something so unusual that happened to Gaia. We know that. It's not a kind
18 of known illness, or easy to find or diagnose illness, and I think it's just important as
19 well for general medical practice to learn from Gaia's death.

20 THE SENIOR CORONER: Well, I haven't said that I won't. I've said that I won't at the
21 moment.

22 LADY YOUNG: Okay.

23 THE SENIOR CORONER: But I have to say that I would expect a hospital trust of the size of
24 University College London Hospitals to be able to pull together really the best
25 understanding that one could get on a matter like this from within their team. If UCLH
26 can't, then I'm not sure who can. They have very considerable expertise within the
27 trust, and of course I expect the Trust to assist me in this and to make such
28 investigations to attempt to find the answer as they reasonably can, given their
29 collective expertise. I'm getting a nod from Ms Robertshaw there.

30 LADY YOUNG: And how about calling someone from the National Hospital for
31 Neurosurgery and Neurology?

32 THE SENIOR CORONER: Same trust.

33 LADY YOUNG: Okay.

34 THE SENIOR CORONER: It's the same trust.

1 LADY YOUNG: Okay.

2 UNKNOWN SPEAKER 2: Can I just clarify something? Am I right in understanding that you
3 carry on, you have the inquest, but then thereafter -- And the reason, I completely
4 understand, is that it's easier to get the people who you want to give evidence nearer to
5 the date -- it's already a long time -- but then that after that, you have the discretion and
6 you could at that point ask for an independent urologist if you felt that was
7 proportionate?

8 THE SENIOR CORONER: If I felt I needed that, yes. So, what I shall do is we'll hear the
9 evidence -- I'll hear the evidence, and then once all the evidence is heard, I'll then give
10 my preliminary view of whether I need to adjourn or not, and I'll invite submissions on
11 that.

12 UNKNOWN SPEAKER 2: So the inquest, if it goes ahead as it seems it's going to, is not the
13 end of it? It's not --

14 THE SENIOR CORONER: Well, it may be the end of it, but it doesn't necessarily have to be.
15 So it may conclude on that date, but it doesn't necessarily have to, so I have the option
16 of -- either I can conclude on that day, or I may adjourn part-heard. Either is available
17 to me.

18 UNKNOWN SPEAKER 2: And at the moment, do you have any feeling about which way you
19 are likely to go?

20 THE SENIOR CORONER: I don't.

21 UNKNOWN SPEAKER 2: No, okay.

22 THE SENIOR CORONER: Anything else? Ms Robertshaw? No? Well, in which case, I shall
23 see you on the 14th at St Pancras. Thank you very much for your attendance today.

24

25 (Adjourned until Monday, 14 February 2022)

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