

**IN THE DORSET CORONER'S COURT**

**Before  
Dr SIMON FOX QC  
Assistant Coroner**

**INQUEST INTO THE DEATH OF  
RICHARD MARK WESTGATE**

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**DECISIONS FURTHER TO  
PRE-INQUEST REVIEW HEARING  
HELD ON THE 21<sup>ST</sup> OF JULY 2016**

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1. On arriving at the following decisions, I have considered written submissions available to me at the time of the Pre-Inquest Review, together with oral submissions heard during the course of the hearing on the 21<sup>st</sup> of July 2016. Subsequently, I have also been provided with and have read:
  - (a) Family summary of regulatory regime;
  - (b) Submissions of the Civil Aviation Authority on the issue of expert evidence dated the 10<sup>th</sup> of June 2015;
  - (c) Further submissions of the Civil Aviation Authority in relation to the issue of a jury dated the 28<sup>th</sup> of October 2015.
  
2. At the Hearing on the 21<sup>st</sup> of July 2016 I indicated that I would hear

submissions on Article 2, and on other issues on the basis that Article 2 was not engaged. This was because it would be necessary to hear much lengthier submissions on the other issues if I decided that Article 2 is engaged. I indicated that I would give my decision as to whether Article 2 was engaged within 7 days of the hearing; if I decided that Article 2 was not engaged, I would give further directions on other issues as part of that decision; if I decided that Article 2 was engaged, then I would relist the case for a further Pre-Inquest Review to hear further submissions on the outstanding issues.

3. I circulated an Agenda giving my provisional views, where appropriate, before the Hearing on the 21<sup>st</sup> of July 2016.
4. In light of all of the above, my decisions are as follows (adopting the numbering from the Agenda).

**(1) Properly Interested Persons**

5. If Article 2 is not engaged, then there were no further submissions in respect of this and these would remain as directed by Her Majesty's Senior Coroner on the 25<sup>th</sup> of March 2015 i.e.
  - (a) Mr. Westgate's family;
  - (b) British Airways;
  - (c) Civil Aviation Authority.

**(2) Article 2**

6. The issue in this respect is whether the Inquest should be one in which Article 2 is engaged and should therefore be a **Middleton** rather than a **Jamieson** type Inquest.
7. I have firstly asked myself whether there is, at this stage, sufficient evidence to determine the issue and I confirm that I am of the view that I can now make a decision on Article 2.
8. I understand there to be no dispute between the interested persons that the test is as set out in my Agenda and, in particular, those matters listed as to (a), (b) and (c) all need to be satisfied for me to conclude that this should be an Article 2 Inquest.
9. I also understand that there is no dispute between the interested persons that the test on each is that there has to be some credible evidence to support, or grounds to suspect, or it has to be arguable that each of these matters are satisfied. It is that test which I consider below.
10. The family confirmed during the course of the PIR Hearing that it is not argued that there has been a breach of the state's negative duty or the positive duty to put in place a proper judicial system. The family do argue for a breach of the general or systemic duty in failing to have in place a legislative framework which could also be described as a systemic breach.

In particular, the family argue that there is a lacuna not filled by British Airways in that there is no health surveillance required if there is no evidence of exposure.

11. The family assert that there have been failures:
  - (i) To legislate to enforce duties in aviation;
  - (ii) To properly distinguish between duties of HSE and the Civil Aviation Authority;
  - (iii) In that the Civil Aviation Authority is a light touch regulator;
  - (iv) They also rely on the fact of exposure to demonstrate breach.
  
12. British Airways asserts that a legislative framework as constructed needs to be failing as opposed to an individual case or that a framework's conclusion is disputed. They rely on the case of **Budayeva -v- Russia** in respect of a failure of the framework obligation where there is an imminent risk of death in a natural disaster and assert that this suggests that the state has a wide margin of appreciation. They also rely on the case of **Brincat -v- Malta** – a failure to legislate regarding a risk from asbestos of which the state was aware. Again they assert that there is a wide margin of appreciation but that there was a breach in that case because of the knowledge of risk, the period over which that knowledge was present and the seriousness of the risk.
  
13. The Civil Aviation Authority rely on the whole of the regulatory framework, the COSHH Regulations, the Civil Aviation (Working Time) Regulations

2004, the European Aviation Safety Agency Certifications Specifications for Large Aeroplanes CS25 and the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 1996.

14. They assert that there is no confusion between the roles of the HSE and the CAA and they point to the review of evidence by the Committee on Toxicity dated December 2013 and the ongoing investigators of the EASA.
15. On the failure to legislate to enforce duties in aviation, I note firstly that the state was under no legal obligation to apply the COSHH Regulations to aircraft in flight. Those Regulations do apply to aircraft on the ground and Parliament has specifically legislated not to apply them in flight in light of other International, European and National Regulation which does.
16. I also consider that the authorities indicate that the state has a wide margin of appreciation in this respect.
17. I further note that case of **R(FI) v Secretary of State for the Home Department** - *“the emphasis in respect of the framework is on reasonable safeguards, not on regulations of such detail as to minimise to the greatest extent possible any risk to life ..”*;
18. Furthermore there is extensive international, European and national legislation which does apply as set out in the CAA’s Summary and listed in

paragraph 27d) of the CAA's submission dated 18<sup>th</sup> August 2015.

19. For these reasons, I do not consider there to be credible evidence of a failure to legislate to enforce duties in aviation as asserted by the family.
20. In respect of the family's assertion of a failure to properly distinguish between the duties of the HSC and the CAA, I note that those duties are set out in the Family submission at paragraph C 2.3.
21. In addition, they are further highlighted in the CAA's submission dated the 14<sup>th</sup> of August 2015 at paragraph 31. The CAAs' duties are outlined at paragraphs 22, 23, 24 and 26 of the CAA's Summary document, those of the HSE at paragraph 30 and the Memorandum of Understanding explaining the overlap at paragraph 31.
22. In light of the above in my judgment the difference between the duties and roles of the two is adequately clear. I do not consider that there is credible evidence of a failure to properly distinguish between the duties of HSE and CAA such that it would amount to a breach of the legislative framework.
23. Thirdly, the family asserts that the CAA is a "light touch regulator". It seems to me that this is simply a description of how it intends to approach its role and does not in itself found a breach of Article 2. I find no support for this in the authorities. How it in fact carries out it's role is any event covered by the

documents already referred to above. In addition, I note from the family's written submission at Section C 3.3, that this is only in respect of general aviation which does not include commercial air transport. I also note that there are ongoing investigations on the part of the EASA, including an ongoing investigation into cabin air quality, a twenty month investigation due to end in October of this year.

24. For all of these reasons I do not consider there to be credible evidence of a breach in Article 2 because CAA describes itself as a "light touch regulator".
  
25. Finally, the family assert that if the regulatory system was free from breach in its design and adequately implemented in practice, exposure to organophosphate and such sequelae from such exposure as can be proven could not occur. The family rely on a passage from the case of **Middleton** that "*An arguable breach of those duties must be investigated. The investigation should ascertain ..... individual failings that a sound system is expected to detect and remedy before harm is done.*" The family assert that this means that the doctrine *res ipsa loquitur* applies.
  
26. I do not consider that it is sufficient for the family simply to demonstrate injury from exposure to organophosphate and for this to be sufficient to mean that an arguable breach of Article 2 has occurred in the absence of any other breach. This would not be consistent with the arguments in respect of the three previous aspects of breach dealt with above, in addition to the

principle of the wide margin of appreciation set out in the authorities. I find nothing in the authorities to support such a bold submission.

27. For all of the above reasons, I find that there is no credible evidence to support a breach of the obligations under Article 2 in respect of a legislative framework/systemic duty.
  
28. The family also assert that there has been a breach of the operational duty. They argue that the test in this regard is that set out in their submission at Section B 6.2.3(a) and is one in which the actions of the state “*may well*” or “*might*” engender a real risk to health relying on the case of both **Watts** and **LBC** (in 1998 and 2010 respectively). British Airways and the Civil Aviation Authority assert that the appropriate test is that set out in the more recent decision of the Supreme Court in **Rabone**. Accordingly, they assert that a real and immediate risk is required.
  
29. The Supreme Court in the case of **Rabone** reviewed the circumstances in which an operational duty could exist at paragraphs 15 to 20 of the Judgment. At paragraph 21, the Judgment then continues “*It is, therefore, necessary to attempt to discover the essential features of the cases where Strasbourg has so far recognised the existence of an operational duty. It is clear that the existence of a “real and immediate risk” to life is necessary but not sufficient condition for the existence of the duty.*”



30. At paragraph 22, the Court considered certain indicators pointing the way to an operational duty existing. These included where there has been an assumption of responsibility by the state including the exercise of control. The operational obligations therefore apply to all detainees, but are particularly stringent in relation to those who are especially vulnerable.
31. At paragraph 24, the Court stated that a further factor is the nature of the risk. The authorities stress the importance of vulnerability (also emphasised by the family).
32. In my judgment the nature of the risk, as it is presently known in respect of organophosphates, the degree of control and the vulnerability of the victim as relevant considerations in the present case, are all much less than when compared with the other cases in which a breach of the positive obligation has been found in the authorities, such that there is not credible evidence of such a breach on this basis alone.
33. Furthermore I consider that the appropriate test is that set out in **Rabone** – a ‘*“real and immediate risk” to life is necessary is a necessary ... condition*’. The evidence in Mr. Westgate’s case in my judgment does not establish the existence of a real and immediate risk to life which is a necessary condition for the existence of the duty (**Rabone**, paragraph 21).
34. Accordingly, in my judgment, there is no credible evidence of a failure in the

operational duty.

35. If there was credible evidence of a breach of Article 2, then it would be necessary to consider whether there was credible evidence that proper steps taken in this regard would have had a real prospect of avoiding any organophosphate exposure which occurred. It is the family's position that this is satisfied in this case. The Civil Aviation Authority and British Airways assert that it is not.
  
36. If I was satisfied that there was credible evidence of a breach of Article 2, I do not consider that there is credible evidence that proper steps taken to remedy this would have had a real prospect of avoiding any organophosphate exposure. The failures asserted by the family are set out in very broad terms and I can see no adequate evidence to demonstrate that, if they had been remedied in any specific manner, this would have led to particular steps which, in turn, had a real prospect of avoiding any organophosphate exposure.
  
37. Accordingly, even if I am wrong in respect of credible evidence of a breach of Article 2, I do not consider that it is established that any such breach, if remedied, would have had a real prospect of avoiding any organophosphate exposure.
  
38. Thirdly, if there was both credible evidence of a breach of Article 2 and also

that, if remedied, there was a real prospect of avoiding any organophosphate exposure, it would also be necessary for there to be credible evidence that organophosphates caused or contributed to Mr. Westgate's death in order for Article 2 to be engaged.

39. The family's position in this respect is that there is credible evidence that organophosphate exposure caused a disorder of the ganglion and nerve root aspect of the nervous system (with Professor Abou Donia previously asserting involvement of the brain and spinal cord). This resulted in symptoms of numbness in the hands and feet and that this, in turn, was an indirect cause of Mr. Westgate taking an overdose of Pentobarbital resulting in his death.
40. The position of British Airways and the Civil Aviation Authority is firstly that they challenge both the existence of exposure and any link to a disorder at the ganglion and nerve root. More importantly, they assert that any exposure and disorder of the ganglion and nerve root as may be proven is insufficiently direct to satisfy the test of causing or contributing to the death.
41. The test of causation in this regard is in the context of whether any breach of Article 2 has caused or contributed to the death.
42. In my judgment, it is not necessary for the condition caused by the breach of Article 2 to be contained within the medical cause of death for it to satisfy

the test of causation in this context. Clearly that is not the case on any account in Mr. Westgate's case.

43. However, in my judgment, the condition caused by the breach (here alleged to be a condition of the ganglion or nerve root), whilst not necessarily being contained within the medical cause of death at either 1 or 2, should be reasonably proximate to one or other of the conditions named within the medical cause of death to satisfy the test with which I am concerned.
44. The only candidates for the medical cause of death on the available evidence are overdose of Pentobarbital and possibly atheroma and myocarditis. There does not appear to be any evidence at all of any possible link between a disorder of the ganglion and nerve root and the atheroma or myocarditis. This only leaves a link with pentobarbital.
45. The highest the evidence can be put in respect of a link is that the disorder of the ganglion and nerve root resulted in numbness of the hands and feet which (in circumstances of which there is very little evidence) for some reason (at present unexplained) caused Mr. Westgate to take an accidental or intentional overdose of Pentobarbital.
46. Mr. Westgate's unprescribed and unsupervised use over a significant time (demonstrated by hair analysis) of a prescription only drug, pentobarbital, appears to have come as a complete surprise to all of those who knew him -

friends, family and doctors/therapists. There is no direct evidence as to why he was using it over this period.

47. In those circumstances, in my judgment, there is insufficient evidence to support any link between the disorder of the ganglion and nerve root and the Pentobarbital overdose over and above mere speculation and this is not sufficient to satisfy the test of causation which needs to be satisfied on the Article 2 issue.

48. For Article 2 to be engaged, there needs to be credible evidence that there has been a breach of the state's obligations under Article 2, in addition credible evidence that there would have been a real prospect of avoiding any organophosphate exposure if proper steps had been taken and furthermore, credible evidence that organophosphates caused or contributed to the death.

49. In light of the above, my decision is that none of these three tests are satisfied and that this should not be an Article 2 Inquest for the reasons given above.

50. This will have an impact on the remaining Directions.

51. My decision on Article 2 can and will be revisited if, in due course, that is appropriate.

### (3) Scope

52. I noted the following as my provisional view in the Agenda which I prepared before the Pre-Inquest Review Hearing on the 21<sup>st</sup> of July 2016 –

*“In light of the above my provisional view, subject to representations, is that the issues to be addressed will be –*

- a) Who the deceased was;*
- b) The medical cause of death;*
- c) How, when and where the deceased died;*
- d) If the deceased died from ingestion of pentobarbital, did the deceased do so intending to take his own life;*
- e) Alternatively did the deceased take an unintentional overdose of pentobarbital without intending to take his own life;*
- f) If the deceased died from myocarditis or atheroma, were these naturally occurring disease processes.*

*My provisional view subject to representations is that whether or not in life in the period of months or years before his death the deceased was suffering from an illness caused by exposure to organophosphates in the course of his employment as a commercial pilot is not a proper issue to be the subject of the Inquest.”*

53. In respect of scope, some of the arguments referred to above in respect of whether there is credible evidence that organophosphates caused or contributed to the death are again relevant.

54. In their written submission dated 19<sup>th</sup> of July 2016, the family highlight a further passage from the case of **Dallaglio**:

*“The Court did not however rule that the investigation into the means by which the*

*deceased came by his death should be limited to the last link in a chain of causation. That would not be consistent with the conclusion 14 ..... and it would defeat the purpose of holding an Inquest at all if the inquiry were to be circumscribed in [this manner]. It is for the Coroner conducting an Inquest to decide on the facts of a given case at what point the chain of causation becomes too remote to form a proper part of his investigation."*

55. British Airways agree with my provisional view in their submission dated the 20<sup>th</sup> of July 2016, referring to a number of cases which support the contention that how wide the inquiry is, is ultimately a matter for the Coroner and will rarely be the subject of a successful Judicial Review and argue that a factor need not be the proximate or the sole cause of death but it must have played an active and direct role in death.
56. The Civil Aviation Authority agrees with my provisional view.
57. The relevant law is set out above and in addition in the interested persons' legal submissions and my provisional view expressed in my Agenda. None of the interested persons had any further oral submissions in respect of scope, if I found that the Inquest was not one in which Article 2 was engaged (as I have now found). I have a wide discretion as to the scope of my inquiry.
58. I have considered the expert evidence which is presently available from those

experts already instructed by the Coroner. I have also considered other scientific evidence contained within the papers provided by the family's current and previous solicitors, including a report from Professor Abou-Donia and a Paper published by Abou-Donia et al on the subject of Mr. Westgate.

59. The expert evidence has been the subject of significant written and oral submission by the interested persons. Those submissions have, at times, contained significant criticism of various experts by the respective interested persons. It is not my role at this stage to make any assessment of the credibility of the respective experts but simply to ascertain what the evidence demonstrates.
60. The evidence at this stage suggests that Mr. Westgate died from an overdose of Pentobarbital but that myocarditis and atheroma may also be relevant.
61. There is also some evidence to suggest that he was suffering from a neuropathy and some evidence in turn that this is consistent with exposure to organophosphates but I should note that this evidence is countered by other evidence suggesting this not to be the case.
62. There is no evidence as to why Mr. Westgate was using unprescribed pentobarbital, let alone evidence to support that he was using it because of symptoms related to a neuropathy. This can only be speculation at present.



63. Even if there was evidence to demonstrate that he was taking pentobarbital because of symptoms related to a neuropathy, I do not consider that it would be appropriate to include in the scope of my inquiry whether that condition should properly in life have been labelled as “aerotoxicity” or otherwise as a neuropathy caused by occupational exposure to organophosphates. The correctness of a diagnosis made in life may be a matter for the family to investigate and challenge in the Civil Courts; however, a Coroner’s Inquest is, in my view, not a proper forum for that investigation when there is only such a possible or speculative indirect and remote link at most between the condition and the cause of the deceased’s death.
64. Accordingly, my decision is that the scope of the Inquest is as set out in my provisional view within the Agenda for the Pre-Inquest Review.

#### **(4) Jury**

65. In oral submissions, all of the interested persons agreed that I was not required to sit with a jury, nor should I sit with a jury, in an exercise of my discretion, if I decided that Article 2 was not engaged in the Inquest. In the light of this, I confirm my provisional view as expressed in the Agenda and I will not sit with a jury.

## **(5) Witness List**

66. The lay and expert witnesses which I intended to call are set out in my provisional view within the Agenda for the Pre-Inquest Review. The only further submission that was made at the Pre-Inquest Review was that British Airways requested that Ronald Rijnbeek gives evidence by video as opposed to under Rule 23. I am happy to direct that Mr. Rijnbeek give evidence by video.
67. I note that the family are not, at this stage, requesting for Professor Abou-Donia to give evidence.
68. The witness list therefore remains as recorded as my provisional view in the Agenda save for Ronald Rijnbeek being called to give evidence by video as opposed to his statement being read.

## **(6) Disclosure**

69. If the Inquest is not an Article 2 Inquest, the family had no submissions in respect of disclosure. British Airways submitted that Mr. Rijnbeek's report to the Chief Prosecutor would be relevant. I agree and I will ask Mr. Rijnbeek to provide this document.
70. The Civil Aviation Authority requested that the following records, which are already available, are provided to Dr. Marrs, Professor Dolan and Dr. Clarke. I will ask my office to forward those records to those experts such

that they have seen them by the time of the Inquest. I will not ask them at this stage to prepare a further report in the light of those records. The records are:

- (a) The Priory Hospital Bristol.
- (b) The Priory Hospital Roehampton.
- (c) Chelsea and Westminster Hospital.
- (d) The Portland Hospital.
- (e) The Edinburgh Sleep Clinic.

71. I shall also ask my office to write to Dr. Steve Parish at The Hove Clinic requesting an explanation regarding the whereabouts of records the clinic holds in the name of Richard Westgate or West, bearing in mind that Dr. Parish was copied into letters from Dr. Peter Harvey, Dr. Angus Kennedy, Dr. Richard Bowskill and Dr. Macquire-Samson.

72. I shall also ask my office to write to the following requesting copy medical records in the name of Richard Westgate or West in light of those matters submitted at paragraph 16 of the Civil Aviation Authority's written submission dated the 20<sup>th</sup> of July 2016:

- (a) Dr. Mulder in the Netherlands;
- (b) The Neurotherapy Centrum, Hilversum;
- (c) Dr. Hageman, Neurology Department, Medich Spectrum, Twente Hospital;
- (d) Dr. R.A. van der Kuil, Chiropractie BV, Van Panhuysstraat 45, 2203 JP

Noordwijk, the Netherlands;

(e) Dr. L.G. Salimans, Hoofdstraat 52, 7213 CZ Gorssel, the Netherlands.

73. I will also ask my office to request that Dr. Mulder provide a copy of the medical dossier presented by Mr. Westgate on arrival at his clinic.

74. I will also ask my office to request that both Dr. Mulder and also Mr. Rijnbeek are asked to provide a list of the medications which were found in Mr. Westgate's hotel room and of which a photograph was taken.

75. Finally, the Civil Aviation Authority requests that I obtain all correspondence between BALPA with Mr. Westgate and those treating him in Holland. Bearing in mind the fact that this is not an Article 2 Inquest and the scope which I have indicated above, in my judgment this correspondence is not relevant to the matters which the Inquest will cover and therefore I will not be requesting this correspondence.

#### **(7) Hearing Bundle**

76. There were no submissions in this respect and therefore I direct as per my provisional view that this should contain the witness statements and reports of those listed in Section 4 above. Each expert witness will be provided with a copy of that Bundle for review before the Inquest.

**(8) Hearing Length, Venue and Video Link/Other Arrangements**

77. There were no further submissions and therefore I confirm my provisional view that:

The Hearing will be listed for seven days;

The venue will be confirmed but it is likely to take place in Bournemouth;

We will seek to arrange a video link for oral witnesses based in the Netherlands and a Dutch translator will be arranged.

**(9) Other Matters**

78. No further submissions were made and I make no further directions.

79. I am grateful to all three Counsel and their legal teams for their submissions in this case.

**DR. SIMON FOX, Q.C.**  
**27<sup>th</sup> July 2016**