PARK SQUARE BARRISTERS

Simon Connolly

Call: 2019 (Solicitor 2003)

Inquests and Inquiries

Ranked in The Legal 500 (2022) for Inquests and Inquiries

"He's a very good operator and an effective advocate." "He is a very personable barrister and clients really like him." Chambers & Partners 2022

"*Simon is a fantastic inquests lawyer. In addition to having an encyclopedic knowledge of coronial law, he has impressive medical knowledge. He is always well-prepared."* Legal 500 (2022)

"on a solid foundation of representing clients throughout his distinguished career as a solicitor Mr Connolly has moved seamlessly to the bar to deliver the same high quality of work. His knowledge in healthcare ensures a wealth of instructions. He has a confident yet amenable approach in court. A very capable advocate indeed" Legal 500 2021

Simon is a specialist and expert inquest practitioner, with inquests constituting his principal area of practice. His expertise is such that Simon was appointed to the Attorney General's Panel of Regional Civil Counsel (C List) after only six months in practice at the Bar as a transferred solicitor, following an open process which the Attorney General described as "*fiercely competitive*".

In consequence of Simon's healthcare regulatory law background, his inquest practice heralds a strong healthcare aspect. He is regularly instructed to represent corporate healthcare providers and their employees in addition to individual practitioners across all healthcare disciplines on the instruction of MDO's, insurers and employers. Simon's general sector and specific clinical knowledge are impressively well developed.

Simon spends much of his time appearing before Coroners sitting with a jury in multiweek death in custody cases which engage Article 2 ECHR, in which he will regularly represent the prison

Education:

1999 - LLB (Hons) 2:1, University of Hull

2000 - College of Law (Chester)

Career:

2000-2003 - Forbes Solicitors (Lancashire)

2003-2007 - Henry Hyams Solicitors (Leeds)

2007-2011 - The Medical Protection Society (Leeds)

2011-2019 - BLM LLP (Manchester/ Leeds)

2018 - Higher Rights of Audience (Criminal)

healthcare provider and appear with and against experienced counsel, including members of the Attorney General's A and B lists (representing the Ministry of Justice).

Simon's experience of such cases means that he has comprehensive understanding of prison processes (both discipline and healthcare), including transfers, reception screening, first night, location, movement, ACCT management, general discipline and healthcare provision. He also very much understands the unique complexities of life and work within the secure estate and the daily pressures faced by those detained and who work within it.

Simon's more traditional inquest practice has seen him represent surgeons, anaesthetists, physicians, psychiatrists, GP's, nurses and pharmacists in addition to primary urgent care out of hours providers, care homes (staff and providers) and other private health and social care service providers. Since his transfer to the Bar, Simon has expanded his inquest practice to include the representation of police forces and Local Authorities.

Simon has an uncomplicated approach to his advocacy which finds favour with his tribunal and also those he is instructed to represent.

Notable Cases:

Article 2 Inquests:

Inquest touching the death of DA (Doncaster):*13 day inquest with Simon representing the healthcare provider. Simon successfully applied to admit the detail of DA's serious previous conviction on grounds of its relevance to his anxieties and his death and to obtain expert evidence to demonstrate that DA was likely already brain dead at the time of his discovery.*

Simon represented the healthcare provider in a 13 day inquest concerning the death of DA whose mental health deteriorated following his transfer into a new prison. Simon successfully persuaded the Coroner to admit evidence of the Deceased's serious previous conviction as probative of his anxieties and his deteriorating mental state. Relying on his own medical knowledge, Simon also persuaded the Coroner to obtain supportive expert medical evidence as to causation and that DA was already brain dead at the time of the assessment of the emergency response nurses in view of the efforts of attending paramedics subsequently to restore circulatory functioning. Conclusion: Narrative.

Inquest touching the death of CS (Kent):*8 day remote inquest for the MoJ concerning the death of a sixteen year old male in a YOI who complained of suffering with a headache in the gym. Communication issues contrived in CS not being seen by healthcare. His subsequent deterioration was attributed to an undiagnosed and congenital cerebral venous malformation.*

Simon represented the Ministry of Justice in an 8 day inquest concerning the death of CS who had been remanded to a HMYOI in respect of serious charges. CS complained of a headache whilst using the gym and was returned to his cell for monitoring. The inquest scrutinised his overall management and communication issues between prison and healthcare staff which contrived in him not being assessed by healthcare. CS was subsequently discovered unresponsive in his cell and was transferred out for emergency medical treatment where a catastrophic cerebral bleed attributed to an undiagnosed and congenital cerebral venous malformation (AVM) was identified. Conclusion: Narrative.

Inquest touching the death of JD (Wakefield):*4 day inquest for the healthcare provider regarding JD who died on her first night in custody further to a recall and when she was suffering with*

severe drug and alcohol withdrawal symptoms. Hypothesise for her death included drug withdrawal, opiate and/ or cocaine misuse or cardiac abnormality with the examination of relevant expert witnesses involved.

Simon represented the healthcare provider in a 4 day inquest concerning of JD who had been recalled to prison shortly after her release and who presented with symptoms of severe drug and alcohol withdrawal. Despite overnight monitoring by healthcare staff, JD was discovered deceased the day after her entry into the prison. Post-mortem investigations failed to identify a cause for her death. The inquest considered hypothesise for JD's death which included substance misuse and cardiac in its origin with Simon exploring the temporal association between opiate ingestion and cardio-respiratory depression and the longer-term association between of cocaine abuse and serious cardiac arrythmia with various expert witnesses. Conclusion: Narrative.

Inquest touching the death of LM (Durham):*4 day inquest for the MoJ regarding LM who was remanded for murder and who was unable to contact his family due to issues with his prison PIN. LM took his own life shortly after being told that he was not on the list for an anticipated visit.*

Simon represented the Ministry of Justice in a 4 day inquest concerning the death of LM who had been remanded into custody in respect of the most serious charges involving his former partner. Whilst LM was assessed to be at low-risk of suicide on entry into the prison, he complained of a malfunctioning PIN to enable external communication and an absence of personal visits. Simon persuaded the Coroner to admit correspondence sent by LM to family members inviting them to visit him and demonstrated that he took his own life shortly after being told that his name was not included on the visits list on the death of his death. Conclusion: Suicide.

Inquest touching the death of PS (Stourport):*5 day inquest for the healthcare provider regarding PS who had been extradited from France. Delays in the uploading of prescription information and a lack of community information resulted in the withdrawal of PS's pain management medications. The Coroner accepted Simon's Galbraith Plus submission that it would be unsafe to leave causation due to PS's prolonged stability without his medications.*

Simon represented the healthcare provider in a 5 day inquest concerning the death of PS who had been extradited from France. ON entry into the prison, PS provided prison healthcare with the details of his French GP and also a prescription print-out which had not been scanned into his medical record by the time of medication reconciliation the following day. Consequently, healthcare did not attempt to confirm the accuracy of that information and his prescriptions were stopped for reasons of safety given the absence of correlating information for their clinical indication. Whilst PS's cell-mate stated that PS had successfully managed the physical effects of the withdrawal of his medication, PS went on to unexpectedly take his own life some weeks later. The Coroner accepted Simon's *Galbraith Plus* submission that it would be unsafe to leave the issue of causation to the jury given PS's apparent stability over a reasonably protracted period of time. Conclusion: Narrative.

Inquest touching the death of DM (Isle of Wight):*12 day inquest regarding DM who took his life some months after deciding to disengage from the prison regime in consequence of a refused Parole Board decision. The inquest scrutinised his access to prescribed and non-prescribed medications and whether an ACCT should have been opened.*

Simon represented the healthcare provider in a 12 day inquest concerning the death of DM who took his own life several weeks after intentionally disengaging with the prison regime following a

refused Parole Board decision. DM ingested excessive amounts of Amitriptyline, Codeine and Paracetamol, only one of which was prescribed to him. The inquest explored issues of post-mortem redistribution of toxicology samples in addition to the adequacy of DM's medication and mental health management during his time in custody and whether an ACCT should have been opened when DM decided to disengage with the regime. Conclusion: Narrative.

Inquest touching the death of GS (Stafford):*5 day inquest for the healthcare provider in relation to GS who had initially complained of ear-ache but who had failed to attend follow-up appointments and died due to a cerebral abscess. The Coroner accepted Simon's submissions that Article 2 was not engaged in operational or systemic aspects at the conclusion of the evidence.*

Simon represented the healthcare provider in a 5 day inquest concerning the death of GS who had been assessed by a nurse in relation to a complaint of an ear infection two weeks before his death but who sadly failed to attend follow-up appointments for further investigation. GS did not request healthcare assistance thereafter. GS's cell-mate raised the alarm as to his deterioration on the day of his collapse when he was immediately taken to hospital and where a fatal cerebral abscess was diagnosed. GS sadly died a short time following his admission. The Coroner accepted Simon's submissions that Article 2 was not engaged in its operational or systemic aspects at the conclusion of the evidence. Conclusion: Narrative.

Inquest touching the death of RP (Doncaster):*5 day inquest for the healthcare provider regarding RP who was on long-term opiate substitution and alcohol withdrawal therapy. Forensic toxicology evidence suggested that RP had taken double his prescribed dose of methadone which the jury concluded he could only have sourced illicitly.*

Simon represented the healthcare provider in a 5 day inquest concerning the unexpected death of RP who had been on long-term opiate substitution and alcohol withdrawal therapy. The inquest scrutinised RP's management by the clinical substance misuse team and communication between the prison and healthcare. Supplementary forensic toxicology evidence demonstrated that RP had taken double his prescribed dose of methadone on the evening of his death which the jury concluded he could only have sourced illicitly. Conclusion: Narrative.

Medical Inquests: *Shall we replace the existing list with these or add to it? Can we call this section medical inquests instead of traditional inquests?*

Inquest touching the death of AT (Wakefield):*3 day inquest for an NHS Trust regarding AT who presented to ED with symptoms of meningitis and who, sadly, fell from his trolley following his transfer resulting in a traumatic brain injury which exacerbated the impact of the cerebral infection. The case attracted significant media attention.*

Simon represented an NHS Trust in an inquest heard over 3 days concerning the death of AT from meningitis. AT had been unwell for several days and had been assessed by an ANP in the community who had ruled out red-flag symptoms before he presented to the ED. Whilst AT was initially appropriately investigated, diagnosed and treated for meningitis, communication difficulties between hospital sites at the time of his transfer resulted in a short period when he was unsupervised and when he suffered a fall resulting in a traumatic brain injury which exacerbated his existing condition and hastened his sad death. Conclusion: Narrative.

Inquest touching the death of KT (Sheffield):*2 day inquest for a tele-radiology organisation in relation to KT who died shortly after receiving the Astra Zeneca COVID-19 vaccination although*

at a time when the associated clinical syndrome (VITT) was unknown to medical science. The case attracted significant media attention.

Simon represented a tele-radiology organisation and its employed radiologist in proceedings concerning KT, who is believed to be the youngest person to die from Vaccine-Induced Immune Thrombocytopaenia and Thrombosis (VITT) after receiving the Astra-Zeneca COVID-19 vaccine. Whilst KT died some weeks before VITT was first identified as a clinical syndrome, subtle signs of hyperdensity possibly consistent with a developing Cerebral Venous Sinus Thrombosis (CVST) were missed radiologically. The inquest scrutinised the role of the error in KT's subsequent management whilst expert haematological evidence confirmed that the treatment KT received, whilst clinically appropriate in the absence of knowledge of VITT as a clinical syndrome, sadly exacerbated her condition. Conclusion: Narrative.

Inquest touching the death of DK (St Pancras):*2 day inquest for a tele-radiology organisation in relation to DK who presented to the ED at the height of the pandemic with symptoms consistent with sepsis of unknown aetiology. Whilst DK responded well to antibiotic therapy, she contracted COVID in hospital and sadly died.*

Simon represented a tele-radiology organisation in inquest proceedings concerning the death of DK who presented to the ED at the height of the COVID-19 pandemic with an abnormal swelling to her jaw and systemic physical complaints which were possibly consistent with a developing sepsis. Radiological investigations by the treating Trust were delayed due to concerns about the use of contrast in DK's proposed scanning and uncertainties about the functioning of her kidneys. A non-contrast scan was later forwarded for external review via use of an MSK template which contrived in a failure to identify the presence of an abscess. Despite DK's improvement in response to antibiotics, she went on to contract COVID-19 and deteriorated rapidly given her reduced physiological reserves as a consequence of the infection. Conclusion: Narrative.

Inquest touching the death of FT (Chesterfield):*5 day inquest regarding FT, a vulnerable adult who was discovered to have taken a non-prescribed and potent anti-psychotic medication which caused her death. The Coroner was critical of the actions of the prescribing nurse although not her then-employer (Simon's client) in relation to governance issues.*

Simon represented the former owners of a care home in relation to the death of FT in 2012. The inquest was heard in 2022. FT was a vulnerable young woman who was otherwise physically well and who died unexpectedly some hours after the evening medication round. Subsequent investigation by the Coroner and the police identified the presence of excessive amounts of a non-prescribed anti-psychotic medication. The inquest scrutinised the actions of the prescribing nurse and the care home in respect of governance issues relating to her employment and supervision. Conclusion: Narrative (neglect in respect of the actions of the nurse).

Inquest touching the death of KS (Doncaster):*Simon represented a care home and its staff members in relation to the death of KS from pneumonia in circumstances where he did not receive a prescribed course of antibiotics. KS's co-morbidities suggested that he was unlikely to have survived had he received the medication.*

Simon represented a care home and various members of its nursing staff in this inquest which concerned the death of an elderly and vulnerable resident from pneumonia. Whilst KS had been prescribed antibiotics by a GP, internal communication issues within the home contrived in their not being collected or administered to him. Simon's questioning of the pathologist demonstrated that KS's co-morbidities were such that it could not safely be said that he probably would have survived had he received the antibiotics. A PFD report was avoided. Conclusion: Narrative.

Inquest touching the death of AG (Bolton):*Simon represented a GP in connection with the death of AG who was separated from her usual sources of medical and social support due to lockdown and who began to self-medicate to manage her chronic pain. Simon's GP client's management was not criticised.*

Simon represented a GP who had been responsible for the management of a patient with a chronic pain diagnosis and who found herself separated from her usual sources of medical and personal support as a consequence of lockdown. Following her unexpected death, post-mortem toxicological investigations identified the presence of excessive levels of opiate-based medications in her system which the Coroner attributed to her self-medicating. Simon's GP client's management was not criticised. Conclusion: Misadventure.

Traditional Inquests:

Inquest touching the death of ES (Bolton) Simon represented a GP who prescribed Oromorph to a patient with a differential cancer diagnosis. The patient succumbed to a respiratory arrest days later. Simon challenged the pathology and toxicology evidence to establish a cause of death of (1a) pneumonia and (1b) COPD and not opiate toxicity.

Inquest touching the death of JM (Liverpool) Simon represented a Consultant Anaesthetist following the death of a severely disabled young boy who suffered a serious extravasation injury during surgery and arrested post-operatively. Whilst the death was explained by a rare and previously undiagnosed congenital heart condition. Simon's client faced an assertion of "situational blindness" by his response to the arrest, which was successfully refuted. Conclusion: Narrative (natural causes).

Inquest touching the death of Baby SD (Rochdale) Simon represented a Consultant Obstetrician following the death of a neonate from sepsis within the context of post-natal hyperbilirubinemia which developed following a missed ante-natal Anti-D injection. The case involved complex neonatology and paediatric pathology evidence as to causation and preparation for exchange transfusion. Conclusion: Neglect.

Inquest touching the death of MC (Preston) Simon represented a Consultant Radiologist based in Northern Ireland who remotely reported on out of hours films for English Trusts in a case involving an orbital abscess related death in which subsequent local scanning was delayed although, as was established, not as a result of the actions of Simon's client. Conclusion: Neglect.

Inquest touching the death of MS (Northumberland) Simon represented an Out of Hours provider who employed a German locum GP who diagnosed a potentially fatal cardiac arrhythmia in a student who became lost to follow-up. Conclusion: Natural Causes.

Inquest touching the death of IJF (Manchester) Simon represented a Birmingham based GP who prescribed an anti-depressant to an adolescent who later went on to take her own life whilst at university in Manchester. Conclusion: Suicide.

Inquest touching the death of HB (Nottingham) Simon represented a national pharmacy chain in inquest proceedings concerning the death of an elderly gentleman from sepsis and in which a prescription for antibiotics was not dispensed. Conclusion: Natural Causes.

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Healthcare Regulatory

Ranked as a “Rising Star” Inquests and Inquiries inThe Legal 500 (2021)

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Simon has practised as a healthcare and professional regulatory lawyer for over a decade, during which time he has represented doctors, nurses, pharmacists and osteopaths in criminal investigations and proceedings and in fitness to practise proceedings before professional (GMC-MPTS/ GDC/ GPhC/ GOsC) and local (NHSE) regulatory bodies and in employment disciplinary investigations and proceedings (MHPS).

Much of Simon’s regulatory work has stemmed from his involvement in prior proceedings where, for example, he has represented the professional at an inquest or during a police investigation or criminal prosecution. Simon has regularly been instructed in regulatory cases with a quasi-criminal dimension involving allegations of sexual misconduct which would equally constitute a criminal offence.

Simon relies upon his extensive experience to analyse and understand how and why allegations against healthcare professionals arise and to devise the most appropriate strategy to defeat or diffuse them. His clinical knowledge and uncomplicated approach does much to gain the confidence of his clients generally and, when necessary, to accept and follow seemingly counter-intuitive advice to adopt a favourable, longer-term case strategy.

Notable Cases:

Dr A: Simon represented an FY2 doctor who was criminally prosecuted for allegedly sexually assaulting two elderly female complainants during consultations which took place in his final (although his first non-hospital-based) rotation. The jury acquitted the defendant within an hour of deliberating. Simon also represented the doctor throughout concurrent GMC proceedings which included appearances before the IOT. Simon was successful in persuading the GMC’s Case Examiners to conclude the case with no further action at Rule 7 stage.

Dr L: Simon represented a Consultant Gastroenterologist who faced an allegation of sexual assault which allegedly occurred during a colonoscopy procedure when the complainant was sedated, with the procedure having been observed by three attending nurses. Simon represented the doctor at his police interview and then successfully persuaded the GMC to

withdraw its IOT referral on the basis of the overwhelming evidence that nothing untoward had occurred. The police and GMC investigations were concluded in the doctor's favour shortly thereafter.

Dr H: Simon represented a Consultant Psychiatrist in a police investigation concerning the death of a patient who had been diagnosed with EUPD and who took her own life hours after her release from a mental health unit having indicated her alleged intention to do so at the time of discharge.

Dr DP: Simon represented an SpR Intensivist during a police investigation relating to an offence of gross negligence manslaughter following an incident of medical misadventure which caused a fatal cardiac arrest. Simon acted in the subsequent inquest proceedings in which his client was criticised by the Coroner and in the consequent GMC investigation which concluded with the doctor's acceptance of a warning.

Dr B: Simon represented a GP in proceedings before the MPT concerning an alleged sexual assault of a female patient which was said to have occurred during a routine chest examination. The complainant's account was sufficiently discredited that the MPT acceded to a submission of "no case to answer" during Stage One.

Dr O: Simon represented the brother of a (then) highly prominent member of the government in proceedings before the MPT which concluded with his suspension.

Mr P: Simon represented a pharmacist who was investigated by the police in relation to an offence of gross negligence manslaughter following a prescription error. The pharmacist was not prosecuted.

Dr A: Simon represented a dual-qualified rheumatologist and osteopath who was investigated by the police, his employing Trusts, the GMC and the GOsC in relation to a complaint of sexual assault which, Simon argued, was explained by the complainant's unfamiliarity with Simon's client and his enhanced qualifications and experience and by a breakdown in communication during the relevant consultation. Simon's client was not prosecuted by the police. He accepted a warning from the GMC and a low level sanction at the GOsC.

Dr S: Simon represented a consultant histopathologist who faced proceedings before the MPT following criticism from a Coroner of a post-mortem examination which required further investigation involving the exhumation of the deceased. Many of the allegations against Simon's client were successfully refuted at Stage One. Those which were admitted or proven were found not to impair the doctor's fitness to practise.

Advisory

Dr DB v GMC (2016) EWHC 2331 (QB): Simon acted for Dr DB in the High Court and in the subsequent Court of Appeal proceedings in challenging a decision of the GMC to release an expert report commissioned during a fitness to practise investigation to a complainant who intended to use that report to further a clinical negligence claim.

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Clinical Negligence and Human Rights Act claims

Ranked as a “Rising star” for Inquests and Inquiries inThe Legal 500 (2021)

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Since his transfer to the Bar and in view of his extensive clinical knowledge of medicine and dentistry, Simon has begun to develop a clinical negligence practice to complement his inquest and healthcare regulatory practice.

Already, Simon has been involved in cases of fatal and non-fatal injury concerning GPs, surgeons and GDPs involved in general practice, general medicine, general surgery, plastic surgery, general dentistry and orthodontics.

Likewise and so as to complement his Article 2 inquest practice, Simon has begun to develop a Human Rights Act claims practice with a focus upon the custodial and healthcare aspects of rights conferred by Articles 2, 3 and 8 ECHR.

Simon’s developing experience in these areas means that he is able to strategise his inquest work to mitigate the prospect of a subsequent claim and to rely upon his experience of having acted in the inquest when called upon to defend a claim against those he has represented.

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