12
King's Bench Walk

Edward Ramsay

Call: 2012
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AREAS OF EXPERTISE

Inquests, Personal Injury, Clinical Negligence, Credit Hire, Fraud, Product Liability, International & Travel, Insurance, Industrial Disease

Edward is ranked as a Leading Junior for Inquests and Inquiries in the Legal 500. He has been described as having "*a natural instinct of which lines of inquiry to pursue with witnesses*" (2020) and in the 2021 edition was noted to be "*very proactive and gives clear and concise advise. Easy to approach and communicate with. Very good on his feet and with witnesses*".

Edward accepts instructions across all practice areas in Chambers. He specialises in healthcare and inquest law and is frequently instructed in lengthy and complex hospital inquests, including enhanced Article 2 inquests and jury inquests.

Inquests

Edward was ranked as Leading Junior for Inquests and Inquiries in the Legal 500 UK Bar 2020 edition. In May 2018 his cross examination of a DVSA witness in the Gurung case was reported on the front page of *The Times.* The inquest received extensive media coverage and led to the recall of over 300,000 vehicles in the UK and a separate Parliamentary Select Committee Inquiry.

Edward represents interested parties at all types of inquest (including Article 2 and Jury), but with particular expertise in hospital inquest cases, principally in the areas of mental health, emergency care, and other serious untoward incidents, but also including primary care, cancer misdiagnosis, failed organ transplantation, obstetric and neo-natal care, and paediatrics.

Edward is also instructed to represent care homes, local authorities, RTA insurers, and fire and rescue services. He has particular experience of cases involving fire safety.

In most of Edward's inquest cases he is instructed to then bring or defend a potential civil action.

Many of Edward's cases have been reported in local and national media and he appears regularly as sole counsel (often against senior juniors and QCs).

He frequently provides advice on issues of evidence and procedure, and has extensive experience in the drafting of written submissions (both at pre-inquest review and final hearings).

He has delivered seminars on the legislative changes to the coronial system following implementation of the CJA 2009. He has detailed knowledge and experience of post-inquest remedies including JR and Section 13 applications.

Recent instructions include/inquests into:

- the Dev Naran inquest (Coroner questions safety of smart motorways after 8 year old killed).
- the Gurung BMW Inquest (Ed Ramsay represents family of Narayan Gurung in widely reported BMW safety recall inquest)
- the Amy Allan GOSH Inquest (Amy Allan death: Significant failings in care by Great Ormond Street Hospital)
- the death of a 19-year-old from drowning in the River Tawe (Article 2 jury inquest)
- the death of an elderly patient following emergency admission to A&E (issues concerning complex histopathology, police investigation; judicial review) – being led by Michael Rawlinson Q.C.;
- the death of a neonate from hypoxic birth injuries following prolonged labour and inadequate resuscitation;
- the death of a 29-year-old man in ITU following allegations of drug-overdose (issues relating to medical cause of death, adequacy of original investigation and inquest, application under Section 13 Coroners Act 1988);
- the death of a 53-year-old woman in hospital from GI bleeding whilst awaiting transfer to another hospital site for emergency interventional radiology (2 week Article 2 inquest);
- the death of a 13-month baby from meningococcal septicaemia following inadequate discharge from A&E;
  – Evening Standard article: '*Doctors must be more aware of meningitis so another baby does not die*'
  – Daily Mail article: '*Doctor sent 13-month-old girl home without fully examining her five hours before she died of meningitis'*
- the death of a 47-year-old patient following elective hemi-colectomy as a result of a possible morphine overdose;
- the death of a 44-year-old male in ITU from alleged over-dose of antihypertensive medication (issues of systemic failure concerning fluid overfill in ITU and delayed treatment for sepsis);
- the death of a patient following hospital discharge after complications arising from TAH procedure (issues concerning processes for discharge and readmission; 3-day inquest).
- the death of a patient detained under s.3 of the MHA 1983 following emergency admission from psychiatric hospital (8 day Article 2 jury inquest)
  – Northampton Chronicle & Echo article: *'Inquest into the death of Northampton patient whose fractured spine went undiagnosed finds care failings'*
- the death of a ITU dependent patient in hospital following a failed attempt to perform a tracheostomy;
- the death of a patient in hospital following pancreaticoduodenectomy or 'Whipple procedure' (issues include consent and appropriate post-operative care);
- the death of an elderly patient in hospital following an upper GI bleed (issues of systemic neglect/failure concerning the over-administration of an NSAID without gastric protection);
  – 12KBW press release: *'Edward Ramsay helps secure rider of neglect for bereaved family in hospital inquest'*
- the death of an elderly patient in hospital following an erroneous wrong site aspiration to the chest (issues of systemic failure and Article 2).
  – 12KBW press release: *'Edward Ramsay represents family in hospital 'Article 2' inquest'*
- the death of an epileptic patient in a care home (cause of death SUDEP but complex issues arising from toxicology analysis);
- the death of an elderly patient in a care home following fall and complex hospital discharge (intracranial bleeding, fracture and infection, issues of neglect, involvement of Health and Safety Executive and Chief Coroner as regards to the statutory obligation to sit with a jury)
  – Coventry Telegraph article: *'Dementia sufferer's death fall blamed on University Hospital neglect'*
- the death of a 25-year-old mother of three from pulmonary embolism following admission to Accident and Emergency (issues regarding delayed diagnosis and treatment, Article 2 and need for jury; 4 PiPs)
  – 12KBW press release: *'Edward Ramsay represents the family of Sian Hollands at Article 2 inquest into her death'*
- the deaths of three residents at an East Sussex hospice following a large fire (instructed by East Sussex Fire and Rescue Service (issues concerning criminal prosecution, suspension of inquest, Article 2 and obligation to sit with jury)(St Leonards hospice patients unlawfully killed in fire, inquest finds);
- the death of a mental health patient (non-MHA) following a fire in the residential care home (issues concerning criminal prosecution, Rule 22 and adjournment of inquest)(Chris Dunning: Secure unit patient's drug death

'accidental');
- the fire-related death of a resident in sheltered accommodation

Qualifications & Awards

Bar Professional Training Course, (Outstanding).

Graduate Diploma in Law, (Distinction).

MA (Oxon) (History & Politics; First Class; 1st place in year).

Major Scholar, Inner Temple (2012)

Scholar, St. Catherine's College, Oxford (2007-2009)

Cases

Jones v HM Coroner for Mid Kent and Medway [2020] EWHC 3733 (Admin) – successful application under s.13 of the Coroners Act 1988 to quash inquisition on grounds of insufficiency of inquiry and new expert evidence as to the medical cause of death.

***Greenway & Ors v Johnson Matthey Plc* [2016] EWCA Civ 408.** Whether platinum sensitisation is an actionable injury and/or capable of giving rise to more than nominal damages in contract and/or an exception to the rule against recovery for pure economic loss in tort.

***McBride v UK Insurance Ltd* [2017] EWCA Civ 144** Whether the Court should revisit its earlier decision in *Stevens v Equity Syndicate Management* [2015] EWCA Civ 93 regarding the correct approach to the calculation of Basic Hire Rates in credit hire litigation.

***R (on the application of Parkinson) v HM Senior Coroner for Kent* [2018] EWHC 1501** – leading case concerning the domestic application of ECtHR jurisprudence on Article 2 in hospital inquests