GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Tuesday 14 April 2009

The Guildhall,
Guildhall Square,
Portsmouth,
PO1 2AJ

BEFORE:

Mr Anthony Bradley
Coroner for North Hampshire
Assistant Deputy Coroner for South East Hampshire

In the matter of Mr Leslie Pittock & 9 Ors

(DAY SEVENTEEN)

MR ALAN JENKINS QC, instructed by **, appeared on behalf of Dr Jane Barton.
MR JAMES TOWNSEND, Counsel, instructed by the Royal College of Nursing, appeared on behalf of a number of nurse witnesses.
MS BRIONY BALLARD, Counsel, instructed by **, appeared on behalf of the acute trust and the PCT.
MR TOM LEIPER, Counsel, instructed by Messrs Blake Lapthorn, Solicitors, appeared on behalf of the families of Brian Cunningham, Michael Packman, Elsie Devine and Sheila Gregory.
MR PATRICK SADD, Counsel, (instructed from 23/03/09 by) appeared on behalf of the Wilson family.

(Transcript of the Official Recording by T A Reed & Co Ltd
13 The Lynch, Hoddesdon, Herts, EN11 8EU
Tel No: 01992 465900)

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(In the absence of the jury)

MR TOWNSEND: I was out of the house earlier than anyone else this morning at 25 to six.

THE CORONER: No, I was before you.

MR TOWNSEND: Oh, right, well, you have upstaged me. It appears that Mr Jenkins had the gift of prophecy on Friday, when he suggested we should start at eleven.

THE CORONER: Yes. He is obviously a wiser man than I am.

MR TOWNSEND: I apologise. It was a disaster and I am not going to bore you with the details of it.

THE CORONER: Welcome anyway. It is nice to see you.

Thank you for your submissions. Mr Townsend, did you have anything more you wanted to do by way of submissions?

MR TOWNSEND: Not at this stage, sir, no. I have put before the Court my list of questions.

THE CORONER: Thank you.

MR TOWNSEND: I anticipate I may wish to say a couple of words, having read my learned friend's submissions, but I think the position is clear, as far as I am concerned, as a non-interested party.

THE CORONER: Fine. Thanks very much indeed. I perhaps ought to share one or two misgivings with you before we start. The first thing I need to be quite clear about is that this is a court of law and that, as lawyers, we deal with the law. If you dishonestly appropriate property belonging to another with the intention of permanently depriving the other of it, you have committed the offence of theft, and you have to have all those elements in order to fulfil that requirement.

The problem that I have here, and I will share it with you now, is the question of gross negligence, manslaughter, and I cannot find grossness of that negligence, and I will say that now. The other problem is that of causation. You may note that we have had five doctors looking at causation. Not one of them gives me drug overdose on causation. There is no mention of it as a cause of death in all the causes of death I have been given, and the jury will need to give various permutations on those, and I will advise them on how to approach that, but I find myself in difficulty from that point of view.

The essence of this inquest – and please bear in mind it is an inquest; it is not a trial; it is nothing more than ascertaining how the deceaseds came by their deaths – the question of causation is going to be vital and I do not find myself being led in that direction. I do not know how you want to address me and how you want to pick that up but that is the difficulty I have.

If this were a different set of proceedings, we would have different criteria. As it is, they are inquests and, as inquests, the jury will be required to find cause of death – that will be really a matter of mental exercise – but also how each individual deceased came by his or her death.

Who wants to start? Mr Sadd?

MR SADD: I am wearing my helmet as I stand.

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THE CORONER: It is a legal difficulty. I know what the families want to achieve and I know how they want to approach it, but the problem I see is that I cannot get over the fences that they want me to get over. If you can give me a pointer, I will think about it.

MR SADD: Sir, that is what I am going to try and do, inevitably.

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THE CORONER: Thank you.

MR SADD: I hope, and I am sure, in fact, that in the time you have had while we were waiting for the innocent Mr Townsend to arrive at eleven, you will have had the opportunity to look at the written submissions, and therefore you will be aware of what I am saying...

THE CORONER: Yes, I am.

D

MR SADD: ...on behalf of the Wilson family, and indeed, your opening comments immediately get to the heart of what you would say are the fatal flaws in the submission I am putting forward.

THE CORONER: Please do bear in mind I am used to doing these things on my own. It is meat to me. I now need to sell it to a jury, and I need to be quite clear of the level at which I

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sell it to them.

MR SADD: Sir, I understand that and I am not ignorant of the hurdles placed in the way of Mr Wilson's case; I let you know that straight away, and the submission that we make to you on unlawful killing is not made idly because it is a very serious allegation to make, a very serious verdict for the jury to consider, and it carries with it enormous repercussions. So it is not an application made to you lightly or dismissively, or in any way without thought to the

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evidence that you have before you.

You will have seen by way of introduction – and I am sorry if I make some blinding glimpses of the obvious in that introduction but, as you will be aware and as you have reminded us throughout the course of this inquest, you are dealing with ten separate deaths; you are dealing with ten separate inquests. The reason why that is important in the context of Mr Wilson's case is that there may be, albeit inadvertently and innocently, a tendency to

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subsume all the deaths together by looking at some generic issues. I would invite you, sir, very, very carefully to keep away from that temptation.

I put it in those terms because there are some generic issues but those generic issues should not cloud the actual matrix that is individual to each particular death, and of course, that applies to Mr Wilson's case.

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Sir, you will see in my introduction at page 1 that I have cut to the chase, as it were, in suggesting two potential verdicts that you can, on the evidence, leave to the jury. Perhaps – and this may come to you as a surprise – most controversially, it is not the first of those verdicts, i.e. the unlawful killing by manslaughter, difficult though that may be for the Wilson family to achieve before you in the submissions, but the second suggested verdict, which is the open verdict. In fact, and paradoxically, the very problems that you have alighted on at the outset are problems that are there, we say, because of the gaps in the evidence, and those gaps in the evidence, as I will come to explain to you in the course of my submissions, are amply demonstrated by Dr Wilcock's difficulty in actually coming to a conclusion as to what the cause of death, or what may have precipitated the decline on the 15th, because he has to defer to expert colleagues, evidence which has not been put before the jury. It is for that reason, sir, that I am asking you to entertain leaving the verdict an open one in the context of Mr Wilson's case, but I will develop that as my submissions go forward.

At page 2, sir, I imagine, and I would hope that at paragraph 1.6 I have not trodden on any or I have not infringed on that very important rule in commenting on the facts, and I am certainly, I hope, not in my submissions inviting you to make any decision on the facts. That would be quite wrong of me but I hope you would understand by reference to my submissions why it is necessary for me to refer to the evidence.

Sir, much of what you have at pages 2-3 is, I imagine, although such a submission and such a verdict will be rare in the day to day coroner's court, nonetheless, I imagine those submissions come to you as no surprise, that is, the basis upon which the approach that you need to adopt. I cite those there, as indeed does Mr Leiper, as, I would hope, helpful background for you in coming to the decision as you must do. Page 3, part 3, again, the unlawful killing by gross negligence and the test to be applied. If I may at this stage take you to *Adomako*. I have cited there---

THE CORONER: That is the anaesthetist's case, is it not?

MR SADD: That is the anaesthetist's case, where an alarm goes off and for a period of ten minutes or so the anaesthetist is unable to find a cause as to why the alarm goes off.

THE CORONER: Nobody thought of the disconnection.

MR SADD: Nobody thought of a disconnection, and he was defended on the basis that the steps that he did take, having initiated the wrong decision, were steps that were reasonable in the circumstances, but that wasn't a defence that in his case the jury accepted.

Can I take you to Mr Leiper's bundle, and what I have avoided doing, sir, is copying the reports all over again, so I am lucky that he has done all this preparation and I am relying on those reports. If I could ask you to go to the penultimate tab, which is where you will find the case of *Adomako*. As you say, sir, you know the factual background to that case. If I could take you, please, to page 7, at the bottom of page 7, you have Lord Mackay setting out his approach to what needs to be established in a case of gross negligence manslaughter. Over the page, on page 8, the passage that I have not gone on to quote in my submissions, if I may read it out to you, sir, because I think it is also relevant to the consideration that you must give today. It is the second paragraph down, where Lord Mackay says as follows:

> "It is true that to a certain extent this involves an element of circularity but in this branch of law I do not believe that that is fatal to its being correct as a test of how far conduct must depart from accepted standards to be characterised as criminal. This is necessarily a question of degree and an attempt to specify that degree more closely is, I think, likely to achieve only a spurious precision. The essence of the matter, which is supremely a jury question, is whether, having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act or omission..."

and what will be troubling you in Mr Wilson's case is the reference to the phrase "The essence of the matter, which is supremely a jury question, is whether having regard to the risk of death involved" and certainly in Mr Wilson's case you may take the view that the risks that you have heard speak of by the experts are risks associated with too great a dosage of morphine, we say, on 14 and 15 October 1998 which in turn carried the risk of going into hepatic coma, and I will take you in due course to a passage in Dr Wilcock's evidence where he says that, as a consequence of that risk, the functions of the body would decline. We will go to that evidence in due course. It is in the transcript of the evidence that he gave before you.

As you know from my submissions, I rely on that and the combination of the Professor's evidence, if I can put it in that way, to substantiate the argument that the dosage of morphine, which we say is an overdose, at the very least contributed to, if not caused the death that ensued.

Sir, at 3.2 of my written submissions, at the bottom of page 3, I set out what is well known to you, sir. Over the page, the four constituent elements of gross negligence manslaughter that you would need to be satisfied of are made out to such an extent that you can leave that before the jury, and your concern is with letters (c) and (d) at the top of page 4, as I understand it.

THE CORONER: Yes.

MR SADD: Sir, the case law appears to establish that there is this rather difficult judgment to understand from Mr Justice Keith, where he makes the distinction between discretion on the one hand and judgment of the coroner on the other. Certainly, as a work-a-day lawyer, I find that a difficult distinction to understand in the context of your discretion in whether or not to leave to the jury a verdict of unlawful killing in a case which appears to be in the balance as opposed to be clear-cut, and I have to recognise that in Mr Wilson's case it is in fact a balance I would be inviting you, as you can see from my submissions, to reconcile in favour of the family, and in favour of leaving that verdict, of course with all the caveats that you would introduce into the direction that you will give to the jury.

Can I then turn, please---

THE CORONER: Before you do that, can you tell me whose negligence we are talking about?

MR SADD: I am talking about---

THE CORONER: You see, you would have to look at an individual, would you not? I can anticipate where you are going with it, but she was not solely responsible; she was not solely in charge. She is part of a team; she is part of a set-up, and so your gross negligence cannot go to any bunch of people at any given time, and was she on duty that day. You have got that problem that goes with it.

MR SADD: Sir, we put it in this way: that we can only, on the case that we present, the negligence that we say is gross was on the 14th and 15th. Following the episode overnight on the 15th and 16th, by then, as it were, Mr Wilson's decline was inevitable. So the actions of Dr Napman and Dr Peters are, in the light of those submissions, irrelevant to what we say. Looking at the 15th and looking at the 14th, the *de facto* position, the position on the ground – I am sorry to be pompous. The position on the ground---

THE CORONER: I know what "*de facto*" means.

MR SADD: Yes, I know, but I know I am not allowed to use Latin expressions. The position on the ground, sir, is that Dr Barton, however one would want to describe it, was in charge, was the overseeing authority there, and the best evidence of that fact, sir, is one, the evidence from the nurses themselves, and the long association and trust that was built up between them and Dr Barton, and the approach that they adopted to her pre-prescribing but, secondly, and particularly in the case of Mr Wilson, the fact that we know there was no consultant supervision at the period we are dealing with. We know that Dr Tandy had gone off on maternity leave in 1998 and you will know from the laborious questioning of Dr Barton by me that, as at October 1998, she accepted that effectively she was in charge, we would say, of what happened on that ward, and that the responsibility for prescribing and care of patients rested with her. The administration of the medication may have been delegated to the nurses but the decision as to what dosages and what medication to prescribe was entirely in her hands, and that is reflected – I can see Mr Jenkins nodding his head, but that is what we say, and on 15 October we know from her own evidence that Dr Barton attended, and we know that, in spite of what Mr Jenkins says about prescription as per need, when one actually looks at the prescription chart (inaudible) and you will be familiar with it by now, what in fact occurs is there is a four-hourly prescription of identical medication over that day, during the course of which Dr Barton is there, and, we say, approving of that course of action.

So we do say that you can identify an individual responsible for and authorising the medication of that type and in that dosage, following her assessment, so she claims – and I do not mean that pejoratively but simply there is no need, she says, for there to be a note. That was her assessment on the 14th of the extent of pain that this individual was in, and that justifies, so she explains, the dosage and type of medication that she introduced, but that is all of a part with her decision on the 14th and what happens on the 15th, and all being relayed back to her authority, her decision and her responsibility.

THE CORONER: But what would you say about the nursing staff, who say that they would not have given medication that they felt was inappropriate, and there were certainly three live witnesses that we had that said that?

MR SADD: Sir, what I say about that is, on the basis of their association with Dr Barton, and, for instance, exemplified by the approach adopted by Sister Hamblin to the doctor's pre-prescribing, that in fact there was very little questioning of Dr Barton's prescribing.

THE CORONER: Effectively subjugated to Dr Barton.

MR SADD: "Subjugated" is… Even I would not use that word, sir, but----

THE CORONER: Well, you have to look at nurses as independent professional people. They are not the three stooges. They are people of considerable experience and merit and one has to respect their opinion, and the three that, certainly, I questioned said quite clearly that they would not have administered medication that they thought was inappropriate.

MR SADD: Sir, if I remember the statements rightly, although I was not here for all of their evidence, but my memory of reading those statements is that in none of those instances did they question, certainly by 1998, the prescriptions being decided on by Dr Barton. You were given no examples of that. Certainly, sir, you had in 1991 the concerns and misgivings expressed by the nursing staff, concerns and misgivings which exemplified exactly what you have set out: the autonomy and responsibility of nursing staff in those situations.

THE CORONER: All those concerns were resolved by 1996, which was the period that I come into.

MR SADD: Sir, that is exactly the point I was going to go on to make, so that, by 1996 any of the concerns that they might have had on the medication were concerns that had been met. Indeed, you may remember, when I asked, the only occasion when I questioned any of the three nurses – I think it was Nurse Turbritt – I asked her, "Well, if you couldn't remember what the concerns were, how do you know they were met?" and you intervened properly then, sir, and said, "Couldn't it be put in a different way? Certainly by 1996 you weren't concerned about the way medication was being prescribed, or implicitly there were no more concerns about that?" and, sir, I say that that carried on being the case through to October 1998, the period with which we are dealing in Mr Wilson's case, so that there is no evidence to go before the jury at present of there being any countermanding or questioning or raising doubts about the prescription or pre-prescribing organised by Dr Barton in the context of Dryad Ward in 1998, and certainly, we say, no supervision of that medicating practice because no consultant.

Of course, the jury have the evidence from Dr Barton that the pharmacist, had he or she had concerns about the doses of medication, would have raised those concerns, but, again, there is no evidence before the jury, and none which you would be relaying to them, about any such concerns being raised in 1998.

THE CORONER: There is also no evidence of in-growing toenails, is there? Do you see what I mean? If it is not there, if the concerns are not expressed, how do you prove a negative?

MR SADD: But, sir, it goes further than that in our case, in the fact that the jury have before them the evidence of three expert witnesses, all of whom criticise the dosage of medication being given to Mr Wilson.

THE CORONER: Why would that not properly be addressed by a narrative verdict?

MR SADD: Because, sir, of the consequences of what that dosage involves, we say. Sir, that is how I expand it in part 4 of my written submission and, sir, knowing, as I do, that you have

not made up your mind as yet, I think 4.1 – it is a word I use, I am afraid, too often – is, I would anticipate an uncontroversial issue.

THE CORONER: Absolutely. I do not think there is any question about that. I think we are all greed there is a duty of care owed.

MR SADD: 4.2, as to whether or not the duty of care was breached, and, sir, that is an issue that is informed by whether or not the breach of the duty of care at this stage is a gross breach; simply whether or not, by reference to those looking at the conduct of the clinicians involved, there was a breach of that duty.

Sir, you will see that I set out at the bottom of page 4 the views before the jury of the expert evidence and, going over, please, to page 5, perhaps an important qualification is in Professor Baker's report at page 15 – and, sir, I give you the reference there. His report is not divided into paragraphs but you find that passage in the middle of the page, as it were. What is important about the qualification placed by Professor Baker in that passage is that, even if there had been a record made of the reason for, or the assessment of Mr Wilson on his admission to Dryad, Professor Baker is saying there that the dosage that was then given was inappropriate, and that is a view echoed by Dr Wilcock and Professor Black. So the criticism and the way in which the breach is sustained is, even if there had been an entry, all three of those experts consider the dosage to have been unjustified.

Sir, if we look perhaps at the expert who was most diffident about these issues in relation to Mr Wilson, and that is Dr Wilcock – and I mean no disrespect to him in putting it in that way – and I say that you will see (i)(c)(i) Mr Wilson was prescribed doses of oral morphine initially as required and subsequently regularly, likely to be excessive to his needs. Mr Wilson subsequently received doses of diamorphine (inaudible) excess to his needs but also, sir, if you go to the note of the evidence, that is, Day 14, and the exchange that I have got, albeit in shorthand, and I hope it will accord with your note, sir---

THE CORONER: Is this you and Dr Wilcock?

MR SADD: It is me and Dr Wilcock, yes. It is our exchange, and, sir, it is really looking at the risks associated with the prescription of morphine in the context of someone with known liver failure, and it is the exchange that we have in relation to this. I am sorry if this is, necessarily, shorthand but it starts looking at the risk of taking morphine, well-known risk in the light of condition, I ask, and Dr Wilcock replies, "Expect most clinicians to know certain drugs have to deal with more carefully where liver failure. Does Mr Wilson fall into this? Yes. Risks associated with giving morphine at higher dose? If dose excessive to needs, would expect to see side effects occur at lower dose." Then I refer to the BNF guidance and---

THE CORONER: Can I just stop you for a second?

MR SADD: Yes.

THE CORONER: "Cannot say the dosage was justified."

MR SADD: Sorry. That is where I am getting to, sir. "In the absence of well documented pain history and justification, don't feel it justified," and I say, "Dosage four times carried

risks?" and Dr Wilcock replies – again, it is in shorthand – "Dose excessive to needs would carry risks of side effects," and he sets out in answer to my question... Well, he asks me, "Risk of what?" and I say, "Hepatic coma, for instance," and he goes on to say, "Risk being dosage excessive to needs, risk focus sedation for hepatic encephalopathy," and goes on to say, "In fairness, yes, did carry a risk of coma. Difficulties. Don't know. Something happened in the early hours of the 16th. Happy to say dose excessive needs puts at greater risk of side effects."

THE CORONER: Yes.

MR SADD: But, sir, perhaps the most telling evidence that we have from Dr Wilcock in this regard is his agreeing with me that the dosage of Oramorph disregarded the safety of Mr Wilson. In other words, he aligned his views about diamorphine, prescribed on the afternoon of the 16th, he aligned those views as set out in the report with views, having heard the evidence of Mr Wilson's son, he was prepared to say that the dosage disregarded Mr Wilson's safety by unnecessarily exposing him to receiving excessive doses or Oramorph.

Sir, we say that, on that basis, the breach of duty is made out. What it leads to, of course, is a very tendentious and controversial issue but certainly (a) and (b) of the four necessary constituent elements of gross negligence by manslaughter are made out and, we say, to the satisfaction of the standard of evidence necessary to prove manslaughter by gross negligence. Sir, that is how I summarise the evidence at 4.2.3 of my submissions. That is the bottom of page 5. In effect, what I have just set out to you is summarised in that, or I hope it is summarised in that paragraph.

THE CORONER: If you made that out, that would show the breach, would it not?

MR SADD: Sir, that is what we say.

THE CORONER: It would demonstrate the breach. OK.

MR SADD: Sir, there is one issue which is, if you want a sub-issue, and it is over the page at page 6. You may consider why this is relevant to the position generally; it is because there is the tension, as exists in all of these cases, but certainly in Mr Wilson's case, between the underlying problems that Mr Wilson had on the one hand and the consequence or probable consequence of those problems and, on the other hand, how to approach medicating those problems. You will remember, sir, that there was an exchange between yourself and Dr Barton, I think after I had asked her questions over the whole of the morning, in relation to the fracture and whether or not it was going to heal.

Sir, it as well to redress the balance of the evidence that is available for you and therefore available to the jury and that is both in the contemporaneous medical records the expectation was of healing, and that was from the clinical orthopaedic department, and I give you there the reference in the medical records at page 21. To save you looking that up, sir, I will just read it out for you. It is an entry dated 13 October 1998, so on the eve of transfer, and it is an entry that was read out to the jury, I think by me, when I was asking Professor Black questions. It reads as follows, sir:

> "Reviewed by medical team. Continues to require special medical nursing care as oedematous limbs at high risk of breakdown. Right foot already about to break down.

> This is due to oedemous secondary cardiac failure and low protein. Also at high risk of self-neglect and injury if starts to take alcohol again. Need to have 24 hour hospital care until heal arm."

Then, sir, that is then transcribed into the transfer record at page 77 of your medical records on Mr Wilson, where under box 5, "Summary of current health status and treatment", you have almost on the bottom line: "Needs 24 hour nursing care until arm is healed."

To supplement that evidence, sir, you also have in Dr Wilcock's report at pages 28-29 his reference to the process of healing that would have gone on. If I may take you to that now, I have quoted it in my submissions, but just so that you are sure that it is there, pages 28 and 29. Sir, starting at page 28, what Dr Wilcock writes in the third paragraph, if I may read it out, is:

> "I note that the orthopaedic team considers surgical fixation of a displaced tuberosity only to ultimately decide against this based on Mr Wilson's wishes and clinical condition. I am not an expert in orthopaedics nor have I seen the x-rays and thus I am unsure to what extent there is some displacement (inaudible) impact upon the anticipated clinical course of the fracture I describe below. If this aspect of the case is considered important, the opinion of an orthopaedic surgeon should be obtained. However, it is my general understanding that pain from this sort of a fracture can initially be severe enough to require strong opioids."

Pausing there, sir, we know that on admission on the 23rd Mr Wilson was prescribed with 10 mg of morphine.

> "Subsequently, the main approaches for pain relief would be immobilisation and weak opioids as offered to Mr Wilson. Movement was likely to aggravate the pain until the fracture begins to heal, a process that can take several weeks and not be fully complete for 12 weeks, although there is wide variation. Nevertheless, one would anticipate that Mr Wilson's pain would improve so that he would be pain-free when the limb is at rest followed by progressive improvement in the movement-related (incident) pain."

THE CORONER: I think it was Dr Barton I asked, was it not, what was going to happen to this arm? It is not being fixed, the fracture is not being reduced. It is sitting there, floating.

MR SADD: But it would heal.

THE CORONER: How would it heal? It would heal if he did not move it but if he is going to be conscious and with us, it is not going to heal, says he, one who knows.

MR SADD: Sorry, sir?

THE CORONER: One who knows. Been there. Done that. You need to fix the fracture.

MR SADD: Well, sir, the difficulty that the jury have is that there is no orthopaedic evidence before them. There is this evidence of Dr Wilcock's and there is the evidence of the treating clinicians at the time, who anticipated, notwithstanding the need for immobilisation, that healing would take place.

THE CORONER: I do not know that that is right either, if you read what they write, because they are not saying, "This is going to heal." They are going to say he is going to be in this position until it heals.

MR SADD: But equally, sir, what they are not saying is that that is not going to happen.

B THE CORONER: No. All right. Go on.

MR SADD: I do not mean that facetiously.

THE CORONER: No, I do understand that but it is such an issue for me that I just wonder why he was transferred. Why transfer Mr Wilson in circumstances where he was in need of positive medical input? Send him to a continuation ward. That was the issue that got me.
C I could not come to grips with that at all, unless it was just stopping the bed blocking. Go on.

MR SADD: Sir, all I was going to say is that, in relation to that issue, you are not provided any assistance, unfortunately, by any of the evidence before you and therefore before the jury but, so far as the particular issue as to whether or not healing could take place, the evidence suggests that it is not all one-sided.

D THE CORONER: He was at Haslar, was he not?

MR SADD: No, he was at QA.

Sir, if I may move on then to the first of the two issues that concern you greatly, and that is the question that needs to be asked, having established duty of care and breach, and we say that those two elements are established, is whether the breach of duty, and to be entirely clear
E about the matter, sir, the breach of duty in this case is the over-prescription of morphine, over-prescription, to use Dr Wilcock's phrase, that disregarded the safety of Mr Wilson. It is as well to look at Dr Wilcock's agreement to that change in his report, because we know from Dr Wilcock's evidence over two days that he would remain unmoved by any attempt at pressure by people like myself and the questions that we might ask them. So where, if you want, movement was allowed, that ought to be treated, I would say, with a good deal of care and taken with a good deal of respect.

F If we then look, please, at 4.3, I set out there, sir, the evidence on which the jury could conclude that the breach of duty caused Mr Wilson's death. First, sir, we have the evidence of Professor Black, and Professor Black is addressing precisely the issue of breach, that is, the dosage of Oramorph, and he is addressing precisely the issue of that breach having taken place on the 14th and 15th, so not looking beyond those dates.

G First, you have his conclusion (a)(i) there, and I give you the reference, and then (a)(ii); sir, you will remember, in the course of questioning by me, Professor Black's change of view in relation to the consequence of the medication, and you will see there that I have highlighted it. It more than likely contributed to the death.

What is the path of that death? Sir, that is described in Dr Wilcock's evidence, and why we say that the causal chain is made out is at page 14. Aside from the evidence that there was a
H risk of going into hepatic coma, at page 40 of Dr Wilcock's report, in the last sentence of the

first paragraph there, although speaking about dosages of diamorphine, what Dr Wilcock says in the last sentence is, "Doses of opioids excessive to a patient's needs are associated with an increased risk of drowsiness," and you have the evidence of Ian Wilson on his visit to see his father on 15 October, evidence that Dr Wilcock had not heard and evidence which caused Dr Wilcock to look again at the effect of the medication. "An increased risk of drowsiness, delirium, nausea, vomiting and respiratory depression." Respiratory depression, as you know, sir, is one of the problems for which hiazine is then prescribed, that is, to help with secretions.

Sir, going back to my submissions, we rely on the evidence not only of Professor Black but also of Professor Baker, which was read to the jury, and I cite the passages there at pages 15 and 18.

Then, sir, we go to the evidence of Dr Wilcock, and if I could take you, please, to his agreement with me, the passage reads as follows. I ask him this question. "I want Dr Wilcock to have the opportunity to comment on the other reports. Start with Professor Black. Maybe you have already dealt with this but, to be clear, do you have any cause to change your view?" and I read out to him paragraph 6.11, which I have quoted in my submissions. Professor Black says, "Regular prescription and dosage unnecessary and inappropriate. Patient with serious dysfunction was cause of deterioration on 15th and 16th, more than minimally contributed to death. What is your view of that?" and Dr Wilcock responds, "I understand how that is reached. If it wasn't for the oedema, my conclusions would be similar. I hadn't seen Ian Wilson's evidence before and the evidence re drowsiness. Would question whether this was because of drugs. Not had experience (inaudible) heart failure."

I ask him the question, "Is this based on subsequent events or simply on the doctor's entry?" and he says, "Both." I ask him the question, "Is the risk of..." I think I must have asked him the question, I hope so; it is simply put in shorthand as "Associated with consequences of hepatic coma." That is in relation, I think, to the use of the drugs. At that stage Dr Wilcock said, "Well, you would need to ask a gastroenterologist as to the effect of the drugs with someone with liver disease and the risk of hepatic coma." That is why, sir, we feel justified in saying at page 7 of my submissions, (ii), that were it not for the pulmonary oedema, his conclusions would have been similar to Professor Black's. You also see where I say, sir, he defers to a gastroenterologist on the risk associated with hepatic encephalopathy but also, sir, you have at (iv), if I can put it in this way, the ambiguity of the evidence that is presently before the jury as set out in that passage. If I may read it out:

> "Although the dose of morphine may well have contributed to Mr Wilson's reduced level of consciousness either directly or by precipitating a hepatic coma, it is difficult to say with any certainty that the dose of morphine he received would have contributed more than minimally, negligibly or trivially to his death because the heart and liver failure could also have done this."

So the analysis of Dr Wilcock is that there are competing causes but none of the causes that he has advised trumps the others. I am sorry; I hope that language does not sound inappropriate in the context of these submissions.

THE CORONER: No, it conveys a very clear message.

MR SADD: It is for that reason, sir, that we conclude that there is evidence before the jury on which they could be satisfied beyond reasonable doubt that the breach of duty in prescribing unsafe levels of Oramorph more than minimally, negligibly or trivially caused Mr Wilson's death. Sir, we say that that meets, and we say to a satisfactory degree, your concerns about the third element of gross negligence by manslaughter. You have in effect two experts making it clear that causation is established and you have the third expert leaving, as it were, the issue undecided because of his inability to know, because it lies outside his specialism, as to the consequences of the medication with someone with encephalopathy which was known at the time.

Sir, the fourth element, and perhaps the most difficult element in the context of Mr Wilson's case, is whether the negligence that we say can be substantiated is negligence that can be categorised as gross.

Looking back on my submissions this morning, it is perhaps unhelpful that I have used the word there "reckless" although when one comes to read *Adomako* it is right in Lord Mackay's decision that he is careful not to try and define "reckless" because it is something that a jury would be able to understand and that one does not need to go down a the complex routes cases like the *Lawrence* decision, and he makes that very clear and if need be, sir, I can take you to those passages, but "reckless" is a word that you can incorporate when looking at the context of gross negligence by manslaughter.

The way I put there, sir, is rather inelegantly set out. I put it one of two ways. There was a serious risk in prescribing Oramorph, but it was prescribed, and at a high initial dose that was unsafe regardless of that risk, or that the serious risk of hepatic coma was not properly appreciated. Sir, even if it were to be concluded on the basis of the evidence before the jury that the risk was not appreciated when it should have been, we say that that is a risk that amounts to a gross one. There are parallels almost with the *Adomako* case because knowing, as Dr Barton would have done, and as she accepted in evidence, of those associated risks, we say that the extent of those risks in the context of Mr Wilson's condition were not properly appreciated, for whatever reason. The jury have the evidence of the fact that, certainly in the records, no such risk is highlighted or identified or chronicled. No such review, as you will have heard Dr Wilcock say should have taken place on the 15th, is recorded in the records, the clinical records on the 15th, notwithstanding that in the nursing records for the 15th the deterioration in Mr Wilson's state of health is marked by the nurse.

Sir, then I set out the catalogue of evidence that is presently before the jury that establishes what we say can amount to negligence that is gross. Just before I move on, if you want to make a note, the discussion that I have referred to in Lord Mackay's decision in the House of Lords on recklessness and the extent to which one needs to go any further is at pages 9 and 10 of the decision.

I am suddenly aware that all my colleagues want to say something, so I should speed up a little. I am sorry.

Looking at the bottom of page 7, I set out what we say Dr Barton would have known, (iii). Summarising the submission at (iii), there is no attempt to justify the dosages in the records of Oramorph.

Then, sir, you have the question raised by – and I know this is a controversial issue – Sister Hamblin's comment. Then at (v) the absence of a rationale for pre-prescribing on 14 October the diamorphine, hiazine, and midazolam. Certainly when you have Dr Wilcock's evidence, when asked about this, I asked him the following questions. Again, this is Day 14. "On 14 October at lunchtime was death inevitable over the next few days? Dr Wilcock: "Not that it could be predicted, no." "How could pre-prescription be justified?" "Prescription in those doses," Dr Wilcock replies, "not what would consider normal practice. Those drugs are commonly used in terminal phase."

At (vi) there, sir, you have what we say is the assumption adopted by Dr Barton for Mr Wilson's care on transfer. The reason why we say that that is relevant is that it informs the approach adopted by the doctor to the dosages and the choice of medication.

THE CORONER: That is exactly right, is it not?

MR SADD: At (ix) I probably went to far too painstaking lengths to establish that, certainly at October 1998, Dr Barton did not feel that her care of patients was exposed to any risk notwithstanding the absence of consultant review. Sir, I say that that would inform, and indeed, I suggested to her, or I hope I suggested to her, that that informed her approach to the care of Mr Wilson. At (x) the expert evidence that the dosage of Oramorph disregarded Mr Wilson's safety. Put differently, no regard was had to his safety.

Sir, over the page at page 9, anticipating both yours and Mr Jenkins' arguments as to the intervention of third parties, if I can put it in that legalistic way, and the extent to which, as Mr Jenkins has sought to establish, actually one would have to look at the conduct of the nurses on the 15th. You have heard what I say about that right at the outset and you have heard and know in fact that Dr Barton attended on the 15th. What is an interesting exercise, sir, is if you do go, when you are considering my submissions, back to the prescribing charts – that is at page 259 onwards of the medical records – you will see at page 261, if you need to make a note, sir, the regularity with which the Oramorph is prescribed on the 15th and at the dosage of 10 mg: 6 o'clock, 10 o'clock, 1400 hours, 1800 hours. Sir, it is in the course of that 24-hour period, the expert evidence relates, 50 mg of Oramorph were prescribed, and that is before, we say, the episode of the 15th/16th takes place, and we know that that must be the case because for the last dose of Oramorph that had been prescribed over the night of the 15th and 16th Mr Wilson would have had to have been woken and the Oramorph given in liquid form. I think it is in liquid form.

THE CORONER: I have some very scrappy notes somewhere.

MR SADD: Sir, it is on that basis that I set out at 4.5 the summary for you, and we say that a jury, properly directed, could conclude that the breach of duty was so serious that it could be criminally liable or should be criminally liable. We also say that, in the light of all that evidence, and most especially the evidence of the experts, such a verdict being left to the jury realistically reflects the thrust of the evidence taken as a whole.

Sir, I make an important qualification, and I hope you do not think it one that in any way implicitly criticises the difficult job that faces you, but we say that the evidence is that evidence that relates only to Mr Wilson's case, and independently of any evidence relating that might be common to the nine other deaths that you are having to deal with.

Sir, you have heard my submissions in relation to an open verdict and the reason why I put that forward. Again, I mean no disservice to you ,sir, in saying that there are gaps in the evidence, and we know that there was the difficulty with the introduction of Dr Marshall's evidence, which you have properly excluded, if only to be able to manage this inquest but, sir, because of Dr Wilcock's leaving that issue open, we say that it would properly lead you to put before the jury an open verdict as to cause of death.

THE CORONER: I could do that in all ten, could I not, because, of course, what we have is an absence of bodies and, except for Mr Cunningham, a definitive cause of death? The open verdict is that the evidence is insufficient upon which to find. That is the open verdict itself but, actually, that is not going to help anyone, is it? One could say that with any historic case and say, "Is that what we are looking for? Is that what the families want, an open verdict?" Would they not rather have some questions answered?

MR SADD: Sir, but in the context of the evidence that is presented to the jury in this particular inquest, there remain gaps.

THE CORONER: I take your point.

MR SADD: Sir, anticipating that you may find yourself concluding that simply a narrative verdict ought to be left to the jury, I set out there the questions that we say, questions that, yes, do point to criticisms but questions that do not identify in those criticisms any particular individual.

THE CORONER: In the submission you have just made?

MR SADD: No, that is in the narrative verdict, sir, as opposed to my submissions on unlawful killing. Sir, you will be pleased to know that I am going to stop but may I take instructions before I finally do so?

THE CORONER: Yes, you may.

MR SADD: Sir, Mr Wilson asks me to – and I hope you would find this a fair point to make – make it plain that treatment of shoulder fractures with the elderly, his understanding is that the vast majority of treatment is by sling and immobilisation rather than by operative treatment but there it is. I just ask you to note that.

THE CORONER: It would normally be a backslab, and, as I understand it, Dad did not have a backslab, did he? As I understand it, he did not even have a sling, did he? He would have done initially but on transfer did he have one?

MR SADD: He had a collar and cuff, sir, as you will see in the records before you. Sir, unless I can help you any further, those are my submissions.

THE CORONER: Thank you very much. Mr Leiper.

MR LEIPER: Thank you. As you know, I appear on behalf of four of the families.

THE CORONER: Certainly. Thank you for your submission, which is very comprehensive.

MR LEIPER: I am grateful for that, sir.

THE CORONER: I have to say I have not yet read it in detail. I have scanned it.

MR LEIPER: Perhaps in the circumstances, sir, I might take you through the submissions.

THE CORONER: Certainly. Mr Packman first?

MR LEIPER: Yes. Sir, before I do so, I think it is important to emphasise at the very outset that you, sir, are concerned with ten distinct deaths, and any concerns that sir may have in relation to issues of causation and grossness cannot be looked at absent the factual matrix of each of the ten cases, and while there may be legitimate concerns in relation to some cases, the fact that they exist in those cases does not mean that they apply in all. It is my respectful submission that, in relation to at least three of the cases that I address you upon today, those concerns, while properly raised, have an answer and, in the light of that answer, we say in relation to the cases of Packman, Devine and Cunningham that an unlawful killing verdict should properly be left to the jury.

As I say, I will come on to the details of the particular cases but just so far as the generality is concerned, sir mentioned at the outset that there was no expert evidence in relation to opioid toxicity and raised that as a potential concern in relation to cause of death. You have heard expert evidence from both Professor Black and Dr Wilcock as to the mechanism of death in circumstances where excess sedative and opiate analgesia is administered, and they have both confirmed that death can occur secondary to excess analgesia and sedative medication through the mechanism of either respiratory depression or through coma or through lack of hydration or through lack of food, four distinct mechanisms that they have identified, and the issue that sir has to consider, in our respectful submission, is whether or not those four mechanisms may apply in relation to, so far as I am concerned, the cases of Packman, Devine and Cunningham.

If and in so far as sir does have a concern as to the absence of evidence in relation to opioid toxicity, it is a concern which could properly be addressed by sir at this stage. Sir is aware of the plethora---

THE CORONER: I am aware that people can die of opiate toxicity. I am well aware of that.

MR LEIPER: Absolutely, and the reason why I raise the submission as I do is that sir said that it was as a consequence of the absence of that evidence that you were concerned in relation to all the cases about establishing a causative link between breach and death. The simple point that I wanted to make at this stage, sir, is that, clearly, the evidence that you call before these ten inquests is entirely a matter for you. You have heard submissions and you are aware of the fact that a number of the families were anxious that you should call other evidence, and you will know that some of the other expert evidence, perhaps directly, more directly, addresses the issue of opioid toxicity than the experts that sir has heard from.

What we say is that, if and in so far as sir is concerned that there is a lacuna in the evidence which has been given, that is something which could easily be remedied by calling an appropriate expert, and if and in so far as sir feels that there is a lacuna, we would go so far as saying that sir is under a duty to do so.

Against that as a background, sir, if I could turn, please, to the case of Packman, as suggested, in the light of the eloquent way in which Mr Sadd has addressed you, sir, I will endeavour not to go over the ground that he has covered, and I will in the first instance confine submissions to the issue of gross negligence manslaughter beginning at paragraphs 12 and 13 of the Packman written submissions.

Paragraph 12 there sets out the legal test for causation. Negligence must have caused the death in the sense that it more than minimally, negligibly or trivially contributed to the death. That is the legal test that these experts have applied and it is the one that, in our respectful submission, should be adopted by you, sir, in determining the evidential sufficiency.

As to grossness, the relevant passage is that which appears in *Adomako*, which says that it is supremely a jury question. The jury clearly has to be satisfied on an evidential basis of there having been a breach but, once they have ascertained that, it is for them to assess the seriousness of that breach. As Lord Mackay says, that is, as I say, supremely a jury question.

THE CORONER: I think he started off by saying it was initially a matter for the Coroner to look at and, if he felt it could fall into the category, then the category would be put to the jury.

MR LEIPER: Exactly, sir.

THE CORONER: I think that is it, is it not?

MR LEIPER: Exactly so, exactly so, but in assessing how bad a breach is...

THE CORONER: That is their job.

MR LEIPER: ...that is their job.

THE CORONER: Yes, absolutely.

MR LEIPER: Exactly so. Exactly so. In grappling with issues of causation, the starting point, in my respectful submission, is establishing what the breach is, because before you have identified what the breach is, one cannot go on to identify what the causal consequence is.

THE CORONER: It is consequential, is it not? Is there a duty, breach of the duty, consequential damage?

MR LEIPER: Exactly so and, sir, under paragraph 15 of the Packman submissions you have seen that I have set out there what we say are two distinct duties, both of which require separate consideration in the context of the Packman case and, as it happens, in the Devine and the Cunningham cases.

The first is that there is a duty on the part of the clinical assistant to provide what I have referred to as rehabilitative care. It is a duty to provide care with a view to curing, in this case, Mr Packman's condition until she has arrived at a reasonable decision that his condition would not be responsive to curative treatment.

THE CORONER: Was it Dr Wilcock or was it Professor Black said that you can do them hand in hand?

MR LEIPER: I think they both said it.

THE CORONER: I think that is probably right.

MR LEIPER: I think that is absolutely right in the circumstances but it is conceivable that, while you may pursue fulfilment of those two duties concurrently, the causative consequences of failing to pursue one may be different from the causative consequences of failing to pursue the other. So what sir has to be satisfied of in the first instance is whether or not there is a breach of one or both of those distinct duties, the second duty being the duty to provide medication for the relief of symptoms which was proportionate to Mr Packman's needs. As Professor Black made absolutely clear, for obvious reasons, it is inappropriate for a doctor to take unnecessary risks.

Sir will see that under paragraph 18 I have set out those matters upon which we rely in support of the contention that there is sufficient evidence to go before the jury of there being a breach of that first distinct duty, the duty to provide curative care. If sir will indulge me just to go through a brief resumé of the relevant facts in relation to Packman, I know how many cases sir is dealing with, and you only having been burdened with these submissions in the course of this morning, it may help if I do just remind you of some of the key facts. Mr Packman was relatively young compared with a number of the other people.

THE CORONER: It is interesting. I am looking at this aged 68, the deceased. That is not old. I am nearly there.

MR LEIPER: Exactly so. Exactly so, and sir is aware of the fact that in the two weeks prior to his being admitted to the Gosport War Memorial Hospital he had been in the Queen Alexandra Hospital, where his condition had very much been improving. Sir is familiar with the references in the medical records to his temperature going down, his cellulitis settling, blood test results improving, wounds improving and antibiotics being discontinued, and you heard personally, sir, from Victoria Packman, who said that he looked the best he had for years. He was happy and chatty and keen to go home. You remember other parts of her evidence about the picture really appearing very, very positive; much, much better than it had done for many years.

Then it appears to be agreed between the experts or it is agreed between the experts that as at 26 August, so only three days after he is being admitted to the Gosport War Memorial Hospital, he suffers an acute illness, and that is the gastrointestinal bleed. If one goes over the page to page 5, so far as Dr Wilcock was concerned, it was obvious that that is what had happened from the fact that there had been a fall in haemoglobin and there was subsequent evidence of melena stools.

Dr Wilcock was clear in his evidence in relation to there having been stark omissions on both 26 August and on 27 August, and you will see that they are set out there: perform a thorough medical assessment, no basic medical observations, no medical examination. The blood results that had been requested by the consultant earlier on that day had not been obtained. There was an omission so far as Dr Wilcock was concerned to transfer him to an acute

medical unit, and there was a clear omission so far as both Dr Wilcock and Professor Black were concerned to discuss his condition with on-call physicians and geriatricians.

I took the clinical assistant to her medical note on page 55 of the bundle, and sir will remember that that was confirming that she was content that nursing staff should confirm death.

B THE CORONER: I think the point that concerned me there was that, with the continuation of melena stools, one would anticipate that the bleed was continuing. Dr Barton took a differing view and said that she considered that was probably passing through the system. That caused me a little bit of concern, I have to say. The continuation of melena stools I think would be indicator that the bleed is continuing, for what it is worth.

C MR LEIPER: Yes. Sir has heard the expert evidence about that and, if and in so far as it was continuing, it underlines the importance of doing something about it, and we heard Professor Black's evidence, which was to the effect that by the beginning of September the position was irretrievable.

THE CORONER: Yes.

D MR LEIPER: But not before then. In so far as those criticisms are justified on 26 August, they are clearly justified on 27 August, where there is clear evidence of the deceased's condition having improved. Sir will remember references to there being a marked improvement in his condition; there are two separate references to that in the medical records.

THE CORONER: Yes.

E MR LEIPER: If and in so far as there was good reason to admit to transfer him on the 26th, that reason did not appear to apply on the 27th, certainly so far as Dr Wilcock was concerned. But the omissions were compounded on 27 August in that, not only was there an absence of good reason, so far as Dr Wilcock was concerned, to transfer him, but there was also an omission to obtain blood results, which we know were available as at that stage, and there was also an omission to comply with the recommendation of Dr Ravi.

F THE CORONER: What, for the further blood test?

MR LEIPER: Yes. Sir quite sensibly, if I may say so, said in relation to Mr Wilson that one actually has to identify an individual who was responsible for these breaches and, sir, in my respectful submission, there is no difficulty about that in this case: the clinical assistant saw Mr Packman on a regular basis. Certainly on the 26th, 27th and 28th she saw him. There was some uncertainly so far as she was concerned about the 29th and 30th but she certainly saw him on the 31st. The reasons that she gave for not having acted, not having transferred G him, were firstly in relation to the risks of transfer, and sir will remember the evidence of Professor Black, which was to the effect that they were very low, and secondly, that he had been marked "not for resuscitation" and sir heard the clear evidence of both Dr Wilcock and Professor Black that that "not for resuscitation" marking should not have excluded him receiving appropriate treatment.

H THE CORONER: I think there was some evidence that the "not for resuscitation" would be in the event of a cardiac arrest.

MR LEIPER: Yes.

THE CORONER: There would not be resuscitation but I think it was quite specific to that, was it not?

MR LEIPER: Absolutely right, sir, yes.

THE CORONER: OK.

MR LEIPER: In the light of the foregoing, it is submitted that it would be open to the jury to find that the clinical assistant was in breach of her duty to provide curative treatment following that gastrointestinal bleed.

The next issue is whether or not there is a breach of duty in providing proportionate symptomatic relief, and sir is reminded of the following evidence. This is on page 6 of my submissions. The aim when administering the opioids is to relieve the symptoms with a proportionate dose, and we know that it was at the clinical assistant's request that the deceased received diamorphine beginning at 40 mg over 24 hours, increasing to 60 and then to 90 over a period of five days.

THE CORONER: I've got it at 20.

MR LEIPER: I think that was the initial prescription but I think actually the initial dose was 40.

THE CORONER: I will check that. Thank you.

MR LEIPER: What we have is Dr Wilcock's evidence to the effect that the use of the diamorphine and the midazolam was inappropriate. He says the doses were excessive to Mr Packman's needs. There was inadequate assessment of any discomfort which might require relief and no justification for the increases. Professor Black went as far as saying they were not justified by the contemporaneous medical records. Then sir will remember the evidence of the deceased's daughter, Victoria, about how that medication affected him, him becoming increasingly "spaced out", as she called it. The change was dramatic and became progressively worse.

The reason put forward by Dr Barton for the administration of the analgesia was in relation to significant sacral sores, and sir will remember that those sores had been in place while at the Queen Alexandra Hospital and no such medication had been deemed appropriate then.

Now, what flows from---

THE CORONER: Can I stop you? We probably need a two-minute break. Do you want a two-minute break out of the room or a two-minute break in the room? It is just for the equipment.

MS BALLARD: I would welcome a comfort break, sir.

(A short adjournment)

THE CORONER: It was 40 mg on the 30th.

MR LEIPER: I am grateful for that, sir.

THE CORONER: I am wrong; you are right. Good. OK.

B MR LEIPER: Sir, I was on page 6 of the Packman written submissions.

THE CORONER: Yes.

MR LEIPER: So far as causation is concerned, I hope I can take this relatively briefly. It is the view of Dr Wilcock that causation is made out in the circumstances. He has expressed the view that it was the inappropriate management of the gastrointestinal haemorrhage
C together with his exposure to unjustified and inappropriate doses of diamorphine and diazepam that contributed more than minimally, negligibly or trivially to the death.

Now, if and in so far as Professor Black has expressed a different view, and, sir, in the course of today we will hear reference to his having said that there was a "terrible" prognosis, ultimately it is a matter for the jury, and where one expert has expressed one view in clear, black and white terms, it must be a matter for them as to whether or not they prefer that view
D to the view of somebody who is saying something else.

Just in so far as Dr Wilcock's evidence is concerned, I anticipate that in the course of today you may hear submissions about his expressing a single view about what was appropriate clinical practice in the circumstances. I asked him specifically, when answering what would he have expected, to make absolutely clear as to whether or not in his view there would be a body of reasonable opinion that would take a different view, and he said in so far as such a
E body existed, he would say so. No such qualification was made to the evidence he gave.

Sir, so far as grossness is concerned, again, it is supremely a jury question but there are, in my respectful submission, sufficient matters here which would entitle the jury to find that the breaches identified by Dr Wilcock were gross. Presumably, all doctors can make a misdiagnosis in some circumstances but the question is whether or not there were aggravating
F features here and, in my respectful submission, there were. I say that because of the clear evidence on the medical records suggestive of an internal haemorrhage, both before 26 August and after 26 August. I think on seven separate dates there are numerous different entries in relation to black, tarry faeces, et cetera, and several references from cross-examination, sir, have been before you.

The blood results – again, it is clear from that. If those two bits of evidence had been put together, as Dr Wilcock said, it is clear that the diagnosis was gastrointestinal bleeding.

G

This is a general practitioner who is acting at the direction, or should be acting at the direction of a consultant geriatrician, Dr Ravi, who made clear what should be done in the circumstances, and---

THE CORONER: I am trying to remember what Dr Barton said about the set of batch results, that they got lost in the woodwork.

H

MR LEIPER: I do not think they were ever done.

THE CORONER: I know they were not done and she was asked why they were not done, and I am not sure we ever got a reply to that, did we?

MR LEIPER: So far as the Packman family is concerned, there was certainly no satisfactory reply.

A SPEAKER: They were signed by Dr Barton.

MR LEIPER: The first results.

THE CORONER: No, the first one. I am just wondering why the second set of tests were not done, and I am not sure I ever got a reply.

MR LEIPER: Sir, those omissions in relation to blood tests, which would have revealed the nature of the problem, and those omissions in relation to picking up what should have been, in our respectful submission, glaringly obvious from the medical records, is against the backdrop that the clinical assistant believed that the deceased would be unlikely to recover, and in circumstances where you are omitting to do what a responsible general practitioner should do in those circumstances, and you know that as a consequence of an absence of treatment that individual is likely to die, in those circumstances, in our respectful submission, there is clearly sufficient evidence which would entitle a jury to find that what happened was grossly negligent in these circumstances.

That is so far as a breach of curative care is concerned. So far as the excessive doses of diamorphine are concerned, sir will see at the bottom of page 7 the way in which it is put. The clinical assistant knew of the risks, she knew of the relevant principles which guard against that risk by means of the use of the analgesic ladder, she knew that it was inappropriate to run the risk of adverse---

THE CORONER: Hang on with the analgesic ladder. Paracetamol, temazepam, diamorphine, Oramorph, then diamorphine. You would not say that is going up the analgesic ladder?

MR LEIPER: Not in this case, sir, no, absolutely not.

This is a matter which is repeated in the other submissions that we made, but the clinical assistant was aware of concerns so far as Nurse Turnbull was concerned, of concerns as regards the inappropriate use of analgesia causing premature deaths. That was knowledge she had back in 1991 and, notwithstanding those concerns, there was no proper compliance, so far as Dr Wilcock was concerned, with the analgesic ladder. It is for that reason that he arrived at the conclusion that he did, that there were features which existed. So, it being supremely a jury question, in our respectful submission, those matters are matters which are sufficient to allow a jury to elevate it into the category of grossness.

THE CORONER: Thank you.

MR LEIPER: Sir, what I did at the outset of these submissions in relation to Mr Packman was to suggest three questions which should be put to the jury in the alternative, which would form the basis of a narrative verdict, and those are set out at paragraph 9.

THE CORONER: (Pause) I will be with you in a second. Yes, thank you.

MR LEIPER: Now, what we say is that, in the circumstances of this case, it is right that the jury should be asked whether or not conduct was appropriate or inappropriate. Sir has raised concerns as to whether or not it is appropriate that a jury should be invited to consider questions which may result in a judgemental response. Sir, I have set out the authorities at paragraphs 6-8 which, in our respectful submission, make it clear that, in the unusual circumstances of this case, that clearly is a proper approach.

THE CORONER: It is an available approach you mean.

MR LEIPER: It is an available approach, absolutely, and, because of what is said in those authorities, we would go further and say that it is an appropriate approach in the circumstances of this case, and if sir needs to be persuaded about that, I would ask for the opportunity at some stage to go through the relevant authorities to explain why we say that.

THE CORONER: (Inaudible)

MR LEIPER: If I can take it that sir does not need…

THE CORONER: *Middleton* is the most recent, is it not? No, it is not.

MR LEIPER: *Middleton* is the most helpful authority and I anticipate that sir will hear submissions in due course about it being an Article 2 case and the inappropriateness of transposing Article 2 cases to non-Article 2 cases, and it is the cases of *Longfield* and *Sutovich*(?) referred to at paragraph 6 which make it quite clear that that is incorrect and, as I say, sir, if and in so far as you need persuading about that, I would welcome the opportunity to take you to those authorities in due course.

THE CORONER: Thank you.

MR LEIPER: If and in so far, sir, as you are not persuaded to leave either a verdict of unlawful killing or the narrative, answering the specific questions that we have asked, we would ask you, sir, to leave a verdict incorporating neglect to the jury.

THE CORONER: Yes, I have thought about that as well, but leave it with me.

MR LEIPER: It seems that the advantage of the narrative verdict which deals with the specific questions that we have set out would be to bring out those facts of the case clearly. It would enable the jury to express a conclusion on the key factual issues in the case.

THE CORONER: That is why I want to go in that direction. I am hearing the submissions and I will think about them, but that is why I wanted to pick up on that, because trite, Home Office category verdicts are not going to answer people's questions. You can walk away with an open verdict, you can walk away with an unlawful killing, but it actually does not answer the question that people want to have answered.

MR LEIPER: Yes, yes.

THE CORONER: Far be it from me... Let us take the submissions.

MR LEIPER: I am very grateful for that indication, sir. I do not want to push at an open door, if that is what it is. The authorities do say that it is part and parcel of the process of the conducting of inquests that it is appropriate to bring out as many of the facts concerning the deaths as public interest requires, and it is for that reason that we suggest the questions are asked in the order we suggest they be asked, identifying whether or not there was a breach in the first instance...

THE CORONER: That is going to be an issue.

MR LEIPER: I understand that.

THE CORONER: I am not for or against. I just need to think about that very carefully if that is the direction we are going in.

MR LEIPER: Absolutely and, as I say, sir, if and in so far as you do need any persuading about that, I will take you to the relevant bits of the authorities.

THE CORONER: All right.

MR LEIPER: Sir, can I move on to the case of Elsie Devine? Sir, I hope, has two documents at the beginning of the bundle of authorities. The first is entitled "Submissions as to verdict".

THE CORONER: Sorry, where am I looking?

MR LEIPER: The submissions as to verdict that I have done, and immediately behind that there should be a document, which is a document that has been prepared by the Code A Code A

THE CORONER: (Inaudible) document.

MR LEIPER: Exactly so.

THE CORONER: (Inaudible)

MR LEIPER: It contains a number of very astute comments which I will take you to in due course, but it is something which arrived overnight and I had not had the opportunity to incorporate into my written submissions.

Sir, if I begin where I have left off in relation to Packman with the narrative verdict suggested questions, you see the suggestions at paragraph 9, and sir will see the way in which it is put is similar to the way in which it is put in relation to Packman. There are two separate issues that sir needs to consider in analysing whether there is sufficient evidence of breach of duty. The first is whether or not that which was done was appropriate in relation to her medical condition, her suspected deterioration in kidney function, and the second is whether or not the

administration and dosage of analgesia and sedative medication was proportionate – again, two distinct issues.

Going to page 4, the standard of care, we say, is identical to the standard which applied in relation to Mr Packman. So far as matters relevant to breach of the duty to provide curative care are concerned, sir, I set those out at paragraph 18, and the key points are, in our respectful submission, that the deceased had been admitted for rehabilitative care. At the time of her admission she was under a renal physician at the Queen Alexandra Hospital, being seen between every six weeks and---

THE CORONER: Was that Dr Stephens?

MR LEIPER: Exactly so, sir, and Cranfield(?), and she was being reviewed by the physician in relation to her functioning of her kidneys every six weeks to two months. A blood test was received which showed an increase in her creatinine level. It was an increase to 360, a rise from some 200 some seven or eight days previously, the 9th of the 11th. For reasons that sir will now be familiar with, there was good reason to be cautious about the significance to be attached to that increase in creatinine levels.

THE CORONER: It was Wilcock that said that the level of creatinine was even higher than he would have expected given the trimethoprim, was it not?

MR LEIPER: It was.

THE CORONER: He deals with that...

MR LEIPER: He dealt with that in the context of what had happened at the Queen Alexandra Hospital, and he said if one compared one result with the other, there was a question mark in his mind.

THE CORONER: Yes.

MR LEIPER: Dr Barton was unaware of the creatinine level results at the Queen Alexandra Hospital. She was only aware at the material time of the increase in November. In those circumstances, where there is clear guidance from the manufacturers of the product which states specifically that creatinine levels can rise in a reversible way from the administration of trimethoprim, then, in those circumstances, it is appropriate to be cautious about attaching too much significance to that as a result.

THE CORONER: I am not sure on her evidence that she was particularly aware of the trimethoprim at the QA.

MR LEIPER: No, she was not. Exactly right, sir. She did not know about that.

THE CORONER: She faltered slightly but I do not think it meant anything to her.

MR LEIPER: No, and the significance of that, sir, in this case is that, so far as Dr Wilcock was concerned, because there was a rise to 288 while she was at the Queen Alexandra, and the rise when she was at Gosport was to 360, in those circumstances he felt that may be evidence of a deteriorating kidney function separate from the administration of trimethoprim.

THE CORONER: Over and above, yes.

MR LEIPER: The clinical assistant's position was different, because she was unaware of the comparator at the Queen Alexandra Hospital, so all she had was a rise in the creatinine level together with knowledge of the fact that a rise in creatinine level can happen as a consequence of the administration of trimethoprim.

THE CORONER: Yes.

MR LEIPER: In those circumstances, we say that it was incumbent on her to be cautious about the significance to be attached to that blood test result.

Dr Wilcock said that in the absence of conclusive evidence of terminal illness, he would expect a referral back to the renal physician. Now, that did not happen in this case and there was no clinical assessment done to identify the nature of any deterioration in her renal function. Instead, there was an assumption – and we would say an inappropriate assumption – that that blood test result could be equated with a terminal illness.

Dr Dudley, in his report – and I will come on to that in due course – mentions some things which could have been done to stabilise the position and, obviously, none of those were done and, while it is a matter of causation, he said that if those things had been done, her position may have been stabilised for a period of days. I will come back to that in due course when dealing with causation.

So, sir, we say that there is prima facie evidence of a breach of the duty to provide curative care, and we also say – and I think this will be uncontentious, or at least I hope it will be uncontentious in the circumstances---

THE CORONER: Do not be too sure of anything!

MR LEIPER: ---of this case, in light of the expert evidence which has been given, that there was a breach of the duty to give proportionate symptom relief on 18 November and 19 November 1999.

I have set out at paragraph 20(a) the guiding principle in relation to symptomatic relief and reminded sir of the details of the fentanyl patch being administered at 0915 on 18 November, the length of time it remained in place, and then reminded sir as to what the recommended starting dose was. Wilcock's view was that the fentanyl patch was excessive to her needs. It contained up to, he said, four times the recommended dose of opiate analgesia. No justification in the notes for it and no logic, so far as Dr Wilcock was concerned.

THE CORONER: Nor anyone else, I think. I do not think anybody saw the logic of it.

MR LEIPER: Whether or not the clinical assistant did, it will be a matter for the jury, having heard the evidence they have heard, to determine whether or not it was justified in the circumstances, and---

THE CORONER: · I think justified and the logic of it... I could not see it.

MR LEIPER: No. As I say, sir, I do not want to push at an open door. Sir sees the points about who it should have been used for in paragraph (f), chronic intractable pain, and then I have taken the liberty of reminding sir as to what the evidence was in relation to the absence of there being any pain on the morning of 18 November 1999, looking at the nursing records, the psychiatric review and, of course, the family, who visited.

Dr Wilcock was quite clear that, if and in so far as there were symptoms which needed to be relieved, a measured approach was appropriate, and that clearly did not happen in this case. That is paragraph (h). One remembers that the deceased was able to take oral medication on the morning of 18 November, and one remembers that Dr Wilcock draws a distinction between the assertion that someone is not taking medication from the contemporaneous assertion from the psychiatrist that tablets were making her mouth sore. That is quite different, he says. There was no justification or we say there is evidence of an absence of justification for its use in the circumstances, which should be left to the jury.

Moving to the position after the 18th, the 19th, when sir will remember that further analgesic medication was given, we had the episode of unusual behaviour happening on the morning of the 19th. We have the evidence from Lynn Barrett that that was out of the norm. It was recorded as being a marked deterioration in behaviour, and it coincided with the time when the fentanyl patch was likely to be most effective, and all experts recognise that risks associated with excess opiates are aggravated confusion and delirium, and both Professor Black and Dr Wilcock acknowledged that the fentanyl patch could have been a relevant factor explaining that.

Dr Barton accepted that every time you assess a patient on medication it is appropriate to assess the adequacy of the levels of medication, and her evidence was to the effect that no consideration was given to the fentanyl patch as being a possible explanation for the episode of behaviour on 19 November. Again, we say prima facie evidence of breach.

Dr Wilcock recommends the more measured approach, and instead of there being a measured approach, the deceased received the chlorpromazine injection, which Professor Black said was between two and four times the recommended dose. She received 40 mg of diamorphine – again, four times the recommended dose – and that was given while the fentanyl patch was still applied. "A substantial overdose", in the words of Professor Black.

THE CORONER: That is the 40, is it not, 40 mg?

MR LEIPER: Exactly, sir. Then there was midazolam which was given. It was given within one hour of the chlorpromazine, when at least a period of three hours should been left between the two, and the amount which was given, so far as Dr Wilcock was concerned, was four times the recommended starting dose of midazolam. In view of the foregoing, it is submitted that it would be open to the jury to find that the clinical assistant was in breach of her duty to provide proportionate symptom relief on 18, 19, 20 and 21 November.

Now, sir, moving to the issue of causation, it would be open to the jury, we say, to reject the expert evidence that Elsie Devine was terminally ill as a result of a deterioration in the condition of her kidney. They would be entitled to do so for the reasons that I have set out on page 8. Firstly, there is the evidence that her death was not typical of patients dying with chronic renal failure, which is generally more gradual in onset, together with increasing weakness and drowsiness. A gradual physical decline over days and weeks would be more

typical and, sir, I have reminded you at paragraph 24(b) of the absence of any evidence of there being a gradual physical decline in the case of Elsie Devine.

We know that the blood tests should not be determinative of the physical decline, and I reminded you, sir, of the evidence in relation to creatinine levels at paragraphs (i) to (iv), and at paragraph (d) agitation displayed by the deceased was not determinative of physical decline and, again, the two reasons for that, against a background of her having been aggressive in October, firstly there is the thioridizine, which sir will remember was discontinued on 17 November, so the day before the fentanyl patch was administered, and Dr Wilcock's evidence that agitated behaviour may be caused when you stop thioridizine where it has been given appropriately. The second matter is the agitated behaviour on 19 November possibly being contributory, the evidence about the link between that and the fentanyl patch the day before.

Sir, in view of the foregoing, it is submitted that it would be open to the jury to find that the expert evidence from Dr Dudley has not satisfactorily addressed those issues, and those are not the only issues that he has not addressed. Sir will know that the family's position in relation to Dr Dudley was that if it was possible for him to come along, all well and good, and we could explore these issues with him, and these issues are of central importance in relation to whether or not Elsie Devine was dying.

Sir, the supplementary note which has been attached to the back of the submissions that I have given set out, in my submission, some very telling points which the Code A would wish you to read and consider carefully before directing the jury in relation to the weight which should be attached to Dr Dudley's evidence. I do not propose to go through them all at this stage but suffice it to say that the Code A have set out clearly those matters which cast further doubt on the accuracy of Dr Dudley's view and which they have not had the opportunity of exploring with him.

THE CORONER: Absolutely.

MR LEIPER: If and in so far as they refer to documents, and they do in there, they have those documents. I think they very helpfully summarise the evidence contained in those documents in this note, but those documents are there and are available for sir should you not be satisfied with the description they have made of the relevant points. That is an invitation to you, sir, should you want to take it up.

THE CORONER: Thank you.

MR LEIPER: In determining whether the *Galbraith* threshold as to causation by overdose is met, sir is reminded of the following evidence. This is paragraph 26 of my submissions. We know from Professor Black on Day 1 that the effects of excessive amounts of opiate and sedative medication are cumulative, and if one looks at Professor Black's original report on page 1, he made it clear, at that stage, at any rate, that he reckoned there was sufficient evidence to be able to link the date of her death with the analgesic medication she had been given. The bottom of page 1 of his report reads: "The effect of higher than standard dosage of diamorphine and midazolam may have shortened her life by a short period of time," and sir will also remember the contents of Dr Wilcock's report at page 4, which was to the effect that Dr Barton's response to this was to further expose Mrs Devine to inappropriate and/or excessive doses of midazolam and diamorphine that could have contributed more than

minimally, negligibly or trivially to her death. If and in so far as he moved from that position, it was as a consequence of Dr Dudley's report, and we say that because (inaudible) evidence, caution should be applied to it.

Sir, we know the elderly and frail and those with renal impairment are particularly vulnerable to excess analgesia. The clinical assistant herself recognised that there was a serious risk that the deceased, with her previous history of kidney problems, would not survive the strength of drugs given. She admitted that. We know what the mechanism of death can be from opiate---

THE CORONER: I think she solved it on the basis of a balancing exercise, did she not? The analgesia was a question of balance for her. I think that is what she said.

MR LEIPER: I think that may well be right, sir, and so far as the two experts are concerned, the balancing exercise was done incorrectly, in that excessive amounts were given.

We know what the mechanism for death associated with excess analgesia is: loss of consciousness, dehydration, lack of food and respiratory depression. We know that on the 19th at three o'clock in the afternoon the deceased was completely comatose. We also know that at no time following her becoming unresponsive was she provided with hydration or food, and we also know that on the following day, on 20 November, the deceased appeared to stop breathing for long periods and would then suddenly take a very deep breath. So far as Professor Black was concerned, those were the classic breathing symptoms associated with respiratory depression caused by an opiate overdose.

THE CORONER: I do not think that is what he said.

MR LEIPER: I asked him, when dealing with general principles, what the classic symptoms or what the symptoms of respiratory depression are, and sir will remember that I put a number of questions to him, including whether or not if breathing was laboured that was an indication.

THE CORONER: Was that the time we had the conversation about what was laboured breathing and what was shallow breathing?

MR LEIPER: Exactly so, but he was clear that where there is evidence of an individual appearing to stop breathing for long periods and then suddenly taking a very deep breath – it will be in sir's note of my cross-examination when I was dealing with general principles with him – he said that was a symptom, not a conclusive symptom, but it was absolutely compatible with evidence of respiratory depression.

Given the foregoing, sir, it is submitted that it would be open to this jury to find that the immediate cause of Elsie Devine's death was the excessive amount of opiate and sedative medication.

Sir will remember that I took you to the legal test for causation: more than minimal, trivial, negligible. If the jury were to accept Dr Dudley's evidence, it would be open to them to find that the deceased's death had been hastened by a few days. His opinion was that the deceased's condition could have been treated by simple measures – this is page 11 of his

report – such as stopping diuretics, the use of intravenous fluids and/or antibiotics, which measures, he states, may have improved or stabilised her condition for a few days.

THE CORONER: Sorry? Am I rejecting Dudley or accepting Dudley?

MR LEIPER: I am saying that if the jury were to accept his evidence, and that is a matter for them, now that his evidence is before the Court, were the jury to accept his evidence, it would be open to them to find that Elsie Devine's death had been hastened by a few days. It would then, in our submission, be a matter for the jury as to whether the hastening of death by a few days would amount to a more than minimal, negligible or trivial contribution to her death. They could perfectly properly make that finding on the basis of Dudley's evidence.

Sir, so far as grossness is concerned, paragraph 30, we know it is supremely a jury question but there are a number of indicators here which we say could properly elevate it from the simple breach to the category of grossness, and sir will see how I have set them out there. All those matters we say could quite properly allow the jury to find that the two breaches that I have endeavoured to identify earlier on in the submissions fall into the category of gross.

Sir, it is for those reasons that we respectfully submit that there is sufficient here to enable a jury to return a verdict of unlawful killing in relation to the case of Elsie Devine.

THE CORONER: Thank you. Break now till ten past two. Then we will get going on Cunningham.

(Luncheon adjournment)

MR LEIPER: Sir, before turning to the facts of the case of Cunningham, could I refer you very briefly, please, to the references and the page numbers of the authorities that I would like you to consider? If you have the Cunningham submissions in front of you, paragraph 3, where there is a reference to neglect, the relevant passage in *Jarvis* is---

THE CORONER: Sorry, what are you looking at? As we sit here, what are you looking at?

MR LEIPER: The Cunningham submissions.

THE CORONER: Sorry.

MR LEIPER: In paragraph 3 there is a reference to neglect. The guidance is at *Jarvis* paragraph 13-43. In paragraph 4 there is a reference to the *ex parte Douglas Williams* case. It is pages 4 and 5 of that I would like you to consider at paragraph 6. It is paragraph 29 in particular that I would like you to read, and so far as the *Sutovich* authority is concerned, it is the paragraphs 96-98. If sir would not mind just turning up those first two, the *Longfield* case, which you should find in your bundle at tab 2, and it is paragraph 29. Sir will see it is a short paragraph:

> "*Middleton* was concerned with a death in custody in which Article 2 of the European Convention on Human Rights was engaged. This factor led the House of Lords to conclude that the restrictive approach to the law as stated in *Jamieson*, that an inquest was only concerned with how death occurred and not with how and in what circumstances it occurred, could no longer be supported. But the comments made by

the House are not restricted to verdicts in cases of death where the State may have had a hand and are of general application."

Sir, a similar point in the following authority, paragraphs 96-98, Sutovich. It is a very long authority on the facts. For the purpose of reading the facts, paragraphs 1-3 I think give an adequate summary. Then paragraphs 96-98 contain the relevant principle of law. If sir has paragraph 96 in front of him:

> "This is not a case in which Article 2 applies. It is therefore not a case in respect of which the Convention requires the circumstances of death be investigated in way which would be appropriate should the Article be of application."

Then it goes on to suggest what should be included in the narrative verdicts.

If one drops down to paragraph 98, four lines down:

> "Even absent the requirements of Article 2 of the Convention, the function of an inquest is to seek out and recall as many of the facts concerned with the death as public interest requires."

That is the key passage, in my submission. Going over the page, sir is familiar with the case of *Middleton* and is aware of the fact that now it is suggested that the verdict ought to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case. That sir is familiar with.

THE CORONER: Yes.

MR LEIPER: So far as the case of *Cash* is concerned, it is paragraphs 47-52. I do not invite sir to read it now but I would be grateful if sir could read it before determining verdict.

Then the final authority is the authority of *Smith.* I am afraid, sir, that a copy of it has not found its way into the bundle and I will endeavour to get a further copy over to you, sir, but its significance---

THE CORONER: I am just wondering if I have a copy with me. If I have, it is in the retiring room.

MR LEIPER: I am very grateful for that indication. I am sure it is an authority that sir will be fully familiar with. It is paragraph 45 of the judgment which I have set out in my submissions.

> "Ms Moore submits that a verdict which speaks of a failure is in danger of transgressing Rule 42(b) and the addition of the adjective 'serious' crosses the line."

Sir will remember that was a case in which the verdict recorded a serious failure to recognise and take appropriate steps.

> "It is, she says, not neutral but pejorative. The Court made clear that the prohibition is against framing a verdict in such a way as to appear to determine any question of civil liability. The word "determine" is important. A finding that there was a failure

to act in a particular way does not appear to determine the question of civil liability. It no doubt will assist a potential clamant but it is the evidence which is elicited which will in the end be material, not the verdict of the coroner or the jury. No doubt assertions that there has been a breach of duty of care or that there was negligence should be avoided but I do not think that findings of fact, however robustly stated, can be forbidden."

Sir, it is in the light of, firstly, the fact that the *Middleton* principles about the expanded verdict apply in non-Article 2 cases and, secondly, those three authorities, which make it clear that judgemental conclusions of a factual nature are permissive in appropriate cases inform our submission that the questions we have suggested should be the ones that the jury should be invited to consider.

THE CORONER: Thank you.

MR LEIPER: Sir, turning as quickly as I can now to the case of Mr Cunningham, the first three pages, or the first two and a half pages deal with the principles upon which I have already addressed you. You see at the top of page 3 the three questions which we say are appropriate in this case, and sir will now be familiar with the pattern that has been adopted: curative care and symptom relief, and then the question of causation if any inappropriate acts are found by the jury.

Sir, so far as the verdict of unlawful killing is concerned, Mr Farthing would wish the jury to be allowed to consider a verdict of unlawful killing on two separate bases. The gross negligence basis is as detailed in the submissions that you have before you. He would also wish the jury to consider one of the other ways in which a verdict of unlawful killing might be returned, and that is that they should be invited to consider whether this is a case in which the clinical assistant caused the death of Mr Cunningham in the use of excess opiate and sedative medication and whether she did so intentionally. That is one of the two bases upon which Mr Farthing would invite you to consider go before the jury. The ingredients of the offence are plainly similar and require no further elaboration from me.

Going over the page to page 4, the duty of care, standard of care. It is the two-limbed approach that we contend for as being the appropriate one here.

THE CORONER: Can I stop you for just a moment? There is something in my mind that I need to write down before I forget about it. (Pause) Sorry. Thank you very much.

MR LEIPER: Sir, it is paragraph 16. Where a patient is considered to have a poor prognosis, Professor Black told us that it was appropriate to provide care for the relief of symptoms and rehabilitative care concurrently, and it is submitted that there was a breach on the part of the clinical assistant in relation to those distinct duties in relation to Mr Cunningham.

Dealing with the first---

THE CORONER: Was that her evidence?

MR LEIPER: Sorry?

THE CORONER: I thought her evidence was that she said yes, there was a rehabilitative side to it as well as the palliative side, or was that not in relation to Mr Cunningham?

MR LEIPER: Sir, I do not think it was her evidence in relation to Mr Cunningham. I detail what it is that we say, or the effect of her evidence on the following page. If I could take you to that...

B THE CORONER: Sorry. Am I anticipating?

MR LEIPER: No, no. It is absolutely on point, as it were. Paragraph 18, the matters that we would invite sir's attention to are, firstly, that Mr Cunningham was admitted for rehabilitative care. Sir remembers that it was on 21 September that Mr Cunningham was seen by Dr Lord at the Dolphin Day Hospital. He was then admitted to the Dryad Ward, and sir will remember the letter, reference at page 457, "with a view to more aggressive treatment of
C sacral ulcer."

At the time of his admission the consultant geriatrician he was under had set out a clear care plan, and sir will be familiar with the contents of that, the three limbs that I set out in paragraph (b) and, sir, the effect of the evidence, we say, is that that care plan was not followed. The clinical assistant treated him as though he was terminally ill from the moment of his arrival, and in support of that we rely on her entry at page 645 in the bundle. We rely
D on the fact that Mr Farthing, on attending on 21 September, was told that he was not going to live. He did not receive the high protein diet to help improve his nutrition and help the wound healing that had been recommended, and once he had become unresponsive, and he was completely unresponsive so far as Mr Farthing is concerned by 23 September, and no hydration or infusion was provided until the time and date of his death on the 26th.

Paragraph (d), sir, records the evidence as my instructing solicitor has recorded it of
E Dr Barton's explanation for what happened. The reason why Dr Lord's care plan was not followed was that the clinical assistant took a different view from Dr Lord in relation to the deceased's prospects of survival. Her personal assessment and examination led her to take a different view to Dr Lord in relation to his survival prospects. The significance of that, sir, in this context is that Dr Lord, at the conclusion of her statement, records that recommended treatment can be altered without further consultant input if there is a change in the patient's
F condition. I think that is in the concluding three lines of the statement.

She made her assessment on 21 September. The clinical assistant made her assessment also on 21 September, and Dr Wilcock confirmed, if and in so far as it needed confirming, that there had been no change in his condition between the two assessments. In the absence of a change in the deceased's condition, and in the absence of further consultant input, it is submitted that it would be open to the jury to find that the clinical assistant was in breach of
G her duty to provide the curative care recommended by Dr Lord to the deceased.

Sir, the second limb is in relation to proportionate symptom relief. At page 6 of the submissions at paragraph 20, I wish to draw attention to the following evidence that sir will remember. The first is the guiding principles in relation to the use of analgesic and sedative medication, and the important principle that where a dose is given which is excessive to a patient's needs, it may result in a loss of consciousness, drowsiness, delirium or agitation, and in such circumstances consideration should be given to a review of the propriety of
H continuing the level of analgesia administered. The significance of that in Mr Cunningham's

case is, firstly, that the original recommendation in relation to analgesia had been by Dr Lord. Her recommendation was that it should be between 2.5 and 10 mg as required. Sir will remember that when Mr Cunningham arrived at Dryad Ward he was fully conscious. Later that evening, at quarter past eight, he received 10 mg of Oramorph and at ten o'clock that evening – sir will remember the entry in the medical records at page 754 – he was sedated and, notwithstanding his sedation, at ten past eleven that evening the syringe driver was commenced and continued until he died.

Now, absent from the medical records is evidence of an adequate assessment, we say, of the nature or origin of the symptoms being treated, of the need for increases and the effect of the medication on the deceased. The clinical assistant asserted that the deceased was in agony and that was the reason for the level of analgesia she was giving, and we say that is not borne out by the contemporaneous evidence nor indeed by the evidence of Mr Farthing, who visited him on the 21st.

Over the course of the next six days the doses of diamorphine increased from 20 mg to 80 mg and midazolam increased from 20 to 100. So far as Professor Black was concerned there was insufficient in the medical records to explain the increases, which required to be justified. So said, 23 September Charles Harding attends to find his stepfather totally unconscious, and in questioning the clinical assistant, she accepted that consideration was never given to the possibility that the deterioration in his condition may have been due to the excessive opiate analgesia, and that is a step which we say the expert evidence suggests that she should have done.

In circumstances where there is no or alternatively no adequate assessment of the nature of the symptoms or the propriety of the continuation of the opiate analgesia and/or the effect of the medication on the deceased, it is submitted that it would be open to the jury to find that the clinical assistant was in breach of her duty to provide proportionate symptom relief.

Sir, if I can turn to the issue of causation, in determining whether the *Galbraith* threshold as to causation is met, I respectfully remind sir of the following evidence. The first is that Dr Lord considered it was appropriate to keep the deceased's place at the nursing home open for a period of at least three weeks. Dr Wilcock suggested that a care plan would not have been written up for the deceased if Dr Lord felt that there was no chance. While the deceased's overall prognosis was poor, or even very poor, there may have been scope for some improvement.

There was no reference to respiratory difficulties or signs of pneumonia in Dr Lord's assessment and six days later the deceased died of bronchopneumonia, and, as sir will remember, Professor Black confirmed that bronchopneumonia can occur as a secondary complication of opiate and sedative induced respiratory depression. Professor Black, importantly, said that while he thought the deceased was likely to die anyway, the analgesic and sedative medication may have slightly shortened his life.

Sir, in the absence of a change in circumstances, it is submitted that it would be open to a jury to find that Dr Lord's three-week time estimate was based upon an assumption that the deceased would be treated in accordance with the recommended care plan. In the event, the deceased was dead within a week. It is submitted that it would be open to the jury to conclude that the deceased, had he been treated in accordance with Dr Lord's care plan, and in the absence of analgesic and sedative medication, would have lived for a period longer

than he did, and, in view of the foregoing, it is submitted that it would be open to the jury to find that the breaches or alleged breaches by the clinical assistant made a more than minimal, negligible or trivial contribution to his death on 26 September.

THE CORONER: You do know that we are talking beyond reasonable doubt, to the criminal standard of proof?

B MR LEIPER: Sir, yes. I do know that and, if and in so far as sir finds that the evidence fails to get to that standard, these submissions are relevant, in my submission, in relation to the propriety of the questions which are suggested in the narrative verdict, where there is a lesser standard.

THE CORONER: Thank you.

C MR LEIPER: Sir, so far as grossness is concerned, you have seen the submissions that we set out there. We say that, given Mr Cunningham's need for treatment, his age and frailty, he was at heightened risk of death from excess analgesia. The clinical assistant knew that excessive doses of diamorphine could cause respiratory depression. She knew that it could cause loss of consciousness, death, delirium and confusion. She was familiar with the principles of the analgesic ladder, and of the need for particular caution in the administration of strong opioids to the elderly, and she knew that it was not appropriate to run the risks of D adverse consequences inherent in administering doses in excess of the recommended starting dose.

Notwithstanding that, she proceeded with a course of analgesia which we say the jury would be entitled to find was excessive for his needs. We also say that there was no adequate explanation for failing to follow the care plan recommended by Dr Lord, and where you have clear instructions from someone senior to you in the medical hierarchy, that is an aggravating E feature which would enable that breach to be elevated to the category of grossness.

In view of the foregoing, sir, it is submitted that it would be open to the jury to find the clinical assistant breaches of duty to the deceased were gross and, sir, if and in so far as you are against us in relation to that, we would invite you, sir, to consider the verdict of neglect and a narrative verdict in accordance with the questions set out in the submission.

F THE CORONER: Thank you.

MR LEIPER: Sir, so far as Sheila Gregory is concerned, you have my written submissions. I do not think there is anything I need add to them.

THE CORONER: No, I am more than happy with that. Thank you very much indeed.

G MR JENKINS: Sir, I will be very short. You have had my written submissions. I do not know whether you have had a chance to look at them.

THE CORONER: Yes, I have. I do not know what I have done with them. Here. Thank you.

MR JENKINS: Can I suggest the initial view that you advanced to us this morning, namely H that there simply is not the quality of evidence on the question of causation or indeed on the

issue of gross negligence to leave any of these allegations to the jury and the possibility of returning a verdict of unlawful killing.

You have, as you have identified, a medical cause of death in each of these cases.

THE CORONER: Well, I have a selection of causes of death, and they are all medical causes of death not dealing with drug overdoses.

MR JENKINS: Indeed. In those circumstances, it is quite wrong, I suggest, to leave to a jury the possibility of returning a verdict of unlawful killing.

So far as the possibility of an open verdict is concerned, I would suggest that is not appropriate, and I echo the sentiment that you have suggested, that it does not answer any questions. There is a sentence or so in *Jarvis* suggesting that it might occasionally be mischievously asked for a coroner to leave the possibility of an open verdict. I am not suggesting that is the basis upon which it has been put.

THE CORONER: Mr Sadd, what is he suggesting?

MR JENKINS: No, no. I will read it. I am reading from *Jarvis* at 13-37.

> "Coroners must also guard against the mischievous seeking of open verdict in order to have a death clouded in suspicion but there will be cases where there is a real doubt and any other conclusion would be unjust."

That is added to in the third supplement, and I do not think I need take you to it.

If there is clear doubt, then an open verdict might well be appropriate, but there is not here.

THE CORONER: It is not even that, is it? It is if the evidence is insufficient upon which to find. That is the open verdict. It is just not on here.

MR JENKINS: I agree.

So far as the proper approach to be taken is concerned, you have been given some authorities. I too am grateful to Mr Leiper for having put them in the bundle for you. Can I just take you to *Douglas Williams*? I know you have looked at the passage already.

THE CORONER: Where are you?

MR JENKINS: It is *Douglas Williams*. It is the first tab in the bundle. It is the fifth page of that judgment, from the judgment of the Master of the Rolls, Lord Woolf. I am going to read from just over halfway down the page. It is Lord Woolf dealing, and having recited the passage from *Galbraith*, Lord Woolf goes on:

> "The conclusion that I have come to is that so far as the evidence called before the jury is concerned, a coroner should adopt the *Galbraith* approach in deciding whether to leave a verdict. The strength of the evidence is not the only consideration and in relation to wider issues the coroner has a broader discretion. If it appears there are circumstances which in particular situation mean in the judgement of the coroner,

acting reasonably and fairly, it is not in the interests of justice that a particular verdict should be left to the jury, he needn't leave that verdict. For example, he need not leave all possible verdicts just because there is technically evidence to support them. It is sufficient that he leaves those verdicts which realistically reflect the thrust of the evidence as a whole. To leave all possible verdicts could in some situations merely confuse and overburden the jury."

THE CORONER: One would wonder these days what every possible verdict is.

MR JENKINS: I agree. There have been, may I suggest, with respect, some efforts made today to suggest that technically there is evidence upon which a jury could reach that decision. I would suggest that is not the thrust of the evidence, that there was gross negligence here. I have dealt with the issue of causation, and I echo the view that you have already expressed.

One has to deal with the situation that actually faced those at the War Memorial Hospital, and to the extent that commentary can be given on Dr Barton's role, one has to focus on the limited extent of her role. She was always busy. She was eager to hear from nursing staff and others about the condition of the patients. I am going to ignore the noise from the back.

THE CORONER: I will do the same, until such time as I cannot ignore it any more, and then I will do something about it.

We know that she asked for more time because she felt that the job needed more time, and she was given more time, but not much.

THE CORONER: Is that the rise from four to five sessions?

MR JENKINS: It was. But there is still one and a half allocated to her partners. We know that she was there, and this was the management decision that she should be there, for a very limited part of the working day.

So far as note-keeping is concerned, obviously, there are criticisms in that regard, and it may or may not be the case that Dr Wilcock is right to say that time is an elastic concept. We are not in the Nottingham Coroner's Court, and it is not a proper approach for a court to take to say, "If it is not noted, it did not happen." That is completely the wrong way in which to go about things. Note-keeping does not cause or contribute to death. If an examination is made of a patient but not noted, that may be a cause for criticism of the doctor but it cannot contribute to death. If there is a justification for the medication but that is not noted, that again cannot lead to death at all.

What it can lead to is the sort of criticism that we have heard of some of the prescribing, that there is no justification for it – in brackets written in the notes. Much play has been made throughout the course of the inquest that that prescription was unjustified, that there was no justification for it. Again, one has to look at the conditions that Dr Barton was facing and was dealing with. We know of many of the prescriptions that they incorporated a range which was known about by the nursing staff, suggested, I think, by the nursing staff, and certainly agreed by the various consultants who were there. None of these patients were actually administered the full range of what was prescribed for them.

The phrase has been used again and again that the prescription was unjustified or inappropriate or irrational. It is not the prescription---

THE CORONER: Those are different things, are they not? Justified is one that is given justification, and that is what is missing, is it not? That is what everybody has referred to throughout, that there was no note saying why that was started.

B MR JENKINS: That is right.

THE CORONER: Why that was the dose.

MR JENKINS: But it will be obvious that if you give someone rather less time to do the job than the job properly requires, the job will not be done as in an ideal world it would be.

C So far as the drugs were concerned, what was important was the administration of the drugs. The prescription cannot do anything. The drug has to be given, and what we know in every case is that it was nursing staff who were providing the medication, and we have to analyse not just the role of the doctor who may have prescribed or continued a prescription, but also that of the nursing staff.

D Now, I have dealt with that in my written submissions and I do not repeat that now. I do not think I need to. What I have said, though, is that for anyone to focus on the question of unlawful killing, they have to look at the position of each individual whose actions are being analysed. It has to be shown that that individual knew the requisite facts or was aware of them, and that in relation to those facts they were grossly negligent. There is no valid criticism of gross negligence here.

E The other point is, it cannot really be said on the evidence that the doctor prescribing knew everything about the patient. If the patient's condition changed, it is not at all clear that the doctor was informed about it that day. If some of the medications – and we will see examples in a moment – were written up as required, it was not a medical decision as to which of the drugs should be given or which dose. Those decisions were made by nursing staff.

F There is, I suggest, no proper basis for saying that Dr Barton was aware of the condition of every patient every time they were to be given some more medication. We know that the nursing staff would approach their task conscientiously. That is the evidence of those who have spoken about it in the witness box, about the giving of medication and that they would not have given medication if they thought it was inappropriate.

G I do not need to deal in any depth with 1991. We know that those were essentially concerns by nurses who had had no training, who had not had previous experience of syringe drivers, and who felt somewhat at a loss to deal with them. That was dealt with at the hospital, and those concerns were not current or live concerns in 1996 or thereafter, at the time with which we are concerned.

Can I deal with three cases, no more, and deal with some of the concerns that were expressed by those beside and behind me. So far as Mr Wilson is concerned, when he was brought to the War Memorial Hospital he was in bad shape. He had had a difficult journey. Ian Wilson, H his son, told us that it was a four-hour transfer. There was other evidence to suggest it was

less, but from the son it was a four-hour transfer, and his father had had a rather bad journey. What we know is that Dr Barton assessed Mr Wilson once he arrived, and it was clearly her view that he was in bad shape. She wrote up paracetamol to be given as required. She also wrote up Oramorph on 14 October as required. The dose she wrote up, given the strength of the medication, was 5-10 mg, and the nurses undoubtedly would have approached Mr Wilson after that time and made an assessment as to how he was doing and what level of pain he was in, and he was given Oramorph 10 mg, the top end of the range that Dr Barton had suggested might be appropriate on the as-required prescription. That was a nursing decision and it was undoubtedly made based on how Mr Wilson presented to the nursing staff.

Now, it is criticised, the decision to give Oramorph, but we know, sadly, Mr Wilson's liver function was such that any pain killer, any form of opiate, paracetamol, aspirin, were all contra-indicated for someone with hepatic impairment in the way that he had.

We know that on 15 October Dr Barton was there again and on that occasion she wrote up Oramorph as a regular prescription. We do not know what was said to her by the nursing staff. We do not know what she was told about how he tolerated the Oramorph that he had. Dr Barton did not make a note. In the statement that she read and in the answers that she gave she could not recall what had happened on that occasion, but she would have had feedback from the nursing staff. We know that she regularly did.

There is an entry in the medical records from Sister Hamblin for 15 October saying that Oramorph was commenced four-hourly for pain in the left arm. That is on the 15th. That is why it was given. We know that after that time there was a significant decline in Mr Wilson's condition. Dr Napman saw him on the 16th, and thought it was possibly a myocardial infarction or a deterioration in his liver function. We know that after Dr Napman saw him, the syringe driver with diamorphine was started. We know Dr Peters saw Mr Wilson a day or so later.

So far as gross negligence is concerned, there is not any. There is no evidence of it. So far as causation is concerned, we know Dr Wilcock very pointedly declined the invitation to point at the medication as having played a role in his death. He pointed to the other conditions as being a full enough explanation of the death. No suggestion from him that any medication did in fact play a role.

Is there the material there for a jury, properly directed, to come to a conclusion of unlawful killing, a verdict as to which they are sure? Plainly not. You have a broad discretion so far as these matters are concerned. This does not satisfy the *Galbraith* test and it would be wholly inappropriate. It would not follow the thrust of the evidence in the case. All we have heard from nursing staff, medical staff, who actually dealt with this patient would not follow the thrust of that to allow a jury to consider such a verdict. It would be unsafe if they were to return it.

So far as Mr Packman is concerned, you will recall the evidence of Professor Black. It is at page 15, paragraph 6.6. The prognosis for Mr Packman or someone with his conditions was terrible. The quotation in his report reads as follows:

> "Such patients almost invariably deteriorate and die in hospital."

Mr Packman had the worst bed sores that the experienced nurse, Shirley Pullman, had ever seen. She had worked for 20 or more years in nursing. We know that Mr Packman had a significant deterioration in his condition, probably from a gastrointestinal bleed, one that Dr Barton attended after. It was one of two or so diagnoses that Dr Barton considered. On the question of whether it was appropriate to transfer Mr Packman, given his then condition, Dr Barton explained that she did not think that there would be anything that people would be able or would wish to do for him. She made a comment about the anaesthetists, who, if he was to have an investigation, an endoscopy, would need to deal with Mr Packman. She said the anaesthetists would not want to deal with him because he was not safe.

THE CORONER: Was it about Mr Packman that she made the point of how long was he going to sit on a trolley, waiting to be seen to?

MR JENKINS: Yes. I think it was. There were two patients where the question of whether they should be transferred was raised. The other was Mrs Devine. I will come to that later. So far as Mr Packman was concerned, it was her view that this was not a suitable case for transfer. Professor Black did say – this is page 16, paragraph 6.8 – that in view of Mr Packman's other problems, it was within the boundaries of a reasonable decision not to transfer, just to give him palliative care only.

So far as causation is concerned, this was a view that he repeated in evidence. Professor Black's report certainly says on page 17, paragraph 6.12, that the doses of diamorphine used were required to control his symptoms and did not contribute in any significant fashion to his death. The doses of diamorphine used were required to control his symptoms. The proposition that that might or should be left to a jury as a basis for unlawful killing really does not stand up.

So far as Mrs Devine is concerned, on 18 November she was refusing medication. Dr Taylor's note in the clinical notes is at page 156. Mrs Devine, undoubtedly because of her kidney condition, had deteriorated over the previous few months. She had been attacking staff, interfering with other patients, there were problems of a management level that were had on the ward, there would be concerns about approaching someone behaving as Mrs Devine did with a syringe, and it is undoubtedly the combination of problems that Mrs Devine exhibited that Professor Black offered the view that she was an example of the most complex problems that are dealt with in geriatric medicine: confusion, behavioural difficulties, together with an underlying serious medical condition.

Dr Barton was faced with a difficult situation, a patient who was refusing medication, who was aggressive and threatening, but who needed, for her own safety as much as that of anyone else, to be calmed down in some way. It was in those circumstances that Dr Barton thought that the administration of a patch, rather than tablets which the patient would not take or an injection, which might be too dangerous, might be a suitable way of dealing with distress and agitation, and we know that it proved possible later in the day to administer another drug by, I think, the oral route.

THE CORONER: I do not think it was, was it? Was it chlorpromazine?

MR JENKINS: That might be right. It was an injection. I know that it was (inaudible).

THE CORONER: No.

MR JENKINS: By 19 November, the following day---

MR LEIPER: Just to clarify the facts, should it assist at all, the fentanyl patch was on the 18th in the morning. That was followed by chlorpromazine the following day, on the 19th.

MR JENKINS: On the 19th---

THE CORONER: Are you there?

MR JENKINS: I will not finish in two minutes but I might finish in three.

THE CORONER: You might be cut off in your prime.

MR JENKINS: On the 19th – this is Black, paragraph 6.16 – Mrs Devine was terminally ill. He said it was a reasonable view to come to, that conclusion. Paragraph 6.17: at that stage it would be inappropriate not to offer palliative care. We know from Dr Dudley's report that strong opioids are used in the management of patients with serious kidney disease. We know that fentanyl played no role in the death. You will recall I put it to Professor Black that it was nonsense to suggest, if there was any overdosing of opiate, that the fentanyl should have played a role in her death some two and a half days later, and he agreed.

We have talked about curves and I do not know that I understood it or that anyone else did, but we did talk about curves of levels in blood. Shall I pause there?

THE CORONER: Do you want to change that?

(End of audio file)

THE CORONER: Thank you.

MR JENKINS: So far as the final 58 hours of Mrs Devine's life are concerned, they are (inaudible) Professor Black. He said---

THE CORONER: I heard a musical movement. Where did that come from?

A SPEAKER: I am sorry. That's mine.

THE CORONER: Oh. Put twenty quid into the box.

MR JENKINS: Mrs Devine's final 58 hours are commented on by Professor Black. It is not an indication of a drug death.

We have heard some evidence about trimethoprim, the suggestion that that could have led to a raised creatinine. Dr Reid knows of that as a theoretical possibility. He had never seen it. He did not think it was happening in this case. So far as Dr Wilcock is concerned, he did point out that the reading for creatonine in the War Memorial was significantly higher than it had been elsewhere. If trimethoprim had played a role, it was undoubtedly a continuing decline in Mrs Devine's kidney function.

We have the report of Dr Dudley. He is someone who you have been invited to kick into the long grass, if I can put it in that way. He is actually the expert on renal function and kidney problems. He has given a clear explanation as to the sort of treatment that is provided for patients in terminal stages of kidney disease, and he has given a very clear indication of the sorts of medication that he used, and he has given a clear indication of the picture that one can sometimes have as the patient moves towards death. Mrs Devine fell within each of those brackets. There is no basis here for the suggestion that there was gross failure in care.

Neglect has been touched upon in relation to several of these cases. There is no gross negligence in relation to any of these.

Would it have been appropriate to transfer Mrs Devine off to a kidney unit? I do not think it is seriously being suggested. It is being suggested she could have been transferred back or referred back to Judith Stephens, the consultant renologist who was dealing with her but I do not think we have any indication as to the timescale. What would have been the clinical appointment that would have been given? I do not know that it has been suggested that there were urgent appointments that could be taken up. One's suspicion is that, had there been a referral back, there might have been a clinic date given in a number of weeks' time.

THE CORONER: That is supposition, is it not?

MR JENKINS: Yes.

So far as Mr Cunningham is concerned, Dr Barton did not take a different view to that of Alfia Lord. All of the doctors who dealt with Mr Cunningham thought that his condition was extremely poor. We do not have to interpret from Alfia Lord's letter saying that the nursing home should be asked to keep his bed for another three weeks. We do not have to interpret from that that she thought his life expectancy was at least three weeks. We have her own evidence. Dr Lord's statement was read and she made it absolutely plain that her view was that his condition was extremely poor.

Sir, those are my submissions.

THE CORONER: Thank you. Mr Townsend?

MR TOWNSEND: Sir, I can be very, very brief indeed because, plainly, the majority of the submissions that are made really do not affect my clients directly at all. Indeed, there is no substantial criticism of them.

May I make two general points with respect to the approach on the law? In so far as the narrative verdict is concerned, Mr Leiper correctly took the Court to the authorities that say that the narrative verdict is not restricted to the *Middleton* Article 2-type case. However, it is important, in my submission, that that is qualified, otherwise there is a danger in imagining – which I am sure, sir, you do not – that a broad scope inquiry is necessarily therefore available or appropriate in all cases.

THE CORONER: The Government decided this was not going to be one of those, did they not?

MR TOWNSEND: No, and furthermore, sir, I make this point. In the passage that Mr Leiper read out, he points out that it is the public interest that has to be considered in framing the questions, and in an Article 2 case the public interest is very, very different from an inquest of this sort. It was for that reason that last week I put before the Court some suggested questions, simply concentrating on the main thrust in this case, which appears to be concern over the use of diamorphine. It is matter for you, sir, as to how far you wish to expand the matter beyond that limited scope of inquiry but I do invite you to consider that that really is the main focus of each of these inquests.

THE CORONER: Yes.

MR TOWNSEND: The second matter, which follows on from what Mr Jenkins has said, is the possibility of the neglect verdict. As Mr Jenkins touched on briefly, and indeed, as appears in the helpful skeleton that Ms Ballard has submitted, neglect of course means a gross failure of some sort or another, and it is important, in my submission, that the term is not used too flexibly.

THE CORONER: Can we distinguish between neglect and negligence?

MR TOWNSEND: Yes.

THE CORONER: You are talking to me now of neglect.

MR TOWNSEND: Yes. That is the potential verdict that has been raised. It is a high threshold in my submission, a threshold that is illustrated by the example given by the Master of the Rolls in the *Jamieson* case itself. He makes the point in the context there, of course, of prison suicides, that a failure – in other words negligence by the prison authorities in failing to prevent a death – would not of itself be enough, and he goes on to give an example of something that might be enough: a prison warder passing a prison door and actually seeing a prisoner making the preparations to kill himself. That, in my submission, gives the flavour of the kind of failure that is necessary in order for a neglect verdict even to be considered and, in my submission, that simply is not reached on any of the facts of these ten inquests.

Those are my submissions.

THE CORONER: Thank you. Ms Ballard, can I just clarify something before you address me? When I was talking about the prospects of this last week, or however long ago it was, I wondered how far the scope of any questions for the jury might go, and I raised at that point the question of how one would look at the governance of Gosport. I do not think that is appropriate and I do not propose going in that direction. I note from your submissions that you canvass that. No, I think you are quite right. I do not think it is right to head in that direction. That is a separate issue and that is something that, as I say, the Government chose not to do.

MS BALLARD: Well, sir, then I can be extremely brief, because that was the main thrust of what I was going to submit to you. I would just pick up on some remaining questions regarding the question of neglect. As well as being gross, there has to be a gross failure to provide basic medical care, and something which no-one has touched upon thus far is the level of medical care concerned. I think there can be no suggestion that the complexities of the issues that have been considered, the questions that are called into consideration regarding

the decisions, regarding and requiring the input of considerable expert evidence, that any of this falls into the realms of basic medical care. There have been suggestions that there have been failures to take temperatures or to take blood pressures or readings such as that.

THE CORONER: That was on the part of the doctor, was it not?

MS BALLARD: In any event, none of those are causative, and they have to be. They have to be on the balance of probabilities, and I draw your attention to the case of *Khan*, which I refer to within my written submissions. I merely highlight that point. Sir, I believe that everything else has been adequately canvassed before you and I do not wish to just repeat matters which have been adequately put before you thus far. My main concern was where you were intending to go with asking questions as to the general clinical regime at Gosport.

As to the jury questions that I have put before you, sir, which incorporates some of the consideration of the points raised by Mr Townsend on Thursday, which was when we were last before you, it is just to make the point that, when I list those patients to whom the questionnaire should relate to at the heading, that should include---

THE CORONER: You have missed out Mr Packman.

MS BALLARD: I did. There was a reason for that but, as has been pointed out to me by someone else, it is potentially unclear. What I mean is to point out that those questions at (c) and (d) are specific to the cases of Packman and Devine. The rest are relevant to all the deaths.

They are a variation on the theme that has been suggested to you by all parties in fact, but really the focus is on what Mr Jenkins was saying to you on Thursday, that if there is not thought to be any causal connection between the medication and/or other decisions and death, then there would be no need to go into considering whether or not the administration of medication in those circumstances was appropriate, and that, I think, is the appropriate way, or rather the appropriate order in which to take those issues.

Sir, I do not need to delay you any further.

THE CORONER: Thank you.

There is no doubt in these ten cases that I will proceed by way of narrative verdict. The reason for that is that the alternatives – I hesitate to use the word "trite" but the Home Office category of unlawful killing is inappropriate, the gross negligence is inappropriate, for all the reasons that we have heard. The perhaps most significant factor is the standard of proof that would be required in those verdicts. In order to find those, I would have to have a jury that was satisfied beyond reasonable doubt, that is, so that they are sure that those verdicts are appropriate and on the evidence that we have, they cannot be, as a matter of fact and as a matter of law.

The question of causation is something that they certainly cannot be satisfied on, and out of the ten deaths, I do not have one cause of death that is suggestive of drug overdose. The verdicts that I have had from the certification, from Professor Black and from Dr Wilcock, supported where appropriate by Dr Dudley and Dr Petch, are natural causes of death, and there is nothing unnatural about them. Coronial law will say to me quite clearly that the

investigation that I need to conduct is on the basis of the medication, the appropriateness of it and not looking in any way at an unnatural cause of death.

Against that background, and in the light of the public interest in these cases, the appropriate way of dealing with that is inviting the jury first of all to do the choice, reasoned choice, of the cause of death for each of the deceased, and I will advise them as best I can in the light of my experiences, and then to answer questions, and I have drafted questions, and I am not sure that they are in the right order. It is something really that I think might benefit from a bit of guidance from the floor.

Did the administration of any medication contribute more than minimally or negligibly to the death of the deceased? If yes, was that medication given for therapeutic purposes? If yes, was that medication appropriate for the condition from which the deceased was suffering? I think that is about as far as I can go without infringing anything under section 42.

I think that is where I am going to jump off with the jury tomorrow, unless, in the light of those, there is anything you want to say to me.

MR TOWNSEND: Sir, a very minor matter, and it is me being pedantic perhaps. Might you consider in relation to (3) the condition and symptoms from which the deceased was suffering? It is really that "condition" might be thought of as being the underlying medical condition only.

THE CORONER: I take that. Right. I may be some time with the jury tomorrow. I will speak as quickly as I can. The notes that I have are fairly vast but they are not going to cover every single point, but hopefully they will cover the points that I consider are relevant to the jury's deliberations.

All right. Ten o'clock tomorrow.

MR TOWNSEND: Unfortunately, sir, I am not able to be here tomorrow because of a part-heard case. Mr Green, my instructing solicitor, will be here. He is taking the dangerous route of coming up from Exeter tomorrow morning, so I hope he is luckier than I am.

THE CORONER: You are obviously a much travelled bunch! Right. Ten o'clock tomorrow morning. Thank you very much indeed.

(Adjourned until 10 a.m. the following day)