DAY 17

Blake Lapthorn

File Note

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Code A

Client: Private

Matter: Gosport War Memorial -v- Gosport War Memorial Hospital

Matter No: 516130/000001/JCW/GOSPORT

Author: Gemma Bailey

Date: 14/04/2009

Units: 1

Attendance on Client
1 Units (Gemma Bailey) - Unknown - Gosport War Memorial

GWMH Day 17

Coroner – thanks for submissions. Any further?

JT – none as non interested party.

Coroner –need to be clear court of law and as lawyers deal with law. Problem = gross negligence manslaughter, cant find grossness. Also have problem of causation. 5 doctors looking at causation. Not one says drug overdose on causation. No mention as cause of death. Jury will need advice on how to approach. Difficulty in that point of view. Inquest not trial. Cant get over fences want to.

PS – will try to help with that. Will be aware of submissions on behalf of IW and what coroner will say are flaws of these submissions.

Coroner- need to sell to jury, be clear what level sell to them.

PS – not ignorant of hurdles in place. Submission of unlawful killing = serious submission and serious verdict with serious consequences. Dealing with 10 deaths and 10 inquests. Important here as may be a tendency to subsume deaths together by looking at generic issues. Invite coroner not to do that. There are some generic issues but those should not cloud individual issues to each death. Pg 1 introduction suggests 2 potential verdicts which can on evidence be left to jury. Unlawful killing not most controversial, controversial = open verdict. Problems there because of gaps in evidence, demonstrated in Dr Wilcock's difficulty in coming to conclusion about what caused decline as he had to defer to other experts which evidence has not been put before jury. Pg 2 – para 1.6 not inviting to make decision on facts, but necessary to refer to evidence. Pg 2-3, although such a verdict rare, submissions will be no surprise. TL also cites them as helpful background. Pg 3 – part 3, Adomako

Coroner – anaesthetist case

PS – yes. Alarm goes off for 10 minutes or so, no one knew why. Steps he took were reasonable in circumstances but not accepted by jury. TL's bundle, penultimate tab. Know factual background to that. Pg 7 – bottom Lord McKay sets out approach to what needs to be established in gross negligence manslaughter. Pg 8, not quoted in submissions but relevant today – question of degree as to how far conduct must depart from norm to be criminal. Having regard to risk was conduct so bad in all circumstances to amount to criminal act or omission. In IW's case question will be about risk of death involved. We say too great a dose on 14-15th which led to coma. Dr Wilcock says dose given would have led to decline. Say morphine contributed or caused death. 3.2 – set out 4 elements of gross negligence manslaughter. Coroner will be concerned with elements c and d. Case appears to be in balance rather than clear cut. Recognise IW case in balance but ask to reconcile in favour of family to leave verdict to the jury with caveats.

Coroner- whose negligence talking about? Would have to look at an individual. Anticipate where going but JB not solely responsible or in charge.

PS – on case present, negligence say is gross is 14th and 15th. By then decline inevitable. Actions of Dr Knapman and Dr Peters irrelevant. De facto position is that JB was in charge, was overseeing authority. Best evidence of this is evidence from nurses themselves, and approach they adopted to pre prescribing, and fact no consultant supervision during that period – Tandy on maternity leave. Know from questioning of JB that she accepted she was in charge and responsibility for care and prescribing rested with her. Administration of medication may have been left to nurses. On 15/10 know JB attended and in spite of what AJ says re prescription as per need, when you look at prescription chart it shows 4 hourly prescription of medication, JB there and approving of that course of action. JB says no need for note.

Coroner – what about nursing staff who say wouldn't have given inappropriate medication?

PS – on basis of their association with JB, and approach taken by Hamblin, very little questioning of prescribing process.

Coroner – subjugated? Look at nurses as independent people.

PS – no examples of nurses questioning prescriptions. In 91 were concerns.

Coroner – concerns resolved by 96.

PS – by 96 concerns had been met. No evidence to go before jury on any questioning or doubts about pre prescription. Jury have evidence from JB about pharmacist but no evidence before jury about concerns being raised by 98.

Coroner – if concerns not expressed, how do you prove?

PS – jury have evidence of 3 expert witnesses all of whom criticise medication being given to Mr Wilson.

Coroner- why not properly addressed by narrative verdict?

PS – because of complexity. 4.1 – anticipate duty of care owed.

Coroner – no disagreement with that

PS – breach. Simply whether or not by reference to those looking at conduct involved whether there was a breach. Set out views of experts. Pg 5 – Baker's report pg 15. Even if record made of reason for or assessment of Mr Wilson on admission, Baker says dosage then given is inappropriate. Echoed by Dr Wilcock and PB. Even if entry, experts consider dose unjustified. Morphine likely to be excessive to needs. Dr Wilcock and PS – exchange of words looking at morphine being given to someone with known liver failure. Dont feel dose justified. Dose excessive to needs would carry side effects. Most telling evidence is when Wilcock agrees that dosage of morphine disregarded his safety by unnecessarily exposing him to receiving excessive doses of oromorph. Say elements a and b made out to necessary standard.

Coroner – if made that out would show breach.

PS – yes. One issue, pg 6, tension exists between underlying problems and consequence or probably consequence, and how to approach or medicate those problems. entry in medical records on eve of transfer – reviewed by medical team, requires specialist care. Oedema, risk of self neglect and injury. Needs 24 hour care until healed arm. Dr Wilcock also makes reference to healing process. Weak opioids can be given to make pain free, and help movement.

Coroner- asked JB what would happen to arm.

PS – would heal.

Coroner – would heal if didn't move it. Need to fix fracture.

PS – no orthopaedic evidence before jury.

Coroner – not saying he will heal, say he will be in that position until it heals.

PS – doesn't say it wont heal.

Coroner - Wonder why transferred. Send him to recovery ward.

PS – no evidence with that issue. Was at QA. Question to ask = whether breach = over prescription with morphine.4.3 – let out evidence on which jury can conclude caused Mr Wilson's death. During questioning PB changed view of consequence of medication. Pg 40 – aside from risk of coma, Wilcock says may be a link. Coma, respiratory depression. Rely on evidence of PB and Baker.

Evidence then with them. Hadn't seen wilson's evidence before. Qyestion whether condition based on drugs of heat failure.

Were it not for oeddema the condition would have needed through1 similar . have 2 experts making clear causation clear, and one where no responded yet. Unhelpful that bundle says jury ant understand obiter. Can take jury to those relevant passages. Serious risk of oromorph. JB had opportunity for rare position.

Evidence before jury establishes gross negligence manslaughter, no attempt to justify dosages in records.pre prescribing on 14th. When staff asking if prescription authorised. At 10/09 JB didn't feel carer patient open to an risk. Look at conduct of nurses on 15th for last oromorph given Mr Wlison would have to have had his leg plastered. Say jury properly directed on jury. We say evidence = that evidence relating only to Mr Wilson's case

Say properly leave before coroner to decide cause of death.

PS – remain gaps in evidence .

IW – made comment re sling and need for it

TL – 4 submissions. Important to emphasise that 20 distinct deaths factual matrices. Packman , devine and cunningham, believe all unlawful killing. If concern re absence of evidential information.

Coroner = families anxious call other expert.

PS - Dont want to go over what PS already said. As to grossness, this is a jury question as per Adomako.

Coroner – initially a matter for corner to look at it the direct jury. Jury must assess how bad injury is.

TL – identify what beach is. 2 distinct things happening -duty to decide. Jury to be asked if breach

of duty of care. Blood test results improve, wounds improve etc. Also heard from VP that he looked best he had for years, very positive. Agreed between experts that 3 days before transfer suffer first GI bleed. Blood results not obtained omission to transfer to acute medical unit.

TL - heard PS say position inevitable and death would result at one point. Omissions compounded 27/08. No good reason for transfer but also omission to obtain blood results and comply with recommendation of Dr Radley. Must identify individual making omissions – here clinical assistant saw on regular basis. Some uncertainty whether saw 29 and 30th. Reasons given for not transferring were risks of transfer and fact marked NFR.

Coroner- specific to cardiac arrest.

TL- yes. Clinical assistant in breach of duty following GI bleed, breach of duty in providing care. Aim of opiods is to reduce pain. Heard Dr Wilcock say doses excessive to needs, no justification in records. JB said analgesia given as sacral sores. Re causation for Packman – view of Dr Wilcock that causation made out – inappropriate management of GI bleed and doses that contributed to death. If PB expressed different view saying terrible prognosis then matter for jury. Where one expert expressed a different view they must decide which they prefer. As far as grossness concerned it is a jury question but matters here entitling jury to find that breaches were gross. All doctors can make misdiagnosis in some circumstances but say here aggravating features – medical records clearly suggest internal haemorrhage on 26/08 and afterwards. Numerous entries to tarry faeces. Blood results also clear. Dr Ravi made clear what should have been done.

Coroner – second lot of results?

TL – never done.

Coroner – not sure why not done

VP – first results signed

TL – omissions to blood tests would have revealed problem. Clinical assistant believed deceased unlikely to recover. Sufficient evidence to entitle jury to find gross negligence. As far as excessive doses concerned, JB knew risks and relevant principles in analgesic ladder.

Coroner – wouldn't say going up ladder in this case?

TL – no. JB aware of concerns re Nurse Turnbull re inappropriate use of excess analgesic causing premature deaths. Dr Wilcock said no proper compliance with analgesic ladder.3 questions for jury in alternative for narrative verdict in para 9 of submissions. Right that jury should be asked if conduct appropriate or not. Coroner raised concerns where jury asked to consider questions which may result in judgmental result. Say an appropriate approach here.

Coroner- Middleton most recent.

TL – Middleton most helpful authority. Anticipate will hear submissions re it being article 2 case and therefore not appropriate but is inappropriate. If not persuaded to leave narrative verdict or unlawful killing then ask for neglect.

Coroner – thought about that.

TL – narrative verdict will allow those facts relevant to be answered.

Coroner – want to do that as other verdicts wont answer people's questions.

TL – authorities say appropriate to bring out as many of facts concerning deaths as public interest requires. Suggest questions asked in order put forward.

Coroner – that will be an issue. Will need to think about this if we go down this route.

TL – Devine.

TL – 2 docs at beginning of bundle. First is submissions, second is an additional document. Narrative verdict – suggestions for questions at para 9. Similar to Packman. 2 issues to consider – dosage of administration appropriate? Say standard of care same as Packman. Breach set out at para 18 – admitted for rehab care. At time of admission under renal physician. Blood test showed increased cretanine- good reason to be cautious about this increase.

Coroner – Wilcock said cretanine even higher than would expect.

TL – JB unaware of cretanine results from QA. Only aware of increase in November. Where clear guidance from manufacturers of product stating that cretanine can rise in reversible way from trimethaprin, then appropriate to be cautious to attach significance to this.

Coroner – not sure she was aware of trimethaprin?

TL – no she wasn't. Significance is that because there was rise may be evidence of decline in kidney function. JB's position different as unaware of comparator. Dr Wilcock said would expect referral back to renal physician. Didn't happen here and no assessment done to identify nature of deterioration. Dr Dudley said if things had been done position may have been stabilised for a few days. Evidence of breach of duty to provide care and also in light of evidence given breach of duty to give proportionate symptom relief. Wilcock said patch excessive – 4 x recommended dose, no justification. Matter for jury to determine whether justified. Measured approach appropriate but didn't happen. 19th – unusual behaviour that morning, out of norm. Coincided with time patch most likely to be effective. Risks of excess opiates = aggravation and delirium. JB accepted that appropriate to assess adequacy for each patient. No consideration given to patch contributing to behaviour on 19th. Substantial overdose given. 3 hours should have passed before syringe driver started,

but only an hour passed. Open to jury to find in breach of duty to provide proportionate symptom relief. Causation – open to jury to reject expert evidence that terminally ill as result of deterioration in kidneys. Evidence her death not typical for renal failure – normally more gradual decline. No gradual decline here. Know blood tests shouldn't be determinative of physical decline. Supplementary note sets out some telling points the family wish coroner to read and consider carefully before directing jury in relation to weight to attach to Dudley's evidence. Set out those matters which cast further doubt on Dudley's view. Para 26 of submissions – know from PB excessive opiates cumulative. If look at original report he said sufficient evidence to link date of death with analgesic medication given. JB knew risk of death with opiates given.

Coroner- said question of balance.

TL – experts say balancing act done incorrectly. Know not provided with hydration or food after driver started. PB said classic symptoms of respiratory depression. Open to jury to find cause of death was excessive opiate medication. If jury accepted Dudley's evidence could accept that death hastened by few days. Then for jury to decide whether hastening would amount to more than minimal negligible or trivial cause of death. Submit sufficient evidence for verdict of unlawful killing.

TL – before Cunningham refer coroner to page numbers and authorities to consider. Para 3 reference to neglect – Jarvis para 13-43. Para 4 – Williams pg 4-5, para 6 – para 29, Sutavic para 96-98. Longfield – para 29, death in custody. Not a case where A2 applies. Function of inquest = seek out and record as many facts as public requires. Cash – para 47-52. Smith – get copy, para 45 of judgement. Judgemental conclusions of factual nature are permitted.

First 3 pages of Cunningham submissions already dealt with. Pg 3 lists questions thought to be appropriate in this case – curative care and symptom relief, and causation. Unlawful killing – CF would wish jury to consider verdict of this on 2 separate bases: gross negligence as detailed in submissions, and jury to consider other way – i.e. whether case where JB caused death of AC in use of excess opiate and whether she did so intentionally.

Coroner- hear what saying.

TL – pg 4 – duty of care and standard of care, 2 limbed approach. Para 16 where poor prognosis PB said appropriate to provide care to relieve symptoms and treat. Breach by JB here.

Coroner – thought she said rehab side as well as palliative side. Or not in relation to AC?

TL – AC admitted for rehab 21/09 after being seen by Dr Lord at day hospital. Say care plan not followed. Treated as though terminally ill from moment of arrival. When CF attended 21/09 told wouldn't live. Didn't receive high protein diet. Unresponsive by 23/09, no nutrition or fluids provided. Reason why care plan not followed was JB took different view from Dr Lord to prospects of survival. Dr Wilcock confirmed no change in condition. In absence of this JB in breach of duty to provide curative care. No evidence of adequate assessment, or symptoms being treated. JB said AC in agony hence high analgesia. Not mentioned in notes. Over next 6 days doses increased significantly. PB said couldn't be justified. Open to jury to find JB in breach of duty to provide symptom relief. Causation – Dr Lord considered appropriate to keep nursing home place open for 3 weeks. Dr Wilcock said care plan wouldn't have been written if felt no chance. Whilst overall prognosis poor may have been scope for some improvement. No reference to respiratory difficulties or signs

of pneumonia. Medication may have slightly shortened life. Open to conclude that had AC been treated in accordance with plan would have lived for longer.

Coroner – aware talking criminal standards – beyond reasonable doubt.

TL – yes. Grossness – seen submissions. Given need for treatment, age and frailty was higher risk of death from analgesia. JB familiar with analgesic ladder and knew not appropriate to run risks of administering higher doses. Say analgesia excessive and no adequate explanation for not following care plan. Where clear instructions from someone senior you should follow them. Open to jury to find breach of duty gross. Would also consider verdict of neglect or narrative verdict.

Coroner – Gregory?

TL – nothing further to add.

AJ – fairly short. Coroner has written submissions. Isn't quality of evidence re causation. Medical cause of death given for each case.

Coroner – have selection of them. None deal with drug overdose.

AJ – wrong to leave to jury verdict of unlawful killing. Re open verdict also not appropriate. Doesn't answer any questions. Sentence in Jervis saying may be mischievous to ask coroner to leave open verdict. Will be cases where real doubt and any other decision unjust. No real doubt here.

Coroner – if evidence insufficient on which to find. Not the case here.

AJ – proper approach – given some authorities. Williams, pg 5 strength of evidence not the only issue. If circumstances where not in interest of justice to leave verdict before jury then he doesn't have to leave that verdict. Efforts made today to suggest jury could reach decision of unlawful killing. Suggest not the case. Concur with view coroner already expressed. Focus on limited extent of JB's role. Always busy, eager to hear from staff. Know asked for more time, given more time. Criticisms re note keeping. Not in Nottingham court so not proper approach to say if not noted it didn't happen. Note keeping doesn't and didn't contribute to death. If examination not noted then may be cause for criticism but cant contribute to death. Look at conditions JB facing. Know many prescriptions incorporated a range, known by nursing staff and agreed by consultants. None of patients administered full range prescribed. Prescriptions described as unjustified, irrational.

Coroner – missing the justification as no note saying why doses given.

AJ – as far as drugs concerned what is important is administration. Know nursing staff providing medication. Dealt with in submissions, don't need to repeat now. Have said for focus on unlawful killing have to focus on individual, show knew requisite facts or aware of them and in relation to those they were grossly negligent. Nothing like that here. If condition changed not clear when doctor was informed. Some of medications written as required, not medical decision which should be given or what dose, that decision was made by nursing staff. No proper basis to say JB aware of each patient's condition. Know nursing staff will do job conscientiously and wouldn't have given if thought inappropriate. 3 cases – Wilson: when admitted to GWMH in bad shape. Difficult journey, long transfer. Know JB assessed him on arrival and her view that in bad shape. Wrote up paracetamol as required and oromorph 5-10mg. Given 10mg, top end of range, nursing

decision, no doubt made on how he presented to nursing staff. Know liver function such that any pain killer was risky for someone in Mr Wilson's condition. Know on 15th JB wrote oromorph as regular prescription. Dont know what told by nursing staff. Entry in medical records from Hamblin saying oromorph commenced regularly for pain in arm. Decline after this, possible MI, syringe driver started. As far as gross negligence concerned there is no evidence. Dr Wilcock declined opportunity to say medication contributed to death. Unsafe to put gross negligence verdict before jury. Re Packman recall evidence of PB, prognosis terrible, worst bed sores Hallman ever saw. Significant deterioration probably from GI bleed, one of two or so diagnoses considered. Given condition JB decided not appropriate to transfer. Said anaesthetist wouldn't deal with him. PB said within boundaries of reasonable decision not to transfer. Doses of diamorphine required to control symptoms and didn't contribute to death. Divine – 18/11 refusing medication. Deteriorated over previous few months, attacking staff and patients. Problem of management level. PB said on 19/11 terminally ill. Reasonable view to come to. Inappropriate not to offer palliative care. Know from Dudley's report strong opiates are used for kidney disease. Heard about trimethaprin. Dr Wilcock said reading in GWMH higher than elsewhere. If trimethaprin had played role then was still a decline. Report from Dudley, given clear explanation about treatment given and picture as patient moves towards death. Neglect mentioned in several of these cases, no gross failure. Appropriate to transfer ED? Not being suggested. Suggested could refer back to Dr Stephens but no indications as to timescale. As far as AC concerned, JB didn't take different view to Dr Lord. All those treating thought poor condition. Dr Lords statement made plain that condition poor.

JT – majority of submissions don't affect clients directly. 2 general points re approach on law. Re narrative verdict, TL took court to authorities which say narrative verdict not restricted to A2 cases. Important that that is qualified.

Coroner – govt decided this wasn't going to be public enquiry.

JT – public interest in determining questions. Different here hence putting forward suggested questions last week before the court. Next matter = neglect verdict. Neglect = gross failure of a sort. Important the term isn't used too flexibly.

Coroner- distinguish between neglect and negligence.

JT - High threshold as illustrated by Jameson. Failure would not of itself be enough. Simply not reached here.

Coroner – when talking last week wondered how far scope of questions for jury may go. Raised question about governance of GWMH. Dont think appropriate now. Not right to head down there as is separate issue, government chose not to do.

BB – remaining questions regarding neglect. As well as gross has to be gross failure to provide medical care. No one touched on level of medical care concerned. Suggestions of failure to do basic tests

Coroner – only on part of doctor though.

BB – refer to Khan in submissions. Everything else adequately discussed before. Main concern where going with GWMH but not being discussed. Jury questionnaire, when list patients to whom questionnaire relates to should include Mr Packman. Questions of c and d specific to Packman and Devine, others relate to all deaths.

Coroner – no doubt will proceed by way of narrative verdict as alternatives inappropriate for reasons heard. Most significant factor = standard of proof required. To find those would have to satisfy jury beyond

reasonable doubt that verdicts appropriate. On evidence we have they cant be. Causation cant be satisfied on. Out of 10 deaths don't have 1 which suggests death due to overdose. Not looking at unnatural cause of death. In light of public interest in cases appropriate way is to invite jury to do reasoned choice of cause of death for each. Coroner will advise as best can. And then they will answer questions. Have drafted them but not sure if in right order.

1. Did medication contribute more than minimally or negligently to death of deceased.
2. If yes was it given for therapeutic purposes?
3. If yes was it appropriate for condition?

As far as can go on that.

JT – in relation to 3 consider condition and symptoms suffering from.

Coroner – yes. Notes vast, may be some time with jury tomorrow. 10 am tomorrow.