In the matter of the inquest into the death of

GLADYS MABEL RICHARDS

SUBMISSIONS AS TO VERDICT

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1) These submissions are prepared on the instructions of Gillian McKenzie, Daughter of Gladys Mabel Richards ("the Deceased").

2) It is respectfully submitted that two verdicts should be considered by the Coroner:

   a) A Narrative Verdict which answers the questions set out below;

   b) Unlawful Killing.

3) In the absence of either or the above verdicts being considered by the Coroner, the Coroner will be invited to consider a verdict incorporating Neglect.

Deciding Whether to Leave a Verdict

4) In determining whether or not to leave a verdict to the jury, it is submitted that the starting point are the principles set out in R v. Galbraith [1981] 2 All ER 1060 as adopted for the purpose of an inquest in in R v HM Coroner (ex parte Douglas-Williams) [1999] 1 WLR 344. It is submitted that this is the same test to be applied when the coroner is sitting alone and determining which verdict they should consider in a particular case.

Narrative Verdict

5) It is for the Coroner to consider the form of verdict which will elicit the jury's factual conclusion on the central issues in the inquest.

6) This applies in relation to cases where Article 2 is not engaged as well as cases where Article 2 is engaged:

   a) R (Longfield Care Homes Ltd) v HM Coroner for Blackburn [2004] EWHC 2467, paragraph 29

b) R (on the application of Sutovic) v Northern District of Greater London [2006] All ER(D) 248 (May)

7) In eliciting the jury's factual conclusion on the central issues in the inquest, the prohibition on attributing criminal or civil liability in The Coroners Rules 1988 ("CR") rule 42 and CR 1988 rule 36(2) must not be infringed.

8) Eliciting the jury's factual conclusion on the appropriateness or otherwise of acts or omissions which may have contributed to a death does not offend CR 1988 rule 42 or rule 36(2). Recent examples include:

a) R (Middleton) v H.M. Coroner for the Western District of Somerset [2004] UKHL 10, [2004] 2 AC 182, the verdict was overturned because the jury had not been able to express their view as to whether appropriate precautions had been taken to prevent the deceased's death. The verdict suggested by the House of Lords was "*The deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him from doing so"* was deemed to embody a judgmental conclusion of a factual nature, which did not infringe CR 1988 rule 36(2) and rule 42 ;

b) R (on the application of Helen Cash)(Claimant) v H.M. Coroner for Northamptonshire (Defendant) & Chief Constable of Northamptonshire (Interested Party)[2007] EWHC 1354 (Admin). In that case, the Coroner accepted a submission that the narrative verdict should be "entirely descriptive, neutral and non-judgmental", and directed the jury accordingly. The inquest was quashed, in part because the coroner's direction to the jury had the effect of preventing them from embodying in it "a judgmental conclusion" of a factual nature on the disputed factual issues at the heart of the case.

c) R. (on the application of Smith) v Oxfordshire Assistant Deputy Coroner (2008) EWHC 694 (Admin) (QBD (Admin)). The Narrative verdict was in these terms:- "On the 13th August 2003 Jason George Smith was on active service when found suffering with heatstroke at the Al Amarah stadium where he was stationed. He was taken to a medical centre at Abu Naji Camp where he died. Jason George Smith's death was caused by a serious failure to recognise and take appropriate steps to address the difficulty that he had in adjusting to the climate." Paragraph 45 of the Judgment reads *"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. It is, she says, not neutral but pejorative. ... 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 a question of civil liability. It no*

doubt will assist a potential claimant, 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 a 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."

Narrative verdict: Suggested Questions

9) It is respectfully submitted that the Coroner should consider returning a Narrative Verdict which addresses the following questions:

a) Was the management of the Deceased's medical condition on Daedalus Ward at Gosport War Memorial Hospital appropriate or inappropriate?

b) Was the administration and dosage of painkilling and sedative drugs to the Deceased when she was admitted to the Ward appropriate or inappropriate?

c) If the answer to questions 1 and/or 2 is "inappropriate", do you consider that the inappropriate act/ acts caused or contributed more than minimally, negligibly or trivially to her death on 21 August 1998?

Unlawful Killing

Overview

10) The elements of unlawful killing are set out in R v. Adomako [1995] 1 AC 171. At page 187, Lord Mackay said,

"... in my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such a breach of duty is established the next question is whether that breach caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death ... was such that it should be judged criminal."

11) To return a verdict of unlawful killing, the jury have to be satisfied that:

a) An individual owed a duty of care to the person who died;
b) That the individual was in breach of that duty by her act or omission;
c) That the breach was so serious or gross as to be properly categorised as criminal;

d) That the grossly negligent breach of the duty of care caused the death of the deceased.

12) The test for causation was confirmed in R v HM Coroner (ex parte Douglas-Williams) [1999] 1 WLR 344. Lord Woolf delivered the leading judgment, in which he set out the various requirements for gross negligence manslaughter. He said of causation: *"that negligence must have caused the death in the sense that it more than minimally, negligibly, or trivially contributed to the death".*

13) As to whether a breach is properly categorised as gross is, as Lord Mackay said in R v. Adomako [1995] 1 AC 171, at page 187D, "supremely a jury question". The context in which the question has to be considered is all important. Lord Mackay said at page 187C that the context was the risk of death. There are two principle ways of establishing that an individual has been grossly negligent: one route involves establishing that an individual had an actual appreciation of the risk of death, and deliberately chose to run that risk. In the absence of evidence of subjective recklessness, an individual may still be deemed grossly negligent if, on an objective basis, having regard to the risk of death involved, his/her conduct was so bad in all the circumstances as to amount to the crime of manslaughter.

Evidence

Duty of Care

14) The Clinical Assistant of the Deadalus Ward in August 1998 owed the Deceased a duty of care.

Standard of Care

15) It is submitted that the duty of care owed by the Clinical Assistant to the Deceased, encompassed distinct duties

a) to provide care with a view to rehabilitation until she arrived at a reasonable decision that her condition would not be responsive to treatment [Black];

b) to provide medication for relief of symptoms which was proportionate to her needs. A doctor should not run unnecessary risks [Black].

16) Where a patient is considered to have a poor prognosis it is appropriate to provide care for the relief of symptoms and rehabilitative care concurrently [Black].

17) There is a prohibition under CR 1984 rule 40 against addressing the learned Coroner on matters of fact. Jervis on Coroners paragraph 12-149 recognises the need to refer to the evidence when making legal submissions: in order to support the proposition that it is appropriate as a matter of law to leave the suggested verdicts to the jury (or, as in this case, to the coroner sitting as tribunal of fact),

Causation

⊗ Note taking + written record of prescips was unsatisfactory. Everyone agreed this. Decis's can't be justified by records.

Anticip Prescribing - pall. doses on 11/8 + laxg. of pall care used on 11/8. Anticip until later in her care. This anticip prescip hastened death. Prof F sees analgesia hastening death. Prof B saw it as factor.

Decis to move to syg dr. not supported by evidence or records. If decis was correct, high doses OIC but needed to be recorded properly even if people are busy ∴ decision isn't a proper one.

these submissions of necessity make reference to certain key aspects of the evidence.

Evid of Prof Black 5.2 & 5.3.
Prescrip of 11/8 - Prof Black felt too wide, etc.
No intervening review of prescrip before 17/8.
Profs F & B = No justific in records/evid for move to the syr. driver. Criteria for syr. dr. was in BNF. She was able to swallow at 6.30am on 18/8. Dr B decided she didn't at 8.00am.
No need to give pain killers during this time.
No justific for failure to follow analgesic ladder.
Once th'hold passed, option to use syr. dr.

Breach of that duty

18) Oral submissions

Causation

19) Oral submissions

Grossness

20) In determining whether the Galbraith Threshold as to grossness is met, the Court is reminded of the following evidence:

a) The greater the dose, the greater the risk to the individual [Black]

b) At 91, frail, with a history of falling while in care, and having had 2 recent procedures, the Deceased was at a heightened risk of death

c) The Clinical Assistant knew
   i) that the Deceased was sensitive to morphine
   ii) that excessive doses of diamorphine could cause respiratory depression, loss of consciousness and death, delirium, confusion, agitation
   iii) the principles of the analgesic ladder [Barton]
   iv) of the need for particular caution in the administration of strong opioids to the elderly [Barton]
   v) that it was not appropriate to run the risk of adverse consequences inherent in administering doses in excess of the recommended starting dose, unless there was no other way of controlling the symptoms [Barton]
   vi) of the contents of the British National Formulary, and the difference between prescribing oral morphine and diamorphine [Barton],

d) The Clinical Assistant must have recognised that there was a serious risk that with the Deceased's sensitivity to morphine, there was a serious risk that the Deceased would not survive the strength of drugs given but nevertheless went on to run it. [Barton].

e) There was no compliance with the analgesic ladder. The prescribing was inappropriate, too wide, potentially hazardous and not in the best interests of the patient [Black];

21) In view of the foregoing, it is submitted that it would be open to the Coroner to find that the Clinical Assistant's breaches of duty to the Deceased were gross.

22) In such circumstances all the elements of the offence of gross negligence manslaughter, as set out in Adomako are met. Therefore the verdict of unlawful killing can be left.

Code A

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(*) Neglect verdict – if decis to move to pall care was incorrect, removal of fluids wld = Neglect. Decis would have to be justified by written records. Balance of probs test for Neglect. Cld be incorp'd in another verdict.