In the matter of the inquest into the death of

GEOFFREY MICHAEL PACKMAN

SUBMISSIONS AS TO VERDICT

1) These submissions are prepared on the instructions of Victoria Packman, Daughter of Geoffrey Michael Packman ("the Deceased").

2) It is respectfully submitted that two verdicts should be left to the Jury:

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

   b) Unlawful Killing.

3) In the absence of either or the above verdicts being left to the Jury, the Coroner will be invited to leave a verdict incorporating Neglect to the Jury.

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.

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 Jury should be invited to return a Narrative Verdict which addresses the following questions:

a) Was the management of the Deceased's medical condition on and after 26/08/99 appropriate or inappropriate?

b) Was the administration and dosage of diamorphine and midazolam to the Deceased between 30/08/99 and 03/09/99 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 his death on 03/09/99?

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 the 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 Dryad Ward in 1998-1999 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 curing the deceased's condition ("rehabilitative care") until she arrived at a reasonable decision that her condition would not be responsive to curative treatment [Black day 5];

b) to provide medication for relief of symptoms which was proportionate to her needs. A doctor should not run unnecessary risks [Black day 5].

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 day 5]. It is submitted that the Clinical Assistant was in breach of both these distinct duties to the Deceased.

17) There is a prohibition under Coroners Rules 1984 section 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, these submissions of necessity make reference to certain key aspects of the evidence.

Breach of Duty: Curative Care: Matters relevant to the Galbraith Threshold

18) In determining whether the Galbraith Threshold as to a breach of duty to provide curative care is met, the Court is reminded of the following evidence:

a) Aged 68, the Deceased was admitted to the Gosport War Memorial Hospital for rehabilitative care [108] [Victoria Packman Day 10]

b) In the previous two weeks, 6th-23rd August 1999, his condition at the Queen Alexander Hospital had been improving: His temperature and cellulitis began to settle [48,49], his blood test results improved[196, 200, 211] his wounds improved, antibiotics were discontinued [51], his Barthel score improved [163]. He looked the best he had for years: he was happy and chatty and keen to go home. [Victoria Packman Day 10];

c) On 26/08/99, he suffered a gastrointestinal bleed [Wilcock day 13];

d) The gastrointestinal bleed was apparent from a fall in haemoglobin and melaena stool [Wilcock day 13];

e) On 26/08/99 the Clinical Assistant omitted
   i) To perform a thorough medical assessment: no basic observations (e.g. temperature, heart rate, blood pressure) appear to have been done and no medical examination (e.g. heart sounds, chest, abdomen) appear to have been carried out. [Black day 6]
   ii) to obtain or act upon the blood test results [Wilcock day 13]
   iii) to transfer him to an acute medical unit [Wilcock day 13]
   iv) to discuss his condition with on-call physicians/geriatricians or cardiologists[Wilcock day 13]

f) Instead the Clinical Assistant recorded that she was happy for nursing staff to confirm death [55];

g) On 27/08/99, notwithstanding that the Deceased's condition had improved [63] [97], the Clinical Assistant omitted
   i) To perform a thorough medical assessment: no basic observations or medical examination appear to have been carried out.
   ii) to obtain or act upon the blood test results [Wilcock day 13]
   iii) to obtain the further blood tests recommended by Dr Ravi [Wilcock day 13]
   iv) to transfer him to an acute medical unit [Wilcock day 13]
   v) to discuss his condition with on-call physicians/geriatricians or cardiologists[Wilcock day 13];

h) The Clinical Assistant saw the Deceased regularly;

i) The risks of transfer were very low [Black day 6];

j) A 'not for resuscitation' status should not have excluded him from receiving appropriate treatment [Black day 6] [Wilcock day 13];

k) Over the days that followed there was a continued lack of an appropriate medical assessment of Mr Packman's condition [Wilcock day 13].

19) In the light of the foregoing, it is submitted that it would be open to the Jury to find that the Clinical Assistant's was in breach of her duty to provide curative treatment.

<u>Breach of Duty: Proportionate Symptom Relief from 30/08/99: Matters relevant to the Galbraith Threshold</u>

20) In determining whether the Galbraith Threshold as to a breach of duty to provide proportionate symptomatic relief is met, the Court is reminded of the following evidence:

a) The aim when administering opiods is to relieve the pain with a proportionate dose. A dose excessive to a patient's needs may result in loss of consciousness, drowsiness, delirium, agitation [Wessex Guidelines p.39 – 41]. In such circumstances consideration should be given to a review of the propriety of continuing with the level of analgesia administered.

b) At the Clinical Assistant's request, the Deceased received Diamorphine begins at 40 mgs over 24 hours, increases to 60mgs, and then up to 90mgs over a period of 5 days, and Midazolam increasing from 20 mgs over 24 hours to 80mgs over the same period.

c) The use of diamorphine and midazolam was inappropriate [Wilcock day 13].

d) The doses were excessive to his needs [Wilcock day 13].

e) There was no adequate assessment of any discomfort which might require relief [Wilcock day 13] and no justification for the increases.

f) The high level of doses were not justified by the contemporaneous medical records [Black day 6]

g) The Deceased became 'spaced out'. His eyes were glazed and his head would nod about. He appeared very sleepy. He was not able to hold a cup or pick up anything in order to eat. The change was dramatic and he became progressively worse. [Victoria Packman day 10]

h) The Clinical Assistant stated that she anticipated the Deceased would have experienced pain from his significant sacral sores [Barton day 12]. The Deceased's sores did not cause him pain when assessed on 23/08/99 [54]; his only analgesic at the Queen Alexander Hospital was paracetamol.

21) 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.

Causation

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

a) It is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligibly or trivially to his death. [Wilcock day 13];

b) An endoscopy could have been performed; the problems were not insurmountable [Black day 6]

c) The likelihood is that the cause of the Deceased's gastrointestinal bleed was a peptic ulcer which can be cured with appropriate treatment. It is a potentially reversible condition that could have been managed by transfer to the acute hospital for appropriate resuscitation with intravenous fluids, blood transfusion and further investigation [Wilcock day 13];

d) An analysis of the blood results dated 26/08/99 would have made a diagnosis of gastrointestinal haemorrhage likely [Wilcock day 13];

23) In view of the foregoing, it is submitted that it would be open to the Jury to find that the Clinical Assistant's breaches of duty to the Deceased made a more than minimal, negligible or trivial contribution to his death on 03/09/99.

Grossness

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

a) There were numerous entries in the medical notes suggestive of internal haemorrhage:
   i) 13/08/99 [52]
   ii) 19/08/99 [137]
   iii) 23/08/99 [54]
   iv) 30/08/99 [79]
   v) 31/8/99 [63] [79] [83]
   vi) 01/09/99 [55] [64] [83]
   vii) 02/09/99 [81]

   The Clinical Assistant accepted that black stools were evidence of a bleeding ulcer [Barton tl xx day 12]. She stated that she was unaware of his gastro intestinal bleed [Barton day 12]. The Clinical Assistant stated that if she had been aware of the blood results on 27/08/99, she would have recorded the result. [Barton day 12]

b) The omission to obtain and/or act upon the blood results on 26/08/99 and on 27/08/99 and thereafter were in breach of the Consultant Geriatrician Dr Ravi's documented request; the Clinical Assistant was aware of the requests [62]

c) The Clinical Assistant accepted that she knew that the Deceased was very unlikely to recover on Dryad Ward. [Barton day 12]

d) The Clinical Assistant knew
   i) that excessive doses of diamorphine could cause respiratory depression, loss of consciousness and death, delirium, confusion, agitation [Barton day 11]
   ii) the principles of the analgesic ladder [Barton day 11]
   iii) 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 day 11]

iv) of concerns at Gosport in 1991 as to the risk of premature deaths caused by diamorphine [Turnbull day 8]

e) There was no compliance with the analgesic ladder.

25) In view of the foregoing, it is submitted that it would be open to the Jury to find sufficient aggravating features surrounding the Clinical Assistant's breaches of duty to the Deceased to justify a finding that the breaches gross.

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T.R.G.LEEPER

April 14th, 2009