In the matter of the inquest into the death of

ARTHUR DENNIS BRYAN CUNNINGHAM

SUBMISSIONS AS TO VERDICT

1) These submissions are prepared on the instructions of Charles Farthing, Step- Son of Arthur Dennis Bryan Cunningham ("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 following his admission to the Gosport War Memorial Hospital appropriate or inappropriate?

   b) Was the administration and dosage of diamorphine and midazolam to the Deceased between 21/09/98 and 26/09/98 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 26/09/98?

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) The Deceased was admitted for rehabilitative care: on 21/9/98 the Deceased was seen by Dr Lord at the Dolphin Day hospital who admitted him to Dryad Ward at Gosport War Memorial Hospital "with a view to more aggressive treatment on the sacral ulcer"[457]

b) At the time of his admission, the Consultant Geriatrician he was under had set out a clear care plan [643];

   i) she admitted him for more intensive therapy to his ulcer, as opposed to terminal care;

   ii) she recommended a high protein diet to help improve his nutrition and help wound healing, indicating that he might live long enough to benefit from this,

   iii) she asked the nursing home to keep his bed open for the next three weeks at least

c) This care plan was not followed. The Clinical Assistant treated him as though terminally ill from the moment of his arrival:
   i) See Clinical Assistant's entry dated 21/09/98 [645];
   ii) At the Dryad Ward on 21/09/98, Charles Farthing was told that the Deceased would die;
   iii) the Deceased did not receive the high protein diet to help improve his nutrition and help wound healing recommended [Barton day 11];
   iv) once he had become unresponsive, no hydration or other infusion was provided.

d) The reason it 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 [Barton day 11];

e) Dr Lord stated that recommended treatment can be altered without further consultant input being required if there is a change in the patient's condition [Lord 35 p.23]. Dr Lord's assessment was made on 21/09/98 [642]. The Clinical Assistant's assessment was also made on 21/09/98 [645];

f) There had been no change in his condition in between the two assessments [Wilcock day 13].

19) 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's was in breach of her duty to provide curative treatment to the Deceased.

<u>Breach of Duty: Proportionate Symptom Relief: 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) On 21/09/98, the Consultant Geriatrician had prescribed 2.5mgs to 10 mgs of morphine "as required";

c) On 21/09/98, on his arrival at the Dryad Ward, the Deceased was fully conscious;

d) On 21/09/98, at 20:15 the Deceased received 10 mgs of oramorph [752] At 22:00 the Deceased was sedated [754];

e) At 23:10 hours that evening the regime for opiate analgesics moved from a regime where they were to be administered on an as required basis, to a regime where they were administered continuously via a syringe driver;

f) Absent from the medical records is evidence of adequate assessment
   i) of the nature or origin of symptoms being treated,
   ii) the need for the increases,
   iii) the effect of the medication on the Deceased.

g) The Clinical Assistant's assertion that the Deceased was in agony is not born out in the medical records [Barton day 11];

h) Over the course of 6 days, s/c 24 hours doses of diamorphine increased from 20mgs to 80 mgs, and midazolam increased from 20mgs to 100 mgs;

i) There was insufficient in the medical notes to explain the increases which require to be justified [Black day 5];

j) On 23/09/98 Charles Farthing finds his step father totally unconscious; The Clinical Assistant's accepted that consideration was never given to the possibility that the deterioration in his condition may have been due to excessive opiod analgesia [Barton day 11].

21) In circumstances where there is no, alternatively no adequate, assessment of the nature of the symptoms and/or the propriety of the continuation of 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's 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) Dr Lord considered that it was appropriate to keep the Deceased's place in the Nursing Home open for at least three weeks [Lord 35 p.23] [457]. A care plan would not have been written up for the Deceased, if Dr Lord felt that there was no chance [Wilcock day 13]. While the Deceased's overall prognosis was poor, there may have been scope for some improvement [Wilcock day 13].

b) There was no reference to respiratory difficulties and no signs of pneumonia in Dr Lord's thorough assessment

c) Six days later the Deceased died of bronchopneumonia: Bronchopneumonia can occur as a secondary complication of opiate and sedative induced respiratory depression. [Black day 5]

d) While Professor Black stated that he thought the Deceased was likely to die anyway, the analgesic and sedative medication may have slightly shortened his life [Black day 5]

23) In the absence of a change in circumstance 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 the week. It is submitted that it would be open to the jury to conclude that the Deceased, had he been treated in accordance with the care plan and in the absence of the analgesic and sedative medication, would have lived for a longer period than he did. 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 26/09/98.

Grossness

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

a) Given his need for treatment, age and frailty, the Deceased was at a heightened risk of

death;

b) 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) of the need for particular caution in the administration of strong opiods to the elderly [Barton day 11];
   iv) 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];
   v) of concerns at Gosport in 1991 as to the risk of premature deaths caused by diamorphine [Turnbull day 8];

c) The absence of a satisfactory explanation for omitting to follow Dr Lord's care plan and omitting to monitor the affects of the opiate and sedative analgesia.

25) 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 were gross.

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T.R.G.LEEPER

April 14th, 2009