In the Hampshire Coroner's Court

INQUEST INTO THE DEATH OF
ROBERT WILSON

Submissions on behalf of the
family of Robert Wilson

1. INTRODUCTION

1.1 Although as a matter of practical and administrative convenience ten inquests have been heard at the same time, it is uncontroversial that the Coroner is dealing with 10 separate deaths arising on ten separate dates. It follows that the jury will need to return ten separate verdicts.

1.2 It also follows that the consideration of what verdicts to leave has to be addressed separately in relation to each of the ten deaths. This is regardless of whether the reality may be the verdicts left open to the jury will be the same in most cases.

1.3 As with the other cases, Mr.Wilson's death has to be addressed separately by the jury.

1.4 In relation to the Wilson family , aside from the verdict(s) determined by the coroner, the jury should be left with two potential verdicts in the particular circumstances of Mr.Wilson's death (in addition to consideration of a narrative verdict) namely, a verdict unlawful killing by gross negligence[1] and an open verdict.

1.4.1 In summary, in relation to unlawful killing by gross negligence leaving such a verdict to the jury is both in the interests of justice and realistically reflects the thrust of the evidence as a whole :

(a) given the expert analysis presented to the jury of the approach adopted to Mr.Wilson's care on Dryad

and

(b) notwithstanding the serious underlying problems (fracture, oedema, liver) presented by Mr.Wilson on his transfer on 14 October 1998

1.4.2 In relation to an open verdict leaving such a verdict is sustainable in the light of Dr.Wilcock's evidence that he would want to defer to a gastro-enterologist in relation to the effect of the doses of medication on Mr.Wilson given his underlying liver disease. No such evidence was placed before the jury (although available)

[1] A verdict of unlawful killing by unlawful act is not sustainable on the evidence

and the jury is therefore left with Dr.Wilcock's qualified evidence, set against that of Professor Balck and Professor Baker.

1.5 In relation to direction as to the content of a narrative verdict the Wilson family adopt the submissions put forward on behalf of Mr.Gregory, Mrs.Devine, Mr.Packman and Mr.Cunningham (including the reliance placed on the cited authorities), recognising that the discretion as to the scope and breadth of direction of such a verdict must lie with the coroner.

1.6 Whilst it is recognised that the *Coroners Rules 1984* rule 40 prohibits a person from addressing the coroner on the facts, these submissions adopt those made on behalf of Packman et al , namely that it is necessary when making submissions on potential verdicts, that evidence given before the jury should be raised in support of those submission. It remains the case however that the coroner should on no account be invited to make findings of fact based on the evidence or to address discrepancies in the evidence.

2. UNLAWFUL KILLING BY GROSS NEGLIGENCE : APPROACH ADOPTED BY THE COURTS

2.1 The coroner's approach in deciding whether or not to leave this verdict to the jury is that followed in a criminal trial, *R v Galbraith*[2], (see *R. v HM Coroner Ex Parte Douglas- Williams*),

> How then should the judge approach a submission of 'no case'? (1) if there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case. (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence. (a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case. (b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where one possible view of the facts *is* evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury. It follows that we think the second of two schools of thought is to be preferred.....There will of course as always in this branch of the law, be borderline cases. They can be safely left to the discretion of the judge.
>
> (Lord Lane CJ, at pg. 1042)

2.2 In *Douglas-Williams* having cited the above passage, Lord Woolf MR went on to adapt it to the role of the coroner at an inquest,

> The conclusion that I have come to 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 a particular situation mean in the judgment of the coroner, acting reasonably and fairly, it is not in the

[2] [1981] 1 WLR 1039

> interests of justice that a particular verdict be left to the jury he need not leave that verdict. He for example need not leave all just because there is technically evidence to support them. It is sufficient if 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 and if that is the coroner's conclusion he cannot be criticised if he does not leave a particular verdict.

2.3 This passage has subsequently been interpreted by Keith J in *R (on the application of Helen Cash) v HM Coroner for Northamptonshire*[3],

> 25. Lord Woolf was not saying in *Douglas-Williams* that there may be circumstances in which a verdict of unlawful killing should not be left to the jury, even if such a verdict would be open to the jury to reach on the application of the *Galbraith* test. If he had been saying that it would have been necessary to consider whether that guidance should be refined in those cases where the inquest is intended to be the mechanism by which the obligation under Art 2 is to be discharged. What Lord Woolf was saying in Douglas-Williams is apparent from the issues in that case. .....what Galbraith requires, although referred to as an exercise of discretion in a borderline case, is really an exercise of judgment. It being a matter of judgment rather than discretion - which by definition means that there could in law have been only one correct answer, even if identifying what the correct answer was may have been difficult - the question is whether the coroner's judgment on the issue was correct

2.4 There are cases therefore where the coroner will *not* leave the verdict to the jury where the evidence at its highest could not satisfy the test for unlawful killing by gross negligence as set out in *R v Adomako*[4] .

3. UNLAWFUL KILLING BY GROSS NEGLIGENCE

3.1 The test for unlawful killing by gross negligence is well-established and well-known. It is that propounded by Lord Mackay LC in *Adomako,*

> '..in my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of duty of care towards the victim who has died. If such a breach of duty is established the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether breach of duty should be characterised as gross negligence and therefore 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 the risk of death to the patient, was such that it should be judged criminal.'
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> (pgs 7 - 8)

3.2 As applied to inquests and in the context of the direction a coroner would give the jury when leaving a verdict of unlawful killing by gross negligence the following elements have to be satisfied (whether in fact the jury would return the verdict),

(a) the existence of a duty of care

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[3] [2007] EWHC 1354 (Admin)

[4] [1995] 1 AC 171 HL

(b) a breach of that duty of care amounting to negligence

(c) the breach must have caused the death in the sense that *' it more than minimally, negligibly or trivially caused the death'* [5]

(d) *' the degree of negligence has to be such that it can be characterised as gross in the sense that it was of an order that merits criminal sanctions rather than a duty merely to compensate the victim.'* [6]

3.3 Although determining whether negligence in any given context is *'gross'* is an issue for the jury, a negligent act can be properly described as gross where there is shown to be an appreciation of a serious risk of death but a decision taken nonetheless to run that risk.

3.4 For a jury to return a verdict of unlawful killing by gross negligence the jury would have to be satisfied beyond reasonable doubt[7].

4. LEAVING VERDICT OF UNLAWFUL KILLING BY GROSS NEGLIGENCE IN RELATION TO MR.WILSON DEATH

4.1 *A duty of care was owed the deceased*

4.1.1 This is uncontroversial given the setting in which Mr.Wilson found himself on transfer from Queen Alexandra Hospital to Gosport War Memorial Hospital on 14 October 1998. Those responsible for Mr.Wilson's ongoing medical care including Dr.Barton will have owed him in law a duty of care.

4.2 *The duty of care was breached -*

4.2.1 Although *Coroners Rules 1984*, rule 42 prohibits a verdict being framed so as to determine civil or criminal liability, it is nonetheless a necessary element of a verdict of unlawful killing by gross negligence that the jury are satisfied that a breach causative of Mr.Wilson's death occurred.

4.2.2 The evidence before the jury on which breach could and can be maintained (without addressing the coroner on the facts) is as follows :

(a) the expert evidence of Professor Black both in his report and in his evidence before the jury -

(i) in his report at pgs. 16-17, paras. 6.7 - 6.8; 6.11 (reference to dosage being *'inappropriate'*)

(ii) before jury (day 6) : no justification in medical records

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[5] See *Douglas- Williams* pg. 7

[6] See *Douglas-Williams* pg. 7

[7] *R v West London Coroner ex p Gray* [1988] 1 QB 467

for use of oramorph on 14 and 15 October 1998

(b) the expert evidence of Professor Baker read to the jury -

Pg.12 - On the information contained in the records..the commencement of oramorph was not adequately justified

Pg. 15 - Even if Mr.Wilson did have pain from the fracture that was not controlled by paracetemol, regular doses of 10 mg oral morphine would not have been the appropriate treatment. Other non-opiate or weak opiate medication should have been used first. If these medications had failed to adequately reduce the pain, a low dose of morphine (2.5-5mg) as had been used in the early days of [Mr.Wilson's] admission might have been reasonable.

(c) the expert evidence of Dr.Wilcock both in his report and in his evidence before the jury as to his view on the safety of the levels of morphine prescribed on 15 October 1998

(i) Report : pg.37 -

Mr.Wilson was prescribed doses of oral morphine initially p.r.n and subsequently regularly, likely to be excessive to his needs ...Mr.Wilson subsequently received doses of diamorphine over the last 48h of his life that were likely to be excessive to his needs

See also pg.38, 43

(ii) In his evidence before the jury and having been taken to a passage in his report at page 44 (*' This was to a degree that disregarded the safety of Mr.Wilson by unnecessarily exposing him to receiving excessive doses of diamorphine.'*) Dr.Wilcock agreed that that the dosage of oramorph on 14 and 15 October 1998 *' disregarded the safety of Mr.Wilson by unnecessarily exposing him to receiving excessive doses of* [oramoph]'

4.2.3 All three experts (Black/Baker/Wilcock) are critical of the dosage of medication prescribed to Mr.Wilson on his admission to Dryad ward on 14 October 1998 in the light of his presenting symptoms. This criticism extends beyond the fact of there being no entry in the medical records to justify the type and level of prescription. Those entries that there are do not justify the prescription or level of dosage of oramorph and are to be compared with the approach adopted by QAH before transfer.

4.2.4 To the extent that it is relevant (and was raised by the coroner with Dr.Barton) there was no expert orthopaedic evidence before the jury on whether Mr.Wilson's shoulder fracture would heal. Such evidence that there is contained in the medical records cited to the jury (references to expectation of arm healing - pgs 21,77) and in the expert report of Dr.Wilcock, pg.28 -29 -

> Movement is 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 was pain-free when the limb was at rest, followed by a progressive improvement in the movement-related ('incident') pain.

4.3 *The breach of duty more than minimally, negligibly or trivially contributed to Mr.Wilson's death*

4.3.1 The evidence on which the jury could conclude that the breach of duty caused Mr.Wilson's death is as follows :

(a) the expert evidence of Professor Black both in his report and in his evidence before the jury,

(i) in his report at paragraph 6.11,

> It is my view that the regular prescription and dosage of oramorphine was unnecessary and inappropriate on 15th October and in a patient with serious hepatocellular dysfunction was the major cause of deterioration, in particular in mental state, on the night of 15th and 16th. In my view it is beyond reasonable doubt that these actions more than minimally contributed to the death of Mr.Wilson

(ii) in his evidence before the jury (day 6) changing his written conclusion (*'[In my view this treatment was negligent] and more than minimally contributed to the death of Robert Wilson.'*) to *'...more than **likely** contributed to the death'.*

(b) The expert evidence of Professor Baker read to the jury :

Pg.15 Although Mr.Wilson did have congestive cardiac failure, ...his death would have been hastened by opiate administration and the path to death may well have been initiated by the commencement of oramorph on 14/10/98

Pg.18 Bearing these qualifications in mind, in my opinion, Mr.Wilson did fall into the category of patients who might have left hospital alive if the oramorph had not been commenced on his transfer to Dryad ward.

(c) The expert evidence of Dr.Wilcock ;

(i) In his evidence to the jury (day 14) Dr.Wilcok when questioned by Mr.Sadd on cause of death was invited to

comment on the conclusions as to cause of death reached by Professors Black and Baker.

(ii) He stated that were it not for his concerns about the effect of the pulmonary oedema - ' *issue of oedema making it difficult to state anything beyond reasonable doubt re cause of deterioration'* - his conclusions would have been similar to Professor Black's (see above).

(iii) He deferred to a gastro-enterologist on the risks associated with hepatic encephalopathy (Dr.Marshall, whose report is not before the jury).

(iv) In his written report his conclusion on causation relating to the effect of medication on 14 and 15 October 1998 remains equivocal (pg.45) ,

> 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 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

(emphasis added)

4.3.2 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.

4.4 *The negligence can be categorised as gross*

4.4.1 The jury could conclude beyond reasonable doubt on the evidence available to them that the breach in prescribing the level of dosage of oramorph was reckless - that is, that there was a serious risk in prescribing oramorph but that it was prescribed and at a high initial dose that was unsafe regardless, or that the serious risk of hepatic coma was not properly appreciated - in the light of the following evidence taken as a whole:

(i) The contrast between the approach to pain relief medication up to and including 13 October 1998 as recorded in the medical records and the approach adopted on transfer to Dryad on 14 October 1998, both in relation to immediate need and prospective need.

(ii) Dr.Barton's knowledge that :

(a) Mr.Wilson had serious liver disease

(b) Morphine carried risks to those with liver disease of

inducing hepatic coma

(c) Mr.Wilson had not had oramorph at the level of dosage or frequency at QAH

(d) Mr.Wilson's pain had been managed by paracetemol and one-off dosages of codeine phosphate at QAH

(e) In palliative care the risks associated with morphine prescribed to those with liver disease should not be a deterrent to its use

(iii) The absence in the clinical records for 14 and 15 October 1998 of entries noting :

(a) a pain assessment

(b) a review of the medication once prescribed

(c) a review of Mr.Wilson's noted deterioration (in the nursing records and in Iain and Neil Wilson's statements) and its possible causes

(iv) Sister Hamblin's statement that Mr.Wilson had been transferred for terminal care

(v) The absence of a rationale for pre-prescribing on 14 October 1998 diamorphine, hyoscine and midazolam

(vi) The assumption on one view of the evidence that Mr.Wilson was in terminal decline and that this informed the approach to his care

(vii) Dr.Barton's review on 15 October and the regularity with which oramoprh was prescribed on that day

(viii) The absence of consultant review in October 1998 (and since April 1998)

(ix) The view of Dr.Barton that in spite of the pressures in October 1998 being the same as those she identified in early 2000 (when she resigned) she was did not consider that the patients on Dryad were exposed to risk

(x) Expert evidence that the dosage of oramorph disregarded Mr.Wilson's safety – put differently no regard was had to his safety

4.4.2 In anticipation of counter-arguments relating to a break in the chain of causation given the intervention of nursing staff on 15 October 1998 (thereby creating a critical flaw in the above submission) :

(a) Dr.Barton was in overall charge and determined prescribing

(b) Dr.Barton attended on 15 October 1998 : she was in a position to review the effects of the medication and to review the 4 hourly prescription

(c) Her long-standing nursing staff knew of her approach

4.5 *Summary -*

4.5.1 There is evidence on which the jury properly directed could conclude that the dosage of oramorph caused Mr.Wilson's death.

4.5.2 There is evidence on which the jury properly directed could conclude that the breach of duty was so serious that there should be criminal liability.

4.5.3 Leaving the jury with a potential verdict of unlawful killing in the circumstances of the evidence they have before them in relation to Mr.Wilson's death realistically reflects the thrust of that evidence taken as whole. It does so *independently of the evidence relating to the other 9 deaths.*

4.5.4 This is a verdict properly open to the jury to reach.

5. AN OPEN VERDICT

5.1 In the light of Dr.Wilcock's evidence that in the absence of expert evidence addressing specific causes of death his conclusion on cause of death remains contingent. This is to be contrasted with the conclusions of Professor Black and Professor Baker.

5.2 The possibility of this verdict reflects the gaps in the expert evidence before the jury.

6. NARRATIVE VERDICT : SUGGESTED QUESTIONS

6.1 It is contended on behalf of the Wilson family that the following questions should be included in the narrative verdict left to the jury :

1. On transfer to Dryad Ward on 14 October 1998 what physical condition was the Deceased in?

2. Was the management of the Deceased's condition on transfer to Dryad ward on 14 October 1998 appropriate or inappropriate to that condition?

3. Was the administration and dosage of oramorph to the Deceased appropriate or inappropriate to the Deceased's needs on 14 and/or 15 October 1998?

4. Was the pre-prescription of diamorphine, hyoscine and midazolam on 14 October 1998 appropriate or inappropriate to the Deceased's needs?

5. If the answer to 2 is 'inappropriate' do you consider that that the management caused or more than minimally, negligibly or trivially contributed to the Deceased's death on 18 October 1998? If so in what way or ways?

6. If the answer to 3 is 'inappropriate' do you consider that that the dosage of oramorph on 14 and 15 October 1998 more than minimally, negligibly or trivially contributed to the Deceased's death on 18 October 1998? If so in what way or ways?

7. If the answer to 4 is 'inappropriate' do you consider that that the administration of diamorphine, hyoscine and midazolam caused or more than minimally, negligibly or trivially contributed to the Deceased's death on 18 October 1998? If so in what way or ways?

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13 April 2009 **Patrick Sadd**