IN THE PORTSMOUTH CORONER'S COURT

IN THE MATTER OF: -

AN INQUEST INTO THE DEATHS OF TEN PATEINTS

AT THE GOSPORT WAR MEMORIAL HOSPITAL

Submissions on behalf of

HAMPSHIRE PRIMARY CARE TRUST AND

PORTSMOUTH HOSPITALS NHS TRUST

INTRODUCTION

1. The following submissions are made on behalf of Hampshire Primary Care Trust and Portsmouth Hospitals NHS Trust, the successor organisation to, *inter alia*, Portsmouth Healthcare Trust.

2. In accordance with rule 40 of the Coroners Rules 1984 every reasonable effort has been made to avoid references to the factual evidence presented to the court in the course of the inquest hearing. Insomuch as these submissions do touch upon matters of fact, such references are necessary to place the legal submissions in context. If support for this approach is needed the same can be found from the case of Lin v Secretary of State for Transport [2006] EWHC 2575 (Admin) per Moses LJ at paragraph 56.

THE GALBRAITH PRINCIPLE

3. Whilst it is accepted that it is the Learned Coroner's discretion to determine how to elicit the jury's conclusions on the central issues canvassed during the course of the inquest the Learned Coroner should only set down for the jury those verdicts considered appropriate as a matter of law and as justified by the evidence ('the Galbraith Principle').

4. A recent helpful analysis of the same can be found from the case of *R (on the application of Ernest Bennett) v. HM Coroner for Inner South London & Ors* [2007] EWCA Civ 617 per Waller LJ at paragraphs 27 – 30. The following guiding principles can, it is submitted, be extracted:

    a. It is the coroner's duty to act as a filter to avoid injustice by only leaving to a jury those verdicts which it would be **safe** to return (para 27 quoting the earlier case of *R v HM Coroner for Exeter and East Devon, ex parte Palmer* (unreported));
    b. Although the coroner should not "*decide matters which are the province of the jury*", they are entitled to consider the question whether it is safe to leave a particular verdict on the evidence available to the jury;
    c. If after such consideration the coroner concludes that a verdict, if reached, would be perverse or unsafe, then he should refuse to leave such a verdict to the jury.

5. With those principles in mind, the Trusts submit that in this case it would be inappropriate to leave the following verdicts / matters to the jury:

    a. Unlawful killing;

    b. Neglect; and

    c. Comment on the clinical regime at the time.

UNLAWFUL KILLING

6. The particular form of unlawful killing which the Learned Coroner may be urged to leave to the jury is gross negligence manslaughter.

7. The circumstances in which gross negligence manslaughter could arise were considered with specific reference to inquests by the Court of Appeal in *R v. Inner London South District Coroner, ex parte Douglas-Williams*. It was said that for gross negligence manslaughter there must be:

   a. Negligence consisting of an act or failure to act;

   b. The negligence causing the death in the sense that it more than minimally, negligibly, or trivially contributed to the death; and

   c. The degree of negligence was 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.

8. Proof of these requisite elements is required to the criminal standard, namely beyond all reasonable doubt.

9. None of the factual or expert analysis into the deaths of any of the ten patients from the Gosport War Memorial Hospital, the Trusts submit, passes the evidential threshold to allow the jury to safely conclude so that they are sure that any act or omission more than minimally contributed to the death.

NEGLECT

10. The legal principles governing the use of such a rider remain unchanged from the decision in *R v. HM Coroner for North Humberside and Scunthorpe ex p Jamieson* [1995] QB 1.

11. Before such a verdict can be returned the court would need to be satisfied that:

a. There existed a relationship of dependency between each of the individual ten patients and the staff at the Gosport War Memorial Hospital (unlikely to be disputed);

b. There was a gross failure to provide basic medical / nursing care. It is accepted that the word 'gross' imports a value judgement and therefore this is usually a matter for the jury. However, it will be a matter for the Learned Coroner to balance, where relevant, the contrasting views of Professor Black, Dr Wilcock, Dr Dudley and Dr Petch in order to determine whether there is sufficiency of evidence on the questions of grossness and / or basic care to leave neglect in any form to the jury. The very existence of a dispute however must raise doubts as to both the severity of any shortcomings and / or the lack of sophistication and / or complexity involved in administering / prescribing medication for the elderly which is necessary to conclude that the care was basic.

a. A clear and direct causal connection between the gross failure and the death. Although the requirement in this context for a clear and direct causal connection is not a liability – based causation, but rather simply a lost opportunity to render care (Jervis on Coroners, 12th Edition, paragraph 13-47), it is still necessary to establish causation on the balance of probabilities (*R (on the application of Khan) and HM Coroner for West Hertfordshire v. Chief Constable of Hertfordshire Constabulary* [2002] EWHC 302 (Admin) per Richards J at paragraph 43). This will involve analysis of the intervening events between any gross failure which is identified and the death (for example, the various unrelated and often irreversible co-morbidities with which these patients invariably suffered). The question, it is submitted, for the Learned Coroner to consider is: what evidence is there to allow the jury to safely conclude that the patient would not have died at the same time in any event as a result of their general condition.

THE CLINICAL REGIME AT THE TIME

12. No criticism is made as to the conduct or scope of the inquest to date.

13. Prior to the start of the hearing it was directed by the Learned Coroner and accepted by the Interested Persons that this was an inquest of a *traditional kind* the deaths having occurred prior to the coming into force of the Human Rights Act 1998 (*R (on the application of Christine Hurst) v. Commissioner of Police of the Metropolis* [2007] UKHL 13).

14. It is trite law that when conducting such an inquest and enquiring as to "*how*" the deceased came by his/her death (rule 36 of the Coroners Rules 1984) the Learned Coroner need only consider "*by what means*" death arose (per Lord Bingham MR in *R v. HM Coroner for North Humberside and Scunthorpe ex p Jamison* [1995] QB 1) and not "*by what means and what circumstances*" (per Lord Bingham in *R (Middleton) v. West Somersetshire Coroner* [2004] 2 AC 182) (per Sir Anthony Clarke MR para 106 *R (Takoushis) v. HM Coroner for Inner North London* [2006] Lloyd's Rep Med 57).

15. Despite an absence of its requirement to do so, the inquiry into the Gosport War Memorial deaths has extended beyond that which would be required of an inquest of a *traditional kind*. Particular reference is made to the analysis of the clinical regime in existence at the time.

16. It is accepted that whilst it is not uncommon for the inquiry in an inquest of a *traditional kind* to stretch wider than strictly required for the purposes of a verdict (and that "... *how much wider is pre-eminently a matter for the Coroner* ..."), in such circumstances, however, not all matters explored need necessarily be incorporated into the verdict.

17. Indeed in certain situations, for example where facts bearing on civil liability have been explored, such expressions / reflections are expressly prohibited (rule 42 of the

Coroners Rules 1984). Another such example is when the inquest is of a *traditional kind* and the matters explored are not directly causative of the death.

18. In the Trusts' submission any consideration of the clinical regime falls squarely into this latter category and as such need not and indeed should not be incorporated into a narrative verdict by means of a questionnaire or otherwise.

19. Although it is accepted that reflecting the central factual issues canvassed during an inquest is a requirement of any verdict, even one following an inquest of a *traditional kind*, this is only so true, it is submitted, so long as the issues canvassed are relevant to the subject matter into which it is the Learned Coroner's duty to inquire and do not offend against the relevant regulatory rules.

BRIONY BALLARD

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London, EC4Y 1BQ
13th April 2009

Jury Questionnaire (Pittock; Lavender; Lake; Service; Cunningham; Devine; Wilson; Spurgin and Gregory) ? Packman

A: History

(a) Certification details
(b) Time and place of death
(c) From what medical condition(s) did the deceased suffer at time of their admission?
(d) How would you describe their prognosis on admission to Gosport War Memorial Hospital?

B: The Death

(a) What was the medical cause of death, if ascertainable?

(b) Did the administration of any medication contribute more than minimally or negligibly to the deceased's death? If the answer is 'no', then you need not answer the questions below;

a. If the answer to the above question is 'yes', was the medication given to the deceased in accordance with clinical geriatric practice at the time?
b. If not, what medication at what date and / or time?
c. In what respect was the medication inappropriate?

(c) *Specific to Packman and Devine*: Did the decision not to transfer the patient back to the acute hospital contribute more than minimally or negligibly to the deceased's death?

(d) If the answer to the above question is 'yes', was this decision within the boundaries of a reasonable clinical decision?

C: General Issues:

(a) What was the level of medical and nursing cover for Dryad and Daedalus wards?

(b) Was the level of medical and nursing cover appropriate for these wards?

(c) How and to what extent did any shortcomings you have identified in medical and / or nursing cover impact upon the care of the ten patients concerned?

(d) To what extent did any shortcomings you have indentified in medical and / or nursing cover arise from the bed pressures facing the acute hospitals in the area (namely the Royal Haslar, Queen Alexandra and St Mary's)?

(e) Were the acute hospitals facing bed pressures because of political pressure to adhere to waiting lists and / or because of the standard pressures prevalent in the local community?