IN THE COURT OF APPEAL

BETWEEN

R

-v-

BENJAMIN GEEN

ADVICE AND GROUNDS OF APPEAL

AGAINST CONVICTION

---

1. The Applicant was convicted on the 18th April 2006 of two counts of Murder and fifteen counts of Grievous Bodily Harm, following a trial before Mr Justice Crane sitting at the Oxford Crown Court. The Applicant was later sentenced to 35 years imprisonment. I was instructed, following conviction and sentence to advise on whether any grounds of appeal against conviction exist, particularly in light of the new evidence of Dr Pumphrey and Dr Mark Heath, which are discussed in detail below.

2. For the reasons I have outlined below, I advise that there are grounds of appeal against conviction.

Factual Background

3. For a full outline of the background, the Court is referred to the attached case summary. In summary, the Crown alleged that the Applicant, who is a nurse, injected a number of patients with a variety of unauthorised lethal doses of drugs, including muscle relaxants, insulin and sedatives, which caused them to stop breathing. Fifteen of the patients recovered and later left the hospital and two of the patients died. When the Applicant was

arrested, he was in possession of a syringe, which had contained a drug which can cause a respiratory arrest.

4. There was no direct evidence that the Applicant unlawfully injected any patients with a drug to induce a respiratory arrest. The Crown was unable to rely on any individual, either medical or civilian, who witnessed the Applicant giving any of the drugs suggested by the Prosecution. Finally, there was no direct evidence that any of the patients received any of the drugs which the Prosecution allege. The whole Prosecution's case was built around medical theory to explain how each of the patients had a respiratory arrest or breathing difficulties.

Grounds of Appeal

Ground 1 – Fresh Evidence of Dr Pumphrey

5. The first ground of appeal derives from the new evidence of Dr Charles Pumphrey who is a Consultant Cardiologist at St Georges Hospital, London. The Oxford Radcliffe Hospital's NHS Trust, following a claim by the estate of Mr Onley for damages, instructed Dr Pumphrey to provide advice on Mr Onley's cause of death. Dr Pumphrey's report was later served on the Applicant by the Crown. It is the opinion of Dr Pumphrey that Mr Onley died of liver failure brought on by septicaemia and that his death had nothing to do with the any act by the Applicant:

> *"it is my view, it is unlikely that this rapid deteriorating liver failure can be attributed to the unauthorised treatment given by Mr. Geen"*

Background behind Mr Onley

6. Mr. Onley was admitted to the Horton General Hospital Accident and Emergency department on 21st January 2004. He had only recently been discharged from hospital having had a triple Coronary Artery Bypass Graft on 31st December 2003. Following his release, Mr Onley had developed an infected wound and a chest infection. On arrival at the Accident and Emergency department, Mr Onley was handed over to Nurse Jennifer Banks.

7. Dr Onley stated that he had not felt well since his bypass operation and for the last three to four days had been aching all over, shivering, feverish, and thirsty. The day before he had

fallen and was now unable to weight-bear. In 1990, he had also suffered a myocardial infarction and since then had suffered from angina.

8. Nurse Banks stated that she checked Mr Onley's blood sugar level and gave him insulin. During the night, Mr Onley also received saline and antibiotics. Nurse Banks finished her shift at 07.00 - 07.15. The Applicant first saw Mr Onley at around 08.00 when he gave him his morning medication. The Applicant checked Mr Onley's blood sugar level, at 08.05. He did a morning set of observations and Mr Onley seemed stable for his condition. The Applicant stayed with him for about 5-10 minutes.

9. Dr Arnold, a Consultant Physician, arrived to examine Mr Onley at around 08.30. On arrival, Mr Onley was found to be pale and apnoeic (not breathing), with a good pulse. A mask and bag were used for the purposes of artificial ventilation. Mr Onley was intubated and his lungs were ventilated artificially. His pupils were described as 'average and reactive.' There was no response to pain and administration of Naxolone produced no immediate response. Blood gas analysis at 08.48 showed that there had been an accumulation of some metabolic acids since an earlier analysis at 06.11; the base deficit had increased from 2.4mmol/litre. The arterial oxygen tension was 16.1kPa. By 09.15, there was some respiratory effort, but it was inadequate. By 09.25, there was spontaneous respiratory effort; Mr Onley was gagging on the tracheal tube, which was removed.

10. Mr. Onley suffered a cardiac arrest at 12.55pm following the onset of hypotension. He remained very ill and in the evening became unconscious. Mr. Onley's lungs were ventilated artificially and he was transferred to the Intensive Therapy Unit at the John Radcliffe Hospital, Oxford. He died the following day.

11. A post mortem was carried out by Dr David Davies. It was noted that Mr Onley developed acute liver failure and despite active medical support he failed to respond and died. The cause of death was cited as *"ischaemic heart disease due to coronary artery atheroma"*.

The evidence at trial

12. The Crown relied on a number of experts at trial, primarily Professor Aikenhead who argued that Mr Onley's death was a consequence of the first respiratory arrest. He stated that the arrest was caused by the Applicant administering a muscle relaxant, which would have

resulted in a respiratory arrest. The muscle relaxant would have worn off in approximately 30-40 minutes, which is consistent with the observation that there was some respiratory effort at 09.15.

13. The defence relied on an equal amount of experts. Dr Lack, who is also a Consultant Anaesthetist, stated that Mr Onley died as a result of his various ailments and was at risk of sudden death at anytime. He could not be sure that he had a hypoglycaemic attack, but he may have had a stroke and he found no need to conclude that there was a muscle relaxant was administered.

14. The Crown called two Pathologists, Professor Carey and Milroy, who stated that if there was a respiratory arrest at 08.30 it would have contributed significantly to the death of Mr Onley.

15. Dr Davis, the Pathologist who carried out the post mortem on Mr Onley agreed that the cause of death related to the heart and that the respiratory arrest was a contributory factor.

16. The Applicant called Dr Amadi, a Cardiologist, who stated that Mr Onley was an ill man with a number of conditions and after many cardiac arrests he was on a downward slope. The heart was abnormal and the infarction finding-thrombosis-confirms the first attack was a heart attack. The drop in the Mr Onley's blood pressure, indicates either that there was no significant effect from any respiratory arrest or that the heart was not capable of responding, to the adrenaline because it was incapacitated. If there was a respiratory arrest he would struggle to link it to the cardiac arrest and regarded the blocked bypass as significant.

17. The defence also relied on the evidence of Dr Patel, a Pathologist, who stated that the longer the time between a respiratory arrest and death, the less likely for it to be the cause of death. The post mortem showed no signs of a respiratory arrest, which could have caused death.

Evidence of Dr Pumphrey

18. Dr Pumphrey's evidence was not before the trial jury. Dr Pumphrey is an independent expert instructed by the NHS Trust and not by the defence or the prosecution. His opinion was based on reading the medical records and the Pathologist's reports. Importantly, Dr

Pumphrey does not take issue with the Prosecution's assertion that the Applicant caused the respiratory arrest. His evidence is that the respiratory arrest did not cause Mr Onley death.

19. It is submitted that as a consequence of this evidence the conviction on Count 1 of the Indictment is unsafe.

Ground 2 – Fresh Evidence of Dr Mark Heath

20. As there was no direct evidence that the Applicant had given any unauthorised drugs to the patients the Crown relied on the opinion of an anaesthetist who provided a theory as to how the respiratory arrest occurred. The Anaesthetist, Professor Aikenhead, provided a pharmacological basis for each of the arrests. In his opinion, the primary drug used by the Applicant was a muscle relaxant. It was the Prosecution's case that seven patients received a muscle relaxant, which included the two patients subject to the two murder counts.

21. There is now new evidence from Dr Mark Heath, a Consultant Anaesthetist, which casts doubt on this assertion.

Dr Mark Heath

22. Dr Heath is an Assistant Professor of Clinical Anaesthesiology at Columbia University in New York City. Over the past several years, as a result of concerns about the mechanics of lethal injection as practiced in the United States, he has performed many hundreds of hours of research into the techniques that are used during this procedure. He has testified as an expert medical witness in courts in Maryland, Georgia, Tennessee, Kentucky, Virginia, and Louisiana in the following actions: *Baker v. Saar*, No. WDQ-05-3207 (D. Md.); *Reid v. Johnson*, No. 3:03cv1039 (E.D. Va.); *Abdur'Rahman v. Bredesen*, No. 02-2236-III (Davidson County Chancery Ct., Tenn.); *State v Michael Wayne Nance*, 95-B-2461-4 (Ga. Superior Ct.); *Ralph Baze & Thomas Bowling v. Rees*, 04-CI-01094 (Franklin County Circuit Ct., Ky.), and before state district court Judge Ramona Emanuel in Shreveport, Louisiana in February 2003. He has filed affidavits that have been reviewed by courts in the above states and also in California, Pennsylvania, New York, Alabama, North Carolina, South Carolina, Ohio, Oklahoma, Texas, Missouri, and by the United States Supreme Court.

23. Dr Heath is an authority on the physical effects of muscle relaxants and their use on patients who are awake at the time they are administered. Dr Heath has reviewed all the notes of the

patients alleged to have been given a muscle relaxant by the Applicant. In Dr Heath's opinion, there is no evidence that any of the patients he reviewed received a muscle relaxant.

Muscle Relaxants

24. There are two types of muscle relaxants, depolarising and non-depolarising. This case refers only to the use of non-depolarising muscle relaxants. This type of muscle relaxant paralyses all voluntary muscles, but does not affect sensation, consciousness, cognition, or the ability to feel pain and suffocation. Its effect is to render the muscles unable to contract but it does not affect the brain or the nerves. It is used in surgery to ensure that there is no movement and that the patient is securely paralysed so that surgery can be performed without contraction of the muscles. In surgery, a muscle relaxant is not administered until the patient is adequately anesthetised. The aesthetic drugs must first be administered so that the patient is unconscious and does not feel, see, or perceive the procedure. This can be determined by a trained medical professional who provides close and vigilant monitoring of the patient, their vital signs, and various diagnostic indicators of anaesthetic depth. If not anesthetised properly then it is held to a reasonable degree of medical certainty that the use of a muscle relaxant would mean that the patient would consciously experience paralysis and suffocation.

25. If administered alone, a muscle relaxant would not immediately cause a patient to lose consciousness. It would totally immobilise the patient by paralysing all voluntary muscles and the diaphragm, causing the patient to suffocate to death while experiencing an intense, conscious desire to inhale. Ultimately, consciousness would be lost, but it would not be lost as an immediate and direct result of the muscle relaxant. Rather, the loss of consciousness would be due to suffocation, and would be preceded by the torment and agony caused by suffocation. This period of torturous suffocation would be expected to last at least several minutes and would only be relieved by the onset of suffocation-induced unconsciousness.

26. What follows is a summary of all the patients who the Prosecution say received a muscle. As can be seen from the summary all the patients were very ill when admitted to the A &E department. It is the Applicant's submission that there is an alternative explanation in every count for the respiratory arrests. In any event, it is argued, that none of the patients, who were allegedly subject of the GBH, complained of pain when they later recovered.

Hilda Wigram

27. Mrs Wigram was taken by ambulance to the A & E Department of Horton Hospital on Christmas Day 2003, complaining of being unwell for about a week before and later developing vomiting, headache and pain in the back and neck. Mrs Wigram was seen by Dr Butt who diagnosed a subachranoid haemorrhage and prescribed Pethidine and Metoclopramide. Sister Molloy and Nurse Ben Geen drew up the Pethidine while the Sister prepared the Metoclopramide. As Mrs Wigram had not received opiods before, Nurse Molly asked Ben Geen to dilute the Pethidine. Ben Geen said there was no need it, but he would give it slowly. Both nurses returned to the cubicle and Mrs Wigram was fully conscious and able to answer questions. Nurse Geen administered the Pethidine. Mrs Wigram initially became drowsy and quickly became unrousable. She stopped breathing and according to the Sister, Ben Geen said 'I only gave her 50, honest.' This was verified by Mrs Wigram's daughter, Angela Finn and Mrs Finn's husband. Mrs Wigram was taken to the Resus area.

28. After the initial diagnosis, Dr Butt had second thoughts about dose of Pethidine, but he arrived too late to change it. Upon being taken to the Resus room, Naxolone was administered but with no effect. A total of 600mg was administered with no effect. Mrs Wigram was intubated, and the lungs were ventilated artificially. The pupils were dilated and reacted to light. The CT scan showed that Mrs Wigram had suffered a subarachnoid haemorrhage. It was decided to perform a lumbar puncture at around 22.15 hours and ten millilitres of cerebrospinal fluid were removed; the pressure decreased to 6cmH20 from an initial pressure of 22cmH20. 30-60 minutes afterwards, Mrs Wigram started to breathe. Mrs Wigram complained of discomfort but not pain.

29. At trial, Dr Aikenhead said that the respiratory arrest cannot be explained by the underlying condition and the most likely cause of the arrest was the administering of a muscle relaxant.

WALTER COATES

30. Mr Coates was admitted to the A & E department on 29 December 2003. He awoke in the early hours of the morning with severe chest and stomach pains. He asked his son to take him to the hospital at approximately 05.00.

31. Mr Coate's statement refers to the presence of two nurses as he was being taken to the cubicle. Two female nurses put him into a gown and one male nurse placed a heart monitor on his chest and then a female nurse put what he described as a needle into his wrist and blood was taken for analysis. Then a female nurse injected a syringe full of clear liquid into his wrist and he immediately became dizzy on the head and felt himself beginning to faint. He felt he could not breathe and was gasping for breath. Mr Coate's son in his statement said that he thought it was a male nurse who took the blood sample and the two female nurses administered the morphine. After 10-15 minutes, he said that his father looked as if he was struggling for breath.

32. The two female nurses were, Teresa Rumble and Sarah Carter. Rumble stated that Geen cannulated the patient and this took more than one attempt. Carter stated that Geen took the syringe of blood. This is also confirmed by Wendy Darkins. The two nurses went off to obtain the morphine and Geen went off to label the bloods. 10-15 minutes later Mr Coates was in severe distress. He was trying to pull off the oxygen mask and it was difficult to hold him down on to the trolley. He was becoming cyanosed around the lips and mouth. A healthcare assistant, Wendy Darkins, tried to restrain Mr Coate's son and agreed that Dr Jennings had prescribed the morphine without seeing Mr Coates. At 06.20 Mr Coates had a sudden onset of respiratory arrest and Dr Jennings was called. His oxygen saturation decreased despite administration of oxygen. The trachea was intubated without administration of drugs, he was sedated and his lungs were ventilated artificially.

33. Mr Coates was then transferred to the John Radcliffe Hospital in Oxford. By 14.40, Mr Coates had recovered consciousness. He said that he could not remember anything after the morphine had been given. Naxolone of 400mg was administered while Mr Coates was in distress, but this had no effect.

34. Dr Aikenhead said the episode of respiratory arrest cannot be explained by any natural disease process and must have been drug induced. In Dr Aitkenhead's opinion, it can only be explained by the administration of a muscle relaxant drug. It could have been administered by intravenous cannula although there is no evidence to suggest that drugs were given via the cannula. Alternatively, it could have been added to the bag of saline.

35. Although in Mr Coates' statement he states that the drug was delivered by a bolus injection, if a muscle relaxant was added to the saline and administered rapidly it would have resulted in a gradual loss of consciousness, an appreciation that breathing was impaired, a gradual impairment of ventilation, an increase in the arterial carbon dioxide tension, a feeling of panic, a decrease in arterial oxygen saturation, respiratory arrest and an ability to intubate the trachea without the administration of any other drugs. Administration of a MR though a bag of saline would result in a more gradual onset of respiratory distress.

36. Dr Lack disagreed arguing that a muscle relaxant is never administered to conscious patients-something is always given before surgery. The twitching of the muscles was is not consistent with the use of a muscle relaxant.

SHELIA GRAY- SNOOK

37. Mrs Gray-Snook was admitted to the Accident and Emergency on 2nd January 204 complaining of a fast heart rate with palpitations. She was seen by a triage nurse at 08.45.

38. Triage was carried out by Staff Nurse, Ann Missington. She took a history and she was put on an ECG and a cardiac monitor. Dr Thomas gave an adenosine, a diagnostic drug which only lasts for seconds and she out a query for digoxin and then handed over to Dr Butt.

39. Mrs Grey-Snook had a history of arterial fibrillation 6 months earlier. She was seen by Dr Thomas at 09.40 who noted that the palpitations had started at 17.00 the previous day. There was also a history of angina and a stent had been inserted. In her statement, she said that she was given a dose of drugs via venflon, but she cannot recall by whom. She said that she was seen by a consultant, probably Dr Butt and he raised the possibility of a cardio version. She remembers no more until she woke up.

40. DC Cardio version was performed at around 19.50 and an anaesthetic senior house officer was present. The benzodiazepine was administered in a dose of 10mg; atropine 1mg was administered to prevent the onset of a slow heart rate. A single synchronised DC Shock of 200 Joules was administered and resulted in conversion to sinus rhythm. The anaesthetist senior house officer noted that the procedure was uneventful. An anaesthetist was paged, who wanted to intubate, but Dr Butt decided that all that was needed was a dose of Midazolam.

41. At around 20.20, SGC blood pressure fell and a doctor was called. The doctor found that the airway was clear, but that there was no spontaneous respiratory effort. She was intubated and artificially ventilated. At about midnight, she began to respond to command by opening her eyes and moving her arms and legs, although with much reduced power.

42. Dr Aikenhead gave evidence that the respiratory arrest cannot be explained by the underlying condition or the administration of Midazolam. The administration of either a large dose of a long-acting opioid analgesic drug such as morphine, or the administration of a non-depolarizing muscle relaxant as a continuous infusion was suggested.

43. Dr Lack disagreed stating that a well known complication of cardio-inversion is a stroke. The absence of the sign of stroke on the CT scan is likely to be because it was done immediately before that would show up. Since she had no memory that suggests a brain malfunction- while that could be due to a drug, it could also be due to a stroke. He accepted that because she was properly anti-coagulated, a stroke was less likely. A muscle relaxant was possible but would not have caused a loss of consciousness for 15 hours and if done by infusion it would have to have been a large amount.

44. The defence also called a Cardiologist, Dr Amadi, who said a mini stroke has been redefined to include symptoms not revealed on a CT scan and, anyway, if a scan is taken too early it may not reveal a stroke. The facts were in keeping with a mini stroke and this is a recognised complication of a DC. It can occur 24 hours later, as a clot may be ejected as the contraction of the heart muscles resumes over that period. He conceded that it is unusual for a mini stroke to cause a RA, but it is not necessary to have a substantial clot to cause respiratory impairment; it is simply more likely if it is substantial. He accepted that a clot, although recognised complication is in fact uncommon after a DC.

ANTHONY BATEMAN

45. Anthony Bateman was admitted to the A & E Department at 09.30 on 6 January 2004. He had been described by his GP as looking 'absolutely ghastly' and he was in continuous pain and was only just coping at home. He had a history of Congestive Obstructive Pulmonary Disease, severe rheumatoid arthritis, atrial fibrillation and congestive heart failure.

46. He was seen by Dr Hughes, a pre-registration house officer, who recorded a history of anorexia and weight loss had occurred and that he was in no greater shortage of breath than usual. He was also taking a complex array of drugs. Air entry into the lungs was poor and there was gross pitting oedema of the legs. Dr Hughes thought that he might be suffering from cancer and there was also a respiratory tract infection.

47. After he came back from x-ray he started to lose his breath and Ms Blackwell went off to find a nurse and came back with Nurse Geen. Nurse Geen cannulated the patient and took his bloods and connected Mr Bateman to the saline infusion. A doctor ordered that Mr Bateman be taken back to Resus.

48. He was brought into the room by Nurse Lissington and Nurse Geen. The medical Senior House Officer was also there and they were trying to bag Mr Bateman but his respiratory rate continued to decrease. He eventually seemed to perk up and Dr Ellis decided that Mr Bateman was not to be treated aggressively. Later that day, Mr Bateman died.

49. In Professor Aitkenhead's opinion, it is overwhelmingly probable that the sudden and rapid deterioration in his respiratory function resulted from the administration of a drug. It seems unlikely that he did not stop breathing completely and, in addition, it was some time after the decision to stop resuscitation that Mr Bateman died which suggests he was able to breathe, albeit inadequately. Consequently, if a muscle relaxant was given, it must have been given in a dose less than that required to produce complete paralysis of the diaphragm. A muscle relaxant was probably added to the bag of saline before 10.38 and that it produced a slow progressive deterioration in ventilation, probably over the space of 45 minutes or so. His death could have been prevented by artificial ventilation, probably within less than an hour of the infusion being discounted.

50. Dr Lack disagreed stating that breathlessness was caused by a pulmonary oedema, which was his underlying condition. If it were an infusion, then it would have to be a huge amount, although a litre can go through in 20 minutes. If Mr Bateman was breathing spontaneously then it could not have been a muscle relaxant.

51. Dr Armadi talked of cheyne strokes respiration-this can cause respiration to stop for 30 seconds or so spontaneously and start again. He accepted that cheyne strokes are distinctive

and capable of recognition and it is more common in people who are asleep although it is not rare when they are awake. He also accepted that deep unconsciousness is not characteristic of cheyne strokes and it rarely causes the kind of distress that Mr Bateman suffered.

52. Dr Patel felt that, as there was no post mortem it was difficult to determine as cancer could cause death at anytime if it was present.

Noreen Brooks

53. Mrs Brooks arrived into A & E at 18.43 on 19 January 2004. She was an insulin-dependent diabetic who was resident in Orchard Lodge, because of her mental illness. Her general condition had deteriorated and her diabetes was becoming more difficult to control. She had attempted previously to overdose on insulin.

54. At 19.40, 10 units of Actrapid insulin were injected subcutaneously and 5 minutes later, an infusion of 1 litre of saline was prescribed, to be infused over 30 minutes. From the statement of Nurse Molly, Mrs Brooks was placed on a trolley near a sink because it was a busy evening. She was sweating and breathing quickly, but she was conscious and alert.

55. Dr Bailey then came to see Mrs Brooks, who noted that she had not taken insulin for two days. She has become confused, dehydrated and unwell. Investigations revealed that her blood sugar was very high, the white cell count was elevated and there was a very severe metabolic acidosis. The serum sodium concentration was low-188 mmol/litre and the serum potassium concentration was very high-8.6mmol/litre.

56. Mrs Brooks was then seen by Dr Mahesh, a consultant. He concluded that she was suffering from diabetic ketoacidosis, lithium-induced acidosis and possibly renal tubular acidosis. He recommended fluid resuscitation with 10 litres over 24 hours, an insulin infusion, careful monitoring of the serum potassium concentration and possibly oral bicarbonate when her condition improved.

57. There is a discrepancy as to why she was moved into Resus. Dr Bailey says he thought it was because she suffered a Respiratory arrest. Nurse Shea says it was because more equipment

was needed to treat her. Nurse Shea stated that Mrs Brooks was catheterised; normal saline was administered by the defendant, plus the atracpid, which she, Nurse Shea, gave.

58. A specialist registrar made an entry in the records at 21.30. He was attending Mrs Brooks at 20.30 when she had a respiratory arrest. This seems to be Dr Najeed Rahman. She had good blood pressure, good pulse, her potassium was a bit high, the blood pressure of 140 over 70 was higher than before but within normal range, her cardiac output was normal and she was intubated without sedation. Her GSC was 3 and the pupils were equal and reactive. She was transferred to ITU where she was sedated.

59. Professor Aitkenhead's opinion was that Mrs Brooks was unwell and her blood sugar level was very high, extreme acidosis and low serum sodium concentration could have caused a fit or a coma. However, in the absence of any fit occurring, the onset of a coma would have been insidious, not rapid

60. Even if a fit had occurred, it would not be expected to result in apnoea for a prolonged period of time; breathing might have stopped during the fit, but would then have resumed.

61. While the very high serum potassium concentration could have resulted in a cardiac arrest with a secondary respiratory arrest, it is clear from the records that she suffered a primary respiratory arrest and that her heart did not stop. Indeed her blood pressure after the respiratory arrest was substantially higher than on admission

TIMOTHY STUBBS

62. Mr Stubbs was referred to the Horton Hospital on 5 February 2004 by his GP, because he had reported severe epigastric pain and vomiting. He arrived at the A & E at approximately 18.15 and triage took place 5 minutes later.

63. Mr Stubbs had a history of high alcohol consumption, which was often followed by abdominal pain. He had a history of heavy drinking 5 days prior to admission, and had woken up on the following day with abdominal pain. He had been vomiting 2-4 times per day and on examination,

64. He was dealt with by Nurse Geen who brought a machine to take his blood pressure. Nurse Geen said that Mr Stubbs was sweaty and unsteady when triaged and he informed Dr Kydell of this fact. She said that she saw Mr Stubbs at around 19.00, he had a venflon in and he was sweating a lot. She said a nurse came into her room to say that Mr Stubbs had a low blood sugar level. Dr Kydell requested 50% dextrose. The patient had become unwell, drowsier and was struggling to breath. She said that Nurse Geen put an oral airway in despite being told not to and Mr Stubbs started to gag on it. Mr Stubbs was then taken into Resus, as he was struggling to breathe. Nurse Geen said that Dr Kydell asked for more drugs to be given such as vitamin replacements but as the drugs went in via the cannula, the patient became less and less responsive.

65. Mr Stubbs was lying unresponsive in Resus with a GCS of 3. His respiration ceased and he turned blue. Dr Drew Birch described it as a peri-arrest, breathing not sufficient to sustain life. Lorazepam and Diazemuls were prescribed and Nurse Geen said that Mr Stubbs started to turn blue and have reduced oxygen saturation after these were administered.

66. Professor Aikenhead stated that the urine sample indicates that Mr Stubbs received Midazolam in addition to: Lorazepam, used to treat the fits; Diazepam, which was probably given to maintain the sedation after anaesthesia had been induced; and Temazepam, which was given as night sedation from 7 February 2004. Midazolam has a much shorter half-life than the other drugs which explains why it was found in the urine, but not in plasma.

67. Professor Aikenhead did not think that the Vecuronium in itself was primarily responsible for the deterioration in Mr Stubbs condition. A large dose would cause apnoea, where the evidence is that Mr Stubbs was breathing, albeit inadequately.

68. The most probable sequence of events is that Mr Stubbs was given Midazolam, resulting in loss of consciousness and severe respiratory deficiency either because of central depression or airway obstruction.

69. Dr Lack felt that the symptoms could have been caused by alcohol, but he did not think they were due to a sedative. He did not agree that the presence of Midazolam puts a different complexion on things.

Ground Three - Alternative Verdict - Section 23 Offences Against the Person Act (OAP) 1861

70. The original Indictment carried fifteen counts of **Section 23 OAP 1861**. On advice from the trial Judge, the Crown amended the Indictment to fifteen counts of **Section 18 contrary to Offences Against the Person Act 1961** (GBH) with alternative counts of attempted GBH.

71. It is submitted the Indictment was defective and the offence which properly reflected the evidence on each count was **Section 23**. In the alternative, the Judge erred in allowing the counts of attempted GBH to remain on the Indictment, the correct alternative was **Section 23**.

72. **Section 23** states as follows:

"Whosoever shall unlawfully and maliciously administer to, or cause to be administered to or taken by any other person any poison, or other destructive or noxious thing, so as thereby to endanger the life of such person, or so as thereby to inflict upon such person any grievous bodily harm, shall be guilty of an offence"

73. This ground of appeal should be seen in light of Ground four. As is stated below it is essential that in any trial the Indictment reflects the evidence this ensures that the accused is not convicted of an offence for which he is not culpable. The offence of GBH, left the jury with limited options when considering the issue of murder. If they accept that the applicant intended to cause serious harm, then it follows that if the patient died, the applicant was guilty of murder. This, it is submitted, prevented the jury from considering the issue of manslaughter.

Ground 4 - Misdirection as to Alternative Offence (Manslaughter)

74. There was no alternative on the Indictment to Murder. It is submitted that on the specific facts of this case, the obvious alternative to the offence of Murder was Manslaughter. It is argued that the failure to leave the alternative prevented the jury from returning a verdict which reflects the culpability of the offence.

75. The issue of alternative verdicts, in particular in the case of Murder was discussed in the now leading case of *R v Coutts* [2006] UKHL 39. Here Lord Bingham said:

"I am of [the] opinion that the Judge should have left a manslaughter verdict to the jury. His failure to do so, although fully understandable in the circumstances, was a

material irregularity. While the murder count against the appellant was clearly a strong one, no appellate court can be sure that a jury, fully directed, would not have convicted of manslaughter"

He went on to say:

"The public interest in the administration of justice is, in my opinion, best served if in any trial on indictment the trial Judge leaves to the jury, subject to any appropriate caution or warning, but irrespective of the wishes of trial counsel, any obvious alternative offence which there is evidence to support. I would not extend the rule to summary proceedings since, for all their potential importance to individuals, they do not engage the public interest to the same degree. I would also confine the rule to alternative verdicts obviously raised by the evidence: by that I refer to alternatives which should suggest themselves to the mind of any ordinarily knowledgeable and alert criminal Judge, excluding alternatives which ingenious counsel may identify through diligent research after the trial. Application of this rule may in some cases benefit the defendant, protecting him against an excessive conviction. In other cases it may benefit the public, by providing for the conviction of a lawbreaker who deserves punishment. A defendant may, quite reasonably from his point of view, choose to roll the dice. But the interests of society should not depend on such a contingency."

76. Lord Bingham set out the test for when a direction on an alternative offence should be left to the jury:

    i. Is there an obvious (and viable) alternative offence?

    ii. Is there evidence to support an alternative verdict?

    iii. Is the public interest in the administration of justice being served?

77. It is submitted that the requirements of this three-limbed test can be met and the failure of the trial Judge to direct the jury on any alternative offence is a material irregularity and the conviction must, as in *Coutts*, be quashed.

Ground Five – Defective summing-up

78. The Judge repeatedly erred in not directing the jury on the proper approach they should take to the evidence. The Judge went through the prosecution evidence on the eighteen counts on the Indictment and at the end of each summary the Judge posed a number of questions that the jury could consider. However, the Judge critically failed to remind the jury of the burden of proof and the standard of proof they had to make when considering these questions. As an example when summing-up the evidence of David Long the Judge said:

> *"...the kind of questions you will need to consider are this, are they not, in this kind of situation: first of all, was the defendant alone with the patient, or alternatively, alone with the patient and the relative, who may or may not pick up what was happening? If he was, did that provide an opportunity for giving the patient something other than saline? That is the kind of question you will need to consider in many of these cases."* (page 32 E – F)

79. The Judge, towards the end of David Long's evidence added:

> *"matters to consider: (I shall repeat these every time) opportunity to obtain a drug; opportunity to administer a drug. What do you make of the evidence about what happened? What do you make of the expert evidence about what it could or could not have been?*
>
> *Of course, subject to your consideration of the directions I gave you, what about the more general picture, and whether that throws light, in the way I indicated it could, on this particular patient? Those are the kind of questions that will arise in each of these cases."* (Vol. III page 38 A – E)

80. It is submitted that the Judge was in error in posing the question in the way he did. First, the Judge failed to remind the jury that the Applicant was a nurse and so would have had an innocent association with the Mr Long as he was a patient at the hospital. Secondly, the Judge should have told the jury that the burden always remains on the Prosecution to prove that the Applicant had given something to the patient other than saline. It is submitted that a proper way of posing the question would be as follows:

> *"...the kind of questions you will need to consider are this, are they not, in this kind of situation: first of all,* ***has the Prosecution proved to you that*** *the defendant was alone with the patient, or alternatively, alone with the patient and the relative, who may or may not pick up what was happening? If he was,* ***has the Prosecution proved that it***

provided *an opportunity for giving the patient something other than saline? That is the kind of question you will need to consider in many of these cases* ***Remembering, the standard of proof that Prosecution has to prove to you is so that you are sure.***"

"matters to consider: (I shall repeat these every time) ***has the prosecution proved to you that the defendant had an*** *opportunity to obtain a drug; opportunity to administer a drug. What do you make of the evidence about what happened? What do you make of the expert evidence about what it could or could not have been?* ***Remembering, the burden is always on the experts called by the Prosecution to prove, so that you are sure, that the defendant unlawfully gave Mr Long a drug"***

Of course, subject to your consideration of the directions I gave you, what about the more general picture, and whether that throws light, in the way I indicated it could, on this particular patient? Those are the kind of questions that will arise in each of these cases."

Ground Six – The Judge failed to adequately sum up the defence case

81. The Judge failed to properly sum-up the defence case to the jury. The Applicant gave evidence over two days and was cross-examined and later re-examined. The Judge decided to remind the jury of the Applicant's evidence on each patient as he took them thorough the Prosecution case. By adopting this approach the Judge repeatedly contradicted the applicant's evidence by repeatedly contrasting it with Prosecution's expert evidence.

82. Further, it is submitted that the Judge failed to adequately sum-up the Applicant's interview, only referring to the more controversial areas of the interview thereby leaving the jury with a prejudicial impression of what the Applicant said.

83. The Judge also failed to refer to the defence evidence of two witnesses one gave evidence live and one who was read.

Ground Seven – Failure to change the venue of the trial

84. The Applicant was tried at the Oxford Crown Court, which is geographically not far from the Horton General Hospital, where the Applicant had worked. This case was clearly very emotive: it concerned a nurse who was in a trusted position and who was alleged to have

murdered two patients and seriously harmed sixteen more. It is highly likely that the jury would have known of the hospital, and people who at one time or other would have been a patient at the hospital.

85. Further, the case attracted substantial local and national coverage in newspapers, television and radio. The coverage was all prejudicial to the Applicant, giving only the Prosecution's side of the events.

86. It is submitted that a failure to change the venue for the trial prevented the Applicant from having a fair trial. The Applicant relies on the leading authority of R. v. Stone [2001] Crim.L.R. 465, CA, where following substantial adverse publicity the trial was moved from Maidstone Crown Court to Nottingham Crown Court.

Ground Eight – Failure to discharge jury

87. During the trial, the Judge was told by Court officials that a members of the jury had been discussing the case with people outside their number. The Applicant applied to discharge the jury on the grounds that they may have been unduly influenced by persons outside their number. The Judge after hearing submissions rejected the application. It is submitted that the Judge erred in not discharging the jury (Vol II p.8).

88. Before the commencement of evidence, the Judge directed the jury not to talk to members outside their number about the case. The rationale behind the direction is to ensure that a jury is not influenced by persons outside their group. Guidance on this issue can be found from the **Practice Direction (Crown Court: Guidance to Jurors) [2004] 1 W.L.R. 665 (amending Practice Direction (Criminal Proceedings: Consolidation) [2002] 1 W.L.R. 2870).**

89. At the first stage of learning of possible jury contamination, it is for the trial Judge to investigate the extent of the conversation, what had been discussed, how many jurors were involved, with whom the jury had talked to and if they had a connection with the case. This did not happen. Without this information, the Applicant is prejudiced in his ability to challenge the Judge's decision not to discharge the jury.

90. The Applicant submits that the jury should have been asked, having regard to what they have seen or heard, if they feel able to give dispassionate consideration to the evidence.

They jury should have been allowed to reflect on the matter privately before answering and, further, to bear in mind that bias, being insidious, a person may unconsciously be affected though he may in good faith believe himself to be impartial. (see R. v. Brown (Robert Clifford) [2002] Crim.L.R. 409, CA)

91. The test as to whether the jury should have been discharged is found in the leading authority of Re Medicaments and Related Classes of Goods (No. 2). The question a court should ask itself "whether a fair-minded and informed observer would conclude that there was a real possibility, or real danger, the two being the same, that the jury were or would be biased."

92. In R. v. Docherty [1999] 1 Cr.App.R. 274, CA, the Court stated that where the jury become aware of matter potentially prejudicial to the defendant and of which they should not be aware, the Judge has a discretion as to whether to discharge them; and, where the matter is capable of more than one reasonable interpretation, the test should be applied on the basis of the most prejudicial interpretation: It was said that the discretion was to be exercised in accordance with the test prescribed by the House of Lords in R. v. Gough [1993] A.C. 646.

Ground Nine – Defence counsel was not sufficiently prepared for the trial

93. Due to a change in counsel, trial counsel was instructed late. It was clear that the defence needed more time to prepare their case and so applied for the fixture to be broken. The Judge moved the trial back only four weeks. It is submitted that this was not sufficient and the defence were left in a difficult position.

94. This trial generated thousands of documents, statements and exhibits including a substantial amount of unused material. The evidence was in most part from experts, which raised complex issues of pharmacology, physiology and medical practice. Both the Prosecution and the Applicant instructed a large amount of experts who prepared reports on the eighteen patients.

95. During the trial there were a number of requests made by the Applicant's counsel for time to read reports or prepare cross-examination of the Applicant's experts.

96. Article 6(3)(b) European Convention on Human Rights guarantees the right to adequate time and facilities for the preparation of the defence. The adequacy of the time allowed will depend upon the complexity of the case: see generally Albert and Le Compte v. Belgium, 5 E.H.R.R. 533. It is submitted that this case was highly complex.

97. The Court of Appeal has accepted that there are times when, due to no fault of trial counsel, he may not be fully prepared to conduct a trial. In the recent decision in *R v Ulcay* [2007] EWCA Crim 2379, the Court was of the opinion that even if trial counsel was not prepared for trial he must "soldier on". The Court considered that the issue was whether the defendant had a fair trial. If, as a result, of counsel not being allowed sufficient time to prepare for trial, the defendant does not have a fair trial, the conviction is likely to be unsafe.

---

1 Pump Court
Temple
London

28th April 2008