OPERATION ROCHESTER

Re Helena Service

REVIEW NOTE

Introduction

1. On 5 June 1997, Helena Service, who was aged 99, died.

2. The cause of death was given as 1a congestive cardiac failure, with an approximate interval between onset and death as two days.

3. At the time of her death, Mrs Service was a patient on Dryad Ward at the Gosport War Memorial Hospital ('GWMH').

4. Mrs Service was treated on a day to day basis by Dr Jane Barton, a Clinical Assistant in Elderly Medicine. Dr Barton is now aged 58 (date of birth, 19 October 1948).

5. A thorough investigation into the events leading to and surrounding Mrs Service's death has been carried out by the Hampshire Constabulary.

6. The purpose of this review is to consider whether the evidence reveals the commission of any criminal offence by Dr Barton and, if so, whether there is a realistic prospect of conviction. The criminal offence to be considered is gross negligence manslaughter.

7. I should say at the outset that after careful consideration of all the materials provided by the police I have reached the conclusion that the evidence does not reveal the commission of the offence of gross negligence manslaughter.

8. In reaching this conclusion I have, of course, had regard to the Code for Crown Prosecutors. In conducting this review I have applied the principles in the Code for Crown Prosecutors ('the Code') and I have applied both domestic law and that arising from the European Convention on Human Rights. The Code requires me to consider whether there is a realistic prospect of conviction for a criminal offence (i.e. that a jury is more likely than not to convict) and only then may I consider whether it is in the public interest whether there should be a prosecution. If there is a realistic prospect of conviction (the evidential test) there is a presumption of a prosecution unless the public interest factors against clearly outweigh those in favour. In the review I have set out my understanding of how the relevant law applies to the evidence.

Background

9. Mrs Service, nee Smith, was born on Code A, in Hertfordshire.

10. She married Frank Service in 1929. The couple did not have any children. When Frank retired, they moved to the Stubbington area of Hampshire. Frank died in 1968. Mrs Service stayed in the area, and remained living on her own until 1994, when she moved into a residential home.

11. On 17 May 1997, Mrs Service was admitted to the Queen Alexander Hospital ('QAH'). She appeared to be confused, disorientated and unable to cope in the rest home.

12. In fact, Mrs Service had a number of significant health problems, in particular, longstanding heart failure. This was first diagnosed in 1984, when she also suffered a stroke. In 1989, she fell and fractured her ribs. A chest x-ray again revealed signs of heart failure. In 1992, she was admitted to hospital with a chest infection, and found to be atrial fibrillation. Later that year she suffered a further stroke.

13. On her admission in May 1997, an examination revealed that Mrs Service was suffering from an irregular pulse, owing to atrial fibrillation, and crackles in her chest, which was suggestive of excess fluid in the lungs or an infection.

14. Mrs Service was given intravenous fluid, antibiotics and medication to slow the rate of atrial fibrillation.

15. A further examination later on the day of admission led doctors to believe that the left side of Mrs Service's heart was not pumping properly, causing the build up of pressure in the veins in the lungs, which was in turn causing the build up of excess fluid. It was not considered appropriate to provide Mrs Service with more intensive therapy, or to provide resuscitation in the event of a cardiac arrest.

16. Mrs Service remained at QAH for a number of days. She responded to treatment, but remained confused. On 29 May, she was seen by a consultant geriatrician. His opinion was that although clinically she was better, there was still a degree of heart failure. He doubted whether the rest home could provide her with adequate care, and therefore put her on the list for continuing care at GWMH.

17. Mrs Service was transferred to GWMH on 3 June 1997.

Gosport War Memorial Hospital

Overview

18. GWMH is a 113 bed community hospital managed by the Fareham and Gosport Primary Care Trust. Between 1994 and 2002 it was part of the Portsmouth Health Care NHS Trust. The hospital is designed to provide continuing care for long stay elderly patients. It is operated on a day to day basis by nursing and support staff. Clinical expertise is provided by visiting General Practitioners, Clinical Assistants and Consultants. Elderly patients are usually admitted to GWMH by way of referral from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Dryad Ward

19. Mrs Service was admitted to Dryad Ward. The doctor who dealt with her on a day to day basis was Dr Barton. Dr Barton was a General Practitioner at the Forton Medical Centre in Gosport. She worked at GWMH on a part time basis as a visiting Clinical Assistant. Her responsibilities involved visiting patients on the ward, conducting examinations and prescribing medication.

20. The details of the care provided to Mrs Service on Dryad Ward were recorded in various sets of notes. These notes included the medical notes, the summary notes, the nursing care plan and the drug chart.

21. On her admission, Mrs Service was seen by Dr Barton. She noted that Mrs Service's recent problems included congestive heart failure and confusion. She went on to note that Mrs Service would need palliative care if necessary, and that she was happy for nursing staff to confirm death. Dr Barton also prescribed diamorphine 20-100mg, hyoscine 200-800microgram and midazolam 20-80mg, all to be administered via a syringe driver (over 24 hours).

22. At 2 a.m. on 4 June, a nursing note recorded that Mrs Service was restless and agitated. At 2.15 a.m., midazolam 20mg was commenced via the syringe driver, with some success. However, in the morning it was noted that Mrs Service had deteriorated overnight. At 9.20 a.m., the syringe driver was recharged with diamorphine 20mg and midazolam 40mg.

23. According to the nursing summary notes, Mrs Service continued to deteriorate and died peacefully at 3.45 a.m. on 5 June.

24. The cause of death was given as congestive cardiac failure, with an approximate interval between onset and death of two days.

The Police Investigation

25. Hampshire police first investigated the deaths of elderly patients at GWMH in 1998. This followed the death of Gladys Richards. Mrs Richards died at GWMH on 21 April 1998. Her daughters made a complaint to the police regarding the treatment she had received. The police investigated the matter twice, and submitted files to the Crown Prosecution Service ('CPS'). In August 2001, the CPS advised that there was insufficient evidence to provide a realistic prospect of conviction in respect of any individual involved in the care of Mrs Richards.

26. Local media coverage of the case prompted relatives of other patients who had died at GWMH to complain to the police. These complaints were investigated, but no files were submitted to the CPS.

27. On 22 October 2001, the Commission for Health Improvement launched an investigation into the management, provision and quality of health care in GWMH. The Commission's report was published in May 2002, and set out a number of factors which contributed to a failure to ensure good quality patient care.

28. Following publication of this report, the Chief Medical Officer, Sir Liam Donaldson, commissioned Professor Richard Baker to conduct a statistical analysis of mortality rates at GWMH.

29. On 16 September 2002, Anita Tubbritt, a nurse at GWMH, handed over to the hospital a bundle of documents which minuted the concerns nursing staff had had in 1991 and 1992 regarding, amongst other matters, increased mortality rates in elderly patients and the prescription of diamorphine by Dr Barton. The documents were made available to the police.

30. As a result of this disclosure, Hampshire police decided to conduct a further inquiry.

31. A total of ninety cases were reviewed by the police. These included the death of Mrs Service. A team of medical experts led by Professor Robert Forrest was appointed to conduct the review. The team was not asked draft a report on each case, but to categorise the care provided as optimal, sub-optimal or negligent. Approximately sixty cases were categorised as sub-optimal, and were referred to the General Medical Council. A further fourteen cases, including the present case, were categorised as negligent.

32. The cases categorised as negligent have been the subject of a detailed review by Dr Andrew Wilcock, an expert in palliative medicine and medical oncology, and Dr Robert Black, an expert in geriatric medicine.

33. In Mrs Service's case, reports have been prepared by both Dr Wilcock (dated 19 June 2006) and Dr Black (dated 6 November 2004). In addition, Dr Michael Petch, a Consultant Cardiologist at Papworth Hospital in Cambridgeshire, has also prepared a report (dated 5 April 2006).

Dr Barton

34. As part of the police investigation into Mrs Service's death, Dr Barton was interviewed under caution. The interview took place on 27 October 2005. Dr Barton was represented by a solicitor, Ian Barker.

35. Dr Barton read out a prepared statement, but it was indicated on her behalf that she would make no comment to any material questions. The statement read out by Dr Barton may be summarised as follows:

    (1) Dr Barton carried out an assessment of Mrs Service on her admission. In her view, Mrs Service was very unwell, was probably dying and might well die shortly. She had probably reached the stage of multi system failure [pp.12-13];

    (2) Dr Barton considered that it would have been more appropriate for care to have been given at QAH, but that a return transfer in an ambulance would not have been in Mrs Service's best interests [p.13];

    (3) The diamorphine and midazolam were prescribed in order to relieve anxiety caused by the drowning sensation which pulmonary oedema can cause [p.14];

    (4) The administration of midazolam 20mg was given quite properly. The nursing staff administered this dose without further reference to Dr Barton (she having prescribed the midazolam the previous day) [pp.14-15];

    (5) Dr Barton reviewed Mrs Service on the morning of 4 June. Given that she was now terminally ill, and distressed and agitated, it was entirely appropriate to administer the diamorphine and midazolam [p.15];

    (6) The diamorphine and midazolam were prescribed and administered solely with the intention of relieving Mrs Service's agitation and distress, with the diamorphine having the additional benefit of treating the pulmonary oedema. At no time was the medication provided with the intention of hastening death [p.16].

Statement of Jean Kennedy

36. As part of the investigation into this matter, a witness statement has been taken from Jean Kennedy, a friend of Mrs Service. Mrs Kennedy went to visit Mrs Service at GWMH, on 3 or 4 June. She found Mrs Service in a private room, lying on her back with her mouth wide open. Mrs Kennedy had a conversation with nurse, whom she recalls saying, '*A lady of this age, we have to give her something to make the journey more comfortable for her, for the journey...Sometimes they can be like this for a few days.*'

The Report of Dr Wilcock

37. Dr Wilcock is a Reader in Palliative Medicine and Medical Oncology at the University of Nottingham and an Honorary Consultant Physician of the Nottingham City Hospital NHS Trust.

38. Dr Wilcock has reviewed the care provided to Mrs Service, and prepared a report dated 19 June 2006.

39. Dr Wilcock's opinion may be summarised as follows:

    (1) No adequate assessment of Mrs Service was carried out on Dryad Ward [p.38];

    (2) If she was not actively dying, the failure to rehydrate Mrs Service, together with the use of midazolam and diamorphine, could have contributed to her death more than minimally, negligibly or trivially [p.30];

    (3) On the other hand, if it was thought that Mrs Service was actively dying, it would have been reasonable not to have rehydrated her, and the use of the midazolam and diamorphine would have been justified (although the starting dose of diamorphine was likely to have been excessive for her needs) [pp.30, 31];

    (4) Given that elderly, frail patients with significant morbidity can deteriorate with little or no warning, it may be could be argued that it is difficult to say with complete confidence whether Mrs Service was actively dying or not [p.30];

(5) The commencement of the midazolam could be interpreted as an overreaction to Mrs Service's confusion [p.30];

(6) The death certificate ought to have stated that the period between onset and death was a number of years [p.30].

40. Dr Wilcock concludes as follows [pp.40-41]:

'Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate and contemporaneous patient records, had been attempting to allow Mrs Service a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge, illustrated, for example, by the reliance on large dose range of diamorphine and midazolam by a syringe driver rather than a smaller, more appropriate, fixed dose along with the provision of p.r.n. doses that would allow Mrs Service's needs to guide the dose titration. Dr Barton could also be seen as a doctor who breached the duty of care she owed to Mrs Service by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Service by unnecessarily exposing her to doses of midazolam and diamorphine that were difficult to justify and likely to be excessive to her needs at the time they were commenced.
However, Mrs Service had significant medical problems. Although her cardiac failure appeared to be better controlled by the time of her transfer from [QAH]*, she was becoming progressively frailer, increasingly dependent on others and her blood tests deteriorated again. In this regard, it would not have been unusual if Mrs Service had naturally entered a terminal decline. As such it is difficult to say with any certainty that the dose of midazolam or diamorphine she received would have contributed more than minimally, negligibly or trivially to her death.'*

The Report of Dr Black

41. Dr Black is a Consultant Physician in Geriatric Medicine at Queen Mary's Hospital in Kent, and an Associate Member of the General Medical Council.

42. Dr Black has reviewed the care provided to Mrs Service, and prepared a report dated 6 November 2004. His opinion may be summarised as follows:

(1) On 2 June, Mrs Service was declining as a result of heart failure, a pulmonary embolus or a chest infection, on top of her other problems. There was little doubt she was entering the terminal phase of her illness [para.2.9];

(2) The dose of midazolam 20mg was within current guidance, but was at the top end of the range for elderly patients [para.2.13];

(3) Mrs Service's restlessness on the night of 4 June was probably being caused by her breathlessness and heart disease. Diamorphine might have been the drug of choice, but it is difficult to fault the use of midazolam [para.2.15];

(4) The cause of death was multifactorial. The dose of diamorphine 20mg combined with midazolam 40mg was higher than necessary to provide terminal care to a patient of Mrs Service's age and frailty. This medication may have slightly shortened life, although this could not be proved to the criminal standard. In any event, at most life would have been shortened by a few hours to days [2.19].

The Report of Petch

43. Dr Petch is a Consultant Cardiologist at Papworth Hospital in Cambridgeshire. He has prepared a report dated 5 April 2006. His opinion may be summarised as follows:

(1) By June 1997, Mrs Service's longstanding heart failure was terminal [para.8.1];

(2) Diamorphine is a standard drug for the alleviation of shortness of breath and distress associated with pulmonary oedema. Its administration has been standard practice amongst cardiologists for many decades. Intramuscular and subcutaneous administration is usual [para.8.2];

(3) Mrs Service's prognosis was hopeless [para.8.3];

(4) The prescription of diamorphine 20-100mg together with midazolam was reasonable [para.8.3].

The Legal Framework

44. The ingredients of the offence of gross negligence manslaughter are set out in *R v. Adomako* [1995] 1 A.C. 171. The Crown must establish:

    (1) That there was a duty of care owed by the accused to the deceased;

    (2) That there was a breach of that duty by the accused;

    (3) That the breach resulted in death (causation);

    (4) That the breach is to be characterised as gross negligence and therefore a crime.

45. In determining whether there has been a breach of the duty the ordinary civil law of negligence applies. The test is objective. It is the failure of the accused to reach the standard of the reasonable man placed in the position of the accused.

46. An accused is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of professional opinion skilled in the particular activity in question, even though there is a body of competent professional opinion which might adopt a different technique. (The 'Bolam test', after *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582 at 587.)

47. The breach of duty may arise by reason of an act or an omission.

48. If there has been a breach it is essential to show that the breach was a cause of the death. It is to be noted that the breach need not be the sole cause of death or even the main cause of death. It is sufficient for it to be an operating cause, that is, something which is not *de minimis*.

49. In *Adomako*, Lord Mackay of Clashfern L.C., describing the test for gross negligence, stated:

    '*...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 the breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty*

should be categorised 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 to the patient, was such that it should be judged criminal.'

50. The test was affirmed by the Court of Appeal in *R v. Amit Misra, R v. Rajeer Srivastova* [2004] E.W.C.A. Crim. 2375:

'*In our judgment the law is clear. The ingredients of the offence have been clearly defined in* Adomako*...The hypothetical citizen, seeking to know his position, would be advised that, assuming he owed a duty of care to the deceased which he had negligently broken, and that death resulted, he would be liable to conviction for manslaughter, if, on the available evidence, the jury was satisfied that his negligence was gross. A doctor would be told that grossly negligent treatment of a patient which exposed him or her to the risk of death, and caused it, would constitute manslaughter.*'

51. In *Adomako*, Lord Mackay went on to say:

'*The essence of the matter which is supremely a jury question is whether, having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act or omission.*'

52. The conviction for gross negligence manslaughter was confirmed in the case of *Adomako*. The evidence revealed that the appellant had failed for eleven minutes or so to identify the cause of the patient's respiratory difficulty as a dislodged endothroceal tube. Other means of restoring the supply of oxygen were frantically tried but the simple and obvious procedure of re-attaching the tube was not performed, something that, according to expert evidence, would have been done by a competent anaesthetist within thirty seconds of observing the patient's difficulty. The expert evidence called on behalf on the prosecution was to the effect that the standard of care was 'abysmal' and 'a gross dereliction of care'.

53. Thus for the purposes of liability the test is objective. The *Adomako* test does however require the jury to decide that the conduct of the accused was so bad that it ought to be stigmatised as a crime '*in all the circumstances in which the defendant was placed when*

the breach of duty occurred'. This enables account to be taken of all the circumstances and their likely effect on the actions of a reasonable man.

54. Unlike states of mind such as recklessness and intention, negligence does not presuppose any particular state of mind on the part of the accused. It is a standard that reflects fault on his part. The main feature distinguishing negligence from intention and recklessness (as it is commonly understood) is that there is no requirement that the accused should foresee the risk that the actus reus might occur. Negligence involves an objective assessment of an objectively recognisable risk. Evidence as to the accused's state of mind is not a pre-requisite of a conviction (see *Attorney General's Reference (No. 2 of 1999)* [2000] 2 Cr.App.R. 207, CA).

55. In *R v. Prentice* [1994] Q.B. 302 the Court of Appeal, without purporting to give an exhaustive definition, considered that proof of any of the following states of mind may properly lead a jury to make a finding of gross negligence:

    (1) Indifference to an obvious risk of death;

    (2) Actual foresight of the risk of death coupled with an intention nevertheless to run it;

    (3) An appreciation of the risk of death coupled with an intention to avoid it but also coupled with such a high degree of negligence in the attempted avoidance as the jury consider justifies conviction;

    (4) Inattention or failure to advert to a serious risk of death which goes beyond mere inadvertence in respect of an obvious and important matter which the defendant's duty demanded he should address.

56. The effect of the above authorities may be summarised as follows:

    (1) The starting point of any consideration of gross negligence manslaughter is the decision of the House of Lords in *Adomako*;

    (2) The essence of the matter which is supremely a jury question is whether, having regard to the risk of death involved, the conduct of the accused was so bad in all the circumstances as to amount in their judgment to a criminal act or omission;

(3) Although there may be cases where the defendant's state of mind is relevant to the jury's consideration when assessing the grossness and criminality of his conduct, evidence of state of mind is not a pre-requisite to a conviction for manslaughter by gross negligence;

(4) A defendant who is reckless, in the ordinary sense of the word, may well be more readily found to be grossly negligent to a criminal degree;

(5) Failure to advert to a serious risk of death going beyond mere inadvertence in respect of an obvious and important matter which the accused's duty demanded he should address is one possible route to liability;

(6) The accused can only be guilty of gross negligence manslaughter if the jury is satisfied that his conduct fell sufficiently short of what a reasonable man would have done placed as the defendant was, and that the conduct should be condemned as a crime.

57. It seems to be clear that the situation in which the accused found himself must be taken into account when determining liability and this will include a consideration of such matters as the experience of the accused and the difficulties under which he was acting when he did the act or made the omission of which complaint is made.

58. Support for the proposition that the situation in which the accused found himself may be taken into account when deciding whether the negligence should be judged criminal and, for that matter, whether there is a realistic prospect of conviction, is to be found in *Prentice*. The accused were doctors. They administered two injections to a patient, without checking the labels on the box or the labels on the syringes before doing so. The injections had fatal results. The accused were tried in the Crown Court and convicted after the judge had given the jury a direction on recklessness (whether the risk would have been obvious to a reasonable man). Their convictions were quashed by the Court of Appeal and Lord Taylor CJ stated:

'*In effect, therefore, once the jury found that "the defendant gave no thought to the possibility of there being any such risk" on the judge's directions they had no option but to convict. ...if the jury had been given the gross negligence test, they could properly have taken into account "excuses" or mitigating circumstances in deciding whether the*

high degree of gross negligence had been established. The question for the jury should have been whether, in the case of each doctor, they were sure that the failure to ascertain the correct mode of administering the drug and to ensure that only that mode was adopted was grossly negligent to the point of criminality having regard to all the excuses and mitigating circumstances of the case.'

59. Lord Taylor went on to identify the excuses and mitigating circumstances of the case, which included the individual doctors' experience and subjective belief.

Analysis

Overview

60. Mrs Service was admitted to QAH on 17 May 1997. She was an elderly lady, and appeared to be confused and suffering from a general deterioration. The rest home where she had been resident for a number of years could not longer provide her with adequate care.

61. Mrs Service was suffering from heart failure (which was longstanding), and possibly had an infection. She responded to treatment, but her heart failure remained.

62. On 3 June, Mrs Service was transferred to GWMH. On her admission, Dr Barton prescribed doses of diamorphine and midazolam. At 2.15 a.m. on 4 June, a syringe driver was commenced with midazolam 20mg. Later that morning, at 9.20 a.m., the syringe driver was recharged with diamorphine 20mg and midazolam 40mg.

63. Mrs Service died at 3.45 a.m. on 5 June.

Summary of the Experts' Opinions

64. There is general agreement that by the time the midazolam was commenced on 4 June, Mrs Service was very unwell. Dr Wilcock's view is that it is possible that she was in terminal decline. Dr Black and Dr Petch go further, and state that there was little doubt about this. Dr Petch goes on to describe the prognosis as 'hopeless'.

65. There is also general agreement that midazolam and diamorphine are appropriate drugs to administer to terminally ill patients in Mrs Service's condition. Dr Petch's opinion is that the doses were reasonable. On the other hand, Dr Wilcock and Dr Black state that the doses were excessive for Mrs Service's needs.

66. However, the view of both Dr Wilcock and Dr Black is that it could not be proved to the criminal standard that the doses of diamorphine or midazolam caused death. Dr Black goes on to state that even if they did shorten life, this was likely to have been by a matter of hours or days.

Discussion

67. In assessing whether the evidence in this case reveals the commission by Dr Barton of the offence of gross negligence manslaughter, I have had regard to the following matters:

    (1) Whether Dr Barton breached her duty of care;

    (2) Whether Dr Barton's acts or omissions caused death;

    (3) Whether any breach of duty on the part of Dr Barton may properly be characterised as grossly negligent.

68. There is some evidence that Dr Barton was negligent in prescribing and causing to be administered an excessive dose of diamorphine. However, there is a difference of medical opinion, and Dr Petch, a Consultant Cardiologist, states that Dr Barton's conduct was reasonable. Accordingly, in my opinion it unlikely that negligence could be proved to the criminal standard.

69. In any event, the evidence of all the experts is that Mrs Service was dying naturally. Dr Wilcock and Dr Black state in terms that it could not be proved to the criminal standard that Dr Barton's conduct shortened life. Therefore, in my opinion there is no prospect of proving causation in this case.

70. Furthermore, even if both negligence and causation could be proved, in my view it is highly unlikely that Dr Barton's conduct would be characterised as grossly negligent. In coming to this view, I have had regard to the following matters in particular:

(1) Mrs Service was an elderly and frail patient with a number of significant medical problems;

(2) The prognosis was, in the words of Dr Petch, 'hopeless';

(3) If life was shortened, it would only have been by a few hours or days;

(4) In prescribing midazolam and diamorphine, Dr Barton was attempting to relieve the stress and anxiety of a patient she knew to be actively dying.

Conclusions

71. In the light of what has been set out above, in my opinion the evidence does not reveal the commission of the offence of gross negligence manslaughter.