OPERATION ROCHESTER

Re Sheila Gregory

REVIEW NOTE

Introduction

1. On 22 November 1999, Sheila Gregory, who was aged 91, died.

2. The cause of death was certified as 1a bronco pneumonia.

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

4. Mrs Gregory 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 Gregory'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 Gregory was born on Code A in Shaftsbury, Dorset.

10. In 1934, she married William, and the couple went on to have a daughter, Janet. After William retired, they moved from Shaftsbury to Weymouth, and then to Lee-on-Solent. After William's death in 1984, Mrs Gregory remained in the family home, but after a number of years moved into warden assisted flats in Gosport.

11. In her later years, Mrs Gregory developed a number of chronic conditions, including hypertension and a partial thyroidectomy. In 1990, she was admitted to hospital with an acute episode of obstructive airways disease. In 1991, she was admitted with an episode of abdominal pain, which was thought to be possible pancreatitis. In 1995, she was found to be suffering from a number of problems, including slow artial fibrillation and left ventricular failure. It was also thought possible that Mrs Gregory may have been suffering from early dementia. In December 1998, she was admitted to Haslar with another episode of chronic airways disease and left ventricular failure. Despite being in severe respiratory failure, Mrs Gregory recovered, and was discharged. A chest x-ray, however, revealed that she had heart failure.

12. On 15 August 1999, Mrs Gregory fell and fractured her right hip. She was admitted to the Royal Hospital Haslar ('Haslar'), where the following day the fracture was treated surgically with a dynamic hip screw.

13. Mrs Gregory received occasional doses of weak opioid analgesics. However, the medical notes do not indicate that pain was a problem.

14. On 3 September 1999, Mrs Gregory was transferred to GWMH for continuing care.

Gosport War Memorial Hospital

Overview

15. 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

16. Mrs Gregory 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.

17. The details of the care provided to Mrs Gregory 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.

18. On her admission, in addition to two co-dydramol tablets (to be taken as required), Mrs Gregory was prescribed oramorph 5-10mg, every four hours as required. She was also prescribed diamorphine 20-80mg, hyoscine 200-800microgram and midazolam 20-80mg, via a syringe driver (over a 24 hour period). However, Mrs Gregory did not receive any diamorphine until 20 November.

19. After her admission, Mrs Gregory was reviewed on a regular basis. She had a very poor appetite, and experienced episodes of agitation and confusion. There was a lack of any significant improvement in her mobility. She remained catheterised and experienced faecal incontinence.

20. On 15 November, it was noted that Mrs Gregory was less well.

21. 17 November, the nursing summary note records that Mrs Gregory was not very well, and was becoming distressed and breathless. Oramorph 5mg was administered, with good effect.

22. On 18 November, however, there was a marked deterioration. Mrs Gregory was seen by Dr Barton. She concluded that Mrs Gregory may have had a stroke. Oramorph was commenced regularly, at 5mg every four hours, with 10mg at night. The drug chart was rewritten, reducing the diamorphine range to 20-80mg.

23. On the afternoon of 20 November, the syringe driver was commenced with diamorphine 20mg and cyclizine 50mg. (Cyclizine is an anti-emetic.)

24. There was a further decline on 22 November. Mrs Gregory was breathless and had uncontrolled atrial fibrillation.

25. At 5.20 p.m., Mrs Gregory died.

26. The cause of death was certified as 1a bronco pneumonia.

The Police Investigation

27. 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.

28. 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.

29. 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.

30. 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.

31. 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.

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

33. A total of ninety cases were reviewed by the police. These included the death of Mrs Gregory. 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.

34. 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.

35. In Mrs Gregory's case, reports have been prepared by both Dr Wilcock (dated 22 December 2005) and Dr Black (dated 1 November 2005).

Dr Barton

36. As part of the police investigation into Mrs Gregory's death, Dr Barton was interviewed under caution. The interview took place on 25 August 2005. Dr Barton was represented by a solicitor, Ian Barker.

37. 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 admitted Mrs Gregory to Dryad Ward on 3 September 1999 [p.9];

    (2) From her initial assessment, Dr Barton hoped that rehabilitation might prove possible. However, at the same time, she recognised that Mrs Gregory's condition made it possible that there would be a deterioration [p.10];

    (3) Dr Barton prescribed co-dydramol and oramorph for pain relief [p.10];

    (4) In addition, she also prescribed diamorphine 20-200mg, hyoscine 200-800microgram and midazolam 20-80mg, to be administered via a syringe driver, if necessary [p.10];

    (5) At the time of the prescription, Dr Barton did not consider that it was necessary to administer the medication via the syringe driver. Rather, she was concerned that the necessary medication should be available in the event of a deterioration. She would have been consulted before the drugs were administered [pp.10-11];

    (6) On 11 November, Dr Barton wrote up a further 'as required' prescription in respect of the diamorphine, hyoscine and midazolam at the previously stated doses. Again, the medication was not immediately necessary. Dr Reid would have reviewed this prescription, and did not appear to have any concerns [pp.17-18];

    (7) On 17 November, Mrs Gregory was continuing to deteriorate. In order to relieve distress, oramorph 5mg was administered at 10 p.m. [p.19];

(8) On 18 November, it was decided to administer oramorph 5mg every four hours. The 'as required' prescription in respect of diamorphine, hyoscine and midazolam was again written up [pp.19, 20];

(9) On 18 November, in view of Mrs Gregory's continuing deterioration, Dr Barton felt that it was appropriate to replace the oramorph with diamorphine [p.21];

(10) On 22 November, Dr Reid reviewed Mrs Gregory. He noted that there had been a further deterioration. His notes suggest that Mrs Gregory was experiencing heart failure, and was in fact dying [p.22];

(11) The diamorphine and oramorph were prescribed and administered solely with the intention of relieving the shortness of breath Mrs Gregory was experiencing from cardiac failure, and the anxiety and distress which this was causing her. At no time was the medication provided with the intention of hastening death [p.23].

The Report of Dr Wilcock

38. 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.

39. Dr Wilcock has reviewed the care provided to Mrs Gregory, and prepared a report dated 22 December 2005.

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

(1) Mrs Gregory was a frail and elderly patient, with significant medical problems [p.8];

(2) The initial prescription of diamorphine and midazolam was inappropriate. However, no such medication was administered until 20 November [p.7];

(3) The starting dose of oramorph administered on 18 November was in keeping with guidelines. However, because of Mrs Gregory's advanced age, a smaller dose would have been more appropriate [p.7];

(4) The administration of oramorph and diamorphine was not necessary in order to relieve pain. However, these drugs are used for symptomatic relief of breathlessness. The use of the syringe driver with an anti-emetic was reasonable, given that Mrs Gregory was experiencing nausea and vomiting [pp.10, 11];

41. Dr Wilcock concludes as follows [p.10]:

'*...Mrs Gregory's decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of diamorphine, the physical findings on the day of Mrs Gregory's death would suggest that the dose she was receiving was unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.*'

42. Dr Wilcock has also prepared a draft overview, dated 4 September 2006, in relation to Operation Rochester as a whole. In this overview, Dr Wilcock states that it is '*difficult to judge*' whether Mrs Gregory had entered a 'natural' irreversible terminal decline (prior to the relevant acts or omissions on the part of Dr Barton), as there was '*significant morbidity present*'. Dr Wilcock has added the following note of caution to his opinion:

'*Note: prognosis is difficult to accurately judge and it is best to consider the above an indication, in my opinion, of which end of a spectrum a patient would lie rather than a more definite classification.*'

The Report of Dr Black

43. 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.

44. Dr Black has reviewed the care provided to Mrs Gregory, and prepared a report dated 1 November 2005. His opinion may be summarised as follows:

(1) Mrs Gregory had been lucky to survive her admission in December 1998 [para.6.2];

(2) There is always a very significant mortality and morbidity in elderly people after fractures to the neck of the femur, particularly in those who have previous cardiac and other chronic diseases [para.6.3];

(3) The post operative period at Haslar showed very poor prognostic signs, having regard to Mrs Gregory's age [para.6.4];

(4) On 18 November, there was a failure to conduct an adequate clinical examination. However, it was a reasonable clinical decision to provide a symptomatic response to Mrs Gregory's problems [paras.6.9, 7.2];

(5) The decision to commence the diamorphine on 20 November was reasonable, as Mrs Gregory was dying [para.6.10];

(6) Furthermore, the dose of diamorphine was within a reasonable range [para.6.11];

(7) Mrs Gregory died of natural causes, and her overall clinical management at GWMH was just adequate [para.7.2].

The Legal Framework

45. 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.

46. 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.

47. 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.)

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

49. 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*.

50. 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.*'

51. 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.'

52. 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.*'

53. 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'.

54. 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.

55. 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).

56. 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.

57. 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.

58. 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.

59. 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.*'

60. 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

61. Mrs Gregory was admitted to Haslar hospital on 15 August 1999, with a fractured hip. The following day the fracture was treated surgically with a dynamic hip screw.

62. On 3 September, Mrs Gregory was transferred to GWMH for continuing care.

63. On the afternoon of 20 November, the syringe driver was commenced with diamorphine 20mg and cyclizine 50mg.

64. At 5.20 p.m. on 22 November, Mrs Gregory died.

Summary of the Experts' Opinions

65. The experts agree that Mrs Gregory was a frail elderly patient with a number of significant medical problems, and that her prognosis was poor.

66. They also agree that by 18 November, Mrs Gregory was terminally ill, and that the administration of diamorphine via the syringe driver was reasonable.

67. In short, the experts in this case have concluded that Mrs Gregory died of natural causes.

Discussion

68. 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.

69. The essential question in this case is whether the administration of diamorphine on 20 September was negligent, and a cause of death.

70. In the opinion of both Dr Wilcock and Dr Black, the administration of diamorphine was reasonable. It is also their opinion that Mrs Gregory came to the end of her life naturally. Furthermore, in relation to Mrs Gregory's treatment at GWMH as a whole, Dr Black states that it was 'just adequate'. In these circumstances, in my view, there is no evidence of negligence in this case, and nor is there any evidence that Dr Barton's conduct caused death.

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.