OPERATION ROCHESTER

Re Elsie Lavender

REVIEW NOTE

Introduction

1. On 6 March 1996, Elsie Lavender, aged 83, died.

2. At the time of her death Mrs Lavender was a patient on Daedelus Ward at the Gosport War Memorial Hospital ('GWMH').

3. The cause of death was given as 1a cerebralvascular accident, and 2 diabetes mellitus.

4. During her time on Daedelus Ward, Mrs Lavender 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 Lavender'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 Lavender was born on Code A

10. She married at the age of 22 and had one child, Alan Lavender. Her husband died in 1989.

11. In 1982, Mrs Lavender was diagnosed with diabetes, and became insulin dependent. In her later years, she developed slight rheumatism, became partially blind and was found to have atrial fibrillation (an irregular heart rhythm). She had previously been admitted to hospital following a hypoglycaemic collapse. Nevertheless, Mrs Lavender remained independent until the beginning of 1996.

12. On 5 February 1996, Mrs Lavender suffered a fall at her home. She was taken by ambulance to the Accident and Emergency Department of the Royal Naval Hospital in Hasler, Gosport. On examination she was found to have a deep laceration to the forehead. Tests suggested that the nerves responsible for muscle movements had been damaged somewhere along their path from the brain and down the spinal cord. The notes from the Accident and Emergency Department stated that her cervical spine (neck) was normal. This conclusion, however, appears to have been based on a clinical assessment, and no x-ray of the cervical spine was carried out. Mrs Lavender was admitted to the hospital for observation and further investigation.

13. On 8 February, the physiotherapist noted that Mrs Lavender would not make any voluntary movement owing to pain in both shoulders. She was unable to stand without

assistance, and even then could only manage a few steps. The physiotherapist concluded that the pain in Mrs Lavender's shoulders was a major problem, and accordingly two analgesic drugs, coproxamol and dihydrocodeine, were prescribed.

14. On 9 February, the results of blood tests revealed a number of abnormalities.

15. Mrs Lavender continued to experience pain over the next few days. On 13 February, she was referred for a geriatrician review, and she was seen by Dr Jane Tandy on 16 February. Dr Tandy concluded that Mrs Lavender had most likely suffered a brain stem stroke, which had led to her fall. Atrial fibrillation, from which Mrs Lavender suffered, is a condition which can cause such a stroke. However, it is significant that Dr Tandy was under the impression that Mrs Lavender's neck had been x-rayed, and she assumed that it had been found to be normal. In fact, no such x-ray had taken place. Mrs Lavender was placed on the waiting list for a transfer to GWMH, for rehabilitation.

Gosport War Memorial Hospital

Overview

16. 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.

Daedalus Ward

17. On 22 February 1996, seventeen days after her fall and two weeks before her death, Mrs Lavender was transferred to Daedalus Ward at GWMH, under the care of a Consultant, Dr Althea Lord. In fact, Dr Lord was on annual leave between 23 February and 18 March, and it does not appear that there was any locum cover during this period. Any matters which required input at Consultant level should have been referred to the Elderly Medicine Department at the Queen Alexandra Hospital.

18. The doctor who was responsible for Mrs Lavender's treatment 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.

19. The details of the care provided to Mrs Lavender on Daedalus 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.

20. On admission, it was noted that Mrs Lavender needed minimal assistance feeding, but was severely incontinent and needed a catheter. Owing to continued pain in the shoulders and arms, the dose of dihydrocodeine was increased.

21. On 23 February, trimethoprim, an antibiotic, was prescribed for a presumed urinary tract infection. Results of blood tests revealed various abnormalities.

22. On 24 February, it was noted that Mrs Lavender's pain was not being controlled properly by dihydrocodeine. She was seen by Dr Barton, who commenced her on MST 10mg twice per day. MST is a slow release formulation containing morphine.

23. On 25 February, Mrs Lavender screamed with pain when she was moved, shouting '*my back*'.

24. On 26 February, the medical notes recorded: '*...not so well over weekend. Family seen and aware of prognosis and treatment plan...*[I]*nstitute SC analgesia if necessary*'. Dr Barton prescribed diamorphine 80-160mg and midazolam 40-80mg via a syringe driver, to be administered as required. The syringe driver was not in fact commenced until 5 March. According to Alan Lavender, Dr Barton said to him: '*You do know that your mother has come here to die!*'

25. On 27 February, the results of further tests indicated a decline in Mrs Lavender's renal function, and various other abnormalities.

26. On 4 March, the summary notes recorded that Mrs Lavender had complained of pain, and was receiving extra analgesia as required. She was given oramorph sustained relief tablets 30mg twice per day. These tablets are similar to MST.

27. On 5 March, it was noted that Mrs Lavender had deteriorated over the last few days. She was not eating or drinking. The pain was uncontrolled and she was distressed. The syringe driver was commenced at 9.30 a.m., with diamorphine 100mg and midazolam 40mg.

28. On 6 March, a further deterioration was recorded. Dr Barton noted: '*I am happy for nursing staff to confirm death*'. Medication other than that via the syringe driver was discontinued as Mrs Lavender was '*unrousable*'. She died at 9.28 p.m.

29. The death certificate recorded death as 1a cerebrovascular accident and 2 diabetes mellitus.

The Police Investigation

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

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

36. A total of ninety cases were reviewed by the police. These included the death of Mrs Lavender. 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.

37. The cases categorised as negligent were the subject of an on-going review by Dr Andrew Wilcock, an expert in palliative medicine and medical oncology, and Dr Robert Black, an expert in geriatric medicine.

38. Dr Wilcock and Dr Black have each prepared a report, dated 1 May 2005 and 19 March 2005 respectively, commenting on the care provided to Mrs Lavender.

Dr Barton

39. As part of the police investigation into the fourteen cases which had been reviewed and categorised as negligent, Dr Barton was interviewed under caution in relation to the death of Mrs Lavender. The interview took place on 24 March 2005. Dr Barton was represented by a solicitor, Ian Barker.

40. It was indicated by Mr Barker that Dr Barton would read out a prepared statement, but would not comment further. The statement read out by Dr Barton may be summarised as follows:

    (1) When Mrs Lavender was admitted to GWMH her prognosis was not good, but it was hoped that it might be possible to rehabilitate her [p.9];

(2) In view of the pain Mrs Lavender was experiencing on admission, Dr Barton prescribed dihydrocodeine, two 30mg tablets, four times per day [p.10];

(3) The dihydrocodeine was not controlling Mrs Lavender's pain, so on 24 February, Dr Barton prescribed MST, 10mg twice per day, in addition to the dihydrocodeine [p.11];

(4) Dr Barton increased the dose of MST to 20mg on 26 February, as the previous dosage had been insufficient to control Mrs Lavender's pain [pp.11-12];

(5) Dr Barton discussed Mrs Lavender's treatment with her son, Alan, on 26 February. She may have indicated that his mother might be dying. She would have discussed with him the options for pain relief, and explained that it might become necessary to use a syringe driver and administer morphine. She would have explained that it was possible that the administration of pain relieving drugs might have the incidental effect of hastening death [pp.12-13];

(6) Following discussions with Alan Lavender, Dr Barton wrote up a proactive prescription for diamorphine 80-160mg, together with midazolam 40-80mg and Hyoscine 400-800micrograms [p.13];

(7) Dr Barton reviewed Mrs Lavender on 29 February and 1 March. Over this period she observed a slow deterioration. She did not see Mrs Lavender again until 4 March [p.14];

(8) On 4 March, Mrs Lavender was continuing to suffer pain. Dr Barton therefore increased the dose of morphine, in the form of oramorph slow release tablets, to 30mg twice per day [pp.14-15];

(9) The next morning, it was clear that the pain relief was inadequate. Mrs Lavender had had a very poor night and was distressed. Dr Barton felt it was necessary to administer diamorphine 100mg and midazolam 40mg via the syringe driver. She considered those doses appropriate in view of Mrs Lavender's pain and distress. She felt that the increase in medication was necessary in order to ensure that Mrs Lavender was free from pain and distress in circumstances in which it was clear that she had continued to deteriorate and was now likely to be dying [p.15];

(10) The medication administered via the syringe driver appeared to have been successful in relieving the pain and distress [p.16].

The Report of Dr Wilcock

41. 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.

42. Dr Wilcock has reviewed the care provided to Mrs Lavender, and prepared a report dated 1 May 2005.

43. Dr Wilcock's opinion is that the medical care provided to Mrs Lavender was sub-optimal [p.22]. His conclusions may be summarised as follows:

    (1) Although Dr Tandy attributed Mrs Lavender's symptoms as having been caused by a brain stem stroke, the symptoms were also consistent with cervical spinal cord and nerve trauma caused by the fall [pp.20-21];

    (2) The pain in Mrs Lavender's shoulders and arms was most likely to be related to the fall. Muscle and nerve injury pain respond poorly to strong opioids [p.21];

    (3) There was a failure properly to assess the cause of Mrs Lavender's symptoms at the time of her transfer to GWMH [pp.21-22];

    (4) There was a general failure by Dr Barton to make adequate notes in the medical records in relation to her assessments of Mrs Lavender, and her reasons for prescribing medication;

    (5) The absence of information in the medical records appears to suggest that the Mrs Lavender's symptoms and the possible causes of her deterioration were not adequately assessed. In particular, no assessment appears to have been made as to whether the prescribed doses of morphine could have been contributing to the deterioration of her renal function, whether the morphine was contributing to

her decline generally, and whether her decline was caused by a reversible condition, such as an infection [pp.24-25, 29, 30];

(6) The diamorphine 100mg and midazolam 40mg administered via the syringe driver on 5 March were doses excessive for Mrs Lavender's needs, even if she was dying of natural causes. The starting dose of morphine ought to have been 20-30mg per day. The appropriate starting dose of midazolam was 2.5mg, by intermittent subcutaneous injection, increasing to 10mg per day if Mrs Lavender had, for example, terminal agitation [pp.25, 31-32];

(7) It is possible that Mrs Lavender was dying 'naturally', but it is also possible that her physical state had deteriorated in a temporary or reversible way and that she was not in her terminal phase [p.32];

(8) In situations where diamorphine and midazolam are given inappropriately or in excessive doses, it would be difficult to exclude with any certainty the possibility that they did not contribute more than minimally, negligibly or trivially to death.

44. Dr Wilcock concludes as follows [p.34]:

'If it were that Mrs Lavender had naturally entered the terminal phase of her life, at best, 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 Lavender a peaceful death, albeit with what appears to be an inappropriate and excessive use of medication due to lack of sufficient knowledge.

However, in my opinion, based on the medical and nursing records, there is reasonable doubt that she had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lavender by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lavender by failing to adequately assess the cause of her pain and deterioration, failing to take suitable and prompt action when necessary and exposing her to inappropriate and/or excessive doses of diamorphine and midazolam that could have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton leaves herself open to the accusation of gross negligence.'

45. 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 '*unlikely*' that Mrs Lavender had entered a 'natural' irreversible terminal decline (prior to the relevant acts or omissions on the part of Dr Barton). However, significantly, 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

46. 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.

47. Dr Black has reviewed the care provided to Mrs Lavender, and prepared a report dated 19 March 2005. His conclusions may be summarised as follows:

    (1) Mrs Lavender had been misdiagnosed and had quadriplegia from a high cervical spinal cord injury caused by her fall. This diagnosis appears to have been missed by all the doctors who saw her. The diagnosis of Dr Tandy did not explain all Mrs Lavender's physical symptoms or neurological deficit [paras.6.4, 6.5];

    (2) A number of other serious medical problems appear not to have been properly assessed or investigated. These include a low platelet count, which makes life threatening bleeding a problem; a highly abnormal blood film, which suggests a systemic illness, probably involving the bone marrow; and a very highly rising alkaline phosphatase, which suggests bone or liver pathology [para.6.5];

    (3) All the markers of illness show that, as Dr Barton recognised, Mrs Lavender was seriously ill [para.6.8];

    (4) Even if a high cervical spinal cord fracture had been diagnosed, the potential for neurosurgical intervention in a patient of Mrs Lavender's age and frailty was low [para.6.9];

(5) In view of the complexity of the medical problems, it would have been wise to have obtained a further specialist opinion before deciding that Mrs Lavender was definitely terminally ill. However, there is little doubt that she was moving to a terminal phase of her illness by 5 March [paras.6.10, 6.13];

(6) Commencing MST on 24 February was appropriate [para.6.10];

(7) The 40mg midazolam which was commenced on 5 March was a dose within current guidance, although many believe that elderly patients may need a lower dose, such as 5-20mg [para.6.14];

(8) The diamorphine 100mg which was commenced on 5 March was an excessive dose. The appropriate starting dose would have been 45-60mg [para.6.15];

(9) Together, the diamorphine and midazolam were likely to have caused excessive sedation and respiratory depression. However, there is no evidence to prove beyond reasonable doubt that they had the definite effect of shortening Mrs Lavender's life in more than a minor fashion of a few hours to a few days [paras.6.16, 6.18].

48. Dr Black concludes as follows [paras.7.1, 7.2, 7.3]:

'Mrs Elsie Lavender provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.

...I believe that the overall episode of medical care provided between Haslar and Gosport Hospital was negligent in that an inadequate assessment and diagnosis of this lady's conditions was made. If it was, it was never recorded. The lack of any examination at Gosport, the lack of any comment on the abnormal blood test make it impossible to decide if the care she subsequently received was sub optimal, negligent or criminally culpable. It seems to me that she had several serious illnesses, which were probably unlikely to be reversible, and therefore, she was entering the terminal phase of her life at the point of admission to Gosport Hospital. However, without proper assessment or documentation this is impossible to prove either way.

...The initial symptomatic management of her terminal illness was appropriate. The prescription of the Diamorphine on the 26th February (never given) and the excessive doses of medication used in the final 36 hours was, in my view, sub optimal drug management. These may have been given with the intention of shortening life at the final phase of her terminal illness. However, I am unable to satisfy myself beyond reasonable doubt this did hasten death by anything other than a short period of time (hours to a few days).'

The Legal Framework

49. 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.

50. 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.

51. 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.)

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

53. 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*.

54. 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.*'

55. 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.*'

56. 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.*'

57. 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'.

58. 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.

59. 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).

60. 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.

61. 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.

62. 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.

63. 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.*'

64. 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

65. Mrs Lavender was brought to the Royal Naval Hospital in Haslar by ambulance on 5 February 1996, having suffered a fall at home. She was seen doctors in the Accident and Emergency Department and then admitted to the hospital for observation and investigation. She was seen by Dr Tandy on 16 January, and diagnosed as having suffered a brain stem stroke. She was transferred to Daedalus Ward at GWMH on 22 January, for the purpose of rehabilitation.

66. During her time at GWMH, Mrs Lavender deteriorated. She was prescribed MST on 24 February. At 9.30 a.m. on 5 March, a syringe driver was commenced with diamorphine and midazolam.

67. At 9.28 p.m. on 6 March, Mrs Lavender died.

Summary of the Experts' Opinions

68. Mrs Lavender was misdiagnosed. She had a high cervical spinal cord injury caused by her fall, which appears to have been missed by all the doctors who saw her. The failure of doctors at Haslar and on her admission to GWMH properly to assess Mrs Lavender's condition was negligent. However, even had the correct diagnosis been made, given Mrs Lavender's age and frailty, the potential for neurosurgical intervention was low.

69. The medical notes maintained by Dr Barton were inadequate. They did not set out the reasons for prescribing opiates, or indicate that a proper assessment of Mrs Lavender's condition had been carried out. This raises the possibility that Dr Barton did not properly investigate whether Mrs Lavender's decline was reversible.

70. However, it is likely that Mrs Lavender was entering the terminal phase of her life on her admission to GWMH, and there is little doubt that she was entering the terminal phase by 5 March

71. The essential criticism of Dr Barton is that the dose of diamorphine she prescribed on 5 March, and which was administered via the syringe driver, was significantly higher than the dose which was appropriate in Mrs Lavender's case.

72. As to the effect of the excessive dose of diamorphine (combined with the other drugs administered), Dr Wilcock states that he cannot exclude the possibility that it may have shortened life. Dr Black states that it may have shortened life by hours or a few days.

73. The conclusions of the experts are as follows:

    (1) Dr Wilcock states that if Mrs Lavender had entered her terminal phase 'naturally' (which he believes is, subject to his note of caution, unlikely), Dr Barton could be seen as a doctor who allowed her to die peacefully, albeit by using an excessive dose of diamorphine. On the other hand, Dr Barton could be seen as a doctor who breached her duty of care, to the extent that she disregarded Mrs Lavender's safety, and contributed to his death. In that way, Dr Barton leaves herself open to an allegation of gross negligence.

(2) Dr Black states that given the absence of adequate medical notes, it impossible to decide whether the care provided by Dr Barton was sub-optimal, negligent or criminally culpable.

Discussion

74. 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 act or acts caused death;

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

75. There is evidence that Dr Barton was negligent in prescribing diamorphine in such a high dose, and in failing to carry out a proper assessment of Mrs Lavender, in order to establish whether she had entered the terminal phase. It is possible that negligence could be proved to the criminal standard.

76. There is some evidence that the drugs prescribed by Dr Barton shortened Mrs Lavender's life by, at most, hours or perhaps a few days. However, it cannot be said with any certainty that this was the case. Mrs Lavender may have been entering the terminal phase at the time she was admitted to GWMH. According to Dr Black, she was certainly entering the terminal phase by 5 March, and at that point had several serious illnesses which were unlikely to be reversible. It is my view, therefore, that causation could not be established in this case.

77. Further, in my opinion, it is highly unlikely that Dr Barton's conduct, if it was found to be negligent, would be characterised as grossly negligent. In coming to this view I have had regard to the following matters:

    (1) In the words of Dr Black, Mrs Lavender's case provides an example of a very complex and challenging problem in geriatric medicine;

(2) She was an elderly, frail woman, with a number of serious illnesses, who was dying naturally;

(3) It was appropriate for Dr Barton to provide palliative care;

(4) The care provided by Dr Barton allowed Mrs Lavender to die peacefully;

(5) If the drugs prescribed by Dr Barton did shorten life, the period was only a matter of hours or a few days.

Conclusions

78. 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.