CPS

The CPS incorporates RCPO

Code A

16 August 2010

Dear Code A

Elsie Hester Lavender

You may recall that I wrote to you in December 2006. I write now following the further detailed consideration of the new material obtained by Hampshire Police. I have written similar letters to the other families concerned.

I have set out below my conclusions and the reasons for them.

1. In 2006 the Crown Prosecution Service ('CPS') determined not to prosecute in connection with the deaths of ten elderly patients under the care of Dr Jane Barton at the Gosport War Memorial Hospital ('GWMH') between 1996 and 1999. An investigation into the deaths was conducted by the Hampshire Constabulary and was known as Operation Rochester.

2. The essential conclusion in each case was that, having regard to the Code for Crown Prosecutors ('the Code'), there was no realistic prospect of conviction in respect of Dr Barton or any other individual for an offence of gross negligence manslaughter.

3. Thus as the CPS decided that in each case there was no realistic prospect of conviction accordingly no criminal charges were brought.

4. Since that time, two events of significance have taken place in connection with Operation Rochester. First, inquest verdicts in respect of each of the ten deaths have been returned. Secondly, the Fitness to Practise Panel of the General Medical Council ('GMC') has determined a number of disciplinary charges brought against Dr Barton.

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5. Following the inquest verdicts, and again after the determination of the GMC proceedings, the families of some of the deceased patients asked the CPS to reconsider its decision not to bring criminal charges against Dr Barton.

6. Transcripts of the evidence given at the inquests and the GMC proceedings have been considered to see whether, in light of that evidence, the earlier conclusions remain the same.

7. In reviewing the further evidence I have acted in accordance with the Code. This requires me to consider whether there is evidence to provide a realistic prospect of conviction for a criminal offence (ie is a jury more likely than not to convict). I may only consider the public interest if I am satisfied that there is a realistic prospect of conviction.

8. In summary, having given careful consideration to the new material, it remains my view that the evidence is insufficient to provide a realistic prospect of conviction for an offence of gross negligence manslaughter against Dr Barton in respect of each of the ten deaths I have reviewed.

9. The reasoning in coming to this conclusion is set out below.

10. In considering the matter further and reaching the various conclusions regard has been had to all of the material sent by the police.

The Legal Framework

11. 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.

12. 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.

13. 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.)

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

15. 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*.

16. 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.*'

17. 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.*'

18. 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.*'

19. 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'.

20. 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.

21. 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).

22. 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.

23. 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 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.

24. 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.

25. 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.*'

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

Coroner's Inquests

The nature of an inquest

27. It is necessary at the outset to make some general observations on the nature of an inquest.

28. First, the focus of an inquest is to establish by what means and in what circumstances the deceased came by his death: see section 11(5)(b)(ii) of the Coroners Act 1988 ('CA 1988'); and *R (Middleton) v West Somerset Coroner and another* [2004] UKHL 10, [2004] 2 AC 182, at paragraph 35. The purpose of the inquest is not to determine whether or not a person is guilty of a homicide offence, and no verdict may be framed in such a way as to appear to determine that question: see section 11(6) of the CA 1988; and rule 42 of The Coroners Rules 1984 ('CR 1984'). In the present case, for example, the purpose of the inquest was not to determine whether or not Dr Barton's conduct was negligent, let alone grossly negligent, and the verdicts did not resolve, nor were capable of resolving, that matter.

29. Secondly, the CR 1984 prescribe a hybrid procedure, part inquisitorial and part adversarial. During the proceedings, a person's conduct may be called into question. A person whose conduct is likely to be called into question must be given notice of the inquest, and may be represented. If such a person gives evidence, he may be cross-examined. However, there is no particularised charge or complaint, and the inquisition may not charge a person with a homicide offence. Therefore, no party is called upon to rebut an allegation of criminal wrongdoing. Indeed, no person is allowed to address the coroner or jury as to the facts. (See *Middleton*, paragraph 26.)

30. Thirdly, the standard of proof at an inquest is the civil standard, that is, proof on a balance of probabilities.

31. Fourthly, as is evident from the matters set out above, an inquest is very different from a criminal trial. Unlike an inquest, the purpose of a criminal trial is to determine the question of a defendant's guilt through a purely adversarial inquiry. The burden of proof falls on the prosecution, and the standard of proof is proof beyond reasonable doubt.

32. Fifthly, an inquest verdict does not compel the prosecuting authority to determine the question of whether or not to prosecute in a particular way. Whatever the inquest verdict, the decision whether or not to prosecute must be taken by the prosecutor independently and in accordance with the Code.

33. Sixthly, in any criminal proceedings, the inquest verdict cannot be adduced in evidence as a matter lending support to the prosecution case.

Overview

34. The inquests into the ten deaths were re-opened on 18 March 2009. The proceedings took place in Portsmouth before Mr Andrew Bradley, the Coroner for North Hampshire, and a jury.

35. During the course of the proceedings, evidence was given from a number of individuals. These included Dr Barton herself, and Dr [now Professor] David Black and Dr Andrew Wilcock, the principal experts who had provided opinions during the police investigation.

36. During the hearing, an important difference of opinion between the two experts concerning the use of opiates in the control of distress and agitation in terminally ill patients became evident. On the one hand, Dr Black, supported by Dr Dudley and Dr Petch, stated opiate drugs were the drugs of choice. Dr Wilcock, on the other hand, did not share that view.

37. At the end of the hearing, the Coroner directed the jury to determine the cause of death in each case, and to return narrative verdicts by answering the following questions:

Question 1: Did the administration of any medication contribute more than minimally or negligibly to the death of the deceased?

Question 2: Was that medication given for therapeutic purposes?

Question 3: Was that medication appropriate for the condition or symptoms from which the deceased was suffering?

38. The verdicts, returned by the jury on 20 April 2009, are set out in the table below.

Name	Cause of death	Question 1 (causation)	Question 2 (therapeutic)	Question 3 (appropriate)
Code A	1A Bronchopneumonia 2 Severe depression	No	-	-
Elsie Lavender	1A High cervical cord injury	Yes	Yes	Yes
Helena Service	1A Congestive cardiac failure	No	-	-
Ruby Lake	1A Bronchopneumonia 2 Fractured neck of femur repaired on 5/8/98	No	-	-
Arthur Cunningham	1A Bronchopneumonia 1B Sacral ulcer 2 Parkinson's disease	Yes	Yes	Yes
Robert Wilson	1A Congestive cardiac failure 2 Alcoholic cirrhosis	Yes	Yes	No
Enid Spurgin	1A Infected wound 2 Fractured right hip repaired on 20/3/99	No	-	-
Geoffrey Packman	1A Gastrointestinal haemorrhage	Yes	Yes	No
Elsie Devine	1A Chronic renal failure 1B Amoloydosis 1C IgA Paraprotenaemia	Yes	Yes	No
Sheila Gregory	1A Pulmonary embolus 2 Fractured neck of femur	No	-	-

39. A summary of the relevant matters in respect of each deceased patient is set out below.

Code A

40. The essential features of the evidence, so far as they add to, alter or amplify the material which has already considered, may be summarised as follows:

    (1) Dr Black stated that Mr Code A probably died of a pressure sore, chest infection and drug induced Parkinsonism, together with severe depression, and that his case appeared to show a not untypical pattern of decline of a terminally ill patient.

    (2) Dr Wilcock stated bronchopneumonia was likely to have been the terminal event. It was very difficult to judge the extent of any negative impact the administration of excessive doses of drugs may have had on Mr Code A If it led to a shortening of his life, it may have been by only a matter of hours to a small number of days.

    (3) Dr Barton stated that Mr Code A was transferred to the ward in a poorly condition, and had been considered by consultants at that time to be in terminal decline. He deteriorated further. Her concern was to ensure he did not suffer anxiety, pain and mental agitation as he died. She tried to judge the level of opiates and other drugs to ensure there was an appropriate and necessary level of relief, whilst not administering an excessive level, and to ensure the relief was established rapidly and maintained through the syringe driver.

41. By its verdict, the jury accepted on a balance of probabilities that the administration of medication did not cause death.

Elsie Lavender

42. The essential features of the evidence, so far as they add to, alter or amplify the material which has already considered, may be summarised as follows:

    (1) Dr Black stated that the likeliest cause of death was a high cervical cord injury. He could not say whether the diamorphine administered might have slightly hastened her death, but Mrs Lavender was going to die anyway.

    (2) Dr Wilcock did not contest Dr Black's opinion as to the cause of death. Whilst stating that the prescribed doses of diamorphine and midazolam were excessive for Mrs Lavender's needs, he did not state whether or not their administration contributed to death.

(3) Dr Barton stated she considered that the doses she administered were appropriate in view of the fact that Mrs Lavender was in pain and was distressed. The doses were increased as it was clear that Mrs Lavender had deteriorated further and was likely to be dying. The medication was given solely with the aim of relieving her pain and distress.

43. By its verdict, the jury accepted on a balance of probabilities that the medication administered was a cause of death, but found that the medication was administered for therapeutic purposes and was appropriate for the condition or symptoms from which the deceased was suffering.

Helena Service

44. The essential features of the evidence, so far as they add to, alter or amplify the material which has already considered, may be summarised as follows:

(1) Dr Black stated that he was confident that the cause of death was congested cardiac failure and ischaemic heart disease, together with cerebral vascular disease. It was reasonable to use diamorphine. He himself may have started on a lower dose, but that was down to judgment.

(2) Dr Wilcock stated that he deferred to the opinions of Dr Black and Dr Petch in relation to the cause of death (congested cardiac failure, in Dr Petch's opinion).

(3) Dr Petch's report was read to the jury. [4/34.]

(4) Dr Barton stated that on the morning of 4 June 1997, she formed the view that Mrs Service was terminally ill with heart failure. She was distressed and agitated, and it was entirely appropriate to administer diamorphine and midazolam in the hope of reducing the pulmonary oedema. The drugs were prescribed and administered solely with the intention of relieving Mrs Service's agitation and distress. [7/49.]

45. By its verdict, the jury accepted on a balance of probabilities that the administration of medication did not cause death.

Ruby Lake

46. The essential features of the evidence, so far as they add to, alter or amplify the material we have already considered, may be summarised as follows:

(1) Dr Black stated that the likeliest cause of death was myocardial infarction against a background of heart disease, together with a fractured neck of the femur.

(2) Dr Wilcock stated that he was certain Mrs Lake's immediate cause of death was bronchopneumonia.

(3) Dr Barton stated that as of 19 August 1998, she took the view that Mrs Lake might die shortly. The diamorphine, midazolam and hiazine were prescribed and administered solely with the intention of relieving the pain, anxiety and stress which Mrs Lake was suffering in connection with her congestive cardiac failure.

47. By its verdict, the jury accepted on a balance of probabilities that the administration of medication did not cause death.

Arthur Cunningham

48. The essential features of the evidence, so far as they add to, alter or amplify the material we have already considered, may be summarised as follows:

(1) Dr Black stated that the cause of death was the sacral sore, bronchopneumonia and Parkinson's disease. The administration of the drugs may have slightly shortened life, but Mr Cunningham was going to die anyway.

(2) Dr Wilcock stated that Mr Cunningham was an ill and frail man, whose deterioration was documented over a range of circumstances and by a number of different teams. The terminal event was bronchopneumonia. In reality, he was deteriorating at the very end of his life, and it was not appropriate to pursue aggressively treatment of the sacral sore. It was appropriate to administer diamorphine.

(3) Dr Barton stated that the medication given to Mr Cunningham was provided solely with the aim of relieving his pain, distress and anxiety. By 25 September 1998, it was thought that he was likely to die soon, and that keeping him free from pain and distress was all that could be reasonably achieved in the circumstances. It would have been a miracle if the sacral sore had even started to heal and palliative care was appropriate.

49. By its verdict, the jury accepted on a balance of probabilities that the medication administered was a cause of death, but found that the medication was administered for therapeutic purposes and was appropriate for the condition or symptoms from which the deceased was suffering.

Robert Wilson

50. The essential features of the evidence, so far as they add to, alter or amplify the material we have already considered, may be summarised as follows:

    (1) Dr Black stated that he was relatively confident Mr Wilson died from alcoholic liver disease. However, he could not exclude the possibility that Mr Wilson died from a coma induced by the prescribed oramorph. Under cross-examination, he revised one of the conclusions contained in his report, to the following (words emphasised added): '*In my view, this dose of analgesia* is likely to have *formed a major contribution to the clinical deterioration that occurred over 15 and 16 October...*'

    (2) Dr Wilcock stated that in his opinion the nature of Mr Wilson's rapid deterioration could actually be in keeping with his severe liver failure and heart failure, and that it is difficult to state with any certainty that the doses of morphine and diamorphine could have contributed more than negligibly.

    (3) The report of Professor Baker was read to the jury.

    (4) Dr Barton stated that she was concerned to ensure that a proactive regime of opiate pain relief medication was available in case Mr Wilson's condition deteriorated. Mr Wilson did deteriorate, and on 17 October 1998 there was an expectation that he might die shortly.

51. By its verdict, the jury accepted on a balance of probabilities that the medication administered was a cause of death, and found that, although the medication was administered for therapeutic purposes, it was not appropriate for the condition or symptoms from which the deceased was suffering.

Enid Spurgin

52. The essential features of the evidence, so far as they add to, alter or amplify the material we have already considered, may be summarised as follows:

    (1) Dr Black stated that the likeliest cause of death (on a balance of probabilities but no more than that) was an infected wound, secondary to a fractured neck of the femur.

(2) Dr Wilcock concurred with the cause of death given by Dr Black, but stated that the inappropriate and excessive doses of diamorphine and midazolam would have contributed to death more than minimally or negligibly.

(3) Dr Barton stated that the oramorph, morphine sulphate, diamorphine, midazolam were prescribed and administered solely with the intention of relieving the pain and distress from which Mrs Spurgeon was suffering.

53. By its verdict, the jury accepted on a balance of probabilities that the administration of medication did not cause death.

Geoffrey Packman

54. The essential features of the evidence, so far as they add to, alter or amplify the material we have already considered, may be summarised as follows:

(1) Dr Black stated that the cause of death was Mr Packman's gastrointestinal haemorrhage. Based on the available notes, there would be a varying number of medical opinions as to whether it was a reasonable clinical decision to have provided Mr Packman with symptomatic care only as at 26 August 1999.

(2) Dr Wilcock stated that Mr Packman's treatment was inappropriate, and that his exposure to unjustified and inappropriate doses of diamorphine and midazolam contributed more than minimally or negligibly to his death. Some of the underlying causes of Mr Packman's condition may have been eminently treatable. There does not appear to be any reason (that is, evident from the medical notes) not to have provided that treatment (although one may have existed).

(3) Dr Barton stated that on 26 August 1999, in view of Mr Packman's condition, she felt that transfer to an acute unite with quite inappropriate. She wrote up a prescription for the syringe driver, but did not intend that it be administered at that stage. The use of the syringe driver on 30 August 1999 was appropriate to relieve Mr Packman's distress. By that time he was terminally ill. The drugs were prescribed and administered solely with the aim of relieving Mr Packman's pain and distress, and ensuring that he was free from pain and distress as he died.

55. By its verdict, the jury accepted on a balance of probabilities that the medication administered was a cause of death, and found that, although the medication was administered for therapeutic purposes, it was not appropriate for the condition or symptoms from which the deceased was suffering.

Elsie Devine

56. The essential features of the evidence, so far as they add to, alter or amplify the material we have already considered, may be summarised as follows:

    (1) Dr Black stated that by 19 November 1999, Mrs Devine was terminally ill as a result of renal failure, but it was possible that her deterioration, which was part of an inevitable progression, was more rapid owing to the use of the fentanyl patch. The cause of death was renal failure, together with multiple infracted disease and IgA paraproteinaemia.

    (2) Dr Wilcock, having considered Dr Dudley's report, accepted the conclusion that Mrs Devine had entered the terminal stage naturally as a result of her renal disease. (Dr Wilcock had recognised the existence of this possibility in his original report, but had also raised the possibility that Mrs Devine's deterioration was reversible.)

    (3) Dr Dudley's report was read to the jury.

    (4) Dr Barton stated that on 19 November 1999, it was clear that Mrs Devine's renal function had deteriorated markedly, and that she was dying. The medication was administered with the sole intention of relieving her significant distress.

57. By its verdict, the jury accepted on a balance of probabilities that the medication administered was a cause of death, and found that, although the medication was administered for therapeutic purposes, it was not appropriate for the condition or symptoms from which the deceased was suffering.

Sheila Gregory

58. The essential features of the evidence, so far as they add to, alter or amplify the material we have already considered, may be summarised as follows:

(1) Dr Black stated that Mrs Gregory's slow decline following her fall and operation was a not uncommon picture at the end of a person's life. The dose of morphine administered could be seen as being at the upper limit, but was not exceptional in the circumstances.

(2) Dr Wilcock stated that Mrs Gregory's decline, which was noted over a number of weeks, was in keeping with a natural decline into a terminal phase. However, he could not satisfy himself with a great degree of certainty whether the chest infection should have been treated, or whether it was appropriate to start the patient on diamorphine.

(3) Dr Barton stated that on 18 November 1999, she was concerned that Mrs Gregory was deteriorating and that she might well die. In view of Mrs Gregory's continued deterioration, on 20 November 1999 Dr Barton felt it was appropriate to commence administration of diamorphine via a syringe driver. The next day, it was thought that Mrs Gregory was dying. The drugs were prescribed and administered solely with the intention of relieving the shortness of breath Mr Gregory was experiencing from what Dr Barton believed to be her cardiac failure, and the resulting anxiety and distress.

59. By its verdict, the jury accepted on a balance of probabilities that the administration of medication did not cause death.

The GMC Proceedings

Overview

60. The proceedings against Dr Barton before the Fitness to Practise Panel ('the Panel') of the GMC took place between 8 June and 20 August 2009.

61. The proceedings were brought against Dr Barton by the GMC, the professional body which regulates the practise of medicine in the United Kingdom.

62. The Panel is an independent tribunal, the functions of which include the hearing and determination of charges of professional misconduct brought against medical practitioners.

63. The GMC brought a number of specific charges against Dr Barton in connection with her role in the care of eight of the ten deceased patients whose cases we have reviewed, the exceptions being Helena Service and Sheila Gregory. In addition, charges were brought in respect of four other patients who had been under Dr Barton's care at the GWMH: Eva Page, Alice Wilkie, Gladys Richards and Jean Stevens.

64. The proceedings were adversarial in nature, and were conducted in accordance with the criminal rules of evidence. The burden of proof was on the GMC, and the standard of proof was proof beyond reasonable doubt.

65. At the outset of the hearing, Dr Barton admitted a number of charges. The hearing then proceeded in respect of the contested charges.

66. During the hearing, the Panel heard evidence from a number of witnesses, most of whom had previously made statements to the police during the course of Operation Rochester and given evidence at the inquest. The principal witness called by the GMC was Professor Gary Ford, the Jacobson Chair of Clinical Pharmacology, and an expert in geriatric medicine. Professor Ford, who had not given evidence at the inquest, provided an expert opinion in relation to the conduct of Dr Barton. In relation to each deceased patient, he stated that the prescription of diamorphine and midazolam by Dr Barton appeared to be unjustified and/or excessive. (It appears that the Panel's verdicts were substantially based on this evidence.) He also dealt with matters relevant to causation.

67. Dr Barton gave evidence. In summary, she gave an account which was consistent with her evidence before the inquest and the statements she had previously provided to the police. The essence of her account was encapsulated in the following comment made during cross-examination: '*All these people were dying from the various conditions from which they suffered, and the management that I gave them was palliative and then terminal care for the conditions which killed them. In no way did I contribute to their deaths.*'

68. The determination of the Panel fell into three parts. In Part One, the Panel dealt with a number of general matters. In Part Two, the Panel set out its formal findings of fact. In this part, the Panel made multiple findings that Dr Barton's conduct had been inappropriate, potentially hazardous and/or not in the best interests of her patients. In Part Three, the Panel considered whether the facts proved and admitted would be insufficient to support a finding of serious professional misconduct. In this part, the Panel concluded that the facts were not insufficient to support such a finding. The determination of whether the facts did indeed amount to serious professional misconduct, and the question of sanction against Dr Barton, was adjourned for a further hearing.

69. That further hearing took place in January 2010. On 29 January 2010, the Panel determined that Dr Barton had been guilty of multiple instances of serious professional misconduct. The finding was based on the facts determined by the Panel during the proceedings, Dr Barton's departures from good medical practice and the attendant risks and dangers to patients. By way of sanction, the Panel ordered that Dr Barton's registration be subject to a number of restrictive conditions for a period of three years.

General matters

70. Three matters of general significance to the issues in Dr Barton's case were dealt with by the Panel in Part One.

71. First, the Panel stated that it had heard and accepted evidence from many sources, including Professor Ford, that elderly patients with a range of co-morbidities, such as those routinely found in Dryad Ward at the time in question, had a natural propensity toward sudden deterioration and even death, no matter how well cared for.

72. Secondly, the Panel identified that there was a difference of medical opinion as to the appropriate use of opiates in the control of distress, restlessness and agitation in the cases of patients of advanced age with a range of co-morbidities. On the one hand, there was the experience of Dr Barton, supported by consultants with whom she had worked and by Professor Sikora, an expert witness called on her behalf, that opiates were helpful in dealing with terminal distress, etc, whether or not pain was also present. Professor Ford, on the other hand, did not share this view. He conceded that there might be geriatricians who would give diamorphine to patients who were not in pain, but he noted that such a course is neither promoted nor recommended in the palliative care literature and guidelines. (This range of views echoed the differing expert opinions given during the inquests.)

73. Thirdly, the Panel noted Professor Ford's evidence on the principle of double effect: '*The principle of doubt effect is that one may need to palliate symptoms, and that the treatment one needs to give to palliate symptoms may lead to a shortening of life through adverse effects. That is well accepted as being a reasonable and appropriate aspect that may happen when one adequately palliates symptoms... One has to give drugs and doses that are reasonable and appropriate to palliate symptoms. Then, with certain groups of drugs like sedatives, the issue is giving excessively high doses which have an effect which go beyond what the patient needed to palliate their symptoms.*' The Panel found the following exchange during Dr Barton's cross-examination gave a clear insight into her view on this matter: when asked why she did not reduce the level of Mrs Lavender's medication to keep her alert, Dr Barton responded, '*More alert to feel more pain.*'

74. The cases of the individual patients are summarised below.

Code A *(Patient A)*

75. Professor Ford stated that there was and is little disagreement that Mr Pittock was dying, but the drugs administered to palliate his symptoms were excessive.

76. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

(1) The prescription of diamorphine between 5-10 January 1996: (a) contained a lower dose which was too high (Proved); (b) created a situation whereby drugs could be administered to the patient which were excessive to the patient's needs (Admitted); (c) was inappropriate (Proved), potentially hazardous (Proved) and not in the best interests of the patient (Proved).

(2) The prescriptions of diamorphine and midazolam on 11 January 1996 (a) contained a lower dose which was too high (Proved); (b) created a situation whereby drugs could be administered to the patient which were excessive to the patient's needs (Admitted); (c) was inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

(3) The prescription of diamorphine, midazolam and hyoscine hydrobromide to be administered via a syringe driver on 15 January 1996 was potentially hazardous (Proved).

(4) The prescription of increased doses of diamorphine and midazolam to be administered via a syringe driver on 17 January 1996 was potentially hazardous (Proved).

(5) The prescription of Nozinan on 18 January 1996: (a) in combination with the other drugs already prescribed was excessive (Proved); (b) was inappropriate (Proved), potentially hazardous (Proved) and not in the best interests of the patient (Proved).

Elsie Lavender (Patient B)

77. Professor Ford stated that because any older patient with multiple pathologies can die suddenly, particularly in hospital, it is very difficult to prove beyond reasonable doubt that one cause is the definite cause of death. It was highly likely that drugs contributed to Mrs Lavender's death.

78. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

(1) The prescriptions of diamorphine and midazolam on 26 February 1996: contained lower commencing doses which were too high (Proved); (b) contained dose ranges which were too wide (Admitted); (c) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (d) was inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

(2) The prescription of diamorphine and midazolam on 5 March 1996: (a) in respect of the midazolam only, contained a lower commencing dose which was too high (Proved); (b) contained dose ranges which were

too wide (Admitted); (c) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted): (d) was inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

(3) In relation to the management of the patient: (a) as the patient's condition deteriorated Dr Barton did not conduct an adequate assessment (Proved) and did not obtain the advice of a colleague (Admitted); (b) by those omissions Dr Barton's management of the patient was inadequate (Proved) and not in the best interests of the patient (Proved).

Eva Page (Patient C)

79. Professor Ford stated that cancer was the cause of death. Drugs may have been a contributory factor, but the possibility could not be put any higher as Mrs Page was so ill with advanced cancer.

80. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows. The prescriptions of diamorphine and midazolam on 3 March 1998: (a) contained dose ranges that were too wide (Admitted); (b) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (c) were inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

Alice Wilkie (Patient D)

81. Professor Ford stated that he thought drugs contributed to Mrs Wilkie's deterioration. However, the patient was an old and frail lady with advanced dementia, and was going to die in the near future. In those circumstances, it could not be said that drugs definitely contributed to death.

82. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

(1) The prescriptions of diamorphine and midazolam on or before 20 August 1998: (a) contained dose ranges that were too wide (Admitted); (b) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (c) were inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

(2) Dr Barton failed to assess the patient's condition appropriately before prescribing opiates (Proved), and this failure was not in the best interests of the patient (Proved).

Gladys Richards (Patient E)

83. Professor Ford stated that the predominant cause of death was dementia and a hip fracture.

84. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

    (1) The prescription of oramorphine on 11 August 1998 was inappropriate (Proved), potentially hazardous (Proved) and not in the best interests of the patient (Proved).

    (2) The prescriptions of diamorphine and midazolam on 11 August 1998: (a) contained dose ranges which were too wide (Admitted); (b) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (c) were inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

Ruby Lake (Patient F)

85. Professor Ford stated that he was of the view that the drugs administered to Mrs Lake very likely contributed to her death, but because she had a lot of other medical problems, it could not be concluded that the drugs were the cause of her death.

86. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

    (1) The prescription of oramorphine on 18 August 1998 was potential hazardous (Proved).

    (2) The prescriptions of diamorphine and midazolam between 18-19 August 1998: (a) contained dose ranges which were too wide (Admitted); (b) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (c) were inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

Arthur Cunningham (Patient G)

87. Professor Ford stated that it would be difficult to conclude that the drugs did not pay some part in Mr Cunningham's death through causing deep sedation and respiratory depression. However, the available literature is unclear as to whether palliative sedation therapy significantly shortens life. In Mr Cunningham's case, it was very likely that drugs contributed to respiratory depression and him getting bronchial pneumonia. On the other

hand, he was at high risk of getting bronchial pneumonia and dying anyway, so it could not be concluded that the drugs definitely caused his death.

88. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

(1) The prescriptions of diamorphine and midazolam on 21 September 1998: (a) contained dose ranges which were too wide (Admitted); (b) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (c) were inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

(2) The prescriptions of diamorphine and midazolam on 25 September 1998: (a) contained dose ranges which were too wide (Admitted); (b) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (c) were inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

(3) Dr Barton did not obtain the advice of a colleague when the patient's condition deteriorated (Admitted).

Robert Wilson (Patient H)

89. Professor Ford stated that in his view the drugs had led to Mr Wilson's deterioration and contributed to his death. Mr Wilson had other serious conditions, including liver disease and heart failure, so it could not be said that the drugs were the only cause, but they were most likely a contributory factor. (This view was, to a degree, qualified in cross-examination. The qualification appears to be of general application. [See, further Lavender and Wilkie].

90. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

(1) The prescription of oramorphine on 14 October 1998, in light of the patient's history of alcoholism and liver disease, was inappropriate (Proved), potentially hazardous (Proved) and not in the best interests of the patient (Proved).

(2) The prescription of diamorphine on 16 October 1998: (a) contained a dose range which was too wide (Admitted); (b) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (c) was inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

(3) The prescription of midazolam on or before 17 October 1998 was inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

(4) Dr Barton did not obtain the advice of a colleague when the patient's condition deteriorated (Admitted).

Enid Spurgin (Patient I)

91. Professor Ford stated that he thought it was difficult to conclude that the combination of diamorphine and midazolam did not contribute to Mrs Spurgin's death through sedation and respiratory depression.

92. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

(1) The prescriptions of diamorphine and midazolam on 12 April 1999: (a) contained dose ranges which were too wide (Admitted); (b) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (c) were inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

(2) The diamorphine and midazolam administered via a syringe driver on 12 April 1999 was: (a) excessive to the patient's needs (Proved); (b) inappropriate (Proved), potentially hazardous (Proved) and not in the best interests of the patient (Proved).

Geoffrey Packman (Patient J)

93. Professor Ford stated that there was little doubt that the main cause of death was a gastrointestinal bleed. The drugs may have contributed to death through producing respiratory depression and sedation.

94. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

(1) The prescriptions of diamorphine and midazolam on 26 August 1999: (a) in respect of midazolam only, contained a lower dose which was too high (Proved); (b) contained dose ranges which were too wide (Admitted); (c) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (d) were inappropriate (Proved), potentially hazardous (Admitted) and not in the best interests of the patient (Proved).

(2) Dr Barton's failure to obtain medical advice in relation to the future management of the patient and her failure to undertake further investigation of his condition was inappropriate (Proved) and not in the best interests of the patient (Proved).

Elsie Devine (Patient K)

95. Professor Ford stated that he thought Mrs Devine's deterioration was undoubtedly due to drugs she received, although there may have been other contributing factors. It is difficult to conclude that the drugs did not contribute to Mrs Devine's deterioration and death.

96. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

(1) The prescription of morphine on admission: (a) was not justified by the patient's symptoms (Proved); (b) inappropriate (Proved), potentially hazardous (Proved) and not in the best interests of the patient (Proved).

(2) The prescription of fentanyl on 18 and 19 November 1999 was inappropriate (Proved), potentially hazardous (Proved) and not in the best interests of the patient (Proved).

(3) The prescriptions of diamorphine and midazolam on 19 November 1999: (a) contained lower doses which were too high (Proved); (b) in respect of midazolam only, contained a dose range which was too wide (Proved); (c) created a situation whereby drugs could be administered which were excessive to the patient's needs (Proved); (d) were inappropriate (Proved), potentially hazardous (Proved) and not in the best interests of the patient (Proved).

(4) Dr Barton did not obtain the advice of a colleague when the patient's condition deteriorated (Admitted).

Jean Stevens (Patient L)

97. Professor Ford stated that Mrs Stevens could have died suddenly from natural causes, but the timing is very suggestive of the diamorphine and midazolam having contributed to her death.

98. The charges found proved by the Panel or admitted by Dr Barton may be summarised as follows.

(1) The prescriptions of oramorphine, diamorphine and midazolam on 20 May 1999: (a) were prescribed in the absence of sufficient clinical justification (Proved); (b) in respect of diamorphine and midazolam

only, contained dose ranges which were too wide (Admitted); (c) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (d) were inappropriate (Proved), potentially hazardous (Admitted in respect of diamorphine, Proved in respect of Midazolam) and not in the best interests of the patient (Proved).

(2) The prescription of oramorphine on 21 May 1999: (a) was prescribed in the absence of sufficient clinical justification (Proved); (b) created a situation whereby drugs could be administered which were excessive to the patient's needs (Admitted); (c) was inappropriate (Proved), potentially hazardous (Proved) and not in the best interests of the patient (Proved).

Note keeping

99. A number of charges in relation to note keeping were also found proved by the Panel or were admitted by Dr Barton. These may be summarised as follows. In relation to each of the deceased patients: (a) Dr Barton did not keep clear, accurate and contemporaneous notes (Admitted), and in particular, did not sufficiently record the findings upon each examination (Admitted), an assessment of the patient's condition (Admitted), the decisions made as a result of examination (Admitted), the drug regime (Proved), the reason for the drug regime prescribed (Admitted) and the reason for the changes in the drug regime (Admitted); (b) Dr Barton's acts and omissions in relation to keeping notes were inappropriate (Admitted) and not in the best interests of the patients (Admitted).

Discussion

Overview

100. Two essential matters have arisen for consideration from the inquest and GMC proceedings.

101. First, the proceedings have generated a new body of evidence. Dr Barton has now made admissions, given oral evidence and been subjected to cross-examination. Dr Black and Dr Wilcock have amplified, and in some cases revised, the contents of their original reports, and they too have been cross-examined. A further expert, Professor Ford, has also given oral evidence.

102. Secondly, the proceedings have given an indication as to how some of the important issues in a criminal prosecution might fare when subjected to adversarial scrutiny. The strength of this indication, however, is limited. This is because both sets of proceedings were materially different in nature from criminal proceedings. In the case of the inquests, the proceedings had a limited focus, were not truly adversarial and were determined according to the civil standard of proof. The GMC proceedings also had a limited focus. For example, the

question of causation, an essential issue in any prosecution for an offence of manslaughter, was dealt with in short form, and the issues of negligence and gross negligence fell entirely outside the scope of the proceedings. By way of further example, the evidence of Dr Black and Dr Wilcock was not considered by the Panel.

103. The verdicts and determinations of the inquest and the Panel are not binding on the CPS (and nor would they be admissible in criminal proceedings to support the prosecution case). The CPS must act independently, properly apply the Code, and decide whether the available evidence is sufficient to provide a realistic prospect of conviction.

104. The earlier decisions not to prosecute have been reconsidered in the light of the relevant matters which have arisen from the inquests and the GMC proceedings. I have reached the following important conclusions:

(1) In the case of each deceased patient, the essential balance of the expert evidence remains the same;

(2) Where the opinions of the experts have been revised or amplified, the effect has been to underline the difficulty in this case of proving negligence, causation and gross negligence to the criminal standard;

(3) The three general matters acknowledged by the Panel, namely the natural propensity in elderly patients toward sudden deterioration and even death, the conflict of expert opinion in relation to the use of opiates and the principle of double effect, underline the difficulty in this case of proving negligence, causation and gross negligence to the criminal standard;

(4) The evidence of Professor Ford, whilst highly critical of Dr Barton and providing some additional evidence supportive of negligence and causation, has similarly had the effect of underlining the difficulty of proving negligence, causation and gross negligence to the criminal standard;

(5) The admissions made by Dr Barton during the course of the GMC proceedings provide some additional evidence of supportive of negligence. However, they do not amount to admissions of gross negligence. Dr Barton continues to argue that in each case she was providing palliative care to a terminally ill patient.

105. An analysis and conclusions in respect of each deceased patient are set out below.

Code A

106. The initial conclusion in Mr Code A's case was that negligence, causation and gross negligence could not be proved to the criminal standard. That view remains. The following matters are of significance.

(1) The essential conclusions of Dr Black and Dr Wilcock remain the same.

(2) Professor Ford's opinion is that Mr Code A was dying, but the drugs administered to palliate his condition were excessive. This provides further evidence that Dr Barton may have been negligent, but it re-enforces the conclusions concerning causation and gross negligence.

(3) It is noteworthy that the inquest jury concluded that it was more likely than not that the drugs did not contribute to death. (In a criminal prosecution, it would be necessary to prove causation beyond reasonable doubt.)

Elsie Lavender

107. The initial conclusion in Mrs Lavender's case was that whilst it may have been possible to prove that Dr Barton was negligent, causation and gross negligence could not be proved to the criminal standard. That view remains. The following matters are of significance.

(1) The essential conclusions of Dr Black and Dr Wilcock remain the same.

(2) Professor Ford's opinion is that it is highly likely that the excessive doses of drugs contributed to death. However, this conclusion is qualified by Professor Ford's general observation that in the case of elderly frail patients there is a natural propensity to deteriorate, and die, and it is difficult to prove causation beyond reasonable doubt.

(3) It is noteworthy that, whilst the inquest jury concluded that it was more likely than not that the drugs did contribute to death, it also concluded that the drugs were administered for therapeutic purposes and were appropriate for the condition or symptoms from which Mrs Lavender was suffering. In criminal proceedings, in order to prove negligence (let alone gross negligence), the prosecution would have to prove beyond reasonable doubt, amongst other things, that the prescription of the drugs was inappropriate.

Helena Service

108. The initial conclusion in Mrs Service's case was that negligence, causation and gross negligence could not be proved to the criminal standard. That view remains. The following matters are of significance.

(1) The essential conclusion of Dr Black remains the same. In evidence, Dr Wilcock revised his opinion as to the cause of death, having considered the report of Dr Petch.

(2) It is noteworthy that the inquest jury concluded that it was more likely than not that the drugs did not contribute to death. (In a criminal prosecution, it would be necessary to prove causation beyond reasonable doubt.)

Ruby Lake

109. The initial conclusion in Mrs Lake's case was that negligence, causation and gross negligence could not be proved to the criminal standard. That view remains. The following matters are of significance.

(1) The essential conclusions of Dr Black and Dr Wilcock remain the same.

(2) Professor Ford's opinion is that it was very likely the drugs contributed to death.

(3) It is noteworthy that the inquest jury concluded that it was more likely than not that the drugs did not contribute to death. (In a criminal prosecution, it would be necessary to prove causation beyond reasonable doubt.)

Arthur Cunningham

110. The initial conclusion in Mr Cunningham's case was that negligence, causation and gross negligence could not be proved to the criminal standard. That view remains. The following matters are of significance.

(1) The essential conclusions of Dr Black and Dr Wilcock remain the same.

(2) Professor Ford's opinion is that it was very likely that drugs contributed to death through respiratory depression and bronchial pneumonia. On the other hand, Mr Cunningham was at high risk of getting bronchial pneumonia and dying anyway, so it could not be concluded that the drugs definitely caused his death.

(3) It is noteworthy that, whilst the inquest jury concluded that it was more likely than not that the drugs did contribute to death, it also concluded that the drugs were administered for therapeutic purposes and were appropriate for the condition or symptoms from which Mr Cunningham was suffering. In criminal proceedings, in order to prove negligence (let alone gross negligence), the prosecution would have to prove beyond reasonable doubt, amongst other things, that the prescription of the drugs was inappropriate.

Robert Wilson

111. The initial conclusion in Mr Wilson's case was that whilst it may have been possible to prove that Dr Barton was negligent, causation and gross negligence could not be proved to the criminal standard. That view remains. The following matters are of significance.

(1) The essential opinions of Dr Black and Dr Wilcock remain the same (although Dr Black slightly revised his opinion as to the strength of his view that the drugs formed a major cause of death).

(2) Professor Ford's opinion is that the drugs were mostly likely to have been a contributory factor in Mr Wilson's death. However, this conclusion is qualified by Professor Ford's general observation that in the case of elderly frail patients there is a natural propensity to deteriorate and die, and it is difficult to prove causation beyond reasonable doubt.

(3) By its verdict, the inquest jury concluded on a balance of probabilities that the medication administered was a cause of death, and that, although the medication was administered for therapeutic purposes, it was not appropriate for the condition or symptoms from which the deceased was suffering. However, in assessing the significance of this verdict, it is important to have regard to the following matters: (a) it does not bind the CPS; (b) it is not admissible in criminal proceedings; (c) whilst it deals with the question of appropriateness, it does not deal with the question of negligence or gross negligence; (d) it was returned on the civil, not the criminal, standard of proof; (e) it was returned in the context of the limited focus of inquest proceedings; (f) it was returned without the evidence in the proceedings having been subjected to full adversarial scrutiny.

Enid Spurgin

112. The initial conclusion in Mrs Spurgin's case was that whilst it may have been possible to prove that Dr Barton was negligent, causation and gross negligence could not be proved to the criminal standard. That view remains. The following matters are of significance.

(1) The essential conclusions of Dr Black and Dr Wilcock remain the same.

(2) Professor's Ford's opinion is that it is difficult to conclude that the combination of diamorphine and midazolam did not contribute to Mrs Spurgin's death.

(3) It is noteworthy that the inquest jury concluded that it was more likely than not that the drugs did not contribute to death. (In a criminal prosecution, it would be necessary to prove causation beyond reasonable doubt.)

Geoffrey Packman

113. The initial conclusion in Mr Packman's case was that negligence, causation and gross negligence could not be proved to the criminal standard. That view remains. The following matters are of significance.

(1) The essential conclusions of Dr Black and Dr Wilcock remain the same.

(2) Professor Ford's opinion is that drugs may have contributed to death.

(3) By its verdict, the inquest jury concluded on a balance of probabilities that the medication administered was a cause of death, and that, although the medication was administered for therapeutic purposes, it was not appropriate for the condition or symptoms from which the deceased was suffering. However, in assessing the significance of this verdict, it is important to have regard to the following matters: (a) it does not bind the CPS; (b) it is not admissible in criminal proceedings; (c) whilst it deals with the question of appropriateness, it does not deal with the question of negligence or gross negligence; (d) it was returned on the civil, not the criminal, standard of proof; (e) it was returned in the context of the limited focus of inquest proceedings; (f) it was returned without the evidence in the proceedings having been subjected to full adversarial scrutiny.

Elsie Devine

114. The initial conclusion in Mrs Devine's case was that negligence, causation and gross negligence could not be proved to the criminal standard. That view remains. The following matters are of significance.

(1) The essential conclusion of Dr Black remains the same. In evidence, Dr Wilcock revised his opinion, accepting the conclusion of Dr Dudley that Mrs Devine's condition was not reversible.

(2) Professor Ford's opinion is that Mrs Devine's deterioration was undoubtedly due to the drugs she received, although there may have been other causes. This conclusion must be measured against his general qualification that in the case of elderly frail patients there is a natural propensity to deteriorate, and die, and it is difficult to prove causation beyond reasonable doubt. It must also be measured against the contrary views of Dr Black, Dr Wilcock and Dr Dudley.

(3) By its verdict, the inquest jury concluded on a balance of probabilities that the medication administered was a cause of death, and that, although the medication was administered for therapeutic purposes, it was not appropriate for the condition or symptoms from which the deceased was suffering. However, in assessing the significance of this verdict, it is important to have regard to the following matters: (a) it does not bind the CPS; (b) it is not admissible in criminal proceedings; (c) whilst it deals with the question of appropriateness, it does not deal with the question of negligence or gross negligence; (d) it was returned on the civil, not the criminal, standard of proof; (e) it was returned in the context of the limited focus of inquest proceedings; (f) it was returned without the evidence in the proceedings having been subjected to full adversarial scrutiny.

Sheila Gregory

115. The initial conclusion in Mrs Gregory's case was that negligence, causation and gross negligence could be proved to the criminal standard. That view remains. The following matters are of significance.

(1) The essential conclusions of Dr Black and Dr Gregory remain the same.

(2) It is noteworthy that the inquest jury concluded that it was more likely than not that the drugs did not contribute to death. (In a criminal prosecution, it would be necessary to prove causation beyond reasonable doubt.)

Conclusions

116. In my view, for the reasons set out above, in the case of each deceased patient, there remains in relation to Dr Barton no realistic prospect of conviction for the offence of gross negligence manslaughter.

I hope this is of assistance to you and I have dealt fully with all the matters which been raised since I last wrote to you. If you wish to discuss the basis and reasoning for my conclusions I should be only too pleased to meet with you in London.

Yours Sincerely,

Paul Close,
Special Crime Division.

Code A

From: Code A
Sent: 16 August 2010 17:31
To: Code A
Cc: Code A
Subject: URGENT QUERY in Edward BISSMIRE
Importance: High

Dear Denise,

I understand that Yiana is on leave for the rest of this week and I would be grateful if someone could provide me with the contact details of Counsel who dealt with this case. I understand his name is Gareth.

We had a query surrounding the basis of plea a few weeks ago and Yiana advised that Gareth was best placed to answer this but he was on leave for two weeks so we have been awaiting his return. I understand that he should be back from leave now and would b grateful to speak to him asap.

Thank you for your assistance.

Kindest Regards

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