14-7-05

OPERATION ROCHESTER

Re Code A

Draft ADVICE

Introduction

1. On 24 January 1996, Code A, aged 82, died.

2. At the time of his death Code A was a patient on Dryad Ward at the Gosport War Memorial Hospital ('GWMH').

3. The cause of death was given as bronchopneumonia.

4. During his time on Dryad Ward, Code A was treated on a day to day basis by Dr Jane Barton, a Clinical Assistant in Elderly Medicine. Dr Barton is now aged 56 (date of birth 19 October 1948).

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

6. We have been asked to advise on the question of 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. We should say at the outset that after careful consideration of all the materials provided to us we have reached the conclusion that the evidence does not reveal the commission of the offence of gross negligence manslaughter.

8. In reaching this conclusion we have, of course, had regard to the Code for Crown Prosecutors.

Background

9. Code A was born on Code A.

10. For a great deal of his life he suffered from severe depression. He attempted suicide on a number of occasions, and received in-patient treatment at Knowle Hospital in Wickham in the 1960s, 70s and 80s.

11. In 1993, Code A was living at home and being cared for by his wife, Audrey (who herself died in 2001), when he was again admitted to Knowle Hospital. It was felt that caring for him at home was placing too great a strain on his wife, and it was therefore decided that he should in due course be discharged to the Hazledene Rest Home ('Hazledene').

12. Mr Pittock became progressively worse at Hazledene. He did not socialise with the other residents, and he withdrew into himself. As a result of his deteriorating mental state, Code A was admitted to GWMH on 13 December 1995.

Gosport War Memorial Hospital

Overview

13. 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.

Mulberry Ward

14. On 13 December 1995, Code A was admitted to Mulberry Ward under the care of Dr Victoria Banks, a Consultant in Old Age Psychiatry. Mulberry Ward is the long stay elderly mental health ward at GWMH.

15. On examination, Code A was found to be immobile, depressed and suicidal. He was not eating well and was verbally aggressive to staff. It was noted that he had an under-active thyroid gland and was constipated. Depression was assessed as the main problem.

16. Code A 's medication consisted of sertraline, lithium carbonate, thioridazine, diazepam, temazepam, thyroxine, magnesium hydroxide and codanthrusate.

17. Over the next few days, Code A suffered a fall and had a bout of diarrhoea. An x-ray revealed that he had a possible obstruction in the large bowel. He was also catheterised for urinary retention.

18. On 22 December, it was noted that Code A had developed a chest infection.

19. On 27 December, Dr Banks noted that he was 'chesty, poorly, abusive and not himself at all'.

20. On 2 January 1996, Code A was still poorly, lethargic and his skin was breaking down. He was referred to Dr Althea Lord, a Consultant Geriatrician. Dr Lord noted that Mr Pittock's mobility had deteriorated drastically since his

admission, and that although his chest had improved, he was still bed-bound. She also noted that he was expressing a wish to die.

21. On 3 January, Dr Banks noted that Code A was deteriorating, that he was not eating well and that there were some breaks on his skin.

22. On 4 January, following an examination by Dr Lord, a decision was made to transfer Code A to Dryad Ward as a long stay patient. It was felt that his placed at Hazledene could be given up, as he was unlikely to return. Code A was informed of the poor prognosis.

Dryad Ward

23. Code A was transferred to Dryad Ward on 5 January 1996, under the care of Dr Jane Tandy.

24. The doctor who saw Code A 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.

25. The details of Code A 's treatment were recorded in various sets of notes. These notes included the medical notes, the nursing notes and the drug chart.

26. On 9 January, the medical notes recorded that Code A had a painful right hand, and that he displayed increasing anxiety and agitation. The possibility of prescribing opiates was recorded.

27. On 10 January, oramorph (morphine solution) was prescribed at 5mg every four hours, but this medication was not given until 11 January. Diamorphine 40-80mg and hyoscine (a drug which reduces excessive saliva or retained secretions, and which has sedative properties) 200-400micrograms were also prescribed, but not administered at this stage. At some point on 11 January the drug chart was re-written and the dosage of diamorphine amended to 80-120mg. The drug chart also included an entry for midazolam (a sedative) 40-80mg.

28. On 11 January, the oramorph was given. This continued until 15 January.

29. On 15 January, the medical notes recorded that Code A was to receive 'TLC'. At 8.25 a.m. a syringe driver was commenced, containing diamorphine 80mg, hyoscine 400microgram and midazolam 60mg over 24 hours. Code A deteriorated over the afternoon and became unresponsive.

30. On 16 January, haloperidol (an antipsychotic) was prescribed, with Code A receiving 5mg that day, via the syringe driver. It was recorded in the nursing notes that his condition remained very poor.

31. On 17 January, following a review by Dr Barton, the dosage of the medication was increased. The diamorphine was increased to 120mg, and the midazolam to 80mg. The hyoscine was increased twice, first to 600micrograms and then to 1200micrograms. The haloperidol was also increased twice, first to 10mg and then to 20mg. A further deterioration in Code A 's condition was observed that evening.

32. On 18 January, a further deterioration was noted. Nozinan (or levomepromazine, an antipsychotic) 50mg over 24 hours was commenced.

33. On 19 January, a marked deterioration was noted. On the instruction of Dr Michael Brigg, a General Practitioner deputising for Dr Barton, the haloperidol was discontinued, and the nozinan was increased to 100mg.

34. From 21 January, Code A appeared to be poorly, but much more settled. The nursing notes for 23 January recorded that there was a sudden deterioration at 1.40 a.m. (on 24 January), and that Code A died at 1.45 a.m.

35. The death certificate recorded the cause of death as bronchopneumonia.

The Police Investigation

36. Hampshire police first investigated the deaths of elderly patients at GWMH in 1998, following 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.

37. 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.

38. 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.

39. 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.

40. 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.

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

42. A total of ninety cases were reviewed by the police. These included the death of Code A 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.

43. The cases categorised as negligent are now 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.

44. Dr Wilcock and Dr Black have each prepared a report, dated 25 April 2005 and 31 January 2005 respectively, commenting on the treatment given to Code A at GWMH. They have also each prepared a supplementary report, dated 26 April 2005 and 22 April 2005 respectively, commenting on a number of matters raised by Dr Barton in her police interview.

Dr Barton

45. 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 Code A The interview took place on 3 March 2005. Dr Barton was represented by a solicitor, Ian Barker.

46. 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) By 1998, the demands on Dr Barton's time at GWMH were considerable, and she was left with the choice of making detailed clinical notes or attending patients. In 1996, although the demands were slightly less than in 1998, they were such that making notes in relation to each and every patient assessment was difficult [p.7];

(2) Dr Barton understood from Dr Lord's prognosis on 4 January 1996 that Code A was unlikely to live for a significant period [p.10];

(3) Dr Barton and Dr Tandy saw Code A on 10 January. Dr Tandy wrote 'for TLC' in the clinical notes, indicating that she agreed with Dr Lord's assessment, and that the appropriate treatment was nursing care rather than rehabilitation [p.13];

(4) On the same day, no doubt having liased with Dr Tandy, Dr Barton prescribed oramorph. She also prescribed diamorphine, hyoscine and midazolam on a proactive basis, the concern being that the prescription of oramorph may have been insufficient. It was clear that all that could be given was palliative care, and Code A 's death was expected shortly [pp.13-14];

(5) Dr Barton prescribed the increased doses of diamorphine and midazolam on 11 January. She was concerned that the appropriate medication should be available if it became necessary to relieve any significant development of Code A 's strain, anxiety or distress [p.14];

(6) Dr Barton did not work over the weekend of 13-14 January, but returned to GWMH on the morning of Monday 15 January. She may have been told that Code A 's condition had deteriorated over the weekend, and that he appeared to be experiencing significant agitation and pain. Dr Barton took the decision to commence the administration of diamorphine, midazolam and hyoscine via a syringe driver. She believed that the oramorph was clearly insufficient in relieving Code A 's condition [p.15];

(7) In relation to her general approach, Dr Barton stated: '*My concern...was to ensure that he did not suffer anxiety, pain and mental agitation as he died...I tried to judge the medication, including the increase in the level of opiates to ensure that there was the appropriate and necessary relief of his condition, whilst not administering an excessive level, and to*

ensure that this relief was established rapidly and maintained through the syringe driver.' [pp.15-16];

(8) On 16 January, Dr Barton took the view the medication commenced the previous day had been largely, but not entirely, successful in relieving Code A 's condition. In view of his continued agitation, Dr Barton decided to add haloperidol to the syringe driver [p.16];

(9) On 17 January, Code A appeared tense and agitated. In an attempt to relieve this condition, Dr Barton prescribed a further increase in the dosage of medication to be administered. She was concerned that Code A Code A was becoming tolerant of the medication [p.17];

(10) When Dr Barton reviewed Code A later that afternoon, she did not think that the increase in medication had caused him to become excessively sedated [p.17];

(11) On 18 January, Code A declined further. His agitation returned and staff were having difficulty controlling his symptoms. Therefore Dr Barton increased the dose of haloperidol, and added nozinan to the syringe driver [p.18];

(12) Dr Barton did not work over the weekend of 20-21 January. Code A was seen by Dr Brigg, who did not consider the general regime of medication to be inappropriate in view of Code A 's condition [p.19].

The Report of Dr Wilcock

47. 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.

48. Dr Wilcock has reviewed the care given to Code A at GWMH, and prepared a report dated 25 April 2005.

49. He concludes that the medical care provided to Code A on Mulberry Ward was not substandard [p.22].

50. In relation to Dryad Ward, Dr Wilcock's opinion is that the medical care provided to Code A was sub-optimal [p.22]. His conclusions may be summarised as follows:

    (1) There is and was little doubt that Code A was naturally coming to the end of his life. His death was in keeping with a progressive irreversible physical decline, accompanied in his terminal phase by pneumonia [pp.34-35];

    (2) Dr Barton was entitled to prescribe and administer appropriate drugs (in appropriate doses) in order to relieve the physical or mental suffering of Code A, even if their administration would accelerate Code A's death. Appropriate doses of diamorphine and sedatives do not necessarily hasten death. However, it is difficult to exclude the possibility that inappropriate doses contribute to death more than minimally, negligibly or trivially [pp.18-19, 34];

    (3) The oramorph commenced on 11 January was administered at a reasonable starting dose for someone of Code A's age (although the reasons for prescribing the drug were not recorded) [p.24];

    (4) The 80mg dose of diamorphine administered on 15 January via the syringe driver (prescribed on 10-11 January), was excessive for Code A Code A's needs. An appropriate dose would have been 15mg [pp.25, 31];

    (5) The 60mg dose of midazolam administered on 15 January via the syringe driver, was an above average starting dose for somebody of Code A's

age, but this may have been necessary given that he had been on long term benzodiazepines [pp.25-26];

(6) The addition of a 5mg dose of haloperidol to the syringe driver on 16 January, was a reasonable approach to treating Code A 's delirium or terminal agitation [p.26];

(7) Nozinan is an appropriate drug to use for relieving terminal agitation when the effect of haloperidol is found to be insufficient. The 50mg dose commenced on 18 January was appropriate, although it would have been more usual to have discontinued the haloperidol immediately [p.27];

(8) The medical notes kept by Dr Barton were inadequate, and do not properly record whether Code A 's condition was appropriately assessed or why his medication was prescribed;

(9) It does not appear that Dr Barton gave consideration to the possibility that the drugs she had prescribed were contributing to, rather than relieving, Code A 's symptoms. Doses were increased (for example on 17 January), when in fact a reduction ought to have been considered [pp.33-34].

51. Dr Wilcock concludes as follows [pp.35]:

'*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 Mr Pittock a peaceful death, albeit with what appears to be an excessive use of diamorphine...It is my opinion however, that given the lack of documentation to the contrary, Dr Barton could also be seen as a doctor who breached the duty of care she owed to* Code A *by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of* Code A Code A *by unnecessarily exposing him to excessive doses of diamorphine that could have resulted in a worsening of his agitation. Dr Barton's response to this was to further increase* Code A *'s dose of diamorphine. Despite the fact that*

Code A *was dying "naturally", it is difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton leaves herself open to the accusation of gross negligence.'*

The Report of Dr Black

52. 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.

53. Dr Black has reviewed the care provided to Code A on Dryad Ward, and prepared a report dated 31 January 2005. His conclusions may be summarised as follows:

(1) There is no doubt that Code A 's terminal decline was starting in September 1995 [para.6.5];

(2) Although it is impossible to be absolutely certain what was causing his physical and mental decline, it may be that he was developing a cerebrovascular disease on top of long standing drug induced Parkinsonism, together with persistent and profound depression agitation. It is not uncommon for people with long standing mental and attendant physical problems to enter a period of rapid decline without a single new diagnosis becoming apparent [para.6.7];

(3) By 9 January 1996, Code A 's problems were irreversible. He was dying and terminal care with a symptomatic approach was appropriate [para.6.12];

(4) The use of oramorph on 11 January cannot be criticised. Morphine-like drugs are widely used in supporting patients in the terminal phase of the restlessness and distress that surrounds dying, even where there is no serious pain [para.6.13];

(5) The starting dose of 80mg diamorphine administered on 15 January via the syringe driver was approximately three times the conventional starting dose [para.6.15];

(6) The dose of 60mg midazolam administered on 15 January via the syringe driver was within current medical guidance (5-80mg). However, in elderly patients a dose of 5-20mg may be more appropriate, and the dose administered may therefore have been higher than was required for symptom relief [para.6.16];

(7) The dose of 400micrograms hyoscine administered on 15 January via the syringe driver was appropriately prescribed and given [para.6.16];

(8) The doses of nozinan (50mg on 18 January, increased to 100mg on 20 January) which were administered were within the therapeutic range for palliative care (25-200mg), but exceeded the range which should be used in the case of elderly patients (5-20mg) [para.6.18];

(9) The combination of the high doses of diamorphine, midazolam and nozinan are very likely to have caused excessive sedation beyond the need of symptom control in Code A. The medication is likely to have shortened life, although this could not be established beyond reasonable doubt. However, if life was shortened this would have been by no more than hours to a few days, compared with the position if a lower dose of the drugs had been administered [para.6.19];

(10) The medical notes made by Dr Barton were at best very thin. The lack of information in the notes represented poor medical practice, although this does not prove that the care provided to Code A was sub-optimal, negligent or criminally culpable [paras.6.14, 7.2].

54. Dr Black concludes as follows:

'*In my view the drug management* [at] *Gosport was sub-optimal. There was no written justification at any stage for the high doses of Diamorphine and Midazolam...prescribed to* Code A *...Combinations of the higher than standard doses of Diamorphine and Midazolam, together with the Nozinan were very likely to have caused excessive sedation and may have shortened his life by a short period of time, that in my view would have been no more than hours to days. However, this was a dying man, the family appeared to have been appropriately involved and the patient did eventually die without distress on 24th January. While his care is sub-optimal I cannot prove it beyond a reasonable doubt to be negligent or criminally culpable.*'

Statement of Dr Tandy

55. Dr Tandy has made a witness statement in relation to this case. The statement is dated 20 December 2004.

56. Dr Tandy states that she would have used a lower dosage of diamorphine and midazolam in the syringe driver on 15 January (she points out that she did not see the patient when this dosage was commenced). She states that her usual practice is to use the lowest dosage likely to achieve the desired outcome, thereby diminishing the possibility of adverse effects. The dosage would then be reviewed and increased as necessary [pp.8, 12-13].

The Legal Framework

57. 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.

58. 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.

59. 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.)

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

61. 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*.

62. 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.'

63. 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."

64. 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.'

65. 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'.

66. 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.

67. 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).

68. 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.

69. 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.

70. 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.

71. 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.*'

72. 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

73. Code A was transferred to Dryad Ward on 5 January. By this time he had been assessed by medical staff at GWMH as being terminally ill. The purpose of the transfer was to provide terminal care.

74. During his time on the ward, Dr Barton prescribed a number of drugs. Oramorph was administered on 11 January. On 15 January, this was discontinued, and a syringe driver containing diamorphine and two sedatives, hyoscine and midazolam, was commenced. On 16 January, haloperidol, an anti-psychotic, was added to the syringe driver. A further anti-psychotic, nozinan, was commenced on 18 January. The haloperidol was discontinued the following day.

75. On 24 January, Code A died.

Summary of the Experts' Opinions

76. There is no doubt that Code A had naturally entered a period of terminal decline. The decision to transfer him to Dryad Ward with a view to providing terminal care was therefore appropriate.

77. 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 Code A Code A's condition had been carried out. This raises the possibility that Dr Barton did not consider whether or not the drugs which she had prescribed were contributing to Code A's symptoms. However, as Dr Black has stated, although the inadequacy of the notes represents poor practice, it does not prove that the care provided to Code A was sub-optimal or negligent.

78. The essential criticism of Dr Barton is that the doses of diamorphine she prescribed, and which were subsequently administered, were significantly higher than the doses which were appropriate in Code A's case. Dr Black's opinion is that the doses of midazolam and nozinan may also have been excessive. Dr Wilcock, however, states that these doses may have been appropriate.

79. As to the effect of the excessive doses of diamorphine (combined with the other drugs administered), Dr Wilcock states that he cannot exclude completely the possibility that they may have shortened life. Dr Black states that they may have shortened life by hours or a few days, although this could not be proved beyond reasonable doubt.

80. The conclusions of the experts are as follows:

(1) Dr Wilcock states that the care provided by Dr Barton was sub-optimal. She could be seen as a doctor who allowed Code A to die peacefully, albeit by using excessive doses of diamorphine. On the other hand, she could be seen as a doctor who breached her duty of care, to the extent that she disregarded Code A 's safety, and whose acts contributed to his death. In that way, Dr Barton leaves herself open to an allegation of gross negligence.

(2) Dr Black states that Dr Barton allowed Code A to die without distress. Whilst the care she provided was sub-optimal, it could not be proved to the criminal standard that it was negligent or criminally culpable.

Discussion

81. In assessing whether the evidence in this case reveals the commission by Dr Barton of the offence of gross negligence manslaughter, we 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.

82. There is some evidence that Dr Barton was negligent in prescribing diamorphine in such high doses. Her conduct was plainly sub-optimal. However, Dr Black states in terms that it could not be proved beyond reasonable doubt that her conduct was negligent. Code A was a dying man in some distress. The drugs which were prescribed and administered allowed him to die peacefully. Having

regard to these matters, whilst there is some evidence that Dr Barton breached her duty of care, it is unlikely that this could be proved to the criminal standard.

83. The is some evidence that the drugs prescribed by Dr Barton shortened Code A Code A's life by hours or perhaps a few days. However, neither expert can say with any certainty that this was the case. Code A had entered the terminal phase before Dr Barton prescribed any drugs. In our view, therefore, causation could not be established in this case.

84. Further, in our 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 we have had regard to the following matters:

    (1) Code A was an elderly, frail man, who was dying naturally;

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

    (3) The care provided by Dr Barton allowed Code A to die peacefully;

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

Conclusions

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

86. We would be happy to discuss this case in conference and consider the impact of any further evidence on our conclusions.

David Perry

Louis Mably

14 July 2005

6 King's Bench Walk
London
EC4Y 7DR

OPERATION ROCHESTER

Re Code A

ADVICE

DAVID PERRY

LOUIS MABLY

6 KING'S BENCH WALK
LONDON
EC4Y 7DR

020-7583-0410