OPERATION ROCHESTER

Re Robert Wilson

ADVICE

Introduction

1. On 18 October 1998, Robert Wilson, aged 74, died.

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

3. The cause of death was given as 1a congestive cardiac failure, 1b renal failure and 2 liver failure, with an approximate interval between onset and death given as two years.

4. During his time on Dryad Ward, Mr Wilson was treated by Dr Jane Barton, a Clinical Assistant in Elderly Medicine, and a number of her colleagues. Dr Barton is now aged 57 (date of birth, 19 October 1948).

5. A thorough investigation into the events leading to and surrounding Mr Wilson'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, or any of her colleagues, 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. Mr Wilson was born on 8 March 1923. He married for the first time in 1949, and he and his wife had seven children. After obtaining a divorce in 1981, Mr Wilson remarried in 1985. Mr Wilson served with the Royal Navy during the war, leaving the service in 1964. Thereafter, he was employed in various different occupations until he retired in about 1989.

10. By 1998, Mr Wilson was suffering from a number of significant medical conditions, arising from alcoholism. These included serious liver dysfunction (which had been identified in 1997), heart failure and, possibly, an impairment of his renal function.

11. On 21 September 1998, Mr Wilson suffered a fall in his bedroom, after drinking a large amount of alcohol. His wife was away, but he was found by a friend and, in due course, taken by ambulance to the Queen Alexander Hospital ('QAH'). He was seen in the Accident and Emergency Department, and an x-ray revealed that he had sustained a fracture of the greater tuberosity of the left humerus. The fracture was immobilised with a sling, and Mr Wilson was given morphine for pain relief.

12. On 22 September, Mr Wilson was reviewed in the fracture clinic. Although it had been the intention to operate on the fracture, Mr Wilson objected, and the procedure was not carried out. It was clear, however, that Mr Wilson was unwell and that he would be unable to manage at home. He was therefore admitted to Dickens Ward at QAH. Over the next few days, tests revealed abnormalities in his liver and kidney functions, and also suggested a poor supply of blood to the heart. Mr Wilson received various analgesia, including morphine and codeine.

13. On 29 September, Mr Wilson's resuscitation status was changed. Owing to his liver and kidney failure, and the poor prognosis, in the event of an unexpected cardiorespiratory arrest he was not to be resuscitated.

14. On 30 September, it was noted that Mr Wilson's kidney function had improved.

15. On 7 October, he appeared to be brighter, more talkative and eating and drinking more. He was able walk a short distance with help and expressed a wish to return home. However, the next day he was seen by Dr Lusznat, a consultant in old age psychiatry, who found his mood to be low. Mr Wilson stated that there was no point in living. Dr Lusznat considered that he may have developed alcohol related early dementia, or Alzheimer's or vascular dementia. Mr Wilson was therefore commenced on anti-depressants.

16. On 12 October, it was noted that Mr Wilson remained in pain. The next day, it was noted that his weight was increasing (this had occurred progressively since his admission).

17. As Mr Wilson still required both nursing and medical care, it was decided that a short period in a long term NHS bed would be appropriate. Accordingly, on 14 October he was transferred to GWMH. The transfer letter indicated that Mr Wilson was being transferred for continuing nursing care until his arm healed, that he still had a lot of pain in his arm and had difficulty moving it, and that his oedematous legs, which were a consequence of heart failure and low protein, were at risk of breaking down. At the time of his transfer Mr Wilson was receiving codeine, although this was not mentioned in the transfer letter.

Gosport War Memorial Hospital

Overview

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

patients are usually admitted to GWMH by way of referral from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Dryad Ward

19. Mr Wilson was admitted to Dryad Ward at GWMH. At the time of his admission, the consultant in charge was Althea Lord. However, she was on annual leave between 12-23 October, and it does not appear that she had any involvement in Mr Wilson's treatment at GWMH.

20. Mr Wilson was initially assessed by Dr Barton. Dr Barton was a General Practitioner at the Forton Medical Centre in Gosport. She worked at GWMH on a part time basis as a visiting Clinical Assistant. Her responsibilities involved visiting patients on the ward, conducting examinations and prescribing medication.

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

22. At the time of her initial assessment, Dr Barton noted that the plan in respect of Mr Wilson was for '*gentle mobilisation*'. She prescribed a number of drugs. In particular, she prescribed morphine solution 5-10mg every four hours as required, which replaced the codeine he had been receiving prior to his admission. It also appears that she prescribed diamorphine 20-200mg, hyoscine 200-800microgram and midazolam 20-80mg, to be administered subcutaneously.

23. That day, Mr Wilson was given morphine solution 10mg at 2.45 p.m. and 11.45 p.m.

24. On 15 October, Mr Wilson was prescribed morphine 10mg every four hours and 20mg at night. In total, he was given 50mg over the next 24 hours.

25. On 16 October, Mr Wilson was seen by Dr Anthony Knapman, a colleague of Dr Barton's who was covering her duties. He noted that Mr Wilson had declined overnight. Mr Wilson was short of breath, had a weak pulse and was unresponsive. Dr Knapman believed that this deterioration may have been the result of a myocardial infarction (that is, a heart attack) or decreased liver function.

26. At 4.10 p.m. a syringe driver was commenced, containing diamorphine 20mg and hyoscine 400microgram. It was later noted that Mr Wilson appeared comfortable.

27. At 5.15 a.m. on 17 October, the dose of hyoscine was increased to 600microgram. Later that morning, Dr Ewenda Peters, another colleague of Dr Barton's, noted that Mr Wilson was comfortable but had experienced a rapid deterioration. She further noted that nursing staff could verify death. At 3.50 p.m. the syringe driver was renewed with diamorphine 40mg, midazolam 20mg and hyoscine 800microgram. It was noted in the nursing notes that Mr Wilson was slowly deteriorating, and that he required suction on a very regular basis.

28. On 18 October, it was noted that Mr Wilson had again deteriorated. He was seen by Dr Peters. At 2.50 p.m. the syringe driver was renewed with diamorphine 60mg, midazolam 40mg and hyoscine 1200microgram. Later, it was noted that '*all care has been given*', and that his condition continued to deteriorate. It was noted that at 10.30 p.m. Mr Wilson was again suctioned. At 11.40 p.m. it was noted that Mr Wilson had died peacefully.

29. The cause of death was given as 1a congestive cardiac failure, 1b renal failure and 2 liver failure, with an approximate interval between onset and death given as two years.

The Police Investigation

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

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

32. On 22 October 2001, the Commission for Health Improvement launched an investigation into the management, provision and quality of health care in GWMH. The

Commission's report was published in May 2002, and set out a number of factors which contributed to a failure to ensure good quality patient care.

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

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

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

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

37. The cases categorised as negligent 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.

38. In Mr Wilson's case, reports have been prepared by both Dr Wilcock (dated 21 May 2006) Dr Black (dated 19 November 2005). In addition, reports have also been prepared by Professor Baker (dated February 2006), the Head of the Department of Health Sciences at Leicester University, and Dr Jonathan Marshall (dated 28 April 2006), a consultant in the Department of Gastroenterology at the Horton Hospital in Banbury.

Dr Barton

39. As part of the police investigation into the fourteen cases which had been reviewed and categorised as negligent, Dr Barton was interviewed under caution in relation to the

death of Mr Wilson. The interview took place on 19 May 2005. Dr Barton was represented by a solicitor, Ian Barker.

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

(1) Dr Barton assessed Mr Wilson on his admission to Dryad on 14 October [p.12];

(2) Her note of the assessment indicates that she was aware that Mr Wilson suffered from congestive cardiac failure [p.12];

(3) Following the assessment, Dr Barton wrote up prescriptions on Mr Wilson's drug chart. She felt it appropriate to provide pain relieving medication, as Mr Wilson was continuing to experience a lot of pain in his arm. Accordingly she prescribed oramorph 10mg, at a dose of 2.5-5mg as needed, four hourly [pp.13-14];

(4) Dr Barton also prescribed diamorphine 20-200mg, hyoscine 200-800mg and midazolam 20-80mg, probably at the time of her initial assessment. She was concerned that a pro-active regime of pain relief should be available in case of a deterioration. Dr Barton expected, in accordance with normal practice, that nursing staff would contact her before commencing the medication, and that they would be commenced at the bottom end of the dose range [pp.14-15];

(5) Dr Barton saw Mr Wilson again on 15 October. She further prescribed oramorph 10mg, four hourly, and a further 20mg at night. The purpose of this was to ensure that Mr Wilson did not experience pain and distress [p.15];

(6) Dr Barton was absent from GWMH on 16 October, and her duties were covered by Dr Knapman. It is not clear whether the syringe driver was commenced on the instructions of Dr Barton (nursing staff may have made contact with her) or Dr Knapman [pp.15-16];

(7) The starting dose of diamorphine 20mg was broadly commensurate with the total of oramorph 50mg which had been administered the previous day [p.16];

(8) It appears that Dr Peters was on duty on 17 October. It is not clear whether the increase of the doses in the syringe driver at 3.50 p.m. was carried out on the instructions of Dr Barton or Dr Peters [p.17];

(9) Dr Peters was also on duty on 18 October. The increases in the doses on that day were prescribed by Dr Peters, and were in excess of the doses which Dr Barton had previously prescribed [p.18].

Witness Statements

41. During the investigation into this matter a number of witness statements have been obtained from members of Mr Wilson's family, and the nursing staff and doctors who cared for him at QAH and GWMH.

42. Gillian Hamblin was a senior sister on Dryad Ward during Mr Wilson's time at GWMH (she left the hospital in May 2003). She has made two witness statements, dated 11 June and 30 September 2005. She states that on his transfer to Dryad Ward, her prognosis in respect of Mr Wilson was that he was being admitted for terminal care. She carried out the initial assessment. The practice was that doctors relied on nursing staff to carry out initial assessments, and would thereafter write up prescriptions on the drug chart. (This account is plainly inconsistent with Dr Barton's recollection of what happened in Mr Wilson's case, and Dr Barton's note of the initial assessment.) She further states that she increased the doses in the syringe driver at 5.15 a.m. and 3.50 p.m. on 17 October, in order to relieve Mr Wilson's pain. The increase in the doses in the syringe driver at 2.30 p.m. on 18 October was prescribed (verbally) by Dr Peters.

43. Dr Knapman has made a statement dated 20 January 2006. He dose not comment on whether he or Dr Barton authorised the commencement of the syringe driver on 16 October.

44. Dr Peters has made a statement dated 21 July 2005. She states that her note concerning nursing staff verifying death was made in the expectation that Mr Wilson would die shortly. He approved the increase in the doses in the syringe driver on 18 October. The increase was in accordance with BNF guidelines. Dr Peters does not comment on the increase in doses on 17 October.

45. Statements have been made by several members of Mr Wilson's family. It is clear that during his time in hospital, he was frequently visited by his wife and children. They recollect that he improved during his stay at QAH, but that he declined rapidly once he had been transferred to GWMH.

The Report of Dr Wilcock

46. 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.

47. Dr Wilcock has reviewed the care provided to Mr Wilson, and prepared a report dated 21 May 2006. His report is the most recent in this case, and he has had sight of the report prepared by Dr Marshall.

48. Dr Wilcock's opinion is that the treatment provided to Mr Wilson by Dr Barton and Dr Knapman was sub-optimal. His opinion may be summarised as follows:

    (1) The medical records detailing the assessments and treatment in respect of Mr Wilson were inadequate [p.37];

    (2) It does not appear that a proper assessment was carried out on Mr Wilson's admission [p.38];

    (3) The doses of oramorph prescribed and administered on 14, 15 and 16 October were likely to have been excessive for his needs. In general, if paracetamol was considered insufficient, the prescription of a weak opioid such as codeine would be appropriate. Some doctors would prescribe small doses of morphine instead. In Mr Wilson's case, an appropriate dose would have been 2.5mg as required, or every 4 hours [pp.38-39, 43];

    (4) The effect of any morphine given to Mr Wilson should have been evaluated over the first 24-48 hours. This was particularly important having regard to his age, and the impairment of his liver and kidneys [p.39];

(5) The prescription of a syringe driver containing diamorphine, midazolam and hyoscine in the case of a patient transferred for 'general mobilisation' is unusual [p.39];

(6) Furthermore, the dose range of diamorphine 20-200mg was inappropriate, and, even at the lower end of the range, was excessive for Mr Wilson's needs [p.40];

(7) Following Mr Wilson's deterioration on 16 October, Dr Knapman did not record having carried out even the most basic observations and assessments [p.40];

(8) However, given Mr Wilson's combination of severe liver and heart failure, his rapid deterioration (prior to the commencement of the syringe driver) was most likely to have been a terminal event, and it was therefore appropriate to focus his care on comfort measures [p.41];

(9) The doses of diamorphine which Mr Wilson received via the syringe driver were likely to have been excessive for his needs. An appropriate dose would have been 10mg. There appears to be no justification for the successive increases in the doses of diamorphine administered [pp.42-43];

(10) The doses of hyoscine, administered in an attempt to improve Mr Wilson's secretions, could not be considered unusual. However, other measures would have been more likely to help [p.42].

49. Dr Wilcock begins his conclusion as follows [p.44]:

'*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 Wilson a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge, illustrated, for example, by the reliance on* [a] *large dose range of diamorphine by a syringe driver rather than a fixed dose along with the provision of smaller p.r.n. doses that would allow Mr Wilson's needs to guide the dose titration. Dr Barton could also be seen as a doctor who breached the duty of care she owed to Mr Wilson by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Wilson by unnecessarily exposing him to receiving excessive doses of diamorphine.*'

50. At the end of his report, Dr Wilcock deals with the effect of the morphine and diamorphine given to Mr Wilson. His opinion in relation to this matter is of significance:

'...Mr Wilson had significant medical problems. His clinical condition was not stable in that his oedema and thus heart failure were worsening over his time in Queen Alexander Hospital, despite the reintroduction of diuretic thereby. In this regard an acute deterioration in Mr Wilson's heart failure would not have been that unusual, whether or not precipitated by a myocardial infarction, and his death was in keeping with severe heart failure and liver failure which combined to cause a rapid irreversible physical decline. Although the dose of morphine may well have contributed to his reduced level of consciousness, either directly or by precipitating a hepatic coma, it is difficult to say with any certainty that the dose of morphine he received would have contributed more than minimally, negligibly or trivially to his death because the heart and liver failure could also have done this. Similarly, although the doses of diamorphine used were likely to have been excessive to his needs, it is difficult to say with any certainty that the dose of diamorphine he received would have contributed more than minimally, negligibly or trivially to his death, because drowsiness/unconsciousness, the one feature of excess opioid seen in this case, is also a feature of the terminal stage of heart failure and liver failure.'

51. Dr Wilcock has also prepared a draft overview, dated 4 September 2006, in relation to Operation Rochester as a whole. In this overview, Dr Wilcock states that it is '*likely*' that Mr Wilson had entered a 'natural' irreversible terminal decline (prior to the relevant acts or omissions on the part of Dr Barton). Dr Wilcock has added the following note of caution to his opinion:

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

The Report of Dr Black

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 Mr Wilson, and prepared a report dated 19 November 2005. His conclusions may be summarised as follows:

(1) The principal underlying medical problem in Mr Wilson's case was his alcoholic liver disease. This was identified in 1997, where, in addition, he appeared to have the indicators of a poor medium to long term prognosis [para.6.2];

(2) In the first seven to eight days at QAH, there was a deterioration in Mr Wilson's renal and liver function. However, after this time there was an improvement in his condition [paras,6.4, 6.5];

(3) On his admission to GWMH, it does not appear that even a basic clinical examination was conducted [para.6.6];

(4) The care which Mr Wilson required at the time of his admission to GWMH was essentially a continuation of the care which was being provided at QAH [para.6.7];

(5) The decision on 15 October to give regular morphine at 50 mg per day is crucial to the understanding of Mr Wilson's condition after that time. The decision to give oral doses at such a high level was negligent. Such doses, particularly in the case of a patient with severe liver disease, were very likely to have severe implications. Instead, weaker analgesics, which had been successfully used at QAH, ought to have been administered [para.6.8];

(6) Mr Wilson's deterioration overnight on 15-16 October may have been the result of heart failure due to salt and water retention. However, his unresponsiveness makes it almost certain that he was suffering a direct cerebral effect of the morphine, or was being precipitated into hepatic encephalopathy (liver failure). This may or may not have been reversible, but he was probably entering into irreversible terminal decline. The opinion of a senior medical practitioner ought to have been sought [para.6.9];

(7) It was reasonable to start the syringe driver at a dose of diamorphine 20mg. The subsequent increases appear to be unjustified. It is not clear if the decision to administer such increases was a medical or nursing decision [para.6.10];

(8) The prescription and administration of morphine on 15 October was the major cause of Mr Wilson's deterioration, in particular in his mental state, on the night of 15-16 October. It is beyond reasonable doubt that these actions contributed more than minimally to Mr Wilson's death [paras.6.11, 7.3].

The Report of Professor Baker

54. Professor Baker is Head of the Department of Health Sciences, and the Director of the Clinical Governance Research and Development Unit at the University of Leicester.

55. Professor Baker has reviewed the care provided to Mr Wilson, and has prepared a report dated February 2006. His conclusions may be summarised as follows:

(1) Mr Wilson had chronic liver dysfunction, but not full blown liver failure. This dysfunction did not cause death. In the presence of other life-threatening conditions, this may have impaired his ability to recover, and it was reasonable to mention it on the death certificate [p.14];

(2) Mr Wilson did not have renal failure. (The abnormalities which tests had revealed at QAH improved with hydration.) [p.14];

(3) Mr Wilson probably had cardiac failure. However, there is no convincing evidence in the records to confirm a diagnosis of myocardial infarction [pp.14-15];

(4) It is possible that Mr Wilson was also suffering from other unsuspected conditions [pp.14-15];

(5) His decline on 16 October was associated with the regular administration of morphine [p.15];

(6) The prescription of a regular dose of morphine 10mg was not appropriate. Other non-opiate or weak opiate medication should have been used first. If such medication had not been successful in relieving pain, a dose of morphine 2.5-5mg would have been reasonable [p.15];

(7) Although Mr Wilson had congestive cardiac failure, his death would have been hastened by opiate administration and the path to death may well have been initiated by the commencement of oramorph on 14 October [p.15];

(8) In judging whether Mr Wilson might, if the oramorph had not been initiated, have eventually left GWMH alive, several qualifications must be made. The medical records are incomplete. It is difficult to predict with certainty the course of recovery that a patient will follow, especially when the patient is elderly and has a complex mix of several serious clinical problems. Furthermore, new and unexpected problems can arise. Bearing in mind these, and other, qualifications, Mr Wilson might have left hospital alive if the oramorph had not been commenced on his admission to Dryad Ward [p.18].

The Report of Dr Marshall

56. Dr Marshall is a consultant at the Department of Gastroenterology at the Horton Hospital in Banbury.

57. He has examined the treatment provided to Mr Wilson, and prepared a report dated 28 April 2006. His conclusions may be summarised as follows:

(1) Mr Wilson was suffering from chronic liver failure in 1997, and it is likely that he was suffering from cirrhosis of the liver as early as 1994. With such cirrhosis and continued alcohol abuse, survival is typically six months to one year. It is arguable, therefore, that by September 1998, Mr Wilson had already exceeded his expected survival time. Mr Wilson was clearly unwell and his life expectancy was short [pp.13, 17];

(2) Mr Wilson entered a terminal phase at or around 16 October [p.13];

(3) The impact of regular morphine is likely to have hastened his decline. Its sedative effects would have worsened his hepatic encephalopathy, causing a rapid deterioration [p.15];

(4) It does not appear that any appropriate steps were taken to monitor the side effects of the oramorph [p.16];

(5) The doses of medication administered via the syringe driver were terminal care doses, and in the case of a patient with advanced liver disease and hepatic encephalopathy, recovery could not be expected. (It is unclear whether this conclusion also relates to the doses of oramorph administered prior to the commencement of the syringe driver) [p.16];

(6) The administration of the high doses of morphine must be considered reckless. It was predictable, in the clinical context of cirrhosis and escalating opiate dosage, that Mr Wilson could not have survived [p.17].

The Legal Framework

58. 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.

59. 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.

60. 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.)

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

62. 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*.

63. 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.*'

64. 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.*'

65. 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.'

66. 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'.

67. 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.

68. 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).

69. 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.

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

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

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

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

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

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

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

71. 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.

72. 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.*'

73. 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

74. Mr Wilson was a 74 year old man who suffered from a number of significant and serious medical conditions. These included heart failure and chronic liver impairment brought about through the misuse of alcohol. It is likely he was also suffering from an impaired kidney function. He was admitted to QAH on 21 September 1998, after suffering a fall at

home. An x-ray revealed that he had a fracture of the greater tuberosity of the left humerus. The fracture was immobilised by a sling, but not fixed by an operative procedure. Mr Wilson received various analgesia, including some doses of morphine. His heart, liver and kidney functions deteriorated, but then, to some degree, improved. However, it was clear that he was not well enough to return home. Accordingly, on 14 October, he was transferred to GWMH, for care and general mobilisation.

75. Once Mr Wilson was transferred, Dr Barton prescribed high doses of oramorph for pain relief. She also prescribed diamorphine, midazolam and hyoscine, to be administered via a syringe driver. Between 14-16 October, Mr Wilson was given several doses of oramorph. On the evening of 15-16 October he suffered a rapid deterioration. At 4.10 p.m. on 16 October, a syringe driver was commenced containing diamorphine and hyoscine. It is unclear whether this was authorised by Dr Barton or Dr Knapman. At 5.15 a.m. on 17 October, the doses in the syringe driver were increased. The doses were further increased at 3.50 p.m., and midazolam was added. It appears that nurse Hamblin authorised these increases, but it is unclear whether there was any medical input from Dr Barton (or any of her colleagues). Dr Peters authorised further increases in the doses at 2.50 p.m. on 18 October. At about 11.40 p.m. that night, Mr Wilson died.

Summary of the Experts' Opinions

76. It is plain that Mr Wilson was suffering from a number of serious medical conditions. Although there is some disagreement in respect of the extent of those conditions, there is general agreement that Mr Wilson was suffering from heart and liver failure, that the prognosis was poor and his life expectancy was short.

77. In respect of the treatment he received at GWMH, there is general agreement in respect of the following matters:

    (1) The initial assessment carried out by Dr Barton at the time of Mr Wilson's admission to Dryad Ward was inadequate;

    (2) The prescription and administration of oramorph in such high doses was unnecessary and inappropriate, and may properly be regarded as reckless and negligent;

(3) Mr Wilson went into terminal decline on the evening of 15-16 October, that is, prior to the commencement of the syringe driver;

(4) The initial doses in the syringe driver may have been appropriate, but the subsequent increases were unnecessary and excessive. However, at this stage, it was appropriate to provide palliative care.

78. There is a significant difference of opinion as to whether the prescription and administration of oramorph caused Mr Wilson's death. The opinions given by the four experts may be summarised as follows:

(1) Dr Wilcock states that death was in keeping with heart and liver failure and, while the morphine may have contributed to Mr Wilson's unconsciousness, it is difficult to say with any certainty that it contributed more than minimally, negligibly or trivially to death. He also states, in his draft overview, that it is likely that Mr Wilson entered the terminal phase naturally;

(2) Dr Black states that Mr Wilson's deterioration was almost certainly the result of the morphine, although he leaves open the possibility that it was caused by heart failure as a result of salt and water retention. However, at the end of his report, he states that it is beyond reasonable doubt that the morphine contributed more than minimally to death;

(3) Professor Baker states that liver failure did not cause death. Death was hastened by the morphine, and may well have been initiated by its administration. He concludes that, but for the morphine, Mr Wilson might have left GWMH alive;

(4) Dr Marshall states that the morphine was likely to have hastened death. He goes on to state that it was predicable that Mr Wilson could not survive as a result of its administration.

Discussion

79. In assessing whether the evidence in this case reveals the commission by Dr Barton, or any of her colleagues, of the offence of gross negligence manslaughter, we have had regard to the following matters:

(1) Whether Dr Barton or any one else breached their duty of care;

(2) Whether any acts or omissions in breach of duty caused death;

(3) Whether any such acts or omissions may properly be characterised as grossly negligent.

80. There is clear evidence that in prescribing and causing to be administered the high doses of morphine prior to Mr Wilson's rapid deterioration, Dr Barton was negligent.

81. There is no evidence that the commencement of the syringe driver was negligent. Mr Wilson was in terminal decline, and it was appropriate to administer palliative care.

82. There is some evidence that the starting dose of diamorphine was inappropriate, but having regard to the expert evidence it could not be proved to the criminal standard that its administration was negligent.

83. There is, however, clear evidence that the authorisation and administration of the increased doses of diamorphine was negligent. Furthermore, it is of concern that in respect of the increases of 17 October, it is unclear whether there was any medical, as opposed to nursing, input.

84. Nevertheless, it is plain that by the time the syringe driver was commenced, Mr Wilson was already in terminal decline. Our view is that, notwithstanding the high doses involved, it could not be proved to the criminal standard that the medication administered via the syringe driver caused death.

85. The essential question in this case is whether the morphine prescribed by Dr Barton, and administered prior to the commencement of the syringe driver, caused Mr Wilson's death. There is a dispute between the experts in relation to this matter. Dr Wilcock's view is that it cannot be said with any certainty that it did cause death. The opinion of the other three experts is, albeit with some apparent equivocation, that it was a significant cause.

86. In analysing this question, we have had regard in particular to paragraph 5.2 of the Code for Crown Prosecutors:

'Crown Prosecutors must be satisfied that there is enough evidence to provide a "realistic prospect of conviction" against each defendant on each charge. They must consider what the defence case may be, and how that is likely to affect the prosecution case.'

87. We have also had regard to the judgment of Lord Bingham C.J. in *R. v. DPP, ex parte Manning* [2001] Q.B. 330. In analysing the proper the evidential test in the Code, he stated, at paragraph 23:

'*In most cases the decision* [whether or not to prosecute] *will turn not on an analysis of the relevant legal principles but on the exercise of an informed judgment of how a case against a particular defendant, if brought, would be likely to fare in the context of a criminal trial before...a jury. This exercise of judgment involves an assessment of the strength, by the end of the trial, of the evidence against the defendant and of the likely defences.*'

88. Having regard to the above, the following matters are of significance to the issue of causation:

(1) If a prosecution was brought, the prosecution could rely on the evidence of Dr Black, Dr Marshall and Professor Baker;

(2) The evidence of all three experts does, however, contain some apparent equivocations in respect of causation, in that

i. other causes of death are left open as possibilities; and
ii. whilst at times the experts refer to the 'certainty' of death being caused by morphine, at others, they appear to refer to the 'likelihood' of this being the case;

(3) The prosecution experts would be cross-examined on these apparent equivocations;

(4) The defence would almost certainly call Dr Wilcock to give evidence (together with any other experts who agreed with his analysis);

(5) Like the prosecution experts, Dr Wilcock is eminent in his field of expertise.

89. In order to prove the offence of gross negligence manslaughter, the jury must be sure that the negligent acts or omissions in question caused death. In the present case, it is our view that, given the conflict of expert evidence which will inevitably arise, a jury is unlikely to be sure about this issue. In our judgment, it is unlikely that a jury will be able to reject Dr Wilcock's opinion as at least a possibility, notwithstanding the fact that three other experts have reached a different conclusion.

90. Although it has had no bearing on our analysis in the present case, it may be of significant to consider the position of Dr Wilcock and Dr Black in relation other cases which have arisen out of Operation Rochester. Both experts have given opinions in relation to those cases. In each case, Dr Black has stated that causation could not be proved to the criminal standard. In this case, Dr Wilcock has stated that causation cannot be proved. This situation would of course have significant consequences if it was proposed that both doctors should be called as prosecution witnesses in a trial involving Mr Wilson's death and any of the other cases on which we have advised.

91. A further question which is necessary to consider in the present case is whether Dr Barton's negligence, if it did cause death, may properly be characterised as grossly negligent. In our opinion, it is possible that her negligence would be considered gross, but we could not express this view with confidence. The following matters are of significance:

    (1) If causation is proved, Dr Barton would have been responsible for an unnecessary and avoidable death;

    (2) However, in prescribing morphine, Dr Barton was attempting to relieve Mr Wilson's pain;

    (3) Furthermore, on any view, Mr Wilson was extremely ill. His prognosis was poor, and his life expectancy was short. It is entirely possible that, had he not been given morphine, he would not have left GWMH alive.

Conclusions

92. 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.

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Louis Mably

27 October 2006

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