OPERATION ROCHESTER

ADVICE

1. Introduction

1.1 On 21st August 1998 Gladys Mabel Richards, aged 91, died.

1.2 At the time of her death Mrs Richards was a patient at the War Memorial Hospital Gosport, Hampshire.

1.3 Following her death, Mrs. Richards' daughters, Lesley Lack and Gillian Mackenzie complained about the standard of care their mother received at the War Memorial Hospital in the days leading to her death.

1.4 A thorough investigation into the events leading to and surrounding Mrs Richards' death has been carried out by the Hampshire Constabulary.

1.5 I have been asked to advise on the question of whether the evidence reveals the commission of any criminal offence by any doctor or member of the

nursing staff who cared for Mrs Richards during the period of her admission to the hospital, and if so, whether there is a realistic prospect of conviction.

1.6 I should say at the outset that after careful consideration of all the materials provided to me I have reached the conclusion that the evidence does not reveal the commission of any criminal offence.

1.7 In reaching my conclusion I have, of course, had regard to the Code for Crown Prosecutors.

2. Background

2.1 Gladys Mabel Richards was born on Code A

2.2 In about 1991 Mrs Richards was admitted to a residential nursing home in the Basingstoke area. In June 1994 she moved to the Glen Heathers Nursing and Residential Home in Lee on Solent in Hampshire.

2.3 By early 1998 Mrs Richards' condition began to deteriorate. It appears that she became increasingly forgetful and she was less able physically. By late July 1998 she had suffered a number of falls.

2.4 On 29th July 1998, Mrs Richards fractured the neck of her right femur and was transferred from the Glen Heathers Nursing Home to the Royal Hospital Haslar, Gosport where she arrived at about 9.00 p.m.

2.5 On 30th July 1998, despite her confused state, the medical staff at the Royal Hospital Haslar considered her suitable for implantation of an artificial hip joint.

2.6 Mrs Richards remained at the Haslar hospital for a further eleven days and appeared to be making a good recovery.

2.7 On 11th August 1998, having been seen by a consultant geriatrician, Mrs Richards was transferred for rehabilitation to the War Memorial Hospital Gosport where she was admitted to the Daedalus Ward.

2.8 Later that day, Mrs Richards was seen by Doctor Jane Barton, the clinical assistant in elderly medicine. Doctor Barton made an entry in the medical case records which was to the following effect:

> *"Impression frail demented lady not obviously in pain*
>
> *Please make comfortable*
>
> *... I am happy for nursing staff to confirm death"*

2.9 Doctor Barton prescribed a number of drugs:

(i) oramorph (an oral morphine preparation) to be administered by mouth at four hourly intervals;

(ii) diamorphine (a powerful opioid analgesic);

(iii) hyoscine (a drug used to reduce secretions);

(iv) midazolam (a sedative).

2.10 On 13th August 1998, Mrs Richards' artificial hip joint became dislocated.

2.11 On 14th August 1998 Doctor Barton arranged for Mrs Richards to be transferred back to the Haslar Hospital where the dislocation of the hip was reduced.

2.12 Following the operation Mrs Richards did not regain consciousness until 1.00 a.m. on 15th August 1998.

2.13 On 17th August 1998, Mrs Richards was returned to the War Memorial Hospital. Her discharge notes from the Haslar hospital refer to the need for 'care for the next four weeks to ensure her progress'.

2.14 It seems that when Mrs Richards was discharged from the Haslar hospital there was not a stretcher available and she was carried to and from the ambulance on a sheet.

2.15 By the time Mrs Richards was seen at the War Memorial Hospital she was very distressed and obviously in pain.

2.16 That afternoon she was x-rayed. This was done to ensure that she had not suffered another dislocation of her hip. Although no dislocation was found it appears that Mrs Richards was clearly in pain.

2.17 On the morning of 18th August 1998 it was discovered that Mrs Richards had developed a massive haematoma around the site of her hip joint.

2.18 Doctor Barton prescribed diamorphine, midazolam, haloperidol and hyoscine to be given continuously subcutaneously by way of a syringe driver over periods of twenty-four hours.

2.19 This subcutaneous administration of drugs continued until Mrs. Richards died on 21st August 1998.

2.20 Doctor Barton gave the cause of death as bronchopneumonia.

2.21 Mrs Richards was cremated.

2.22 Daedalus Ward at Gosport War Memorial Hospital has twenty-four beds. The consultant in charge of the ward was Doctor Lord. She conducts a ward round twice a week and was contactable at other times on the telephone.

2.23 Doctor Barton was the clinical assistant who visited the ward each weekday morning.

2.24 Philip Beed was the clinical manage in charge of the ward.

2.25 On duty at any given time would be five trained staff and eleven health care support workers. Two of the nurses directly involved in caring for Mrs. Richards were Margaret Couchman and Christine Joice.

2.26 A pharmacist, Jean Dalton, would visit once a week and, if necessary, give advice on medication.

3. **Mrs Lesley Lack**

3.1 Mrs Lack, the daughter of Mrs Richards, is a retired Registered General Nurse. In a statement dated 31st January 2000 she provides a narrative of the relevant events and makes a number of observations.

3.2 The statement may be summarised as follows:

(i) Mrs Lack was unhappy with the care her mother had been receiving at the nursing home and had made a decision that her mother would not return there.

(ii) Following the operation on 30th July 1998 she observed that her mother was responding to physiotherapy and that her medication had been reduced. Also, significantly, she was no longer in need of pain relief.

(iii) On 12th August 1998 she was surprised to discover that her mother had been prescribed 'oramoph' for pain relief. She was told that her mother had been displaying anxiety and crying out. Mrs Lack notes that the cause of the anxiety had not been investigated.

(iv) On 13th August 1998 she was informed that her mother had fallen from a chair.

(v) Between 15th August and 17th August 1998, following the operation to manipulate the hip back into place Mrs Lack noticed that her mother appeared to be recovering.

(vi) On her return to the War Memorial Hospital on 17th August 1998 Mrs Lack saw her mother lying in a position which caused her great pain. She notes that, again, the source of the pain was not investigated.

(vii) On 18th August 1998, when the workings of the syringe driver were explained to her she told the ward manager, Philip Beed, "just let her be pain free". She did not agree to her mother being simply subjected to a course of pain relief treatment "which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death".

3.3 It is a feature of Mrs Lack's evidence that she wishes to draw a distinction between the (apparently high) standard of care received at the Haslar hospital and the care received at the War Memorial Hospital. As she says, "the issue I wish to highlight is that when my mother's condition was correctly diagnosed and treated the pain and discomfort were removed and she recovered well".

3.4 It is right to observe that Mrs Lack's statement is based upon notes she kept following her mother's transfer to the War Memorial Hospital on 11th August 1998. These notes were prepared because she had been advised by Lesley Humphrey, the Quality Manager for the Portsmouth Health Care Trust, to whom she had voiced her concerns that complaints should be in writing.

4. **The Evidence of Mrs Gillian Mackenzie.**

4.1 Mrs Gilliam Mackenzie is the elder daughter of Mrs Richards and the sister of Lesley Lack. Mrs Mackenzie's statement is in similar terms to that provided by her sister.

4.2 The matters of significance appear to be as follows:

(i) On 17th August 1998 it was obvious that Mrs Richards was in great pain.

(ii) From 17th August 1998 she and her sister were given a great deal of attention by the ward manager Philip Beed who acknowledged that Mrs Richards was in great pain and that something had to be done.

(iii) Doctor Barton was told that the Haslar Hospital would accept Mrs Richards but her response was that she did not think it right to send her back to the Haslar Hospital.

(iv) On Tuesday 18th August 1998 Philip Beed explained that nothing could be done for Mrs Richards, who had developed a massive haematoma on the site of her hip operation and the only possible means of treating her was to put her on a syringe driver with Diamorphine so that she would have a pain free death.

(v) Both Mrs Lack and Mrs Mackenzie agreed to the course proposed.

(vi) Doctor Barton spoke to the sisters to ask if the use of the syringe driver had been explained to them and went on to mention the possibility of a chest infection developing.

5. Professor Livesley

5.1 Professor Brian Livesley, the University of London's Professor in the Care of the Elderly, has provided a report into the circumstances surrounding Mrs Richards' death.

5.2 In his summary of the relevant facts Professor Livesley draws attention to the following matters:

(i) On 11th August 1998 Doctor Barton prescribed oramorph and large dose ranges of diamorphine, hyoscine and midazolam. These were to be given subcutaneously and continuously over periods of twenty-four hours for an undetermined number of days.

(ii) On 17th August 1998 there is no evidence that Mrs Richards, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover. Despite this on 18th August 1998, Doctor Barton, who did not seek any other medical opinion, prescribed diamorphine, midazolam, haloperidal and hyoscine to be given subcutaneously and continuously over periods of twenty-four hours.

(iii) Neither midazolam nor haloperidal is licensed for subcutaneous administration.

(iv) When the syringe driver was being used to administer the subcutaneous drugs, there is no evidence that Mrs Richards was given fluids or food in any appropriate manner.

(v) There is no evidence that in fulfilling her duty of care Doctor Barton reviewed appropriately Mrs Richards' condition from 18th August 1990 to determine if any reduction in the drug treatment being given was indicated.

(vi) There is no evidence that in fulfilling their duty of care Mr. Philip Beed, Ms. Margaret Couchman and Ms. Christine Joice reviewed appropriately Mrs Richards's condition to determine if any reduction in the drug treatment they were administering was indicated.

(vii) There is, however, indisputable evidence that the subcutaneous administration of drugs by syringe driver continued without modification from 18th August 1998 until Mrs Richards died on 21st August 1998.

(viii) Although Doctor Barton recorded that death was due to bronchopneumonia there is no clinical pathological evidence that this was correct.

(ix) It is beyond reasonable doubt that the death of Mrs Richards was the result of continuous subcutaneous administration of diamorphine, haloperidal, midazolam and hyoscine in the dosages given.

5.3 In Professor Livesley's opinion Mrs Richards was unlawfully killed, by the continuous administration of drugs actively prescribed by Doctor Barton. He

further concludes that Philip Beed, Margaret Couchman and Christine Joice knowingly and continuously administered diamorphine, haloperidal, midazolam and hyoscine to Mrs Richards when they should have recognised the fatal consequences of so doing.

6. **Doctor Barton**

6.1 Doctor Barton is aged 52 (date of birth 19th October 1948). She qualified in 1972 at Oxford University with degrees MA, Bm, BCh. In 1998 she took up the post of clinical assistant in elderly medicine at the War Memorial Hospital on a part time basis.

6.2 On 25th July 2000 Doctor Barton was interviewed under caution at Fareham Police Station. She declined to answer questions but produced a lengthy prepared statement which contained the following points:

(i) upon admission on 11th August, Doctor Barton was of the opinion that, because of her dementia, her hip fracture and her recent major surgery, Mrs Richards was close to death. She scored 2 on the 'Bartel' scale, a measurement of general physical and life skull capability. The maximum available score is 20;

(ii) she wrote a prescription for a number of drugs which would allow the nursing staff to respond to Mrs Richards' needs based on their own clinical assessment;

(iii) the oramorph given was an appropriate level of pain relief after such a major orthopaedic procedure;

(iv) when she was transferred back to the War Memorial Hospital on 17th August 1998 Mrs Richards had been on intravenous morphine until shortly before her transfer. This was not known to Doctor Barton at the time but in her opinion it explains Mrs Richards's apparent peacefulness upon transfer;

(v) she was preparing to see Mrs Richards's daughters to explain to them what she believed to be Mrs Richards's inevitable decline;

(vi) by 18th August 1998 there had been a marked deterioration from when she had first seen the patient on 11th August; her condition confirmed Doctor Barton's view that she was dying she was "barely responsive and was in a lot of pain";

(vii) she confirms that she spoke to the daughters who reluctantly agreed to the diamorphine administered by syringe driver; she state that "this drug, the dose used and this mode of administration are standard procedures for patients who are in great pain but who cannot safely take medicines by mouth";

(viii) to administer fluids would have been inappropriate on the grounds that it would have caused Mrs Richards further pain and distress;

(ix) she considered that a further transfer of such a frail unwell elderly lady was not in her best interests and would have been inappropriate;

(x) on the morning of 19th August 1998, she considered that Mrs Richards had a "rattly" chest and had developed bronchopneumonia; that is why she described hyoscine;

(xi) there was no significant change in Mrs Richards's condition when she saw her on 20th August 1998;

(xii) following Mrs Richards's death she discussed the case with the Coroner's Officer, a police officer at Casham Police Station. The death certificate was signed giving the cause of death as bronchopneumonia. The Coroner's Officer was satisfied that no further investigation was required.

6.3 In conclusion, Dr. Barton states the following:

"*At no time was any active treatment of Mrs Richards conducted with the aim of hastening her demise. My primary and only purpose in administering the Diamorphine was to relieve the pain which Mrs Richards was suffering. Diamorphine can in some circumstances have*

an incidental effect of hastening a demise but in this case I do not believe that it was causing respiratory depression and was given throughout at a relatively moderate dose"

"Similarly it was not my intention to hasten Mrs Richards' death by omitting to provide treatment for example in the form of intravenous or subcutaneous fluids. By the 18th August it was clear to me that Mrs Richards was likely to die shortly. I believed that transfer to another hospital where she would be in a position to receive intravenous fluids was not in her best interests as it would have been too much of a strain and brought about a premature demise. There is clear evidence that the administration of intravenous or subcutaneous fluids would not have prolonged her life and faced with the complications which could arise such intervention was not in her best interests".

"I explained the position to Mrs Richards' daughters, they did not appear to demur at the time and indeed at no time requested a second opinion".

7. **Philip Beed**

7.1 Philip Beed is now aged 38 (date of birth 21st March 1963).

7.2 At the time of these events in question he was the Clinical Manager in charge of Daedalus Ward at Gosport War Memorial Hospital.

7.3 He has been a nurse for twenty years and has considerable experience of working with elderly patients.

7.4 Mr. Beed was interviewed under caution on 24th July 2000. The effect of what he had to say in interview may be summarised as follows:

(i) The use of a syringe driver is usually, but not always, a signal that palliative care is being instituted.

(ii) Palliative care is concerned with making sure that someone who is dying is comfortable, pain free, clean and dignified.

(iii) A syringe driver works by delivering a dose of soluble medicine subcutaneously over a twenty-four hour period. It is used most commonly for pain control, sedation and control of secretions, most often in the case of patients receiving palliative care. It is used to provide a continuous amount of pain relief.

(iv) With experience, it is fairly easy for the medical and nursing staff to recognise when someone is dying.

(v) There was a great deal of trust between Beed and Doctor Barton. Doctor Barton would visit the ward each weekday morning for about twenty to thirty minutes. If a particular patient needed to be seen she

would be examined but Doctor Barton would not see every patient every day, only those identified by the nurses as requiring attention. The doctor relied on the nurses' judgment.

(vi) When Mrs Richards was first admitted on 11th August she was very confused and very agitated. She was also clearly in pain.

(vii) On 14th August it was clear from an x-ray that Mrs Richards had dislocated her hip. Beed was aware that Mrs Lack was angry about the fact that her mother had dislocated her hip and that there had been a delay in having the injury x-rayed and treated. Beed envisaged problems with Mrs Richards and her family.

(viii) Following her return from the Haslar hospital Mrs Richards was in pain and distress. She was refusing to eat or drink and it was agreed with the family that the priority was to keep Mrs Richards pain free and comfortable.

(ix) There appeared to be some sort of dispute between the daughters.

(x) The pain control was keeping Mrs Richards comfortable but she was still not eating or drinking.

(xi) On 18th August Mrs Richards was reviewed by Doctor Barton who was of the view that she was too frail to be transferred to the Haslar

Hospital and that a syringe driver should be used so that continuous analgesia could be given to keep Mrs Richards comfortable.

(xii) The family agreed to this course which was started at 11.30 a.m. that morning. It quickly established a level of pain control which allowed staff to look after Mrs Richards's property and keep her clean and dignified.

(xiii) Mrs Richards was not given fluids because studies have shown that there is little benefit in giving fluids in those situations.

(xiv) Mrs Richards was monitored regularly between the 17th August and her death. Despite the fact that Mrs Richards appeared to be pain free, the dosages were kept at the same level, as is common practice with a patient who will not recover. Mrs Richards was such a patient.

(xv) The overall picture was of a lady in severe pain and death was likely within a short time.

(xvi) The doses she was on were not the maximum and the drugs prescribed were appropriate. Although Midazolam is not licensed for subcutaneous use, it is commonly used in that way in palliative care.

(xvii) Doctor Barton recorded the death as bronchopneumonia and certainly Mrs Richards had a very rattly chest.

7.5 Mr. Beed is clearly of the view that Doctor Barton's assessment of Mr. Richards's condition was correct. He also states that he would know if something was not proper. It is also significant that before 21st August Mr. Beed was aware that Mrs Lack wanted to make a complaint about the occasion when her mother had fallen from her chair. He facilitated and assisted in the making of the complaint.

7.6 Beed finds it puzzling that Mrs Mackenzie and Mrs Lack are now asking a great many questions which they had every opportunity to ask at the time. He states that he spent a good deal of time with them answering their questions and the amount of time he and the other nurses spent with the family made it difficult to keep the nursing records up to date.

8. **Margaret Couchman**

8.1 Margaret Couchman is now aged 65 (date of birth 16th November 1935).

8.2 At the time of the events in question she was an E grade Staff Nurse on Daedalus Ward and had worked there for twelve years.

8.3 She was interviewed under caution on 29th June 2000.

8.4 Her account of events may be summarised as follows:

(i) Mrs Richards was totally dependent at the time of her admission and her score on the Bartel scale indicated that she was a very high risk patient.

(ii) On her re-admission to the ward on 17th August she was told by one of the support workers, Linda Baldacchino that Mrs Richards appeared to be in pain.

(iii) She spoke to Philip Beed and the daughters who agreed that Mrs Richards should be given Oramorph.

(iv) As far as she was concerned the daughters' only concern was that their mother should not be in any pain.

(v) A drug would not be administered if the nursing staff did not consider it necessary even if told to do so by a doctor.

(vi) When Mrs Richards was put on the syringe driver Mrs Couchman's impression was that she was not dying. She drew the conclusion that Mrs Richards was dying a couple of days before she did, in fact, die.

(vii) By the time Mrs Couchman realised that Mrs Richards was dying the patient was very poorly, with a chest infection.

(viii) The drugs administered by the syringe driver were quite low doses and were quite a common combination.

(ix) The only circumstances in which nursing staff would not give food or drink to a patient would be when it would harm them. For example, if they were unable to swallow, or if it was thought that there was a possibility that it would get into their lungs and kill them.

(x) Fluids can be administered by intravenous drips but such drugs were not used on Daedalus Ward. Fluids can also be administered subcutaneously but at that time that was at the practice on Daedalus Ward, or indeed anywhere in the Trust. However, if a patient were dying, fluids would probably not be administered. There is a body of medical opinion which suggests that people who are dying may be more comfortable without the subcutaneous administration of fluids.

(xi) Mrs Couchman was aware that the daughters were intending to sue the nursing home at which Mrs Richards had broken her hip and bent over backwards to prevent a complaint.

(xii) It was only much later following the death that the daughters said they were unhappy with the standard of nursing care their mother had received on the ward. Mrs Mackenzie had given members of the nursing staff presents to thank them for what they had done and Mrs Richards' easy chair was presented to the ward as a present.

8.5 It is clear from the interview that Mrs Couchman believes that Mrs Richards was cared for in an appropriate and dignified manner. She makes no criticism of Doctor Barton or Philip Beed.

9. **Christine Joice**

9.1 Christine Joice is aged 50 (date of birth 17th December 1950).

9.2 She qualified as a Registered General Nurse in 1989. Since 1989 she has worked almost solely in the care of the elderly.

9.3 She was interviewed under caution on 15th June 2000. The effect of what she had to say may be summarised as follows:

(i) The syringe driver is used to administer morphine in lots of cases; it is the best option for relieving pain when patients are near to death.

(ii) Doctor Barton would prescribe the medication.

(iii) Mrs Richards was very poorly when she was admitted although Mrs Joice was not involved with her very much as she wasn't one of her patients.

(iv) She spoke to the daughters on a few occasions and was aware that they were not happy with the treatment their mother was receiving.

(v) When Mrs Richards was re-admitted on 17th August se was very ill. Mrs Joice was of the opinion that the daughters had a different view of their mothers' health from that of the nursing staff. They believed that she could do a lot more than she actually could. The nursing staff found that she could not eat or drink and could hardly stand up, despite what had been written on the transfer notes from the Haslar Hospital.

(vi) The syringe driver was an appropriate way of administering the drugs and the dosages were the bare minimum.

(vii) The course of treatment was appropriate for someone in pain and for whom nothing more could be done except to make them comfortable.

(viii) Although on 18th August and 21st August when the drug charts show oral medication, Mrs Joice confirms that, in fact, no oral medication was given.

(ix) Mrs Richards was given a course of palliative care to make her more comfortable. On 18th August Mrs Joice made an entry in the nursing notes that Mrs Richards was peaceful and sleeping. Her daughter was upset and angry about her mother's condition but appeared to be happy that her mother was pain free.

(x) On 21st August at 12.13 p.m. Mrs Joice made an entry in the notes stating that 'patient's overall condition deteriorating, medication keeping her comfortable, daughters visited during morning'. Mrs Joice states that although there had been a change in condition, she felt no need to contact Doctor Barton or Philip Beed. She did not think that there was anything that could have been done at that stage to alter the fact that Mrs Richards was dying.

9.4 In summary Mrs Joice's impression of Mrs Richards is that, from the beginning of her admission, she was in pain, suffering from dementia and was very poorly. She states that each patient was constantly assessed by the nursing staff. She believes that Mrs Richards was properly cared for and makes no criticism of Doctor Barton.

10. **Other Members of Staff**

10.1 In the course of a very detailed investigation each of the health care support workers and nurses who worked on Daedalus Ward and had dealings with Mrs Richards have been interviewed under caution.

10.2 It is not necessary to deal with what each has to say in any great detail. The effect of the interview may be summarised in this way:

(i) Mrs Richards was very frail at the time of her admission.

(ii) Mrs Richards received the care appropriate for her condition.

(iii) No criticisms are made of Doctor Barton.

(iv) No criticisms are made of the use of the syringe driver or of the drug regime to which Mrs Richards was subject.

10.3 For example Linda Baldacchino, aged 51, a health care support worker recalls that Mrs Richards was very frail and received the best of treatment. She states that the daughters did not complain about the use of the syringe driver and, in fact, Mrs Mackenzie left on good terms. She saw Mrs Richards on 20th August and in her opinion she was dying. She describes Doctor Barton as caring, kind and sensitive.

10.4 Jennifer Brewer, aged 54, is an E Grade Staff Nurse with twenty-five years experience. She describes Mrs Richards as severely demented and very frail. She wanted Mrs Richards to be kept in bed but says that the nursing staff gave in to her daughters and put her in a chair from which she later fell. She goes on to say:

> *"I think that Mrs Richards got the best care we could have given but I felt that she fell on the floor or was on the floor because she wasn't safe in the chair and I feel that some of our work was disrupted by the daughters' view of her mother's condition".*

She also states that Doctor Barton had the welfare of the patient as her highest priority.

10.5 Sylvia Griffin, aged 62, a nurse since 1972 says that her perception of Mrs Richards was that she was someone who was dying and the treatment she received was a way of making her death as pain free and comfortable as possible. The problem with giving drink or food to Mrs Richards was that she might choke or alternatively not be able to absorb it. She makes no criticism of the treatment.

10.6 Christina Tyler, aged 49, a health care support worker states that Mrs Richards was unwell and had a chest infection.

10.7 There are other examples of comments from nurses and health care support workers which suggest that Mrs Richards was dying.

11. **Jean Dalton**

11.1 Jean Dalton, aged 48, was the pharmacist at the War Memorial Hospital. She was interviewed under caution on 18th July 2000.

11.2 The effect of her interview may be summarised quite briefly. She states that the drugs administered to Mrs Richards were all stock items used routinely in palliative care. She does not criticise the use of the syringe driver or the

amount of drugs prescribed. In the case of the drugs not licensed for subcutaneous use she states that it is accepted throughout the United Kingdom that they are used as they were in this case.

12. **Doctor Lord**

12.1 Doctor Lord, aged 46, was interviewed under caution on 27th September 2000. She has been a consultant geriatrician for over eight years.

12.2 Doctor Lord describes Doctor Barton as dependable and sensible and makes no criticism of her treatment of Mrs Richards.

12.3 In Doctor Lord's opinion the syringe driver is better for the continuous control of pain and it is a matter of clinical judgment as to what drugs are prescribed. She agrees that palliative care is the beginning of the end the aim is to keep patient as comfortable as possible.

12.4 Doctor Lord does not think that the drugs prescribed would have been the direct cause of death. She considers that chest infections are always a risk when people are sedated. She also states that transfer or movement can have a significantly detrimental effect on a patient.

12.5 Significantly, Doctor Lord does not criticise the actions of Doctor Barton or any of the nursing staff. She also states that although Midazalam is not licensed for subcutaneous use it is good practice to use it. Her clinical

impression from her consideration of the medical records and discussions is that Mrs Richards was dying.

13. **The Legal Framework**

13.1 Before considering the case law on gross negligence manslaughter, it may be helpful to deal with negligence as a fault term denoting criminal responsibility.

13.2 Responsibility for some crimes may be incurred by the mere neglect to exercise due caution, where the mind is not actively at fault. This is inadvertent negligence.

13.3 This is to be contrasted with recklessness, as that term is commonly understood, which involves advertence.

13.4 Where negligence is a sufficient basis to incur criminal liability it obviously follows that the crime can also be committed recklessly.

13.5 In the law of tort negligence has an objective meaning. It signifies a failure to reach the objective standard of the reasonable man, and does not involve any enquiry into the mental state of the tortfeasor.

13.6 The same rule applies in the criminal law. A person may be held guilty of negligence although he did not foresee the risk of harm.

13.7 The 'objective' determination of negligence is necessary because if the notional reasonable man, by whom the defendant is judged, is invested with every characteristic of the defendant the standard disappears: the reasonable man would have acted in the same way as the defendant acted. The only exception to the general rule is that children are not subject to the standard of adults; they need show only the standard to be expected of a child of a particular age.

13.8 Where a person causes death through extreme carelessness or incompetence, the law of gross negligence manslaughter is applied. Manslaughter is one of the few remaining crimes that is satisfied by a finding of negligence, though the negligence must be gross. Frequently the defendants in such cases are people carrying out jobs that require special skills or care, who fail to meet the standard which could be expected from them and cause death.

13.9 The early case law indicated that to cause death by any lack of care whatsoever would amount to manslaughter. This was consistent with early development of the law which was more ready to recognise strict liability as a basis for criminal culpability (see *Andrews v. Director of Public Prosecutions* [1937] AC 576 at 582 per Lord Atkin).

13.10 The development of the modern law can be traced to cases in the nineteenth century in which judges began to use the language of 'gross negligence'. Exemplifying this approach is the decision in *R v. Finney* (1884) 12 Cox CC 625 where the accused, an attendant at a mental hospital caused the death of a

patient by releasing a flow of boiling water into a bath. He was not found guilty of manslaughter even though he made no visual check to see if his patient had left the bath at the time he put the water into it. The evidence fell short of establishing the abject failure of care necessary to justify a finding of gross negligence.

13.11 It is clear that the law was concerned to ensure that a higher degree of fault ought to be necessary to incur criminal liability for manslaughter than that sufficient for civil liability for negligence.

13.12 In *R v. Bateman* (1925) 19 Cr.App.R. 8 the Court of Criminal Appeal held that gross negligence manslaughter involved the following elements:

(i) the defendant owed a duty of care to the deceased;

(ii) the defendant breached his duty;

(iii) the breach caused the death of the deceased;

(iv) the negligence or incompetence of the accused was gross, that is, it showed such a disregard for the life and safety of others as to amount to a crime and deserve punishment.

13.13 It is interesting to note that the test was criticised on a number of grounds. First, that it is circular, secondly, that it is uncertain and thirdly, because so

much is left to the judgment of the jury, it is prone to inconsistent applications. In *Andrews v. Director of Public Prosecutions* [1937] A.C. 583, Lord Atkin favoured "recklessness" as an explanation of gross negligence in manslaughter except that he thought that:

> "*.. it is probably not all-embracing for 'reckless' suggests an indifference to risk whereas the accused may have appreciated the risk and intended to avoid it and yet shown such a high degree of negligence in the means adopted to avoid the risk as would justify a conviction.*"

13.14 Although not without difficulty in application, the *Bateman* test (as explained in *Andrews*) was applied in all cases of manslaughter involving negligence until in *R v. Seymour* [1983] 2 AC 493, Lord Roskill, speaking for the House of Lords, took recklessness to be the most suitable term to express the kind of culpability required for liability. The recklessness referred to was of the kind identified in *Caldwell* [1982] AC 341 and *R v. Lawrence* [1982] AC 510, thus an accused would be liable if his conduct had given rise to an obvious and serious risk of physical harm, a risk which he had either foreseen or which he had failed to give any thought. The *Caldwell* and *Lawrence* test involves a consideration of whether the risk would have been obvious to a reasonable man and appears to admit of no exceptions. For example, in *Elliott v. C* (1983) 77 Cr.App.R. 103, a girl of 14 with learning difficulties who had not slept all night wandered into a shed, poured white spirit on the floor, and dropped lighted matches on it. The shed was destroyed. The accused did not

know about the inflammable properties of white spirit. The Divisional Court held that she should nonetheless be convicted of criminal damage, since she should be judged on the basis of whether the risk would have been obvious to the reasonable adult. The Court held that it was bound by precedent and unable to modify the test either for her age or for her mental condition. In *R v. Stephen Malcolm R* (1984) 79 Cr.App.R. 334, the Court of Appeal was invited to amend the test to "an ordinary prudent person of the same age and sex as the defendant" but it felt unable to do so. There are dicta in *R v. Reid* (1993) 95 Cr.App.R. 391 which suggest that modifications can be made to the reasonable man ("afflicted with illness or shock": Lord Goff; "reasonable misunderstanding, sudden disability or emergency": Lord Browne-Wilkinson; "capacity to appreciate risks adversely affected by some condition not involving fault on his part": Lord Keith).

13.15 Although there was dissatisfaction with the rigour of the *Caldwell/Lawrence* test, the principle in *Seymour* was applied fairly consistently by the courts until the decision of the House of Lords in *R v. Adomako* [1995] 1 AC 171. The accused, an anaesthetist, was acting as such during an eye operation, which involved paralysing the patient. A tube became disconnected from a ventilator. The patient suffered a cardiac arrest and subsequently died. The accused was convicted and his appeal to the Court of Appeal, on the question of the true legal basis of involuntary manslaughter by breach of duty, was dismissed.

13.16 The House of Lords was asked to answer the following certified question:

> *"in cases of manslaughter by criminal negligence not involving driving but involving a breach of duty is it a sufficient direction to the jury to adopt the gross negligence test ... without reference to the test of [Caldwell recklessness] ..."*

13.17 Lord Mackay of Clashfern LC, disapproved the dictum of Lord Roskill in *Seymour* (although the decision was not expressly overruled) and held that *Bateman* gross negligence was the appropriate test in manslaughter cases involving a breach of duty (and also in cases of motor manslaughter). In describing the test for gross negligence manslaughter he said:

> *"...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.

13.18 Lord Mackay acknowledged that the test involved an element of circularity but 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".*

13.19 The conviction for gross negligence manslaughter was confirmed in *Adomako's* case. The evidence revealed that he had failed for eleven minutes or so to identify the cause of the patients' 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 of the prosecution was to the effect that the standard of care was 'abysmal' and 'a gross dereliction of care'.

13.20 In the course of his speech in *Adomako*, Lord Mackay did not exclude recklessness as a basis for liability:

"I consider it perfectly appropriate that the word reckless should be used in cases of involuntary manslaughter, but as Lord Atkin [in Andrews v. DPP] put it 'in the ordinary connotation of that word'. Examples of which this was done, to my mind with complete accuracy are Reg. v. Stone [1977] Q.B. 354 and Reg. v. West London Coroner, Ex parte Gray [1988] Q.B. 467."

13.21 The statements said to define recklessness, 'with complete accuracy', in the ordinary connotation of the word are as follows:

(i) indifference to an obvious risk and appreciation of such risk, coupled with a determination nevertheless to run it (*Stone*, supra, p.363E-F);

(ii) to act recklessly means that there was an obvious and serious risk to the health and welfare of [the victim] to which [the accused], having regard to his duty, was indifferent or, recognising that risk to be present, deliberately chose to run the risk by doing nothing about it. It should be emphasised, however, that a failure to appreciate that there was such a risk would not by itself be sufficient to amount to recklessness (*Ex parte Gray*, supra, p.447A-B).

13.22 In *Attorney-General's Reference (No.2 of 1999) (unreported 15th February 2000)* further consideration was given to the basis of liability for gross negligence manslaughter. One of the questions referred by the Attorney-General to the Court of Appeal under section 36 of the Criminal Justice Act

1972 was: 'Can a defendant be properly convicted of manslaughter by gross negligence in the absence of evidence as to the defendant's state of mind?'. In giving the judgment of the Court of Appeal, answering the question posed in the positive, Rose LJ stated:

> *"...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 his state of mind is not a pre-requisite to a conviction for manslaughter by gross negligence. The Adomako test is objective, but a defendant who is reckless [as defined in Stone and Dobinson [1977] QB 354] may well be more readily found to be grossly negligent to a criminal degree".*

13.23 *Stone and Dobinson* was a decision of the Court of Appeal in which Lord Lane CJ stated that *"where a defendant had undertaken a duty of care for the health and welfare of an infirm person the prosecution had to prove a reckless disregard of danger to the health and welfare. Mere indifference is not enough. The defendant must be proved to have been indifferent to an obvious risk of injury to health and actually to have foreseen the risk but to have determined nevertheless to run it".*

13.24 The basis of liability for gross negligence manslaughter was further considered in *R v. Director of Public Prosecutions, Ex parte Jones (23rd March 2000) (unreported)*. The case involved a challenge to a decision not to prosecute in a case in which it was alleged a death had been caused by gross negligence.

13.25 The facts of *Ex parte Jones*, in summary, were as follows. The deceased died as a result of an accident which occurred during the course of his employment. Following the death, the Crown Prosecution Service considered the potential liability of the employer, a company called Euromin, and Mr. Martell its Managing Director. In considering the question of criminal culpability the personal perceptions of Mr. Martell had been taken into account and it was the lack of subjective recklessness which had led to the conclusion that there was no realistic prospect of conviction.

13.26 In giving the judgment of the Divisional Court, Buxton LJ stated:

> *"The law is, therefore, quite clear. If the accused is subjectively reckless, then that may be taken into account by the jury as a strong factor demonstrating that his negligence was criminal, but negligence will still be criminal in the absence of any recklessness if on an objective basis the defendant demonstrated what, for instance, Lord Mackay quoted the Court of Appeal in Adomako as describing as:*
>
> *"... failure to advert to a serious risk going beyond mere inadvertence in respect of an obvious and important matter which the defendant's duty demanded he should address".*
>
> *That is a test in objective terms".*

13.27 It is significant to note that in *Ex parte Jones*, the decision not to prosecute appeared to the Court to have been taken on the basis that subjective recklessness was the sole basis of liability for gross negligence (the reasoning which led to the decision not to prosecute was expressed as follows: 'a jury must be satisfied that the *defendant* by his negligence *showed* such disregard for the life and safety of others as to amount to a crime against the state and conduct deserving punishment').

13.28 It was argued on behalf of the Director that the Crown Prosecution Service had been entitled to take into account Mr. Martell's lack of subjective recklessness on two bases:

(i) if there was subjective recklessness a conviction for criminal manslaughter was easier to obtain;

(ii) without subjective recklessness there was no realistic prospect of conviction.

13.29 The difficulty with this argument was that it was perceived by the Divisional Court to be an *ex post facto* rationalisation of the decision not to prosecute.

13.30 It is significant to note that the Divisional Court, in rejecting the argument, did not say that the absence of subjective recklessness was irrelevant to the question of whether there was a realistic prospect of conviction.

13.31 In *R v. Lidar* [2000] Archbold News 4, the Court of Appeal held that the appropriate direction to the jury, in a case of gross negligence manslaughter by conscious risk-taking, was one framed by reference to recklessness. What has to be proved is an obvious risk of serious harm from the defendant's conduct objectively assessed and an indifference to that risk on the part of the defendant, or foresight thereof plus a determination nevertheless to run it. The facts of the case were that the defendant drove a motor vehicle with the victim hanging from the window with his body half in the car. The victim then fell from the car and suffered fatal injuries. One of the issues was whether self-defence could ever be a defence to gross negligence manslaughter "*because the defendant can only be guilty of the gross negligence offence if the jury is satisfied that his conduct fell sufficiently short of what a reasonable man would have done, placed as the defendant was*".

13.32 In referring to the speech of Lord Mackay in *Adomako*, Evans L.J. stated that the decision of the House of Lords did not suggest that for the future 'recklessness' could no longer be a basis for proving the offence of manslaughter rather, the opposite. He then went on to state:

> *"Indeed, in such a case as the present, we find it difficult to understand how the point of criminality can be reached, where gross negligence is alleged, without identifying the point by reference to the concept of recklessness as it is commonly understood; that is to say whether the driver of the motor vehicle was aware of the necessary degree of risk of serious injury to the victim and nevertheless chose to disregard it, or*

was indifferent to it. If the gross negligence direction had been given, the recklessness direction would still have been necessary. The recklessness direction in fact given [by the judge] made the gross negligence direction superfluous and unnecessary."

14. **Mens Rea**

14.1 The mens rea or culpability element in manslaughter is gross negligence. As negligence is the omission to do something which a reasonable man would do or doing something within a prudent and reasonable man would not do, the only mental element will often be the intention to do the act or to omit to do the act in question.

14.2 In *R v. Prentice* 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:

(i) indifference to an obvious risk of [death];

(ii) actual foresight of the risk [of death] coupled with an intention nevertheless to run it;

(iii) 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;

(iv) 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.

(The Court of Appeal's formulation has been amended to take into account Lord Mackay's observation that the 'risk' in each case must be an obvious risk of death and not merely injury to health.)

14.3 In *Adomako* Lord Mackay cited with approval the observations of Lord Hewart CJ in *Bateman*:

> *"In [a] civil action, if it is proved that A fell short of the standard of reasonable care required by law, it matters not how far he fell short of that standard. The extent of his liability depends not on the degree of negligence but on the amount of damage done. In a criminal court, on the contrary, the amount and degree of negligence are the determining question. There must be mens rea".*

14.4 The reference to mens rea is however not entirely helpful. 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 defendant should foresee the risk that the actus reus might occur.

Negligence involves an objective assessment of an objectively recognisable risk.

14.5 Even though negligence permits the finding of fault for inadvertent wrongdoing it does not require inadvertence. An accused will not be excused by suggesting that his actions were reckless or intentional rather than negligent. The lesser fault standard incorporates the greater and a defendant cannot exculpate himself by pleading that he acted intentionally or recklessly.

15. **Summary of the Authorities**

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

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

(ii) 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;

(iii) 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 his state of mind is not a pre-requisite to a conviction for manslaughter by gross negligence;

(iv) 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;

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

(vi) the defendant 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.

15.2 While there can be no doubt that the test for liability is an objective one, it cannot be the case that the personal awareness of the risk of death on the part of the accused is irrelevant. If it were irrelevant it would lead to the conclusion that evidence of such awareness was inadmissible. "*The main general rule governing the entire subject of evidence is that all evidence which is sufficiently relevant to an issue before the court is admissible and that all that is irrelevant, or insufficiently relevant should be excluded*" Cross and Tapper, 9th Edition, page 55. In *R v. Sandhu* [1995] Crim.L.R. 288, a conviction was quashed where the prosecution proved a mens rea element which was more than was necessary to prove the offence. [The case concerned an offence of strict liability which the prosecution proved had been

committed intentionally by the accused. The conviction was quashed because to adduce evidence which went beyond proof of the elements of the offence was objectionable and prejudicial.]

15.3 If, as is clearly the case, the prosecution adduce evidence of recklessness, it must follow that an accused is entitled adduce evidence which might excuse his conduct.

15.4 The test for liability remains objective, but it is necessary to look at the situation in which the defendant found himself. As Evans L.J. expressed it in *Lidar*:

> "*the defendant can only be guilty of the gross negligence offence if the jury is satisfied that his conduct fell sufficiently short of what a reasonable man would have done, placed as the defendant was.*"

15.5 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.

15.6 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 *R v. Prentice* [1994] QB 302, one of the linked appeals heard by the Court of Appeal together with *Adomako*. 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 *Lawrence* direction on recklessness. As noted above the *Lawrence* direction involved only a consideration of 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".*

15.7 Lord Taylor went on to identify the excuses and mitigating circumstances of the case which included the individual doctors' experience and subjective belief.

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