OPERATION ROCHESTER

Re Arthur Cunningham

Draft ADVICE

Introduction

1. On 26 September 1998, Arthur Denis Brian Cunningham (known as Brian Cunningham), aged 79, died.

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

3. The cause of death was given as bronchopneumonia.

4. During his time on Dryad Ward, Mr Cunningham was treated on a day to day basis by Dr Jane Barton, a Clinical Assistant in Elderly Medicine. Dr Barton is now aged 57 (date of birth Code A).

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

6. We have been asked to advise on the question of whether the evidence reveals the commission of any criminal offence by Dr Barton, and if so, whether there is

a realistic prospect of conviction. The criminal offence to be considered is gross negligence manslaughter.

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

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

Background

9. Mr Cunningham was born on Code A

10. He married in the 1970s, and in the 1980s he and his wife moved to the Gosport area. His wife died in 1989. During the later years of his life, Mr Cunningham lived in various rest homes, the last one being the Thalassa Nursing Home in Gosport.

11. By 1998, Mr Cunningham was a frail elderly man with a number of significant medical problems. For a number of years he had been in and out of hospital. In particular, he had for many years suffered from Parkinson's disease, and suffered pain in his back from an old war wound (for which he received maximal doses of weak opioids). In addition, he had long-term problems relating to constipation and an abnormal full blood count (leaving him susceptible to infections and blood clots). He also suffered from diabetes and depression. His various illnesses meant that he had difficulty walking, and he used a stick and sometimes a scooter.

Gosport War Memorial Hospital

Overview

12. GWMH is a 113 bed community hospital managed by the Fareham and Gosport Primary Care Trust. Between 1994 and 2002 it was part of the Portsmouth Health Care NHS Trust. The hospital is designed to provide continuing care for long-stay elderly patients. It is operated on a day to day basis by nursing and support staff. Clinical expertise is provided by visiting General Practitioners, Clinical Assistants and Consultants. Elderly patients are usually admitted to GWMH by way of referral from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Mulberry Ward

13. On 21 July 1998, because of his difficult behaviour, Mr Cunningham was admitted to Mulberry Ward at GWMH under the care of Dr Victoria Banks, a consultant in old age psychiatry. Mulberry Ward is a long-stay elderly mental health ward at GWMH. It was believed that Mr Cunningham's behaviour was attributable to a combination of depression and dementia, and the purpose of the admission was for an assessment of his physical and mental wellbeing.

14. The cause of Mr Cunningham's abnormal full blood count was diagnosed as probable myelodysplastic syndrome. (Myelodysplastic syndrome is a disorder of the stem cells in the bone marrow which reduces the effective production of various types of blood cells. Those affected typically suffer from anaemia, reduced immunity to infection or an increased risk of bleeding. 30%-40% of patients die of bleeding or infection. In 20%-40% of patients it transforms into leukaemia.) By 26 August, however, Mr Cunningham's blood count was stable.

15. During his stay on Mulberry Ward, Mr Cunningham was commenced on an anti-depressant. His mood remained unstable, particularly at night, and on 17 August he was commenced on carbamazepine, an anti-epileptic drug. The following night he was given a sedative after becoming confused with paranoid and delusional ideas. On 19 August, an anti-psychotic drug was administered.

16. Mr Cunningham also developed a pressure sore, and had two urinary tract infections. He further developed renal impairment, although his renal function improved over time.

17. On 27 August, Dr Althea Lord assessed Mr Cunningham and came to the view that he had generally improved since his admission. He was discharged the next day and returned to the Thalassa nursing home. On 11 September, it was noted by a community psychiatric nurse that Mr Cunningham had settled back well at the nursing home, and that there were no management or behavioural problems.

Dolphin Day Hospital

18. On his discharge from Mulberry Ward, Mr Cunningham received follow-up care at the Dolphin day hospital in Gosport. On 17 September, it was noted by staff at the hospital that he would not wake after a rest on the bed and was refusing to talk, drink or swallow medication. He expressed a wish to die.

19. On 21 September, Mr Cunningham was seen at the day hospital by Dr Lord. She noted that he was still suffering from sores, depression, an element of dementia and urinary retention, as well as his long standing diabetes, Parkinson's disease and back injury. In particular, he was suffering from a sacral ulcer which was causing him pain. Dr Lord admitted Mr Cunningham direct to Dryad Ward at GWMH. She noted that he should receive oramorph (morphine solution) as required if he was in pain. She asked that his bed at the nursing home be kept open for at least three weeks, but also noted that his prognosis was poor.

Re-admission to GWMH

20. Once he had been admitted to Dryad Ward, the doctor who saw Mr Cunningham on a day to day basis was Dr Barton. Dr Barton was a General Practitioner at the Forton Medical Centre in Gosport. She worked at GWMH on a part time basis as a visiting Clinical Assistant.

21. The details of Mr Cunningham's treatment were recorded in various sets of notes. These notes included the medical notes, the nursing notes and the drug chart.

22. On his admission to Dryad Ward on 21 September, Mr Cunningham was seen by Dr Barton. She prescribed diamorphine 20-200mg, hysocine (a drug to reduce retained secretions, with sedative qualities) 200-800microgram and midazolam (a sedative) 20-80mg, all to be administered subcutaneously as required. The drug chart also recorded that, as was the case prior to his admission, Mr Cunningham was to receive oramorph 2.5-10mg as required. Dr Barton made the following entry in the medical notes:

'Transfer to Dryad Ward. Make comfortable. Give adequate analgesia. I am happy for nursing staff to confirm death.'

23. Mr Cunningham received 5mg oramorph at 2.50 p.m. and a further 10mg at 8.15 p.m. It was noted in the nursing summary notes that he remained agitated until 8.30 p.m.

24. At 11.10 p.m., a syringe driver was commenced containing diamorphine 20mg and midazolam 20mg. It was noted that he was peaceful from that time.

25. On 22 September, Mr Cunningham's stepson, Mr Stewart-Farthing, telephoned the hospital. He was told that the syringe driver containing diamorphine and midazolam had been commenced in order to allay Mr Cunningham's pain and anxiety. Apparently, he had tried to wipe sputum on a nurse, saying he had HIV and was going to give it to her. He had also tried to remove his catheter, emptied the bag and removed his dressing, throwing it across the room. In a further incident, he took off his covers and exposed himself. In an entry for that evening in the nursing care plan, it was noted that the syringe driver was running, and that Mr Cunningham had a settled night.

26. On 23 September, Mr Cunningham was seen by Dr Barton. Her assessment was that Mr Cunningham had deteriorated. He had become chesty overnight. At 9.25 a.m. hyoscine 400micrograms was added to the syringe driver. Mr Stewart-Farthing was informed of the deterioration. He asked whether the cause was the commencement of the syringe driver, and was informed by staff that Mr Cunningham was only receiving the small dosage which he needed. At about 1 p.m., Mr Stewart-Farthing and his wife came to the ward and were seen by Sister Jean Hamblin and Staff Nurse Freda Shaw. They were very angry that the syringe driver had been commenced. The nurses again explained that the drugs were being administered to control Mr Cunningham's pain. They made Mr Stewart-Farthing aware that his stepfather was dying and needed to be made comfortable. At 8 p.m., the midazolam in the syringe driver was increased to 60mg.

27. On 24 September, Mr Cunningham was again seen by Dr Barton. She increased the doses in the syringe driver to diamorphine 40mg, hyoscine 800 microgram and midazolam 80mg. These doses were commenced at 10.55 a.m. In the medical records she made the following note:

'*Remains unwell. Son has visited again today and is aware of how unwell he is. SC analgesia is controlling pain just. I am happy for nursing staff to confirm death.*'

28. On 25 September, Mr Cunningham was seen by Dr Sarah Brook, a colleague of Dr Barton. She noted in the medical records: '*Remains very poorly. On syringe driver. For TLC.*' A new drug chart was drawn up with prescriptions for diamorphine 40-200mg, hyoscine 800microgram-2g and midazolam 20-200mg over 24 hours. At 10.15 a.m., Mr Cunningham received doses of diamorphine 60mg, hyoscine 1200microgram and midazolam 80mg.

29. On 26 September, a syringe driver containing diamorphine 80mg, hyoscine 1200microgram and midazolam 100mg was commenced at 11.50 a.m. An entry in the nursing summary notes state that Mr Cunningham appeared to be

deteriorating slowly. He continued to deteriorate, and died peacefully at 11.15 p.m.

30. The cause of death was recorded on the death certificate as bronchopneumonia, although an entry in the medical notes by Dr Brook, dated 28 September, recorded the cause of death as I. bronchopneumonia, II. Parkinson's disease, sacral ulcer.

The Police Investigation

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

32. 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.

33. 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.

34. 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.

35. 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.

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

37. A total of ninety cases were reviewed by the police. These included the death of Mr Cunningham. 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.

38. 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.

39. Dr Wilcock and Dr Black have prepared reports commenting on the treatment given to Mr Cunningham at GWMH. In addition, the police have taken a number of witness statements, and Dr Barton has also been interviewed under caution.

Witness Statements

40. Dr Lord confirms in her witness statement that she admitted Mr Cunningham to Dryad Ward with a view to more aggressive treatment on his sacral ulcer. However, she believed that his prognosis was poor. She states:

'Whilst the treatment plan was aimed at maximising the prospect of an improvement in Mr Cunningham's condition I recognised that his general

condition was very poor and had contributed to the development of the large pressure sore. I felt that he was unlikely to recover.'

41. Dr Brook confirms in her witness statement that when she made the entry in the medical notes dated 25 September 1998, she felt that Mr Cunningham was dying

42. Mrs Hamlin states that Mr Stewart-Farthing was extremely unhappy that the effect of the syringe driver was that he could not speak to his stepfather. She states that Me Stewart-Farthing was offhand with the nursing staff, and that his wife apologised for his behaviour.

43. Mr Stewart-Farthing's view is that the use of the syringe driver was totally inappropriate, and that his stepfather was unnecessarily sedated. He states that he made this clear to the nursing staff. He states that he was amazed that the cause of death was given as bronchopneumonia, and believes that the finding of the post mortem – which confirmed the cause of death – is part of a wider conspiracy. He summarises his theory concerning Mr Cunningham's death in the following way:

'...I have no doubt at all that Brian was the subject of a well oiled disposal machine being administered by a culture of able individuals who were well used to their evil practice. In Brian's case I believe the godfather was Lord, the executioners were Barton and Hamblin and these were aided and abetted by Brook and a corrupt coroner's office.'

Dr Barton

44. As part of the police investigation, Dr Barton was interviewed under caution in relation to the death of Mr Cunningham. The interview took place on 21 April 2005. Dr Barton was represented by a solicitor, Ian Barker.

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

(1) By 1998, the demands on Dr Barton's time at GWMH were considerable, and she was left with the choice of making detailed clinical notes or attending patients [p.6];

(2) Dr Lord's note that Mr Cunningham's prognosis was poor, made after she had assessed him at the Dolphin day hospital on 21 September, meant that Dr Lord felt Mr Cunningham was probably dying [p.12];

(3) Prior to Mr Cunningham being transferred to Dryad Ward, Dr Barton and Sister Hamblin went to see him at the Dolphin day hospital. He was clearly upset and in pain. Once at Dryad Ward, Dr Barton examined him [p.12];

(4) Given Mr Cunningham's very frail condition, and Dr Lord's prognosis, Dr Barton noted that she was happy for nursing staff to confirm death [p.12];

(5) Dr Barton prescribed diamorphine on a proactive basis because she believed that although the oramorph would assist in pain relief, it might be inadequate. The sacral sore was the size of a fist, and was clearly causing Mr Cunningham significant pain and distress. The range of diamorphine was wide, but it would have been commenced at the bottom end of the range and any increase would ordinarily have been referred to her or another doctor [pp.13-14];

(6) Dr Barton also prescribed the hyoscine and midazolam for the purpose of relieving Mr Cunningham's pain, distress and agitation [p.14];

(7) Although she has no specific recollection, Dr Barton believes the syringe driver was commenced on 21 September because a second dose of

oramorph had proved insufficient in relieving Mr Cunningham's pain. Dr Barton cannot recall if she was specifically contacted regarding the commencement of the syringe driver, or whether the dose range and provision had been agreed with nursing staff earlier [p.15];

(8) On 22 September, a Barthel assessment was carried out and Mr Cunningham's score was nil. This indicated that he was totally dependent [p.16];

(9) The decision to add hyoscine to the syringe driver on 23 September was made by Dr Barton [p.17];

(10) Although she has no specific recollection, Dr Barton believes that she would have been contacted about the subsequent increases in the doses administered via the syringe driver [p.18];

(11) The increases were necessary to relieve Mr Cunningham's pain and distress, as it was likely that he had become tolerant to opiates [p.20];

(12) At all times the medication given to Mr Cunningham and authorised by Dr Barton was provided solely with the aim of relieving his pain, distress and anxiety, in accordance with her duty of care [p.22].

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 given to Mr Cunningham in the last months of his life, and prepared a report dated 27 September 2005.

48. He concludes that the care given to Mr Cunningham on Mulberry Ward at the GWMH and at the Dolphin day hospital was not substandard.

49. In relation to Dryad Ward, Dr Wilcock's opinion is that the care provided to Mr Cunningham was suboptimal. His conclusions may be summarised as follows.

    (1) There is little doubt that Mr Cunningham was naturally coming to the end of his life. His death was in keeping with a progressive irreversible physical decline, documented over at least ten days by different clinical teams, accompanied in his terminal phase by a bronchopneumonia [p.42];

    (2) The lack of medical notes makes it difficult to follow in detail Mr Cunningham's progress over the last six days of his life. In particular, Dr Barton made no adequate written justification for commencing the syringe driver or subsequently increasing the doses of the drugs which were administered, and failed to keep proper notes relating to her assessments of Mr Cunningham [p.28];

    (3) The use of diamorphine, midazolam and hyoscine was reasonable [p.40];

    (4) The large dose range of diamorphine prescribed by Dr Barton was likely to have been excessive for Mr Cunningham's needs, although such doses were not in the event administered and Mr Cunningham was not rendered unresponsive [pp.40,42-43];

    (5) There was a lack of adequate guidance as to how the doses of diamorphine and midazolam were to be increased [p.41];

    (6) Sometimes the increases were greater than would be considered typical, and made without written justification [p.41];

    (7) Other strategies could have been employed to manage Mr Cunningham's pain [p.41].

50. Dr Wilcock concludes as follows [pp.42-43]:

'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 Cunningham a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge, illustrated, for example, by the reliance on large dose range of diamorphine by syringe driver rather than a fixed dose along with the provision of smaller 'as required' doses that would allow Mr Cunningham'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 Cunningham by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Cunningham by unnecessarily exposing him to potentially receiving excessive doses of diamorphine. In the event, however, such large doses were not administered, and in my opinion, the use of diamorphine, midazolam and hyoscine in these doses could be seen as appropriate given Mr Cunningham's circumstances.'

The Report of Dr Black

51. 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.

52. Dr Black has reviewed the care provided to Mr Cunningham on Dryad Ward, and prepared a report dated 11 July 2005. His conclusions may be summarised as follows:

(1) By the time Mr Cunningham was admitted to Dryad Ward on 21 September, he was very seriously ill with multiple problems, and had been in decline for at least three months [para.6.21];

(2) In such circumstances, the consultant has to make a judgement whether the problems are easily reversible, which would involve intensive

therapy including drips and surgery, or whether they are likely to be the terminal event of a progressive decline [para.6.21];

(3) The combination of acute problems on top of Mr Cunningham's progressive chronic problems meant that active treatment was very likely to be futile and therefore inappropriate. It was appropriate to admit him into a caring environment for pain relief and symptomatic support [para.6.22];

(4) The starting doses of diamorphine and midazolam administered via the syringe driver were acceptable, and the decision to prescribe the drugs was a reasonable management decision [para.6.26];

(5) The increase in the dosage of diamorphine and midazolam on 23 September was appropriate, and it was reasonable to increase the palliative care regime [paras.6.27, 6.28];

(6) The four-fold increase in midazolam on 24 September appears to be excessive [para.6.27];

(7) The doses of diamorphine and midazolam administered on 25 and 26 September were excessive [para.6.30].

53. Dr Black concludes as follows:

'*7.1. Arthur Cunningham is an example of a complex and challenging problem...in geriatric medicine. He suffered from multiple chronic diseases and gradually deteriorated with increasing medical and physical dependency. It is always a challenge to clinicians to identify the point to stop trying to deal with each individual problem or crisis* [and accept] *that the patient is...dying and that symptom control is appropriate.*

7.2. In my view, Mr Cunningham was managed appropriately, including an appropriate decision to start a syringe driver for managing his symptoms and agitation as part of his terminal illness in September 1998.

7.3. My one concern is the increased dose of Diamorphine in the syringe driver on 25th and 26th September 1998, as I was unable to find any justification for this increase in dosage in either the nursing or the medical notes. In my view this increase in medication may have slightly shortened life for at most no more than a few hours to days, however, I am not able to find evidence to satisfy myself that this is to the standard of "beyond reasonable doubt".'

The Legal Framework

54. 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.

55. 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.

56. 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.)

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

58. 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*.

59. 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.*'

60. 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."

61. 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.*'

62. 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'.

63. 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.

64. 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).

65. 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.

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

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

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

    (3) Although there may be cases where the defendant's state of mind is relevant to the jury's consideration when assessing the grossness and

criminality of his conduct, evidence of state of mind is not a pre-requisite to a conviction for manslaughter by gross negligence;

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

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

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

67. 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.

68. 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.'

69. 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

70. Mr Cunningham was transferred to Dryad Ward on 21 September 1998. By this time, he was frail and had a number of significant medical problems. In particular, he was suffering from a sacral ulcer. Dr Lord, who admitted him to Dryad Ward, noted that his prognosis was poor.

71. During Mr Cunningham's time on the ward, Dr Barton prescribed him a number of drugs. On the evening of his admission, a syringe driver containing diamorphine and midazolam was commenced. Hyoscine was added on 23 September. The doses of the drugs administered via the syringe driver were increased on 24, 25 and 26 September.

72. On 26 September, Mr Cunningham died.

Summary of the Experts' Opinions

73. There is no doubt that Mr Cunningham had naturally entered a period of terminal decline. For some time he had experienced a number of significant medical

difficulties, and in the terminal phase these were accompanied by bronchopneumonia. A palliative care regime was, therefore, appropriate. The use of diamorphine, midazolam and hyoscine was appropriate.

74. The care given to Mr Cunningham was suboptimal. The medical notes maintained by Dr Barton were inadequate and the doses of drugs administered via the syringe driver were increased without written justification. In other respects, Dr Barton did not follow best practice.

75. The experts agree that the doses administered when the syringe driver was commenced were reasonable. Dr Wilcock states that, although subsequently Dr Barton prescribed drugs in doses which were excessive for Mr Cunningham's needs, these doses were never actually administered, and the doses which were administered could be seen appropriate. Dr Black, on the other hand, states that the doses of diamorphine administered on 25 and 26 September were excessive. He states that they may have slightly shortened life by a few hours or days, although this could not be proved to the criminal standard.

Discussion

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

    (1) Whether Dr Barton breached her duty of care;

    (2) Whether Dr Barton's act or acts in breach of duty caused death;

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

77. There is some evidence that Dr Barton was negligent in prescribing diamorphine in such high doses. This conduct, and her failure to make proper notes, was plainly sub-optimal. However, the essential issue in this case is, by causing the

drugs to be administered to Mr Cunningham via the syringe driver, did Dr Barton, in breach of her duty of care, cause his death.

78. Dr Black's opinion is that the doses of diamorphine administered on 25 and 26 September were excessive. Dr Wilcock, on the other hand, states that the doses may have been appropriate. Having regard to the experts' opinions, whilst there is some evidence that Dr Barton breached her duty of care, it is unlikely that this could be proved to the criminal standard.

79. There is some evidence that the drugs administered to Mr Cunningham shortened his life by a few hours or perhaps a few days. However, Dr Black's view is that this could not be proved to the criminal standard. Mr Cunningham was naturally coming to the end of his life. In our view, therefore, causation could not be established in this case.

80. Further, in our opinion, it is highly unlikely that Dr Barton's conduct, if it was found to be negligent and to have caused death, could be said to be grossly negligent. In coming to this view we have had regard to the following matters:

    (1) Mr Cunningham was an elderly, frail man, who was naturally coming to the end of his life, and was, shortly after his admission to Dryad Ward, in the terminal phase;

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

    (3) The care provided by Dr Barton allowed Mr Cunningham to die peacefully;

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

Conclusions

81. 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.

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

David Perry

Louis Mably

24 January 2006

6 King's Bench Walk
London
EC4Y 7DR

OPERATION ROCHESTER

Re Arthur Cunningham

DRAFT ADVICE

David Perry

Louis Mably

6 KING'S BENCH WALK
LONDON
EC4

CROWN PROSECUTION SERVICE
50 LUDGATE HILL
LONDON
EC4M 7EX