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Receiver

Code A

Indexer

OPERATION ROCHESTER

Re Enid Spurgin

Introduction

1. On 13 April 1999, Enid Spurgin, aged 92, died.

2. At the time of her death, Mrs Spurgin was a patient on Dryad Ward at the Gosport War Memorial Hospital ('GWMH').

3. The cause of death was given as 1a cerebrovascular accident, with an onset 48 hours before death.

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Background

9. Mrs Spurgin was born on Code A

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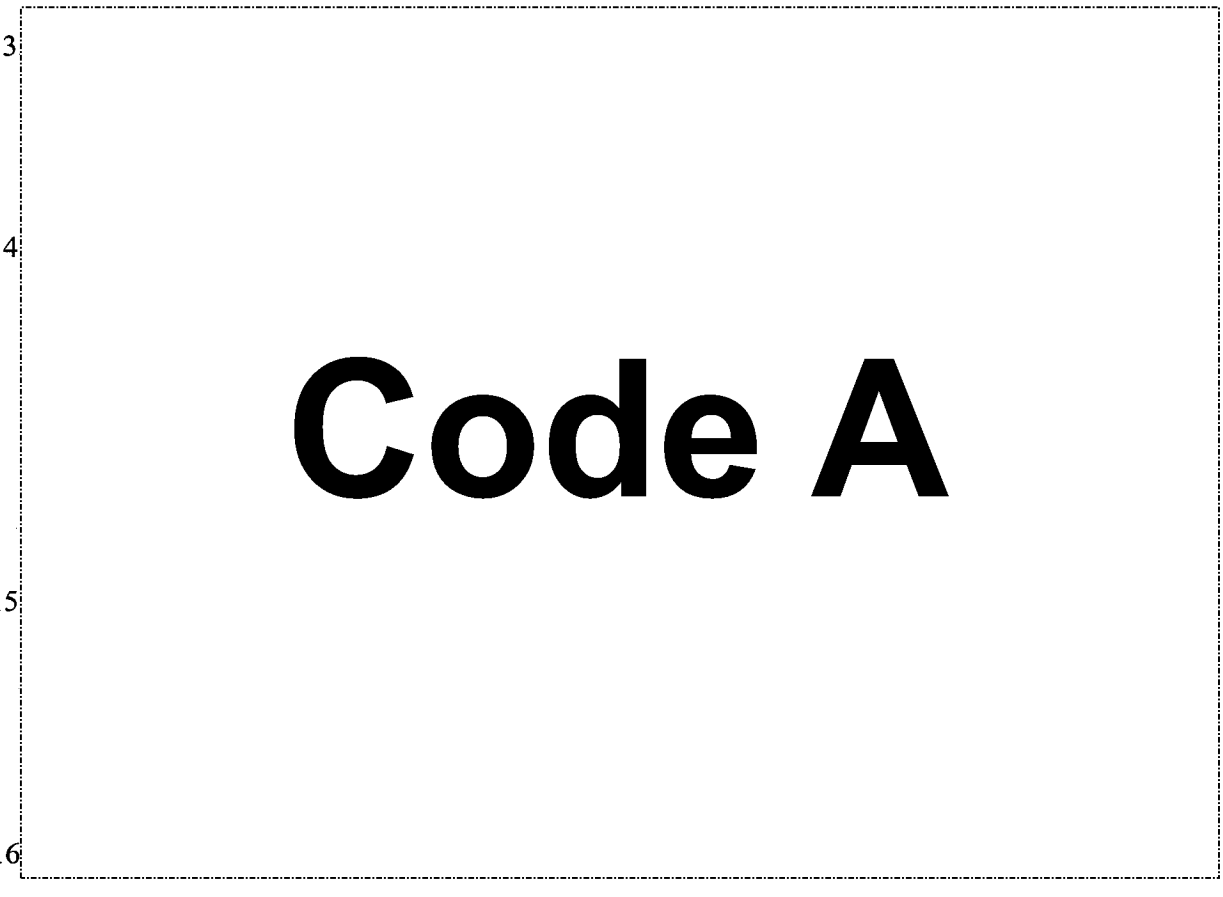

Gosport War Memorial Hospital

Overview

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

Dryad Ward

18. Mrs Spurgin was admitted to Dryad Ward under the care of Dr Reid. However, the doctor who dealt with Mrs Spurgin 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. Her responsibilities involved visiting patients on the ward, conducting examinations and prescribing medication.

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

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The Police Investigation

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

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

38. On 22 October 2001, the Commission for Health Improvement launched an investigation into the management, provision and quality of health care in GWMH. The Commission's report was published in May 2002, and set out a number of factors which contributed to a failure to ensure good quality patient care.

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

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

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

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

43. The cases categorised as negligent were the subject of an on-going review by Dr Andrew Wilcock, an expert in palliative medicine and medical oncology, and Dr Robert Black, an expert in geriatric medicine.

44. In Mrs Spurgin's case, reports have been prepared by both Dr Wilcock (dated 5 March 2006) Dr Black (dated 27 June 2006). In addition, Daniel Redfearn, a consultant orthopaedic and trauma surgeon, has also prepared a report (dated 22 January 2006).

Dr Barton

45. As part of the police investigation into the fourteen cases which had been reviewed and categorised as negligent, Dr Barton was interviewed under caution in relation to the death of Mrs Spurgin. The interview took place on 15 September 2005. Dr Barton was represented by a solicitor, Ian Barker.

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

(1) By 26 March it appears that Mrs Spurgin was considered well enough to be transferred to GWMH for rehabilitation [pp.8-9];

(2) Dr Barton admitted Mrs Spurgin to Dryad Ward. The concern was to reassess her wound and ensure that she had analgesia [p.9];

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Dr Reid

47. Dr Reid was also interviewed under caution in relation to Mrs Spurgin's death. The interviews took place on 11 and 14 July, and 8 August 2006. Dr Reid was represented by a solicitor, Will Childs.

48. Dr Reid's account may be summarised as follows:

(1) The level of note keeping in Mrs Spurgin's case was unacceptable [11 July, 10.58 a.m., p.40];

(2) At the time of Mrs Spurgin's transfer to GWMH, Dr Reid felt that her chances of successful mobilisation was very small [11 July, 9.12 a.m., p.32; 10.04 a.m., pp.4, 35; 8 August, 9.07 a.m. p.8];

(3) The clerking Mrs Spurgin received at the time of her admission to Dryad Ward was inadequate [11 July, 10.04 a.m., p.14];

(4) Dr Barton ought to have conducted a physical examination and recorded the results [11 July, 10.04 a.m., pp.16,18];

(5) The increase level of pain experienced by Mrs Spurgin after Code A indicated that something was wrong [11 July, 10.04 a.m., p.33];

(6) However, it is not uncommon for patients to be in pain afte Code A and it is not unreasonable to wait and see if the administration of analgesia is effective. It would not have been reasonable, therefore, to have expected Dr Barton to have ordered, for example, an x-ray, on the day of Mrs Spurgin's admission. The question is, at what point is it reasonable to commence further investigation? [11 July, 10.04 a.m., p.47];

(7) It is not clear from the medical records at what stage that investigation ought to have taken place in Mrs Spurgin's case [11 July, 10.58 a.m., p.37];

(8) Dr Barton must have prescribed antibiotics because she believed that Mrs Spurgin was suffering from a Code A [14 July, 11.34 a.m., p.20];

(9) When he examined Mrs Spurgin on 12 April, Dr Reid believed that she was in terminal decline [11 July, 10.58 a.m., p.47; 14 July, 9.12 a.m., p.19];

(10) If Mrs Spurgin had a Code A, the implications would have been horrific. It could not have been treated simply with antibiotics, but probably would have involved another operation [8 August, 9.07 a.m., p.7].

(11) Dr Reid reduced the dose Code A Code A was '*too much*' [11 July, 11.50 a.m., p.37].

Statement of Code A

49. Code A, Mrs Spurgin's nephew, has prepared a witness statement dated 17 March 2004. He states that prior to Mrs Spurgin's deterioration on 11 April, both she and he were concerned by the fact that she was not being seen by doctors. On 12 April, he was told by Dr Reid that there was nothing wrong with Mrs Spurgin, and that she had been Code A Thereafter, he was told that Mrs Spurgin had been given sips of water.

The Report of Daniel Redfearn

50. Mr Redfearn is a consultant orthopaedic surgeon at the R Code A Code A

51. He has reviewed the care provided to Mrs Spurgin, and considered the possible causes of her continued post operative pain. His reported is dated 22 January 2006.

52. Mr Redfearn states that his analysis has been hampered by the fact that he has not had sight of the original radiographs, which are no longer available. He also states that it is regrettable that no post mortem was carried out.

53. In his view, Mrs Spurgin suffered a relatively Code A and the Code A Code A which she underwent at Haslar was appropriate.

54. He states that in relation to Mrs Spurgin's continuing pain, a number of diagnostic possibilities are raised from the papers, specifically:

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(2) Code A
(3)

55. Mr Redfearn's analysis may be summarised as follows:

(1)
(2) Code A
(3)

The Report of Dr Wilcock

56. Dr Wilcock is a Reader in Palliative Medicine and Medical Oncology at the Code A Code A and an Honorary Consultant Physician of the Code A Code A

57. Dr Wilcock has reviewed the care provided to Mrs Spurgin, and prepared a report dated 5 March 2006.

58. Dr Wilcock's opinion is that the medical care provided to Mrs Spurgin by Dr Reid and Dr Barton after her transfer to Dryad Ward was sub-optimal [p.30]. His conclusions may be summarised as follows:

    (1) Following his review on 24 March, Dr Reid considered that Mrs Spurgin's pain was the main barrier to rehabilitation [p.25];

    (2) Infrequent entries in the medical notes during Mrs Spurgin's time on Dryad Ward make it difficult closely to follow her progress. The note keeping was inadequate [pp.26, 30];

    (3) Code A [p.33];

    (4) Code A

    (5) Code A

antibiotics. She was not anticipated to be dying. No adequate medical assessment was carried out at this stage (that is, prior to the commencement of the syringe driver) [pp.27, 28, 30-31, 38];

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Code A

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(11) The circumstances of Mrs Spurgin's deterioration and death are not typical of a Code A and there is a lack of sufficient supporting clinical evidence and certainty that this was the most likely cause of her death [p.29];

59. Dr Wilcock concludes as follows [p.38]:

'*Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs*

Spurgin by failing to adequately assess her condition and taking a suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to inappropriate doses of morphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.'

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

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

The Report of Dr Black

61. Dr Black is a Consultant Physician in Geriatric Medicine at Code A in Code A and an Associate Member of the General Medical Council.

62. Dr Black has reviewed the care provided to Mrs Spurgin, and prepared a report dated 27 June 2006. His conclusions may be summarised as follows:

    (1) It is difficult to provide a comprehensive opinion in the absence of the very sparse nature of the GWMH medical notes [para.6.2];

    (2) Mrs Spurgin's case represents a common problem in geriatric medicine. The prognosis after a Code A in daily living before t Code A is generally poor, both in terms of mortality and returning to independent existence. Up to 25 per cent of patients in such a category will die shortly after the Code A from many varied causes and complications [para.7.1];

(3) It would appear that Mrs Spurgin was making reasonable progress at the point of transfer to GWMH. However, given her age and previous medical problems, the prospect that she would be able to return to an independent existence at home was already extremely low [para.6.3];

(4) Starting Mrs Spurgin on a regular dose of strong opioid analgesia immediately from the point of admission to GWMH represented poor clinical practice [para.6.6];

(5) The recommencement o Code A a (MST Code A) on 31 March was appropriate [para.6.7];

(6) There appears to have been a working assumption that Mrs Spurgin's v Code A Code A and the decision to commence a course of a Code A on 7 April was appropriate [para.6.8];

(7) The original cause of Mrs Spurgin's continuing post operative pain was and remains undiagnosed. However, at the time of her deterioration on 11 April, there is no doubt that Mrs Spurgin was dying. The most likely cause was an Code A There was no opportunity for any remedial action to be taken at that stage [para.6.9];

(8) The decision to start the Code A was appropriate [para.6.9];

(9) The staring dose of Code A was excessive. At best, this represents poor clinical judgment. An appropriate s Code A Code A following Dr Reid's review, eight hours after the Code A was commenced) [paras.6.9, 7.2];

(10) Code A

(11) It is virtually impossible to predict how long a terminally ill patient will live, and even opinions of palliative care experts can show an enormous amount of variation. However, although the dose of Code A sed in the last hours was inappropriately high, it cannot be proved beyond reasonable doubt that this had

the definite effect of shortening Mrs Spurgin's life in more than a minor fashion, that is, by a few hours [paras.6.12, 7.2].

The Legal Framework

63. 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.

64. 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.

65. 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.)

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

67. 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*.

68. 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.'

69. 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.'

70. 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.'

71. 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'.

72. 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.

73. 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).

74. 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 appréciation 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.

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

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

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

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

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

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

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

76. 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.

77. 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.'

78. 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

79. Mrs Spurgin was admitted to Haslar on 19 March 1999, having suffered a Code A Code A An operation was performed the next day. On 26 March, she was transferred to GWMH under the care of Dr Reid.

80. During her time at GWMH, Mrs Spurgin continued to experience pain. In order to relieve this, she was given various analgesics. It was also believed that her wound was infected, and she was therefore started on a course of antibiotics.

81. On 11 April, Mrs Spurgin's condition deteriorated. At 8 a.m. on 12 April, on Dr Barton's instructions, Code A was commenced containing Code A Code A At 4.40 p.m., Dr Reid changed the doses to Code A Code A

82. At about 1.15 a.m. on 13 April, Mrs Spurgin died.

Summary of the Experts' Opinions

83. There was a failure by doctors at both Haslar and GWMH properly to assess the cause of Mrs Spurgin's continuing post operative pain. There appear to have been three possible diagnoses:

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(2)

Code A

(3)

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Code A

86. Code A

Discussion

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

(1) Whether Dr Barton or Dr Reid breached their duty of care;

(2) Whether Dr Barton's or Dr Reid's acts or omissions caused death;

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

88. There are two essential criticisms of Dr Barton and Dr Reid. First, there was a failure to take adequate steps to diagnose and treat the cause of Mrs Spurgin's continuing pain, and secondly, inappropriately high dose Code A were administered from 12 April. These matters are considered below.

89. There is no entry in the medical records to suggest that Dr Barton carried out an adequate initial assessment of Mrs Spurgin's condition, or, later, conducted an appropriate clinical examination to establish the cause of her continuing pain. However, it was clear to both Dr Barton and Dr Reid that Mrs Spurgin was in pain, suggesting a problem with her post operative recovery:

(1) Neither doctor can be criticised for not diagnosing Code A This is because it cannot be said with any certainty that Mrs Spurgin had such a condition, and, moreover, in the opinion of Mr Redfearn, the doctors at GWMH could not have been expected to have made such a diagnosis;

(2) As Dr Black has stated, there was a working assumption at GWMH that Mrs Spurgin was suffering from an Code A Both he and Mr

Redfearn have stated that the treatment Mrs Spurgin received at GWMH in respect of any infection was broadly appropriate;

(3) In relation to the possibility of a failure of the post operative fixation, Mr Redfearn states that this appears to have been overlooked by the staff at GWMH. The normal course of investigation would be to request an x-ray. This is, however, what Dr Reid did on 7 April and, although it is not clear whether an x-ray was in fact carried out, by the time Dr Reid next saw Mrs Spurgin, he took the view, correctly in the opinion of Dr Black, that Mrs Spurgin was in terminal decline.

90. The principal criticism of Dr Barton and Dr Reid in respect of their failure to take appropriate steps to diagnose and treat Mrs Spurgin's pain, is that they failed to refer her for an orthopaedic review. In the opinion of Dr Wilcock and Mr Redfearn, given Mrs Spurgin's pain, it must have been clear that there was a problem with her post operative recovery, and that, in the circumstances, there ought to have been such a referral.

91. There is some evidence that the two doctors were negligent in this respect. In Dr Reid's case, however, it is of some significant that he requested an x-ray, but that by the time he next saw Mrs Spurgin, she had fallen into terminal decline. It is also significant to note that in Dr Redfearn's opinion, the treatment Mrs Spurgin received at GWMH in respect of the diagnosed infection was broadly appropriate.

92. The essential question, however, is whether it can be proved to the criminal standard that the failure to refer Mrs Spurgin for an orthopaedic review prior to her falling into terminal decline in fact caused her death. In this respect, the following matters are of significance:

(1) Mrs Spurgin was a frail 92 year old lady. F Code A her prognosis was poor. Dr Black has stated that her case represented a common problem in geriatric medicine, and that up to 25 per cent of elderly patients die shortly after suffering Code A of this type.

(2) Dr Redfearn has identified three diagnostic possibilities, and stated that they were 'potentially reversible'. Dr Wilcock has also used this phrase to describe Mrs Spurgin's condition.

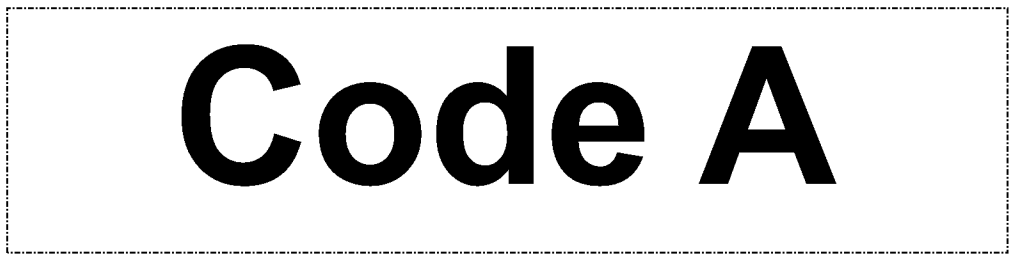
(3) In his draft overview, Dr Wilcock states that it was 'unlikely' that Mrs Spurgin had suffered a natural irreversible terminal decline (prior to the relevant negligent act or omission).

(4) Dr Wilcock, however, couples that opinion with a note of caution, namely that it is difficult accurately to judge a prognosis, and that it should be taken as an indication rather than a more definite classification.

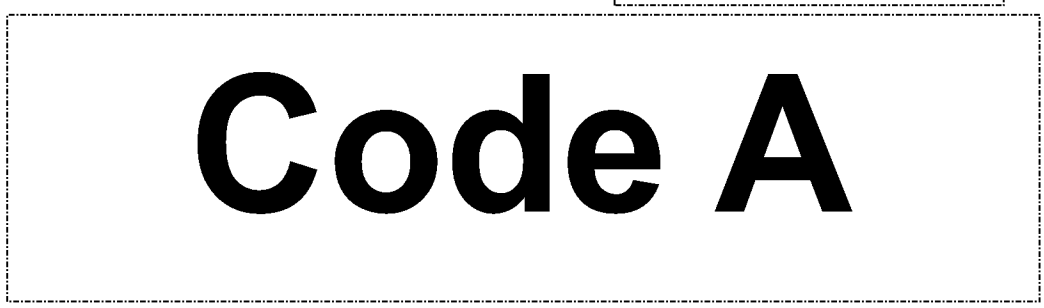
93. Based on the opinions set out above, it is my view that there is no realistic prospect of proving causation to the criminal standard in this case. All of the medical experts leave open the possibility that Mrs Spurgin would have died notwithstanding the failure to refer her for an orthopaedic investigation. This is not surprising, given that it is difficult to judge a prognosis with accuracy and, having regard to her age and frailty, Mrs Spurgin's prognosis was poor in any event.

94. A further issue in the case is whether the excessive or inappropriate administration of diamorphine via a syringe driver might give rise to a charge of gross negligence manslaughter. There is a conflict of expert opinion in relation to the issues surrounding the administration of the diamorphine:

(1) Dr Wilcock states that the Code A



(2) Dr Black's analysis is that, although the dose Code A



95. Based on the medical opinions in this case, in my view there is evidence that Dr Barton was negligent in causing a dose of diamorphine 80mg to be administered on 12 April.

However, I do not consider that negligence could be proved in respect of Dr Reid's Code A

96. Moreover, I do not consider that in either case it could be proved as a matter of law that Code A The opinion of Dr Black is that there is no doubt that Mrs Spurgin was in terminal decline prior to its administration.

97. I should also add that in my opinion, it is highly unlikely that the acts or omissions of Dr Barton or Dr Reid would be characterised as grossly negligent. In coming to this view I have had regard to the following matters:

(1) Mrs Spurgin was a frail elderly lady with a poor prognosis;

(2) It is not possible to diagnose with any certainty the cause of her pain;

(3) It is likely that there wa Code A and the treatment provided at GWMH in this respect was broadly appropriate;

(4) Dr Reid had sought some assurance from the medical staff at Haslar in respect of Mrs Spurgin's c Code A

(5) In administering Code A Dr Barton and Dr Reid were seeking to relieve Mrs Spurgin's pain and distress, at a time when, accurately according to Dr Black, they believed that she was dying;

(6) If the drugs administered via the syringe driver did shorten life, it was likely to have been by a matter of hours.

Conclusions

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

Code A