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OPERATION ROCHESTER

Re Leslie Pittock

Introduction

1. On 24 January 1996, Leslie Pittock, aged 82, died.

2. At the time of his death Mr Pittock 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 Pittock was treated on a day to day basis by Dr Jane Barton, a Clinical Assistant in Elderly Medicine. Dr Barton is now aged 58 (date of birth 19 October 1948).

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

6. The purpose of this review is to consider 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. I should say at the outset that after careful consideration of all the materials provided by the police I have reached the conclusion that the evidence does not reveal the commission of the offence of gross negligence manslaughter.

8. In reaching this conclusion I have, of course, had regard to the Code for Crown Prosecutors. In conducting this review I have applied the principles in the Code for Crown Prosecutors ('the Code') and I have applied both domestic law and that arising from the European Convention on Human Rights. The Code requires me to consider whether there is a realistic prospect of conviction for a criminal offence (i.e. that a jury is more likely than not to convict) and only then may I consider whether it is in the public

interest whether there should be a prosecution. If there is a realistic prospect of conviction (the evidential test) there is a presumption of a prosecution unless the public interest factors against clearly outweigh those in favour. In the review I have set out my understanding of how the relevant law applies to the evidence.

Background

9. Mr Pittock was born on Code A

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Gosport War Memorial Hospital

Overview

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

Mulberry Ward

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

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Dryad Ward

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

24. The doctor who saw Mr Pittock on a day to day basis was Dr Barton. Dr Barton was a General Practitioner at the Forton Medical Centre in Gosport. She worked at GWMH on a part time basis as a visiting Clinical Assistant.

25. The details of Mr Pittock's treatment were recorded in various sets of notes. These notes included the medical notes, the nursing notes 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, Code C 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 Mr Pittock. 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. Dr Wilcock and Dr Black have each prepared a report, dated 25 April 2005 and 31 January 2005 respectively, commenting on the treatment given to Mr Pittock at GWMH. They have also each prepared a supplementary report, dated 26 April 2005 and 22 April 2005 respectively, commenting on a number of matters raised by Dr Barton in her police interview.

Dr Barton

45. As part of the police investigation into the fourteen cases which had been reviewed and categorised as negligent, Dr Barton was interviewed under caution in relation to the death of Mr Pittock. The interview took place on 3 March 2005. Dr Barton was represented by a solicitor, Ian Barker.

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

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

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

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

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

(5) Code C 1 le 's

(6) Dr Barton did not work over the weekend of 13-14 January, but returned to GWMH on the morning of Monday 15 January. She may have been told that Mr Pittock's condition had deteriorated over the weekend, and that he appeared to be experiencing significant agitation and pain. Dr Barton took the decision to commence the Code C

Code C

(7) In relation to her general approach, Dr Barton stated: '*My concern...was to ensure that he did not suffer anxiety, pain and mental agitation as he died...I*

Code C

(8) On 16 January, Dr Barton took the view the medication commenced the previous day had been largely, but not entirely, successful in relieving Mr Pittock's condition. In view of his continued agitation, Dr Barton decided to add

Code C

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(10) Code C

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

The Report of Dr Wilcock

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

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

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

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

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

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

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

    (4) The dose Code A Code A was excessive for Mr Pittock's needs. An appropriate Code A g [pp.25, 31];

    (5) The dose of midazolam 60mg administered on 15 January Code A Code A was an above average starting dose for somebody of Mr Pittock's age, but this may have been necessary given that he had been on long term Code A [pp.25-26];

    (6) Code A

(7) Code A

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

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

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

'At best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mr Pittock a peaceful death, albeit with what appears to be an excessive use Code A *.It is my opinion however, that given the lack of documentation to the contrary, Dr Barton could also be seen as a doctor who breached the duty of care she owed to Mr Pittock by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Pittock by unnecessarily exposing him to excessive doses of diamorphine that could have resulted in a worsening of his agitation. Dr Barton's response to this was to further increase Mr Pittock's dose of* Code A *Despite the fact that Mr Pittock was dying "naturally", it is difficult to exclude completely the possibility that a dose of* Code A *that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton leaves herself open to the accusation of gross negligence.'*

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

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

The Report of Dr Black

53. Dr Black is a Consultant Physician in Geriatric Medicine a[Code A]n [Code A] and an Associate Member of the General Medical Council.

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

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

(2) Although it is impossible to be absolutely certain what was causing his physical

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(4) Code A

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55. Dr Black concludes as follows:

'*In my view the drug management* [at] *Gosport was sub-optimal. There was no written*

Code A

Statement of Dr Tandy

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

57. Dr Tandy states that she would Code A

Code A

The Legal Framework

58. The ingredients of the offence of gross negligence manslaughter are set out in *R. v. Adomako* [1995] 1 A.C. 171. The Crown must establish:

    (1) That there was a duty of care owed by the accused to the deceased;

    (2) That there was a breach of that duty by the accused;

    (3) That the breach resulted in death (causation);

    (4) That the breach is to be characterised as gross negligence and therefore a crime.

59. In determining whether there has been a breach of the duty the ordinary civil law of negligence applies. The test is objective. It is the failure of the accused to reach the standard of the reasonable man placed in the position of the accused.

60. An accused is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of professional opinion skilled in the particular activity in question, even though there is a body of competent professional opinion which might adopt a different technique. (The '*Bolam* test', after *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582 at 587.)

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

62. If there has been a breach it is essential to show that the breach was a cause of the death. It is to be noted that the breach need not be the sole cause of death or even the main cause of death. It is sufficient for it to be an operating cause, that is, something which is not *de minimis*.

63. In *Adomako*, Lord Mackay of Clashfern L.C., describing the test for gross negligence, stated:

'*...the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such a breach of duty is established the next question is whether the breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be categorised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal.*'

64. The test was affirmed by the Court of Appeal in *R. v. Amit Misra, R. v. Rajeer Srivastova* [2004] E.W.C.A. Crim. 2375:

'*In our judgment the law is clear. The ingredients of the offence have been clearly defined in Adomako...The hypothetical citizen, seeking to know his position, would be advised that, assuming he owed a duty of care to the deceased which he had negligently broken, and that death resulted, he would be liable to conviction for manslaughter, if, on the available evidence, the jury was satisfied that his negligence was gross. A doctor would be told that grossly negligent treatment of a patient which exposed him or her to the risk of death, and caused it, would constitute manslaughter.*'

65. In *Adomako*, Lord Mackay went on to say:

'*The essence of the matter which is supremely a jury question is whether, having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act or omission.*'

66. The conviction for gross negligence manslaughter was confirmed in the case of *Adomako*. The evidence revealed that the appellant had failed for eleven minutes or so to identify the cause of the patient's respiratory difficulty as a dislodged endothroceal tube. Other means of restoring the supply of oxygen were frantically tried but the simple and obvious procedure of re-attaching the tube was not performed, something that, according to expert evidence, would have been done by a competent anaesthetist within thirty seconds of observing the patient's difficulty. The expert evidence called on behalf on the prosecution was to the effect that the standard of care was 'abysmal' and 'a gross dereliction of care'.

67. Thus for the purposes of liability the test is objective. The *Adomako* test does however require the jury to decide that the conduct of the accused was so bad that it ought to be stigmatised as a crime '*in all the circumstances in which the defendant was placed when the breach of duty occurred*'. This enables account to be taken of all the circumstances and their likely effect on the actions of a reasonable man.

68. Unlike states of mind such as recklessness and intention, negligence does not presuppose any particular state of mind on the part of the accused. It is a standard that reflects fault on his part. The main feature distinguishing negligence from intention and recklessness (as it is commonly understood) is that there is no requirement that the accused should foresee the risk that the actus reus might occur. Negligence involves an objective assessment of an objectively recognisable risk. Evidence as to the accused's state of mind is not a pre-requisite of a conviction (see *Attorney General's Reference (No. 2 of 1999)* [2000] 2 Cr.App.R. 207, CA).

69. In *R. v. Prentice* [1994] Q.B. 302 the Court of Appeal, without purporting to give an exhaustive definition, considered that proof of any of the following states of mind may properly lead a jury to make a finding of gross negligence:

    (1) Indifference to an obvious risk of death;

    (2) Actual foresight of the risk of death coupled with an intention nevertheless to run it;

    (3) An appreciation of the risk of death coupled with an intention to avoid it but also coupled with such a high degree of negligence in the attempted avoidance as the jury consider justifies conviction;

(4) Inattention or failure to advert to a serious risk of death which goes beyond mere inadvertence in respect of an obvious and important matter which the defendant's duty demanded he should address.

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

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

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

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

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

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

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

71. It seems to be clear that the situation in which the accused found himself must be taken into account when determining liability and this will include a consideration of such matters as the experience of the accused and the difficulties under which he was acting when he did the act or made the omission of which complaint is made.

72. Support for the proposition that the situation in which the accused found himself may be taken into account when deciding whether the negligence should be judged criminal and, for that matter, whether there is a realistic prospect of conviction, is to be found in *Prentice*. The accused were doctors. They administered two injections to a patient, without checking the labels on the box or the labels on the syringes before doing so. The injections had fatal results. The accused were tried in the Crown Court and convicted after the judge had given the jury a direction on recklessness (whether the risk would have been obvious to a reasonable man). Their convictions were quashed by the Court of Appeal and Lord Taylor CJ stated:

'*In effect, therefore, once the jury found that "the defendant gave no thought to the possibility of there being any such risk" on the judge's directions they had no option but to convict. ...if the jury had been given the gross negligence test, they could properly have taken into account "excuses" or mitigating circumstances in deciding whether the high degree of gross negligence had been established. The question for the jury should have been whether, in the case of each doctor, they were sure that the failure to ascertain the correct mode of administering the drug and to ensure that only that mode was adopted was grossly negligent to the point of criminality having regard to all the excuses and mitigating circumstances of the case.*'

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

Analysis

Overview

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

75. **Code A**

Code A

discontinued the following day.

76. On 24 January, Mr Pittock died.

Summary of the Experts' Opinions

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

78. The medical notes maintained by Dr Barton were inadequate. They did not set out the reasons for prescribing opiates, or indicate that a proper assessment of Mr Pittock's condition had been carried out. This raises the possibility that Dr Barton did not consider whether or not the drugs which she had prescribed were contributing to Mr Pittock's symptoms. However, as Dr Black has stated, although the inadequacy of the notes represents poor practice, it does not prove that the care provided to Mr Pittock was sub-optimal or negligent.

79. The essential criticism of Dr Barton is that the Code A

Code A

Code A Dr Wilcock, however, states that these doses may have been appropriate.

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

81. The conclusions of the experts are as follows:

    (1) Dr Wilcock states that the care provided by Dr Barton was sub-optimal. She could be seen as a doctor who allowed Mr Pittock to die peacefully, albeit by using excessive doses of diamorphine. On the other hand, she could be seen as a doctor who breached her duty of care, to the extent that she disregarded Mr

Pittock's safety, and whose acts contributed to his death. In that way, Dr Barton leaves herself open to an allegation of gross negligence.

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

Discussion

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

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

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

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

83. There is some evidence that Dr Barton was negligent in prescribing Code A in such Code A. Her conduct was plainly sub-optimal. However, Dr Black states in terms that it could not be proved beyond reasonable doubt that her conduct was negligent. Mr Pittock was a dying man in some distress. The drugs which were prescribed and administered allowed him to die peacefully. Having regard to these matters, whilst there is some evidence that Dr Barton breached her duty of care, it is unlikely that this could be proved to the criminal standard.

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

85. Further, in my opinion, it is highly unlikely that Dr Barton's conduct, if it was found to be negligent, would be characterised as grossly negligent. In coming to this view I have had regard to the following matters:

(1) Mr Pittock was an elderly, frail man, who was dying naturally;

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

(3) The care provided by Dr Barton allowed Mr Pittock 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

86. 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