Other Document Form

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Title EMAIL CORRESPONDENCE WITH PROF BAKER AND COPY REPORT

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Code A

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O/M	SIO

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Code A

From: Grocott, David
Sent: 19 December 2005 10:21
To: Code A
Cc: Code A
Subject: FW: Op Rochester
Sensitivity: Confidential

Dear Professor Baker,

Can I introduce myself, I'm Detective Inspector Dave Grocott from the Op Rochester Major Crime Team. I've been asked by the Senior Investigating Officer D/Supt Williams to review your report in relation to M Code A h & Cunningham. My responsibility amongst others is the appointment, coordination and review of the experts within this investigation. I ensure that the audit trails in relation to evidence are secure and that the experts adopt a similar format when compiling their reports.

Having reviewed your latest report there are some areas of clarification that I would ask you to consider. Attached to this email is a formal letter of introduction together with a briefing document that I supply to all experts and a template that I ask all experts to try and use.

Could I ask you to address the issues in the letter please. If there is anything I can do to assist or clarify please don't hesitate to contact either myself or Code A

Thankyou

Dave Grocott
D/Insp
Int 641-404
Mobile Code A

From: Baker, Prof R. [mailto: Code A
Sent: 28 November 2005 12:37
To: Code A
Subject: RE: Op Rochester
Sensitivity: Confidential

Dear Code A

Here is a report. I hope is addresses the points raised by Counsel, but please let me know if my comments are not clear.

Richard Baker

Code A

From: Code A @hampshire.pnn.police.uk [mailto: Code A @hampshire.pnn.police.uk]

Sent: 28 November 2005 09:26
To: Code A
Subject: RE: Op Rochester
Sensitivity: Confidential

Good Morning,

It is in fact R[redacted]n, I am away working on another job but if you require further help please e-mail me and I will ring you directly.

Code A

From: Baker, Prof R. [mailto:r Code A
Sent: 28 November 2005 08:44
To: Code A
Subject: RE: Op Rochester
Importance: High
Sensitivity: Confidential

Dear Code A

Can you tell me which Code A you are referring to? I have 10 Code A patients recorded, and need more information to identify which one is of interest.

The Cunningham I have identified is Arthur Cunningham, who died 26 September 1998. I hope this is the right person.

Richard Baker

Code A

From: Code A @hampshire.pnn.police.uk [mailto: Code A hampshire.pnn.police.uk]
Sent: 11 November 2005 09:43
To: Code A
Subject: RE: Op Rochester

Dear Professor Baker,

I wonder if in the first instance you would be able to mark you report as a "draft." This will allow us and Counsel to digest and discuss with you its contents at a later stage. I am as always very grateful for your time in what I have no doubt is an extremely busy schedule.

Kind regards

Code A

From: Baker, Prof R. [mailto: Code A
Sent: 31 October 2005 12:41
To: Code A
Subject: RE: Op Rochester

Dear Code A

Thanks for your message. I will need to go back to my report and give careful thought to the question you have raised. It should be possible to complete this before the end of November as you request, and I will forward a response directly to you. Please do contactme if there is any delay.

All the best

Richard Baker

Code A

From: Code A @hampshire.pnn.police.uk [mailto: Code A @hampshire.pnn.police.uk]
Sent: 31 October 2005 10:48
To: Code A
Cc: Code A @hampshire.pnn.police.uk
Subject: Op Rochester

Dear Professor Baker,

You may recall we have met previously with regard to Operation Rochester and the enquiries being conducted by Hampshire Police at the Gosport War Memorial Hospital. A file has now been passed to the CPS and is being reviewed by Treasury Counsel. They have asked if you are able to expand upon the comment in your statement that the patients might have recovered had they not been given opiates. Of particular note are the cases of CUNNINGHAM and WILSON and to ascertain if your comments extend to these particular patients.

I fully appreciate that this will take some time for you to review and whether or not you are able make comment as asked. I would be grateful if you would have time to consider these matters by the end of November. Of course please feel free to contact me or Code A at any time.

I trust life is treating you well,

Kind regards

Code A

HAMPSHIRE Constabulary

Chief Constable Paul R. Kernaghan CBE QPM LL.B MA

Our Ref. :
Your Ref. :

Professor R. Baker

Code C

Fareham Police Station
Quay Street
Fareham
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PO16 0NA

Tel: 0845 045 45 45
Direct Dial:
Fax: 023 9289 1663
Email: Code C ampshire.pnn.police.uk

12 December 2005

Dear Professor Baker

Operation Rochester

Thank you for taking the time to compile a report regarding the request for clarification from my colleague Detective Constable Code C. I've had an opportunity to read your views in relation to the cases of Arthur Cunningham & Robert Wilson and would ask if you could now prepare a statement of evidential use that could be used in the event of criminal proceedings arising from the case of Robert Wilson. This would be in addition to the statement you prepared in September last year

A brief resume of our investigation is as follows.

Operation ROCHESTER is an investigation by Hampshire Police Major Crime Investigation Team into the deaths of a large number of elderly patients at Gosport War Memorial Hospital. (GWMH) It is alleged that elderly patients who were admitted to the GWMH between 1996 and 1999 for rehabilitative or respite care, were inappropriately administered Diamorphine by use of syringe drivers, resulting in their deaths.

This investigation has been running for some considerable time now and has utilised the skills of a number of medical experts in various fields. Whilst you have not been formally instructed by the investigative team you have provided a number of reports as an expert in your own discipline to various parties assisting with the whole investigation.

One of my roles within the investigation is the briefing and coordination of all potential expert material. In doing this I have to be able to audit and demonstrate what reference material has been used and where the evidence ultimately is elicited from. I'm aware that you have conducted your own enquiries on behalf of the Chief Medical Officer Sir Liam Donaldson, but I have no idea what information you have seen or been given access to specifically in relation to Mr Cunningham or Mr Wilson.

It would be beneficial therefore for all concerned if I could invite you to complete your report following the template we have utilised for all medical experts. This is providing a demonstrable and uniformed approach for everybody. I'm sure that you would agree, each individual facet of medicine can be very complex, especially when it comes to explanation in the written format.

HAMPSHIRE Constabulary

The template follows a very standard layout which I'm sure you will be familiar with. In addition to the template I will also send you a copy of the guidance which I have provided to every medical expert required to complete a report. Not every expert has had the same level of interaction with the police as you, but I always supply a copy of this guide as a way of introducing some of the areas that I have to consider.

At present my enquiries centre on the care and treatment of Robert Wilson and I would ask if you could restrict your comments purely to his case.

In order to assist you further I will arrange for you to receive a copy of all the medical records that the police hold in relation to Robert Wilson. I will also include a copy of a full chronology of the treatment of Mr Wilson whilst he was a patient at both Gosport and Queen Alexandra hospital. This chronology is paragraphed and page referenced for ease of reference.

In brief I would like you to review the medical records of Mr Wilson and hopefully address the following issues. The questions posed are,

1. **Certified cause of death**. In this case was the certified cause of death supported by the medical history of the patient?

2. **Prescription of opiates and sedatives.** In the case of Mr Wilson was his prescribing in accordance with his clinical need?

3. In your statement (080904) you refer to patients who were administered opiates and eventually died who may have recovered and left hospital had they not received this medication. In your opinion did Mr Wilson fall into this category?

In addition to compiling a report you will need to keep all notes you make in relation to this case should they be needed to be disclosed in the future in the event of criminal proceedings. These notes will need to be made available to the police in this event.

If there is anything at all that I can do to assist or clarify further please feel free to contact me on any of the above numbers or my mobile Code A

Yours Sincerely

Dave Grocott
Detective Inspector Major Crime

Report, 28th November 2005

Background

This report has been prepared in response to a request by M Code A or further comments on the possibility that patients might have recovered had they not been given opiates. Particular attention was requested to the cases of Mr Arthur Cunningham and Mr Robert Wilson.

In preparing this report I have consulted my files, including the records made during my investigation. I have not consulted any other sources of information.

The specific cases

The cases of Mr Cunningham and Mr Wilson are considered first. The information is taken from the notes I made when reviewing the medical certificates of cause of death (MCCDs) and when reviewing the medical records (provided for me by Hampshire Constabulory).

Arthur Cunningham

1. Information from MCCD.

The information I have relates to Arthur Cunningham, who died 26 September 1998, aged 79, having last been seen on 25th September. The cause of death was given as bronchopneumonia, Parkinson's, and a sacral ulcer. The patient died on Dryad ward.

2. Information from review of records.

Date of birth: Code C of death: 26.9.98 Age: Sex: male

Fairly advanced Parkinson's attending Dolphin Day Hospital.

Nursing notes
21.9.98 Admitted from DDH with Parkinson's, dementia and diabetes (diet controlled). Catheterised on previous admission for retention. Large necrotic sore on sacrum. Dropped left foot, back pain from old injury. 14.50 oramorph 5mg given prior to wound dressing.
21.9.98 Remained agitated until approx 20.30. syringe driver commenced as requested. Diamorphine 20mg, midazolam 20mg at 23.00. Peaceful following
22.9.98 Mr Farthing telephoned, explained that a syringe driver containing diamorphine and medazolam was commenced yesterday for pain relief and to allay his anxiety following an episode when Arthur tried to wipe his sputum on a nurse saying he had HIV and was going to give it to her.
23.9.98 S/B Dr Barton. Has become chesty overnight, to have hyoscine added to the driver. Stepson contacted and informed of deterioration. Mr Farthing asked if this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed. 13.00 Mr & Mrs Farthing very angry that syringe driver has been commenced. Explained that needed for pain and that

consultant would need to give permission to discontinue. 'He is now fully aware that Brian is dying and needs to be made comfortable.'
24.9.98 diamorphine to 40mg
25.9.98 diamorphine to 60 mg, midazolam 80mg hyoscine 1200mg
26.9.98 diamorphine 80mg, midazolam 100mg; died 23.15

When admitted 21.9.98, the desired outcome in the nursing record was to promote healing and prevent further breakdown of the sacral sore. The DDH notes indicate the patient was admitted to Dryad for treatment of the pressure area.

The drug record indicates that oramorph was written up on 21.9.98 2.5-10mg and started that day, being given 2 doses. Diamorphine SC 20-200mg was written up 23.10, with hyoscine 200-800mg. The dose of hyoscine was given as 800mg to 2 gm 25.9.98, and midazolam 20-200mg.

Mr Cunningham had mylodysplasia, but this was reported as stable 29.8.98 (on discharge from Mulberry ward).

Letter from Dr Lord, 23.9.98 – 'I have taken the liberty of admitting him to Dryad ward at Gosport War Memorial Hospital with a view to more aggressive treatment on the sacral ulcer as I feel that this will now need Aserbine in the first instance.'

Inpatient notes

TUR 1992, Appendix 1942, Parkinson's, spinal fusion 1944; stone r renal pelvis 1992, 1994 – NIDDM;
Wt loss noted 20.7.98, no cause for this discovered other than discontent with rest home.
21.9.98 – DDH; very frail, tablets found in mouth, offensive large necrotic sacral ulcer with thick black scar. Plan – stop codanthramer and metronidazole, TCI Dryad today, Aserbine for sacral ulcer, nurse on side, high protein diet, oramorph prn if pain. 'prognosis poor'

21.9.98 Transfer to Dyad ward. Make comfortable, give adequate analgesia, I am happy for nursing staff to confirm death JAB

25.9.98 Remains very poorly. On syringe driver, for TLC Brook

24.9.98 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 JAB.

26.9.98 died 23.15
28.9.98 death cert (Dr Lord) 1 bronchopneumonia 2 parkinson's disease, sacral ulcer.

Commentary
The patient's sacral ulcer was not treated aggressively; there is no record of the indication for use of a syringe driver, and the early resort to this medication suggests the opposite of aggressive treatment. The patient was certainly ill, although the explanation for the sudden deterioration in the days before admission are not entirely

clear. It is not possible to be certain that more aggressive treatment would have led to a different outcome, but such an approach was not given the chance.

Further comments, November 2005.
When seen by the specialist 21.9.1998 it was noted that the prognosis was poor and that oramorph could be used if the patient was in pain. However, it was also indicated that the purpose of the admission was for more aggressive treatment of the ulcer, including Aserbine, nursing on his side, and a high protein diet. It is not clear from the nursing or medical records whether this 'more aggressive' treatment was initiated, or whether a more conservative approach was taken from the start. For example, there is no information about nursing position or use of Aserbine.

Oramorph was given prior to wound dressing, but diamorphine by syringe driver was started on the day of admission. Use of other analgesic mediation is not mentioned, although the use of a non-opiate analgesic would have been consistent with the aim of 'aggressive' treatment of the sacral sore. The dose of diamorphine – 20 mg – was high. It is generally recommended that to obtain an equivalent level of pain relief, the dose of diamorphine on transfer from oral morphine should be one third of the total daily oral dose (I have a September 1998 copy of the British National Formulary [BNF] that includes a table on page 14 of the doses of subcutaneous diamorphine equivalent to certain doses of oral morphine. 30mg oral morphine every 12 hours i.e. 60 mg in 24 hours, is given as equivalent to 20 mg of subcutaneous diamorphine). Mr Cunningham was not receiving 60mg per day of oramorph, and the dose of diamorphine given, particularly when used with midazolam, would have had a significant sedative effect. The development of bronchopneumonia (signs of being 'chesty' were noted on 23 September) would not be unexpected in these circumstances.

Given these observations, it appears that on the day of admission it was decided that aggressive treatment to heal the ulcer and prolong life was not appropriate and that care should be palliative only, and that death within a short time should be expected. The reasons for this decision are not documented. The commencement of diamorphine by syringe driver, by promoting the onset of bronchopneumonia, would have played a significant role in leading to death. It is not possible from the information in the records to judge whether Mr Cunningham's ulcer would have responded to 'aggressive' treatment, how long he would have otherwise lived, or whether he would have been discharged from Dryad ward alive.

Robert Wilson

1. Information from MCCD.
Date of death 18.10.1998. Dryad Ward. Last seen alive 18.10.1998. Cause of death given as 1a CCF, 1b renal failure, 2 liver failure. Age 75.

2. Review of records

Date of birth: Code C Date of death: 18.10.98 Age: Sex: Male

15.10.98 S/B consultant in old age psychiatry (Dr Lusznat); fracture L humerus following a fall, Code C, poor mobility, Barthel 5, early dementia ??a Code C related. Tazodone started.

He had been an inpatient in 1997 with a chest infection and l Code C Code C intake.

Letter from specialist #L greater tuberosity, shoulder 21.9.98, admitted overnight via A&E; feeling sick. On frusemide, spironolactone and thiamine, decided to agree to operative fixation, admitted ? Dickens ward, appears to have been given diamorphine inj 24.9.98 5mg because of pain in arm. 29.9.98 renal function impaired. 'Not for resuscitation in view of poor quality of life and poor prognosis.' Given IV fluids and referred to psychogeriatrician. 7.10.98 – urea 15.8, creatinine 152. 13.10.98 – still needs nursing care and medical care. He is also in danger of falling ...

14.10.98 Transferred to Dryad ward continuing care. HPC # humerus L 27.8.98 PMH alcohol problems, recurrent oedema, CCF. Needs help ADL, ??? continent, Barthel 7, lives Code C ?? ??. ?? full mobilisation JAB

16.10.98 decline overnight with SOB. O/E bubbling, weak pulse, unresponsive to spoken orders Oedema ++ in arms and legs ?silent MI ? ?? function. Increase frusemide to 2 x 40mg Knapman

17.10.98 illegible entry

18.10.98 died peacefully 23.40

Occupational therapist notes that Mr Wilson's conception of discharge home is totally unrealistic (9.10.98); placement recommended.

The GWMH drug chart indicates: oramorph 2.5-5ml 10mg/5ml from 14.10.98, given 2 doses, then oramorph 15.10.98 10mg/5ml, 10 mg 4 hrly, given on 15 and 16.10.98, with oramorph 20 mg at night, given 15.10.98. (The decline is noted 16.10.98). Diamorphine 20-200mg sc in 24 hrs started 16.10.98, 20mg on 16, 60 on 17 and 60 on 18.10.98 Also, hyoscine 200-800mg/day (400 16, 600 17.10, 1200 18.10.98), medazolam 20-80 mg, 20 mg given 17.10, and 40 mg 18.10.98.

The nursing record indicates oramorph started on admission 14.10.98 by Dr Barton, for pain in L arm. The patient declined night of 15-16.10.98, seen by Knapman on the 16th, then syringe driver started (the drug chart was completed by Dr Barton, not Dr Knapman).

The nursing record in the Nursing Care Plan notes the administration of oramorph 14.10 & 15.10, and records patient sleeping well but becoming chesty and difficulty swallowing medications, plus incontinent of urine (?symptoms due to oramorph). Some morphine was given immediately after the fracture 3.10.98 and 5.10.98, on Dickens ward, but this was not continued – switched to co-codamol, then discharged on paracetamol, 13.10.98.

Commentary

Discharged on paracetamol to GWMH, where oramorph was immediately started (no reason for switch given), and patient began to decline; started on sc diamorphine and medazolam, not clear why, or which doctor made this decision. At the very least this is poor record keeping; it is also likely to indicate inadequate assessment and a too rapid decision to accept decline and death. It could reflect a locally accepted policy of early use of opiates and a passive attitude towards severe illness in the elderly.

Further comments, November 2005.
Mr Wilson was clearly frail, and the prognosis was noted as poor. However, instead of attempting to control pain from the fractured humerus with non-opoid analgesia, oramorph was commenced on admission. Paracetamol had been used before admission, but there is no statement in the records to indicate that paracetamol was not effective, nor any record of use of other analgesic medication as recommended in the Wessex guidelines, nor an assessment of pain such as was recommended in the 1998 version of the guidelines.

Was the commencement of opiate analgesia premature? Since there is so little about this decision in the records it is very difficult to reach a firm conclusion. When viewed in the context of the other cases that I reviewed, there must be concern that opiates were started too soon.

Were lives shortened by premature use of opiates?
In my review, I noted a liberal use of opiate medication, amounting to almost routine use reflecting a culture of 'making comfortable' rather than treating vigorously. The records did not indicate that detailed clinical assessments were undertaken of the causes of pain or the reasons for deterioration in a patient's condition. In some cases, therefore, it seems to me very likely that conditions that could have been readily treated were instead followed by the administration of opiates and subsequent death. This means that some patients would not have lived as long as they would have done if they had received more vigorous treatment. I do not know how many patients' lives were shortened and cannot identify individual cases with confidence, although those in which concerns about the decision to start opiate medication were identified during the review of medical records would be the cases to assess in more detail (Chapter Two of my report).

In those lives that were shortened, the amount of life lost is very difficult to estimate. The patients of Gosport War Memorial Hospital were generally old and frail, and did not have a long life expectancy. Nevertheless, I did feel that some patients, who I could not identify, would have lived long enough to be discharged from hospital.

Richard Baker
Department of Health Sciences
University of Leicester

Robert Wilson BJC/55

1. **CHRONOLOGY/CASE ABSTRACT.** (The numbers in brackets refer to the page of evidence).

1.1. Robert Wilson a 74 year old gentleman in 1998 attended Queen Alexandra Hospital, Portsmouth A&E Department on the 21st September 1998 (125-127) with a fracture of the left femoral head and tuberosity (169).

1.2. Mr Wilson had suffered many years before with Malaria and Diphtheria (143) but was [Code C] at the time of an endoscopy in 1994 (313). In 1997 he was admitted to hospital with a fall, epigastric pain and was found to have evidence of [Code C]. During the 1997 admission, an ultra sound showed a small bright liver compatible with [Code C] and moderate ascites (129). His Albumin was very low at 19 (150) and a bilirubin was 48 (129). All these are markers of serious alcoholic liver disease with a poor long term prognosis. His weight was 100 kgs (152). There is no record of follow up attendance.

1.3. When he attends A&E it is originally intended to offer him an operation on his arm, which he refuses. However, he is kept in A&E overnight for observation (161-2). It becomes apparent by the next day that he is not well, is vomiting (163) and he is needing Morphine for pain (11). His wife is on holiday (11) and it is not thought possible for him to go home so he is transferred on 22nd September to the Care of the Elderly team at the Queen Alexandra Hospital (163).

1.4. The day after admission he is no longer thought fit enough to have an operation on his arm, although he would now be prepared to. He is recognised to have [Code C] [Code C] considerable oedema and abdominal distension on admission (167). He has abnormal blood tests on admission including a mild anaemia of 10.5 with a very raised mean cell volume of 113 and his platelet count is reduced at 133 (239). Five days later his haemoglobin has fallen to 9.7 and the platelet count has fallen to 123 (237). There are no further full blood counts in the notes, although his haemoglobin was normal with haemoglobin of 13 in 1997 (241).

1.5. He is noted to have impaired renal function with a Urea of 6.7 and a Creatinine of 185 on admission (209) and on 25th September Urea of 17.8 and a Creatinine of 246 (203). He is started on intravenous fluids on 27th September (12) and his renal function then continues to improve so that by the 7th

October both his Urea and Creatinine are normal at 6.1 and 101 (199).

1.6. His liver function is significantly abnormal on admission and on 29th his albumin is 22, his bilirubin 82 (he would have been clinically jaundice) there is then little change over his admission. On the 7th October is albumin is 23 and his bilirubin also 82 (199). His AST is 66 (171).

1.7. His vomiting within 24 hours of admission [redacted] but he had also been given Morphine for pain (11). He is started on a Chlordiazepoxide regime (11) as standard management plan to try and prevent significant symptoms of alcohol withdrawal. This has some sedative effects as well.

1.8. His physical condition in hospital deteriorates at first. He is noted to have considerable pain for the first 2 – 3 days, he is found to have extremely poor nutritional intake and has eaten little at home (12). His renal function deteriorates as documented above. He is communicating poorly with the nursing staff (28) and is restless at night on 30th September (30). His Barthel deteriorates from 13 on 23rd September to 3 on the 2nd October (69), his continued nutritional problems are documented by the dietician on 2nd October (16). In the nursing cardex he is vomiting, he has variable communication problems, he is irritable and cross on 1st October (30). On 4th October (16) his arm is noted to be markedly swollen and very painful and it is suggested he needs Morphine for pain (31). The following day he knocks his arm and gets a laceration (16).

1.9. There is ongoing communication with his family which is complicated by inter-family relationships between his first wife's family and his current wife. The plan by 6th October is that he will need nursing home care when he leaves hospital and his Barthel at this stage is 5 (16) (69). However on the 5th the nursing cardex note that he is starting to improve (32) although, he remains catheterised and has been faecally incontinent on occasion.

1.10. On 7th October is now more alert and is now telling the staff that he wishes to return home (17). The nursing staff notes that he is now much more adamant in his opinions (33). However on 8th he had refused to wash for 2 days (18). He is then reviewed at the request of the medical staff by a psycho-geriatrician. The opinion is that he has early dementia, which may be alcohol related and depression. He is noted to be difficult to understand with a dysarthria (117-118). He is started on Trazodone as an antidepressant and

as a night sedative, he is still asking for stronger analgesics on 8th October (35). The letter also mentions (429) rather sleepy and withdrawn..... his nights had been disturbed.

1.11. On the 9th October an occupational therapy assessment is difficult because he is reluctant to comply and a debate occurs about whether he is capable of going home (19). By the 12th October (21) his Barthel has improved to 7 (69) so Social Services say that he no longer fits their criteria for a nursing homeand he should now be considered for further rehabilitation (21). The nursing cardex notes that his catheter is out (35) he is eating better but he still gets bad pain in his left arm (36). His arms, hands and feet are noted to be significantly more swollen on 12th October (36). His weight has now increased from 103 kgs on 27th September to 114 kgs by 14th October (61,63). However his Waterlow score remains at "high risk" for all his admission (71). A decision is made to transfer him for possible further rehabilitation, although the medical review on 13th October states in view of the medical staff and because of his oedematous limbs, he is at high risk of tissue breakdown. He is also noted to be in cardiac failure with low protein and at very high risk of self neglect and injury if Code C Code C. He currently needs 24 hour hospital care (21).

1.12. On 14th October he is transferred to Dryad Ward and the notes (179) say "for continuing care". The notes document the history of fractured humerus, his alcohol problem, current oedema and heart failure. No examination is documented. The notes state that he needs help with ADL, he is incontinent, Barthel 7, he lives with his wife and is for gentle rehabilitation.

1.13. The next medical notes (179) are on 16th October and state that he had declined overnight with shortness of breath. On examination he is reported to have a weak pulse, unresponsive to spoken orders, oedema plus plus in arms and legs. The diagnosis is "? silent MI, ? liver function" and the treatment is to increase the Frusemide. The nursing cardex for 14th October confirms he was seen by Dr Barton, that Oramorphine 10 mgs was given and he was continent of urine. On 15th October the nursing notes 9265) state commenced Oramorphine 10 mgs 4 hourly for pain in left arm, poor condition is explained to wife. On 16th on the nursing cardex he is "seen by Dr Knapman am as deteriorated overnight, increased Frusemide".

1.14. *(possible confusion with the nursing care plan (278), this states for 15th October, settled and slept well, Oramorphine 20 mgs given 12 midnight with good effect, Oramorphine 10 mgs given 06.00 hours. Condition deteriorated overnight, very chesty and difficulty in swallowing medications. Then on 16th it states has been on syringe driver since 16.30 hours. As will be seen from the analysis of the drug chart, Mr Wilson received the Oramorph at midnight on 15th and then 06.00 hours Oramorph on 16th.* The first clinical deterioration is on the night of 15th – 16th October not the night of the 14th – 15th October.

1.15. The next medical note is on 19th October which notes that he had been comfortable at night with rapid deterioration (179) and death is later recorded at 23.40 hours and certified by Staff Nurse Collins. The nursing cardex mentions a bubbly chest late pm on 16th October (265). On the 17th Hyoscine is increased because of the increasing oropharyngeal secretions (265). Copious amounts of fluid are being suctioned on 17th. He further deteriorates on 18th and he continues to require regular suction (266). The higher dose of Diamorphine on the 18th and Midazolam is recorded in the nursing cardex (266).

1.16. Two Drug Charts: The first is the Queen Alexandra drug chart (106-116). This records the regular laxatives, vitamins and diuretics given for his liver disease. The reducing dose of Chlordiazepoxide stops on 30th September for l Code C Code C d the Trazodone started for his mild depression and night sedation. In terms of pain management Morphine, slow IV or subcutaneous 2.5 – 5 mgs written up on the prn side and 5 mgs given on 23rd September and 2.5 mgs twice on 24th September. Morphine is also written up IM 2 – 5 mgs on 3rd October and he receives 2.5 mgs on 3rd and 2.5 mgs on 5th. He is also written up for prn Codeine Phosphate and receives single doses often at night up until 13th October but never needing more than 1 dose a day after 25th September. Regular Co-dydramol starts on 25th September until 30th September when it is replaced by 4 times a day regular Paracetamol which continues until his transfer.

In summary, his pain relief for the last week in the Queen Alexandra is 4 times a day Paracetamol and occasional night time dose of Codeine Phosphate.

1.17. The second drug chart is the drug chart of the Gosport War Memorial Hospital (258-263). His diuretics, anti-depressant, vitamins and laxatives are all prescribed regularily. The regular Paracetamol is not prescribed but is written up on the as required (prn) after the drug chart. This is never given.

Regular prescriptions also contains Oramorphine 10 mgs in 5 mls to be given 10 mgs 4 hourly, starting on 15th October (261). 10 mgs is given at 10 am, 2pm and 6 pm on 15th, 6am, 10 am and 2 pm on 16th. A further dose of 20 mgs at night given at 10 pm is given at 10 pm on 15th October. Although these prescriptions are dated 15th October it is not clear if they were written up on the 14th or 15th.

1.18. On a further sheet of this drug chart (262) regular prescription has been crossed out and prn written instead. Oramorphine, 10 mgs in 5 mls, 2.5 – 5 mls 4 hourly is then prescribed on this sheet. It is not dated but it would appear 10 mgs is given at 2.45 on 14th October and 10 mgs at midnight on 14th October. Further down this page Diamorphine 20 – 200 mgs subcut in 24 hours from Hyoscine 200 – 800 micrograms subcut in 24 hours, Midazolam 20 – 80 mgs subcut in 24 hours are all prescribed. It is not clear what date these were written up. The first prescription is 16th October and the 20mls of Diamorphine with 400 micrograms of Hyoscine are started at 16.10. On 17th October, 20 mgs of Diamorphine, 600 micrograms of Hyoscine are started at 5.15 and the notes suggest that what was left in the syringe driver at that stage was destroyed (262). At 15.50 hours on 17th October, 40 mgs, 800 mgs of Hyoscine and 20 mgs of Midazolam are started and on 18th 60 mgs of Diamorphine, 1200 micrograms of Hyoscine (a new prescription has been written for the Hyoscine) and 40 mgs of Midazolam are started in the syringe driver at 14.50 and again the notes suggest the remainder that was previously in the syringe driver is destroyed.

DRAFT REPORT

regarding

Patient Name (Ref No. egBJC/16)

PREPARED BY: Dr .....

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

Executive Summary please.

1. INSTRUCTIONS

2. ISSUES

3. BRIEF CURRICULUM VITAE

Please insert

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of .....

Any other documentation used during the completion of the report

5. CHRONOLOGY/CASE ABSTRACT

At this point the timeline already prepared could be inserted

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

8. OPINION

9. LITERATURE/REFERENCES

10. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

OPERATION ROCHESTER

Guidance for Medical Experts

Overview.

Operation ROCHESTER is an investigation by Hampshire Police into the circumstances surrounding the deaths of elderly patients at Gosport War Memorial Hospital.

Ten such cases are subject to ongoing investigation. The brief to medical experts in this respect is to examine the medical records and to comment upon the standard of care afforded to those patients in the days leading up to their death. If the care falls below what were then the acceptable standards of the day, the opinion sought would be, how far below the acceptable standards or practice did the care fall?

It may be the case however that the experts determine that the standard of care afforded was acceptable.

Any opinion should be limited to for example, stating that it would have been obvious to the reasonably prudent and skilful doctor in the defendant's position that their actions would hasten or end life.

Whatever the view of the experts, their statements of evidence/reports should be constructed with the following principles in mind:-

1) What treatment should have been proffered in each individual case? Experts should cover in their report the basic conditions of a particular disease and how the symptoms present themselves. They can then go on to describe how the condition would ***normally*** be treated in their own experience, referencing to recognised protocols of the day.

2) When creating reports the experts must bear in mind 'plain speak'. Whilst it is important to be professionally correct, opinions are likely to be challenged by defence experts. Equally reports should be set out in a way that allows for the police/counsel etc to dissect the report and ask for further work or clarification.

3) Experts should have an understanding of the terms Criminal Gross Negligence, and Unlawful Act within the context of Homicide. Language used to describe negligence should be consistent, and if appropriate able to demonstrate why one act is more negligent than another and the level of negligence.

4) When reading the statements of the experts the prosecutor will be looking to apply the criminal standard of proof namely, the evidence to prove any element of the offence must be sufficient to satisfy the jury so that they are sure, or satisfied beyond reasonable doubt. Experts should bear this in mind when expressing opinions or findings so that it is clear as to the level of certainty they can give. Is it for example, only to the level of more likely than not (i.e. on the balance of probabilities), or to the higher level, of being sure so that other reasonable possibilities can be excluded

5) Consideration must be given to explaining the use of statistical information in reports and what the statistics are seeking to establish.

6) Referenced documentation supporting any report must be included.

7) Analysis of supplementary paperwork such as prescription charts/fluid charts/observation charts needs to be undertaken. Paperwork differs from ward to ward let alone hospital to hospital. Ensure that if experts are commenting on procedures that have been carried out and are critical that they have already documented what procedures should have been in place and carried out in ***their*** experience. They cannot assume that the practices they follow are the same as the ones used by the staff at this hospital. They must spell things out.

8) Expert will be supplied with copies of relevant hospital protocols / procedures.

In order to assist experts with an understanding of the law the following passages may be relevant during their determinations.

UNLAWFUL ACT MANSLAUGHTER

'Unlawful act' manslaughter requires that:

(a) the killing must be the result of the accused's unlawful act, though not his unlawful omission. It must be unlawful in that it constitutes a crime. A lawful act does not become unlawful simply because it is performed negligently. The act must be a substantial (more than minimal) cause of death, but not necessarily the only operative cause (see "Causation" below);

(b) the unlawful act must be one, such as an assault, which all sober and reasonable people would inevitably realise must subject the victim to, at least, the risk of some harm resulting there from, albeit not serious harm;

(c) it is immaterial whether or not the accused knew that the act was unlawful and dangerous, and whether or not he intended harm; the mental state or intention required is that appropriate to the unlawful act in question; and

(d) "harm" means physical harm.

(Church [1966] 1 QB 59, DPP v Newbury [1977] AC 500, Goodfellow (1986) 83 Cr App R 23)

GROSS NEGLIGENCE MANSLAUGHTER

"Gross negligence" manslaughter requires the satisfaction of a four stage test:

(a) The existence of a duty of care owed by the defendant to the deceased;

(b) A breach of that duty of care, which

(c) Causes (or significantly contributes to) the death of the victim (see "Causation" below);

(d) And the breach should be characterised as gross negligence and therefore a crime.

(Adomako [1994] 3 All ER 79)

The standard and the breach are judged on the ordinary law of negligence. Those with a duty of care must act as the reasonable person would do in their position. The test is objective. It does not matter that the defendant did not appreciate the risk, provided that such a risk would have been obvious to a reasonable person in the defendant's position. The risk in question is a risk of death.

MURDER

Murder is the unlawful killing of a person with the intention to kill or cause grievous bodily harm. Nothing less will suffice. Foresight that a consequence is almost certain to result is not the same as intention, though it may be evidence of it. There is some legal authority for the proposition that, where the sole, bona fide intention of a doctor is the relief of pain through the administration of drugs, knowledge that those drugs will, as an unwanted side effect, also inevitably hasten the patient's death, that is not murder.

CAUSATION

When prosecuting for an offence of homicide, there are a number of elements the Crown has to prove, and has to prove them to the criminal standard i.e. 'beyond reasonable doubt.' One of those is the element of 'causation'. In simple terms this means that the prosecution must prove that the death was 'caused' (wholly or in part) by the defendant and ought to be straightforward but, '(W)here the law requires proof of the relationship between an act and its consequences as an element of responsibility, a simple and sufficient explanation of the basis of such relationship has proved notoriously elusive.' - *R v Cheshire* [1991] 3 All ER 670.

Recent experience has identified causation as a difficult element to prove in certain types of cases. These are typically, but not exclusively, cases involving medical negligence.

The classic statement on causation in manslaughter was provided by the present Lord Chief Justice in *R v HM Coroner for Inner London, ex parte Douglas-Williams* (1998) 1 All ER 344:

"...that the unlawful act caused death in the sense that it more than minimally, negligibly or trivially contributed to the death.

"In relation to both types of manslaughter it is an essential ingredient that the unlawful or negligent act must have caused the death at least in the manner described. If there is a situation where, on examination of the evidence, it cannot be said that the death in question was [not] caused by an act which was unlawful or negligent as I have described, then a critical link in the chain of causation is not established. That being so, a verdict of unlawful killing would not be appropriate and should not be left to the jury."
(There is an additional 'not' [now in brackets] in the penultimate sentence, otherwise the sentence does not make sense.)

It can be seen from this that the prosecution **must** be able to link the act to at least **an** operative cause of death. It is not sufficient to say that it **may have been** a cause of death.

Hastening/acceleration of death

This can be one of the most difficult aspects of causation. The 'hastening' or 'acceleration' of death and whether depriving a person of the opportunity to live can be a cause of death.

Death is inevitable. Any **action** that brings that day forward can therefore be said to have hastened or accelerated death and will itself be a cause of death. The case most often cited for such a proposition is *R v Dyson* [1909] 1 Cr App R 13. There the defendant had assaulted a child in November 1906 and December 1907. The child died in March 1908 but the charge of manslaughter did not specify the date of the assault (the 'year and a day' rule was then in force.) The child's condition had deteriorated as a result of the 1906 assault but the court said that the judge should have directed the jury to consider 'whether the appellant accelerated the death by his injury of December 1907'. In allowing the appeal the court said that 'it was not absolutely certain that the death had been accelerated' by the second assault as 'death may have been due to a fall'.

This is not a controversial proposition as it is simply a question whether the later act of the defendant brought about the death. Even if the deceased is dying (subject to the *de minimis* rule in *Sinclair*), if the defendant's act shortens life, causation is proved.

De minimis

It would not be sufficient to prove causation if the Crown could only show that the victim would have survived 'hours or days in circumstances where intervening life would have been of no real quality.' It is this meaning that is taken when referring to the *de minimis* rule. For example, if 'V' is dying, is in a coma, on life support and the defendant's act or omission brings forward the date of that inevitable death by hours or even days, if it can be said that there was 'no real quality' of life in that intervening period, the *de minimis* rule would apply. This is to be contrasted with a situation whereby the act or omission caused the coma and ensuing death or where there was a significant period between the act or omission and the ensuing death. It is not possible to be more definite as to the duration here but if 'V' survived in that state for more than a few days, *de minimis* would not apply and the ordinary rule of causation would do so instead.

Multifactorial

The insuperable difficulty comes when the doctors cannot say when or even if he may have died even if treated appropriately. This may be because they do not know the underlying cause of the illness or there are numerous factors present at death and it is not possible to identify which, if any had an operative influence on the death. In instances such as these, the death may be certified as 'multifactorial'. Although such a term should provide a warning to a prosecutor as to proof of causation, it does not necessarily mean that we cannot prove causation. If we can prove that one of the operative causes of death was due to the act or omission of the defendant, then this is sufficient to prove causation. Causation does not require that the particular cause would have caused death on its own, provided it is sufficient to be an operative **contribution** to the cause of death. Therefore, if the doctor in citing 'multifactorial' says that death was caused by a combination of factors and that factor 'X' was a more than minimal **contribution** to death (even if on its own it would not have caused death), if 'X' was caused by the act or omission of the defendant, we can show causation. This is so even if any one of the other factors would have been sufficient to have caused death on their own. This is an area that needs to be carefully analysed. What will not be sufficient to prove causation is a statement that, death was caused by any one or more of a number of causes and it cannot be said for sure that the relevant one was an operative cause, only that it might have been.

David Grocott
Detective Inspector
Major Crime Investigation Team