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.

Nine 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.

The existence of the documents was reported to the police and a meeting of senior police and NHS staff was subsequently held on 19th September, 2002 at Hampshire Police Support Headquarters. The following decisions were made at that meeting:

Further police enquiries were necessary in light of the new information and an enquiry team would be assembled and based at Hulse Road, Southampton. The enquiry team would:

- Examine the new documentation and investigate the events of 1991;
- Review existing evidence and new material in order to identify any additional viable lines of enquiry;
- Submit the new material to the experts and subsequently to CPS;
- Examine individual and corporate liability.

It was decided that a press release was necessary, which would include a free phone telephone number for concerned relatives to contact police. It was also decided that a Police Family Liaisons Officer needed to be appointed.

Third Police Investigation

On 23rd September, 2002 Hampshire Major Crime Investigation Team commenced enquiries. To date, relatives of 90 elderly patients have contacted police with regards to the deaths of the patients at GWMH. A number of these relatives are part of a family group being represented by a firm of solicitors, namely ALEXANDER HARRIS of Manchester. Others contacted police through an NHS direct free phone number or directly, as a result of publicity. Sixteen of these cases were identified by Professor BAKER during his research on behalf of the CMO.

The current police investigation is being conducted in stages, as follows:

Stage One

Enquiries into the documents and events of 1991. (Now completed)

In summary, the events of 1991 were as follows:

- A number of night-nursing staff at GWMH had concerns as earlier stated and held a private meeting to discuss the issues. They were conscious of an on-going case within the NHS of GRAHAM PINK, a Charge Nurse working in the care of elderly patients in Stockport, who was dismissed for "whistle blowing".

- It was decided that three of the nurses would approach the hospital management and raise their concerns. The nurses raised their concerns with the Patient Care Manager.

- A series of meetings took place between management, medical and nursing staff.

- A final meeting took place in which the nursing staff were informed by both the hospital management and medical staff, that the problems raised were due to a lack of understanding by nursing staff concerning the use of Diamorphine. In addition, there was also a training issue in relation to syringe drivers.

- Although the nursing staff were not entirely happy with the outcome of the meetings, they felt that they had done everything they could in raising the issues, but in light of the PINK case, felt there was no more they could do, apart from retaining the documentation.

Stage Two

Obtaining further expert medical opinions for screening purposes (now completed).

This stage involved a team of medical experts in various areas of elderly patient care i.e. Palliative, Geriatric, General Medicine and Nursing, providing their individual and holistic opinions on the treatment of the 90 GWMH, based entirely on information from medical records.

The screening process enabled the medical experts to put the cases into 3 categories as follows:

1. Patient received optimal care and died of natural causes or cause of death unclear.
2. Patient received sub-optimal care and died of natural causes or cause of death unclear.
3. Patient received negligent care and died of natural causes or cause of death unclear.

Cases in category 1 are no longer under investigation. Cases in category 2 are currently being reviewed on a medical/legal bases in order to establish whether Police investigations should continue or whether they should be referred to other regulatory bodies i.e. GMC, NMC.

There are 13 cases in category, 9 of which are cause of death unclear. Investigations are continuing in respect of all 13 with a view to the submission of files to CPS.

In respect of the 9 cases where death is unclear, 4 of these cases have been prioritized in order of seriousness and will be fast tracked to CPS.

Stage Three

This stage is the gathering of evidence in respect of the cases in category 3 and the submission of a file of evidence to the CPS in respect of the first 4 cases.

A Clinical Review Team consisting of experts in Palliative and Geriatric medicine have been appointed with a view to initially reviewing all information regarding the treatment of the four patients and providing their expert opinion as to whether or not any of these patients have been unlawfully killed.

Code A
Detective Sergeant