OPERATION ROCHESTER

Re Ruby Lake

Draft ADVICE

Introduction

1. On 21 August 1998, Ruby Lake, aged 84, died.

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

3. The cause of death was given as bronchopneumonia.

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

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

6. We have been asked to advise on the question of whether the evidence reveals the commission of any criminal offence by Dr Barton, and if so, whether there is a realistic prospect of conviction. The criminal offence to be considered is gross negligence manslaughter.

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

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

Background

9. Mrs Lake was born on Code A

10. Her husband had died in 1983, and from that time she lived alone in her house in Alverstoke.

11. Later on in life, Mrs Lake developed a number of serious medical conditions. Prior to 1998, she had suffered from heart failure, a heart attack, raised blood pressure, an enlargement of the heart, the thickening of heart valves and an irregular heart beat. In addition, she suffered from renal failure, generalised osteoarthritis, gout and leg ulcers. It was also thought possible that she was suffering from CREST syndrome, a generally progressive disease which can lead to death from gastro-intestinal, cardiac, kidney or pulmonary problems. Mrs Lake was mobile, however, and could walk for about one hundred yards before having to stop.

12. On 5 August 1998, Mrs Lake suffered a fall at her home. She was taken to the Royal Naval Hospital in Haslar, Gosport ('Haslar'), where examination revealed that she had fractured the neck of her left femur. Mrs Lake was admitted to Haslar, where she received treatment for the next two weeks.

13. Given her obvious frailty and numerous medical problems, Mrs Lake had a difficult post-operative period at Haslar. She had episodes of confusion and was

agitated at night. She developed a chest infection, and her heart beat was raised and irregular. She did, however, show significant signs of improvement.

14. On 14 August, Mrs Lake was assessed by Dr Althea Lord, a Consultant Geriatrician. Dr Lord noted: '*It is difficult to know how much she will improve but I'll take her to an NHS continuing care bed at GWMH next week.*' She went on to note that Mrs Lake was: '*Frail and quite unwell at present.*'

15. On 18 August, the medical notes record that Mrs Lake was well and awaiting transfer to GWMH. She was transferred later that day.

Gosport War Memorial Hospital

Overview

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

Dryad Ward

17. Mrs Lake was transferred to Dryad Ward, under the care of Dr Lord.

18. The doctor who saw Mrs Lake 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.

19. The details of Mr Lake's treatment were recorded in various sets of notes. These notes included the medical notes, the nursing notes and the drug chart. However, the medical notes only contain two entries. The first records her transfer on 18 August, and the second records her death on 21 August.

20. The entry in the medical records recording her transfer on 18 August was made by Dr Barton. The entry reads:

'Transfer to Dryad Ward continuing care. History of presenting complaint: fractured left neck of femur 5th August 1998. Past medical history: angina and congestive cardiac failure. Catherterised, transfers with two, needs some help with activities of daily living. Bartel score of 6. Get to know. Gentle rehabilitation. I am happy for nursing staff to confirm death.'

21. The nursing notes stated that Mrs Lake had settled in well and slept from 10 p.m. to midnight. However, when she woke up she was very anxious and at times confused. Oramorph 5mg was given at 12.15 a.m., but with little effect.

22. On 19 August, Mrs Lake became breathless. The nursing notes, in an entry timed at 11.50 a.m., record that she had complained of chest pain and was grey around the mouth. Oramorph 10mg/5ml was given, but her pain was only relieved for a short time. Mrs Lake was still very anxious. A syringe driver was commenced at 4 p.m. containing diamorphine 20mg and midazolam 20mg. Mrs Lake had a comfortable night.

23. On 20 August, according to the nursing notes Mrs Lake was very '*bubbly*', meaning that there was a build up of bodily secretions in the throat or top part of her lungs. At 9.15 a.m., hyoscine 400microgram was added to the syringe driver. At 12.15 p.m., it was noted that Mrs Lake's condition had deteriorated overnight. At 4.50 p.m., the doses in the syringe driver were increased to diamorphine 40mg, midazolam 40mg and hyoscine 800microgram.

24. On the night of 20 August, Mrs Lake continued to deteriorate. At 7.35 a.m. on 21 August, the doses in the syringe driver were increased to diamorphine 60mg, midazolam 60mg and hyoscine 800 microgram.

25. Mrs Lake's death was confirmed at 6.25 p.m. on 21 August.

26. The death certificate recorded the cause of death as bronchopneumonia.

The Police Investigation

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

28. 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.

29. 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.

30. 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.

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

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

33. A total of ninety cases were reviewed by the police. These included the death of Mrs Lake. 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.

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

35. Dr Wilcock and Dr Black have each prepared a report commenting on the treatment given to Mrs Lake at GWMH. Dr Wilcock has also prepared a supplementary report, commenting on a number of matters raised by Dr Barton in her police interview.

Dr Barton

36. As part of the police investigation into the fourteen cases which had been reviewed and categorised as negligent, Dr Barton was interviewed under caution in relation to the death of Mrs Lake. The interview took place on 14 July 2005. Dr Barton was represented by a solicitor, Ian Barker.

37. At the beginning of the interview, Dr Barton read out a prepared statement. The statement may be summarised as follows:

(1) By 1998, the demands on Dr Barton's time at GWMH were considerable, and were such that had she spent time making more detailed notes in relation to her clinical assessments, she risked potentially neglecting other patients [p.6];

(2) Although her note on transfer referred to '*gentle rehabilitation*', Dr Barton was aware that Mrs Lake was frail and unwell, as previously noted by Dr Lord. She was conscious that Mrs Lake might not recover, and therefore she noted that she was happy for nursing staff to confirm death [p.12];

(3) Dr Barton prescribed oramorph for pain relief. She was concerned that Mrs Lake might very well require pain relief in view of her recent fracture and her ulcers [p.13];

(4) Oramorph was appropriate in view of Mrs Lake's history of congestive cardiac failure, although in the event it had little effect, and she remained anxious and confused [pp.13-14];

(5) Although no specific entry was made in the medical notes, Dr Barton would have reviewed Mrs Lake on the morning of 19 August. Dr Barton would have been concerned that Mrs Lake's condition had deteriorated overnight, and believed that she might be likely to die shortly. In these circumstances, Dr Barton was anxious that Mrs Lake should have appropriate relief from her pain and distress. Therefore she prescribed diamorphine 20-200mg, midazolam 20-80mg and hyoscine 200-800 microgram, to be administered via a syringe driver. It was Dr Barton's intention that these medications should be started at the bottom end of the dose range, and increased if necessary [pp.14-15];

(6) The oramorph administered at 11.50 a.m. on 19 August was not successful in relieving Mrs Lake's pain over any prolonged period, and therefore the syringe driver was commenced at 4 p.m. [pp.15-16];

(7) Dr Barton does not know whether she was informed at the time that the syringe driver was being commenced, or of the precise doses of diamorphine and midazolam being administered. However, she considers that in the circumstances the doses were entirely appropriate [p.16];

(8) Mrs Lake continued to deteriorate, and the doses administered via the syringe driver were increased. It is possible that Dr Barton was not informed of the increases at the time. In any event, she would have been informed very shortly afterwards and would have been content that the increases were appropriate [pp.16-17];

(9) The diamorphine, midazolam and hyoscine were prescribed and administered with the sole intention of relieving Mrs Lake's pain, anxiety and distress. At no time was any medication provided with the intention of hastening her demise [pp.17-18].

The Report of Dr Wilcock

38. Dr Wilcock is a Reader in Palliative Medicine and Medical Oncology at the University of Nottingham and an Honorary Consultant Physician of the Nottingham City Hospital NHS Trust.

39. Dr Wilcock has reviewed the care given to Mrs Lake at GWMH, and prepared a report dated 10 July 2005.

40. Dr Wilcock's opinion is that the medical care provided to Mrs Lake was sub-optimal [p.25]. His conclusions may be summarised as follows:

(1) The notes relating to the care provided to Mrs Lake on Dryad Ward are wholly inadequate. There is no record which indicates that she was properly assessed, and there is no justification for the prescription and administration of the diamorphine, midazolam and hyoscine [p.26];

(2) The lack of documentation makes it impossible to provide a firm opinion as to the cause of Mrs Lake's chest pain, but it is possible that she was suffering from a chest infection, rather than a heart complaint [p.28];

(3) None of the common causes of chest pain to which Mrs Lake was at risk justified the commencement of a syringe driver containing diamorphine and midazolam [p.30];

(4) In any event, the wide dose range of diamorphine which was prescribed was likely to have far exceeded Mrs Lake's needs. A starting dose of 10mg, rather than the 20mg actually administered, would have been appropriate. Owing to the lack of adequate notes, it is impossible to say whether the increases in the doses were appropriate [pp.29, 31];

(5) The starting dose of midazolam was consistent with the recommended level [p.29];

(6) Although Mrs Lake was an old and frail lady with significant medical problems, she had been generally progressing rather than deteriorating at the time of her transfer to Dryad Ward. The lack of documentation makes it difficult to understand why she deteriorated rapidly [p.32];

(7) It is possible that Mrs Lake had naturally entered the terminal phase of her life. However, it is also possible that her physical state had deteriorated in a temporary or reversible way and that with appropriate medical care she would have recovered [p.32].

41. Dr Wilcock concludes as follows [pp.33-34]:

'If it were that Mrs Lake had naturally entered the terminal phase of her life, 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 Mrs Lake a peaceful death, albeit with what appears to be an inappropriate use of medication due to a lack of sufficient knowledge...However, in my opinion, given the lack of medical and nursing records to the contrary, reasonable doubt exists that Mrs Lake had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lake by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lake by failing to adequately assess her physical state at the time of her transfer and when she complained of chest pain, failing to take suitable and prompt action when necessary and if her physical state had deteriorated in a temporary or reversible way exposing her to the inappropriate use of diamorphine and midazolam in doses that could have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton leaves herself open to the accusation of gross negligence.'

The Report of Dr Black

42. Dr Black is a Consultant Physician in Geriatric Medicine at Queen Mary's Hospital in Kent, and an Associate Member of the General Medical Council.

43. Dr Black has reviewed the care provided to Mrs Lake, and prepared a report dated 29 August 2005. His conclusions may be summarised as follows:

    (1) It is difficult to assess Mrs Lake's progress at GWMH, and the appropriateness of the care provided, owing to the lack of adequate medical notes [p.1, para.6.9];

    (2) Mrs Lake was an 84 year old lady with a number of chronic diseases [p.1];

(3) There is always a significant mortality and morbidity rate in old people following the fracture of the neck of the femur, particularly in those who have previous cardiac and other chronic diseases [para.6.4];

(4) The chest pain that was noted at 11.50 a.m. on 19 August could have been a heart attack, a pulmonary embolus, an episode of angina or some other non-specific chest pain [para.6.11];

(5) At the time of this episode, if Mrs Lake was seriously distressed, the prescription and administration of oramorph 10mg would have been appropriate [para.6.11];

(6) Diamorphine is commonly used to relieve pain in cases involving cardiac disease [para.6.14];

(7) As the administration of the oramorph had not been successful in relieving Mrs Lake's pain, it was probably reasonable to have started with a dose of diamorphine 20mg in the syringe driver at 4 p.m. on 19 August [para.6.14];

(8) The original dose of diamorphine appeared to be for continued chest pain. It is unusual to use continuous diamorphine for chest pain without making a specific diagnosis. Mrs Lake may have been in cardiogenic shock, and in such circumstances it would have been reasonable to use diamorphine in the syringe driver, together with midazolam and hyoscine. However, whether this was in fact the case cannot be determined, owing to the lack of adequate documentation [para.6.15];

(9) The starting dose of midazolam 20mg was within the applicable guidelines, although many doctors believe that a lower dose is more appropriate in the case of elderly patients [para.6.15];

(10) It is impossible to determine the cause of death from the medical notes, and a coroner's post mortem ought to have been conducted [para.6.16].

44. Dr Black concludes as follows [para.7.2]:

'In my opinion the combination of a lack of a documented clinical examination, the lack of prescription of appropriate oral analgesia on admission to Gosport, the decision to start a syringe driver without documentation of a clinical diagnosis or the reason for it in the medical notes, together represent a negligent standard of medical care.

Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Mrs Lake's death. However, I am unable to satisfy myself to the standard of beyond reasonable doubt that it made more than a minimal contribution.'

Witness Statements

45. The syringe driver was commenced by Sandra Hallman, a staff nurse on Dryad Ward. She states that where the administration of drugs via a syringe driver had been prescribed, a senior nurse could start the syringe driver without having to refer the matter back to the prescribing doctor. She states that in Mrs Lake's case, it seems likely that she sought Dr Barton's authority prior to commencing the syringe driver, because she felt uneasy about initiating the procedure.

46. The position of Mrs Lake's relatives may be summarised by reference to the comments made by Diane Mussell, her daughter:

'I found the hospital staff to be helpful with regard to allowing us to stay, they seemed quite caring but I don't recall talking to anyone in any great detail about mum's condition. By the Thursday we were all aware that mum was very ill and we didn't expect her to last that much longer.'

The Legal Framework

47. 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.

48. 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.

49. 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.)

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

51. 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*.

52. 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.'

53. 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."

54. 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.'

55. 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'.

56. 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.

57. 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).

58. 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.

59. 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.

60. 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.

61. 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.*'

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

Analysis

Overview

63. Mrs Lake was transferred to Dryad Ward on 18 August 1998. The purpose of the transfer was to provide what was described as gentle rehabilitation, although it was recognised by Dr Lord that Mrs Lake was unwell, and that it was uncertain whether there would be any significant improvement.

64. During Mrs Lake's time on the ward, Dr Barton prescribed a number of drugs. Oramorph was administered on 18 and 19 August, but it was not successful in reducing Mrs Lake's pain or distress for any length of time. At 4 p.m. on 19 August, a syringe driver containing diamorphine and midazolam was commenced. Over the next two days, the doses in the syringe driver were increased, and a sedative, hyoscine, was added.

65. On 21 August, Mrs Lake died.

Summary of the Experts' Opinions

66. The lack of medical notes made by Dr Barton has severely hampered the ability of the experts in this case to assess Mrs Lake's progress on Dryad Ward, and come to firm conclusions as to whether the care provided was appropriate. The failure of Dr Barton to make adequate notes was plainly negligent.

67. Nevertheless, having regard to all the circumstances of Mrs Lake's case, the experts have formed the following essential conclusions:

    (1) Dr Wilcock states the administration of diamorphine via a syringe driver does not appear to have been an appropriate treatment, and that in any event, the starting dose should have been 10mg, rather than 20mg. It is possible that Mrs Lake may have naturally entered her terminal phase, although there is reasonable doubt that this was in fact the case. If Mrs

Lake had not naturally entered the terminal phase, Dr Barton may have exposed her to excessive and inappropriate doses of diamorphine and midazolam, which may have contributed to her death in more than a trivial way. In that regard, Dr Barton leaves herself open to the accusation of gross negligence.

(2) Dr Black states that the commencement of the syringe driver with diamorphine 20mg was probably reasonable. It is possible that the diamorphine and midazolam contributed in part to Mrs Lake's death, although it could not be proved to the criminal standard that it would have made more than a minimal contribution.

Discussion

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

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

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

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

69. Whilst Dr Barton was plainly negligent in failing to make adequate medical notes, this failure was not a cause of death. Similarly, whilst Dr Barton may have been negligent in failing to conduct an adequate assessment of Mrs Lake's condition, it could not be said that this failure alone caused death.

70. In considering the issue of Dr Barton's negligence, the essential question is whether she breached her duty in causing the particular doses of diamorphine to be administered to Mrs Lake. There is some evidence that Dr Barton was negligent in this regard (that is, the evidence of Dr Wilcock). However, Dr Black

states that it was probably reasonable for diamorphine 20mg to have been administered via the syringe driver. Furthermore, Dr Wilcock and Dr Black are unable to say whether or not Dr Barton was negligent in increasing the doses. Having regard to these matters, whilst there is some evidence that Dr Barton breached her duty of care in causing the diamorphine to be administered via the syringe driver, it would be difficult to prove this to the criminal standard.

71. There is some evidence that the drugs prescribed by Dr Barton shortened Mrs Lake's life. However, Dr Wilcock states that she may have naturally entered the terminal phase, and Dr Black states that it could not be proved to the criminal standard that the drugs made more than a minimal contributed to death. In our view, therefore, it is unlikely that causation could be established in this case.

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

    (1) Mrs Lake was an elderly, frail lady, who may have been dying naturally;

    (2) On any view, in prescribing the diamorphine Dr Barton was attempting to relieve Mrs Lake's pain and distress;

    (3) The care provided by Dr Barton allowed Mrs Lake, who may have been dying naturally, to die peacefully;

    (4) If the drugs prescribed by Dr Barton did shorten life, it could not be said that they made more than a minimal contribution.

Conclusions

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

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

David Perry

Louis Mably

1 March 2006

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