OPERATION ROCHESTER

Re Enid Spurgin

Draft ADVICE

Introduction

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

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

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

4. During her time on Dryad Ward, Mrs Spurgin 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 Spurgin'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 or her immediate supervisor, Dr Richard Reid, 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 Spurgin was born on Code A

10. She married Ronald Spurgin at the age of 26. The couple had no children, and Mr Spurgin died in 1958. Shortly afterwards Mrs Spurgin moved to 59 Knightsbank Road in Gosport, where she continued to live until the last weeks of her life.

11. Mrs Spurgin was generally fit and healthy, and had an enthusiasm for life. However, she had experienced a number of medical problems in her later years. In 1981 she had been diagnosed with a stress fracture of her right hip, and in 1988 was diagnosed with Paget's disease in her pelvis. In 1989 she experienced a probable myocardial infraction. At that time she was noted to have poor eyesight, and to be taking anti-depressants. In 1997, she suffered from depression secondary to failing physical health. Nevertheless, it is clear that Mrs Spurgin remained active and independent.

12. On 19 March 1999, Mrs Spurgin suffered a fall whilst walking her greyhound. She was taken to Royal Hasler Hospital in Gosport ('Haslar'). On examination, she was found to have fractured her right hip. The next afternoon she underwent an operation, where the hip was repaired using a dynamic hip screw. Mrs Spurgin's post operative course was not straight forward. She suffered from leakage from the wound, and her right thigh swelled to twice its normal size. It

was likely that she had developed a haematoma. It was considered (it appears by a Dr Woods) that she was at risk of compartment syndrome. (Compartment syndrome is a complication of fractures, which develops in the early in the post fracture or post operative period, where swelling caused by internal bleeding can result in muscle and nerve death in the affected area.)

13. Mrs Spurgin was given a blood transfusion. She continued to experience pain, and there were concerns about her level of hydration. On 22 and 24 March, she was reviewed by Surgeon Commander Scott. He referred her to Dr Lord for rehabilitation.

14. On 24 March, Mrs Spurgin was reviewed by Dr Richard Reid, a Consultant in Geriatric Medicine. He noted that she was continuing to experience pain, and asked that her analgesia be reviewed. In his subsequent formal letter, he stated that he would be happy to admit Mrs Spurgin to GWMH, but that he was concerned about the pain and swelling to her hip. He requested assurance from the orthopaedic team that, from an orthopaedic point of view, Mrs Spurgin was well enough to be transferred.

15. On 25 March, Mrs Spurgin was again reviewed by Surgeon Commander Scott. He noted that her right leg was increasingly swollen and that a haematoma had developed and broken down. He nevertheless considered that Mrs Spurgin was well enough to be transferred, but warned that her skin required great care.

16. Mrs Spurgin was transferred to GWMH, Dryad Ward, on 26 March.

Gosport War Memorial Hospital

Overview

17. GWMH is a 113 bed community hospital managed by the Fareham and Gosport Primary Care Trust. Between 1994 and 2002 it was part of the Portsmouth Health Care NHS Trust. The hospital is designed to provide continuing care for long

stay elderly patients. It is operated on a day to day basis by nursing and support staff. Clinical expertise is provided by visiting General Practitioners, Clinical Assistants and Consultants. Elderly patients are usually admitted to GWMH by way of referral from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Dryad Ward

18. Mrs Spurgin was admitted to Dryad Ward under the care of Dr Reid. However, the doctor who dealt with Mrs Spurgin on a day to day basis was Dr Barton. Dr Barton was a General Practitioner at the Forton Medical Centre in Gosport. She worked at GWMH on a part time basis as a visiting Clinical Assistant. Her responsibilities involved visiting patients on the ward, conducting examinations and prescribing medication. The ward was staffed by a nursing team, working in shifts.

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

20. At the time of her transfer, Mrs Spurgin's analgesia consisted of oramorph 5-10mg 'as required', and 5mg every four hours, and paracetamol. Her nursing transfer note from Haslar recorded that she was mobile from bed to chair and could walk short distances with a zimmer frame. The skin on her lower legs was paper thin, and her right lower leg was very swollen. The nursing summary notes at GWMH recorded that she had been admitted for '*rehabilitation and general mobilisation*'. However, the transferring process was difficult. Mrs Spurgin experienced pain, and oral morphine was administered on a regular basis.

21. On 27 March, despite regular oramorph, Mrs Spurgin was still in pain. The regular dose was increased to 10mg every four hours.

22. On 28 March, Mrs Spurgin began vomiting in reaction to the oramorph. On Dr Barton's instruction, the oramorph was discontinued, and replaced with metoclopramide (an anti-emetic) and codydramol (a weaker analgesic).

23. On 29 March, the nursing notes recorded that Mrs Spurgin was unable to walk.

24. On 31 March, Mrs Spurgin was commenced on MST 10mg twice daily (this continued until 6 April). She walked in the morning with a great deal of pain, and was given oramorph 5mg, without much effect.

25. On 1 April, Mrs Spurgin's hip wound was oozing large amounts of serous fluid and some blood. This was also noted on 4 April.

26. On 6 April, Mrs Spurgin's dose of MST was increased to 20mg (this continued until 11 April).

27. On 7 April, it was noted that Mrs Spurgin's hip was red and inflamed, and it was thought she might be suffering from an infection. She was seen by Dr Barton and commenced on antibiotics (ciprofroxacin and metronidazole). She was later reviewed by Dr Reid, who noted that she was still in a lot of pain and was very apprehensive. As her hip movement was still painful, Dr Reid requested an x-ray. (It is unclear whether an x-ray was in fact carried out.)

28. On 8 April, it was noted that Mrs Spurgin's wound had oozed slightly overnight, but that the redness at the edges of the wound was subsiding.

29. On 9 April, Mrs Spurgin was catheterised.

30. On 10 April, it was noted that Mrs Spurgin had had a '*very poor night*'.

31. On 11 April, Mrs Spurgin was observed leaning to the left. She did not appear to be well and was having difficulty swallowing. Her wound was inflamed and she was in pain. Oramorph 5mg was administered at 7.15 a.m. She became very

drowsy. At 7.10 p.m. nursing staff telephoned her nephew, Carl Jewell, and informed him that Mrs Spurgin had deteriorated over the afternoon.

32. Mrs Spurgin was seen by Dr Barton on the morning of 12 April. Dr Barton prescribed diamorphine 20-200mg, midazolam 20-80mg, hyoscine 200-800microgam and cyclizine 50-100mg, all on an 'as required' basis, over 24 hours. The drugs were to be administered via a syringe driver. The syringe driver was commenced at 8 a.m. It contained diamorphine 80mg and midazolam 20mg.

33. At about 4.40 p.m., Mrs Spurgin was seen by Dr Reid. He noted that she had become very drowsy since the diamorphine was commenced, was not rousable, and that her breathing was very shallow. He altered the doses in the syringe driver to diamorphine 40mg and midazolam 40mg, but noted that the diamorphine could be increased to 60mg if pain recurred.

34. At 1.15 a.m. on 13 April, it was noted that Mrs Spurgin had died.

35. The death certificate recorded death as 1a cerebrovascular accident, with an onset of 48 hours prior to death. No post mortem was carried out.

The Police Investigation

36. 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.

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

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

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

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

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

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

43. The cases categorised as negligent 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.

44. In Mrs Spurgin's case, reports have been prepared by both Dr Wilcock (dated 5 March 2006) Dr Black (dated 27 June 2006). In addition, Daniel Redfearn, a

consultant orthopaedic and trauma surgeon, has also prepared a report (dated 22 January 2006).

Dr Barton

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

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

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

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

    (3) On 26 March, Dr Barton prescribed oramorph 10mg every four hours [p.10];

    (4) Dr Barton prescribed a further increase in oramorph on 27 March, as she was concerned that the existing doses had not been adequate in relieving Mrs Spurgin's pain [pp.11-12];

    (5) Dr Barton was contacted by nursing staff on 28 March in relation to Mrs Spurgin's vomiting. She advised that the oramorph should be discontinued, and prescribed codydramol and metoclopramide [p.12];

    (6) The codydramol was inadequate in relieving Mrs Spurgin's pain. Accordingly, after a review on 31 March, Dr Barton prescribed MST

10mg twice daily. This was not successful in relieving Mrs Spurgin's pain entirely [pp.13-14];

(7) On 6 April, Dr Barton increased the dose of MST to 20mg, as the existing dose was not adequate in controlling Mrs Spurgin's pain [p.15];

(8) At this time, Dr Barton was concerned that Mrs Spurgin was suffering from an infection. She therefore prescribed a course of antibiotics [p.15];

(9) On 8 and 9 April, Mrs Spurgin's condition remained essentially unchanged. She still continued to experience pain [p.16];

(10) Over the weekend of 10-11 April, Mrs Spurgin's condition deteriorated. The fact that she was leaning to the left raised the possibility that she might have had a cerebrovascular accident [p.17];

(11) Mrs Spurgin further deteriorated over the afternoon of 11 April [p.17];

(12) On the morning of 12 April, Dr Barton prescribed diamorphine and midazolam, to be administered via a syringe driver. The purpose of prescribing these drugs was to provide Mrs Spurgin relief from pain and distress [p.18];

(13) Dr Barton considered that diamorphine 80mg was appropriate at that time, given the fact that the oramorph was clearly inadequate [pp.19-20];

(14) Dr Reid felt it advisable to reduce the dose of diamorphine to 40mg, but noted that it could be increased to 60mg if pain recurred [p.19];

(15) The syringe driver was satisfactory, although Mrs Spurgin appeared to be in some discomfort when attended to, suggesting that even the dose of diamorphine 40mg was not successful in relieving her pain and distress entirely [p.20];

(16) The oramorph, MST, diamorphine and midazolam were prescribed and administered solely with the intention of relieving the pain and distress which Mrs Spurgin was suffering. At no time was the medication provided with the intention of hastening her demise [p.20].

Statement of Carl Jewell

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

The Report of Daniel Redfearn

48. Mr Redfearn is a consultant orthopaedic surgeon at the Royal Preston Hospital, Lancashire.

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

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

51. In his view, Mrs Spurgin suffered a relatively complex hip fracture, and the operative procedure which she underwent at Haslar was appropriate.

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

(1) A significant and untreated compartment syndrome;

(2) Failure of the operative fracture fixation; and

(3) Significant deep tissue infection or abscess formation.

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

(1) Compartment syndrome is a potentially serious but reversible condition. It is not possible from the medical records to say that Mrs Spurgin was suffering from compartment syndrome. However, her symptoms were consistent with the possibility that she was suffering from that condition. It is of grave concern that once this diagnosis was considered as a possibility by doctors at Haslar, Mrs Spurgin was not referred to a more senior surgeon. The condition usually only arises in the immediate post operative period, and it is unlikely that it developed after her transfer to GWMH. Whilst a basic surgical trainee would be expected to be able to identify the condition, a Clinical Assistant in Elderly or Rehabilitation Medicine would not be expected to do so.

(2) A failure in the operative fracture fixation cannot be excluded as a diagnosis to explain Mrs Spurgin's continuing pain. Given, her level of mobility, it would be reasonable to have expected any of the doctors caring for Mrs Spurgin to have considered this possibility. From the medical records, the only concerns in relation to this diagnosis appear to have been raised by Dr Woods at Haslar, by Dr Reid in his letter of 24 March (when Mrs Spurgin was still at Haslar), and again by Dr Reid when on 7 April he requested an x-ray (although it is unclear whether this was carried out).

(3) In relation to the possibility of an infection, the treatment Mrs Suprgin received at GWMH was broadly appropriate, although it would have

been more othodox to have prescribed flucloxacillin rather than metronidazole.

The Report of Dr Wilcock

54. 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.

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

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

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

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

    (3) Although the starting dose of morphine prescribed by Dr Barton on 26-27 March (10mg every four hours) was in keeping with BNF guidelines, in view of Mrs Spurgin's age it would have been prudent to have used a smaller dose [p.33];

    (4) Up to half of patients can experience nausea and vomiting when commencing morphine. The response to Mrs Spurgin's vomiting on 28 March was nonsensical, in that morphine was replaced by codydramol. If her pain warranted regular morphine, the addition of a regular anti-emetic would have been appropriate [pp.26-27, 33];

(5) The exact cause of Mrs Spurgin's deterioration is unclear. It was in keeping with, and was very likely to have been, a potentially reversible condition, such as septicaemia from an infection. This could have been managed by hydration, a reduction in the morphine dose and the administration of appropriate antibiotics. She was not anticipated to be dying. No adequate medical assessment was carried out at this stage (that is, prior to the commencement of the syringe driver) [pp.27, 28, 30-31, 38];

(6) The wide range of diamorphine prescribed by Dr Barton on 12 April included doses which were excessive to Mrs Spurgin's needs [p.36];

(7) The starting dose of diamorphine 80mg in the syringe driver represented a four to six fold increase in Mrs Spurgin's dose of morphine (as compared to the oral dose she had been receiving). There is no apparent justification for such an increase and it was excessive to her needs. An appropriate starting dose in the syringe driver would have been 15-20mg [pp.29, 29];

(8) The excessiveness of the dose of diamorphine, together with the administration of midazolam, would explain why Dr Reid found Mrs Spurgin to be unrousable [p.28];

(9) Dr Reid's decision to continue the diamorphine but at a lower dose was appropriate. However, although he halved the dose of diamorphine to 40mg, this still represented a two to three fold increase in Mrs Spurgin's dose of morphine (as compared with the oral dose she had been receiving), and was coupled with an increase in midazolam (a sedative) to 40mg. Given that Mrs Spurgin was already unresponsive, Dr Reid's decisions were unjustified [pp.28, 37];

(10) An appropriate starting dose of diamorphine in the syringe driver would have been 15-20mg [p.29];

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

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

'*Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking a suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to inappropriate doses of morphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.*'

The Report of Dr Black

58. 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.

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

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

(2) Mrs Spurgin's case represents a common problem in geriatric medicine. The prognosis after a fracture of this type, particularly in patients with

impairments in daily living before the fracture, is generally poor, both in terms of mortality and returning to independent existence. Up to 25 per cent of patients in such a category will die shortly after their fracture from many varied causes and complications [para.7.1];

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

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

(5) The recommencement of strong opioid analgesia (MST 10mg twice daily) on 31 March was appropriate [para.6.7];

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

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

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

(9) The staring dose of diamorphine 80mg was excessive. At best, this represents poor clinical judgment. An appropriate starting dose would have been 40mg (this was the dose which was administered following Dr

Reid's review, eight hours after the syringe driver was commenced) [paras.6.9, 7.2];

(10) The initial dose of midazolam 20mg was within guidelines. The increased dose of 40mg was also within guidelines, although many believe that elderly patients need no more than a maximum of 20mg [para.6.10];

(11) It is virtually impossible to predict how long a terminally ill patient will live, and even opinions of palliative care experts can show an enormous amount of variation. However, although the dose of diamorphine used in the last hours was inappropriately high, it cannot be proved beyond reasonable doubt that this had the definite effect of shortening Mrs Spurgin's life in more than a minor fashion, that is, by a few hours [paras.6.12, 7.2].

The Legal Framework

60. 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.

61. 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.

62. 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.)

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

64. 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*.

65. 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.*'

66. 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."

67. 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.'

68. 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'.

69. 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.

70. 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).

71. 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.

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

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

    (2) The essence of the matter which is supremely a jury question is whether, having regard to the risk of death involved, the conduct of the accused

was so bad in all the circumstances as to amount in their judgment to a criminal act or omission;

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

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

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

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

73. 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.

74. 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.*'

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

Analysis

Overview

76. Mrs Spurgin was admitted to Haslar on 19 March 1999, having suffered a fractured right hip after a fall. An operation was performed the next day. On 26 March, she was transferred to GWMH under the care of Dr Reid.

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

78. On 11 April, Mrs Spurgin's condition deteriorated. At 8 a.m. on 12 April, on Dr Barton's instructions, a syringe driver was commenced containing diamorphine

80mg and midazolam 20mg. At 4.40 p.m., Dr Reid changed the doses to diamorphine 40mg and midazolam 40mg.

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

Summary of the Experts' Opinions

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

    (1) Compartment syndrome. This diagnosis ought to have been examined further by doctors at Haslar, particularly in light of the fact that Dr Woods had identified it as a possibility. However, the doctors at GWMH could not have been expected to have made this diagnosis.

    (2) Failure of the operative fracture fixation. This diagnosis ought to have been examined further by doctors at both Haslar and GWMH. The only doctor at GWMH who appears to have considered it as a possibility was Dr Reid, when he expressed his concerns prior to Mrs Spurgin's transfer, and when he requested an x-ray. However, in the event no proper assessment was made.

    (3) Infection of the wound and hip. This was recognised as a possibility by Dr Barton and Dr Reid, and, save for the prescription of metronidazole rather than flucloxacillin, Mrs Spurgin's treatment was appropriate.

81. On 11 April, Mrs Spurgin's condition deteriorated. Dr Wilcock states that her symptoms were in keeping with an infection. Dr Black's analysis is also that the most likely cause of the decline was an infection to the wound and hip. In Dr Wilcock's view, Mrs Spurgin's condition was potentially reversible. However, Dr Black states that there was no doubt that Mrs Spurgin was dying, and that there was no possibility of taking remedial action.

82. Dr Black concludes that the commencement of the syringe driver was appropriate. There is agreement that the starting dose of diamorphine 80mg was excessive. However, about eight hours later this dose was reduced to 40mg by Dr Reid. Dr Wilcock's opinion is that this dose, especially when combined with midazolam 40mg, was still excessive. On the other hand, Dr Black's view is that the dose was appropriate.

83. In relation to the effect of the diamorphine (and midazolam), Dr Wilcock's view is that the doses would have contributed to Mrs Spurgin's death 'more than minimally, negligibly or trivially'. In contrast, Dr Black states that it cannot be shown to the criminal standard that the high dose of diamorphine hastened death by anything other that a very short period of time, that is, hours.

Discussion

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

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

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

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

85. There is evidence that Dr Barton and Dr Reid were negligent in failing to carry out a proper assessment of Mrs Spurgin's condition, both on her admission to GWMH, and when she deteriorated on 11 April. In our view, it is likely that negligence could be proved to the criminal standard in relation to this matter. However, it cannot be said that either doctor was negligent in failing to diagnose compartment syndrome, as, firstly, they could not have been expected to make such a diagnosis, and, secondly, it cannot be proved that Mrs Spurgin was

suffering from such a condition. Furthermore, it cannot not be said that either doctor was negligent in regard to the treatment of the suspected infection.

86. There is evidence that Dr Barton was negligent in causing diamorphine 80mg to be administered via the syringe driver on the morning of 12 April. In our view, negligence could be proved in relation to this matter.

87. There is a dispute between Dr Wilcock and Dr Black as to whether Dr Reid's alteration of the dose of diamorphine to 40mg on the afternoon of 12 April was appropriate. Given this dispute, it is our view that in relation to this matter, negligence could not be proved to the criminal standard.

88. The offence of gross negligence manslaughter requires proof that a breach of duty caused death. In our view, it cannot be proved to the criminal standard that death was caused by the failure properly to assess Mrs Spurgin's condition prior to her deterioration on 11 April. This is because it could not be proved that but for this failure, Mrs Spurgin would not have died. The various diagnoses explored by the experts in this case all relate to 'potentially' reversible conditions. Understandably given Mrs Spurgin's age and frailty, the possibility is left open that she would have died in any event.

89. At the time of Mrs Spurgin's deterioration on 11 April, there are two potentially negligent acts or omissions to be considered. Firstly, the failure properly to assess the cause of the deterioration, and secondly, Dr Barton's causing of diamorphine 80mg to be administered via the syringe driver. In relation to causation, the report of Dr Black is highly significant. In his opinion, there is no doubt that by this time, Mrs Spurgin was dying, and that her condition was irreversible. He goes on to state in terms that he could not be satisfied to the criminal standard that the administration of the high dose of morphine hastened death by more than a very short period of time, that is, hours. Having regard to Dr Black's report, in our view it could not be proved that any negligence on the part of Dr Barton or Dr Reid at this stage of Mrs Spurgin's care caused her death.

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

    (1) Dr Reid had sought some assurance from the medical staff at Haslar in respect of Mrs Spurgin's orthopaedic condition;

    (2) In administering diamorphine and midazolam, Dr Barton and Dr Reid were seeking to relieve Mrs Spurgin's pain and distress;

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

Conclusions

91. 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.

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

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27 July 2006

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