OPERATION ROCHESTER

Re Geoffrey Packman

ADVICE

Introduction

1. On 3 September 1999, Geoffrey Packman, who was aged 69, died.

2. The cause of death was given as 1a myocardial infarction, with an approximate interval between onset and death of five days.

3. At the time of his death, Mr Packman was a patient on Dryad Ward at the Gosport War Memorial Hospital ('GWMH').

4. Mr Packman was treated under the care of Dr Richard Reid, a Consultant Geriatrician. Dr Reid is now aged 55 (date of birth, Code A).

5. However, the doctor who provided him with care 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).

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

7. We have been asked to advise on the question of whether the evidence reveals the commission of any criminal offence by Dr Barton or Dr Reid and, if so, whether there is

a realistic prospect of conviction. The criminal offence to be considered is gross negligence manslaughter.

8. 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.

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

Background

10. Mr Packman, was born on Code A in Derbyshire.

11. He married Betty in 1956 and, although the couple did not have any children of their own, they adopted a boy, Michael, and a girl, Victoria. In 1969, the family moved to Hampshire, after Mr Packman got a new job in the Portsmouth area. He left his job in 1983 and, after a number of years spent working as a taxi driver, he retired in about 1989.

12. Mr Packman suffered from various significant medical problems. Since 1985, he had suffered from high blood pressure. He was obese, and had a five year history of swelling to his lower legs. By 1998, he had become virtually housebound, and recently he had experienced difficulty mobilising. In April 1999, he weighed 146kg (in excess of 23 stone).

13. On 6 August 1999, Mr Packman suffered a fall in his bathroom at home. Owing to his obesity, he was unable to get up. It took two ambulance crews to lift Mr Packman from the bathroom and into the awaiting ambulance. He was then taken to the Queen Alexander Hospital ('QAH'). Mr Packman was seen in the Accident and Emergency Department, and then admitted to Anne Ward.

14. Mr Packman was initially examined by a consultant and a senior house officer. It was noted that his most significant problems appeared to be an irregular heart rate, an infection in the groin area and lower legs, and immobility. Further tests showed that he was also experiencing renal impairment. Intravenous antibiotics were commenced to

treat the infection, and, owing to urinary incontinence, Mr Packman was catheterised. In the light of Mr Packman's pre-morbid state and multiple medical problems, it was deemed inappropriate to administer resuscitation in the event of a cardiorespiratory arrest, and this decision was marked on his medical records.

15. Over the next few days, Mr Packman's condition improved. However, he remained essentially immobile, and pressure sores over his buttocks, sacrum and thighs required his dressings to be changed regularly. In view of these matters, it was decided to transfer him to Dryad Ward at the GWMH for rehabilitation.

16. The transfer took place on 23 August.

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. Mr Packman was admitted to Dryad Ward under the care of Dr Reid, a consultant. However, the doctor who dealt with Mr Packman 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.

19. The details of the care provided to Mr Packman 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. An entry in the medical notes, which appears to have been made on Mr Packman's admission to Dryad Ward, referred to ongoing problems of obesity, swollen legs and pressure sores. It was initially noted that he was not in pain, although the next day a handling profile noted that pain needed to be controlled. His Barthel score indicated that he was significantly dependent.

21. On 26 August, Mr Packman complained that he felt unwell, and it was noted that he had suffered a further deterioration. He was seen by Dr Barton in the afternoon. She prescribed diamorphine 10mg, which was given at 6 p.m. It appears from the medical notes that Dr Barton diagnosed a possible myocardial infarction, with a possible alternative diagnosis of a gastrointestinal haemorrhage. Dr Barton concluded her entry in the medical notes as follows:

   '*Not well enough to transfer to acute unit. Keep comfortable. I am happy for nursing staff to confirm death.*'

22. At about 7 p.m., Dr Barton prescribed oramorph 10-20mg every fours hours, with 20mg at night. (This was administered until 10 a.m. of 30 August.) Dr Barton also prescribed diamorphine 40-200mg/24h and midazolam 20-80mg/24h, to be administered via a syringe driver. It appears that at about this time, Dr Barton informed Mrs Packman of her husband's condition. (Mrs Packman was herself awaiting major surgery at this time.) Essentially, Mrs Packman was told that he husband was going to die.

23. A previously taken blood test revealed a significant fall in Mr Packman's haemoglobin, which was suggestive of a gastrointestinal haemorrhage. However, staff at GWMH remained unaware of this matter, as the individual trying to telephone the results through to GWMH received no answer from the hospital switchboard.

24. On 27 August, it was noted that Mr Packman showed a marked improvement, although he still remained poorly.

25. On 29 and 30 August, Mr Packman complained of pain to the left side of his abdomen. His condition remained poorly. At 2.24 p.m., the syringe driver was commenced with diamorphine 40mg and midazolam 20mg. This appeared to have the effect of relieving Mr Packman's abdominal pain.

26. On 1 September, Mr Packman was seen by Dr Reid. He noted that the treatment being administered was for '*T.L.C.*', and that the prognosis was poor. The dose of midazolam was increased to 40mg at 3.35 p.m. At 7.15 p.m., the doses in the syringe driver were increased to diamorphine 60mg and midazolam 60mg., as the previous doses were not controlling Mr Packman's symptoms.

27. At 6.40 p.m. on 2 September, the doses in the syringe driver were increased to diamorphine 90mg and midazolam 80mg. Hyoscine 800microgram-2g was also prescribed, although in the event never administered.

28. Mr Packman died at 1.50 p.m. on 3 September. The cause of death was given as 1a myocardial infarction, with an approximate interval between onset and death of five days.

The Police Investigation

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

30. 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.

31. 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.

32. 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.

33. 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.

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

35. A total of ninety cases were reviewed by the police. These included the death of Mr Packman. 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.

36. The cases categorised as negligent have been the subject of a detailed review by Dr Andrew Wilcock, an expert in palliative medicine and medical oncology, and Dr Robert Black, an expert in geriatric medicine.

37. In Mr Packman's case, reports have been prepared by both Dr Wilcock (dated 28 March 2006) and Dr Black (dated 20 June 2006). In addition, Dr Johnathan Marshall, a consultant in the Department of Gastroenterology at the Horton Hospital in Oxford, has also prepared a report (dated 1 March 2006).

Dr Barton

38. As part of the police investigation into Mr Packman's death, Dr Barton was interviewed under caution. The interviews took place on 17 November 2005 and 6 April 2006. Dr Barton was represented by a solicitor, Ian Barker.

39. On 17 November 2005, Dr Barton read out a prepared statement, but it was indicated on her behalf that she would make no comment to any material questions. Subsequently, on 6 April 2006, Dr Barton indeed made no comment when she was questioned about Mr Packman's case in detail. The statement read out by Dr Barton in the first interview may be summarised as follows:

(1) Dr Barton reviewed Mr Packman on his admission to Dryad Ward, although she did not make an entry to this effect in the medical notes. (Throughout his time on the ward, there were in fact several occasions when she was unable to record her reviews) [pp.12, 18];

(2) On 26 August, Dr Barton's impression was that Mr Packman was very ill. In view of his condition and the previous decision that he was not to be resuscitated, her view was that a transfer to an acute unit was quite inappropriate. Such a transfer was very likely to have led to a further deterioration in his health [p.14];

(3) When she saw Mr Packman's wife, Dr Barton would have indicated that he was very ill indeed and that in all probability he was likely to die [p.15];

(4) The syringe driver was commenced on Dr Barton's instructions. It was commenced on the basis that Mr Packman was terminally ill, and that he required relief from pain and distress [p.17];

(5) The subsequent increases in the doses administered via the syringe driver were prescribed by Dr Barton in order to provide effective relief from pain and distress [pp.19-20];

(6) Dr Barton's diagnosis and treatment was reviewed by Dr Reid on 1 September. He also appears to have concluded that Mr Packman was terminally ill, and that the treatment was appropriate [p.18].

Dr Reid

40. Dr Reid was also interviewed under caution in relation to the death of Mr Packman. The interview took place on 8 August 2006. Dr Reid was represented by a solicitor, William Childs. The significant points raised by Dr Reid in the interview may be summarised as follows:

(1) When Mr Packman arrived at GWMH, he was terminally ill. He was not going to become mobile, and his life expectancy was poor [tape 1, p.25; tape 7, p.20];

(2) In circumstances such as those faced by Dr Barton on 26 August, it is necessary to make a judgment as to whether it is appropriate to transfer a patient to an acute unit [tape 2, p.18; tape 7, p.12];

(3) From 26 August onwards, there does not appear to have been any investigation into Mr Packman's illness [tape 4, p.42];

(4) When Dr Reid saw him on 1 September, Mr Packman was in a terminal condition as a result of a gastrointestinal bleed [tape 6, p.38];

(5) In the circumstances, the use of diamorphine was appropriate in order to bring his pain and distress under control [tape 4, p.21];

(6) Dr Reid complied with his duty of care to Mr Packman [tape 7, p.29].

The Report of Dr Wilcock

41. 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.

42. Dr Wilcock has reviewed the care provided to Mr Packman, and prepared a report dated 28 March 2006.

43. Dr Wilcock's opinion is that the medical care provided to Mr Packman by Dr Barton and Dr Reid was sub-optimal [p.30]. His conclusions may be summarised as follows:

(1) The infrequent entries in the medical notes make it difficult closely to follow Mr Packman's progress during his time on Dryad Ward [p.28];

(2) On 26 August, there was no adequate assessment of Mr Packman's deterioration. Dr Barton made no attempt to confirm the diagnosis of myocardial infarction, and she made no attempt to obtain the results of the blood test [pp.30, 31, 36];

(3) In fact, Mr Packman's deterioration was more in keeping with a gastrointestinal haemorrhage, and, whilst she identified this as an alternative diagnosis, Dr Barton failed to take appropriate steps to confirm it as the cause of the deterioration [p.33];

(4) In Mr Packman's case, the gastrointestinal haemorrhage may have been a potentially treatable and reversible condition, and ought to have been treated as an emergency [p.37];

(5) Mr Packman ought to have been transferred to an acute hospital setting. Dr Barton's decision that he was not well enough to be transferred was not appropriate. She ought to have taken advice from colleagues [pp.30, 34, 38];

(6) The doses of oramorph, and the doses of diamorphine and midazolam administered via the syringe driver, were inappropriate, and excessive for Mr Packman's needs [pp.39, 40, 42, 43].

44. Dr Wilcock concludes as follows [pp.45, 46]:

'*Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mr Packman by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Packman by failing to adequately assess his condition and taking suitable and prompt action. Mr Packman could have had a potentially treatable and reversible medical condition, which presented with a serious complication (i.e. bleeding). He should have been urgently and appropriately assessed and transferred to an acute medical unit. He was not appropriately assessed, resuscitated with fluids, transferred or discussed with the on-call medical team. In my view, there was no obvious reason why it was not appropriate to provide Mr Packman with this usual cause of action*...[In] *my opinion, the ongoing use of regular morphine and subsequent use of diamorphine and midazolam were inappropriate; their use was not obviously justified and the doses were likely to be excessive to Mr Packman's needs. In my opinion, it is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligible or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.*'

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

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

The Report of Dr Black

46. 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.

47. Dr Black has reviewed the care provided to Mr Packman, and prepared a report dated 20 June 2006. His conclusions may be summarised as follows:

(1) At the time of his transfer to GWMH on 23 August, Mr Packman's prognosis was 'terrible'. Patients suffering from gross obesity and deep and complex pressure sores almost invariably deteriorate and die in hospital, despite the best efforts of staff [para.6.6];

(2) Mr Packman's deterioration on 26 August was the result of a massive gastrointestinal haemorrhage [para.6.7];

(3) In retrospect, the first bleed may have occurred on or about 13 August, when it was noted at QAH that Mr Packman had passed a black stool. However, this would not have been clear at the time, and his treatment at QAH was appropriate [para.6.5];

(4) On 26 August, although Dr Barton did not confirm a diagnosis of a gastrointestinal haemorrhage, and in fact thought that a myocardial infarction was more likely, she correctly identified that Mr Packman's condition was

serious, and that it could not be managed appropriately in a community hospital [para.6.7, 6.8];

(5) The decision by Dr Barton that Mr Packman was too ill to be transferred, and that he should be managed symptomatically at GWMH, was a complex and serious decision. It ought to have been discussed with the consultant in charge, and, if possible, the patient and his family [para.6.8];

(6) However, in view of Mr Packman's other problems, it was within the boundaries of a reasonable clinical decision to provide at this stage only symptomatic care. The chances of Mr Packman surviving any level of treatment were very small indeed [para.6.8];

(7) In fact, from 26 August, Mr Packman was dying [para.6.10];

(8) The doses of oramorph and diamorphine administered to Mr Packman, although higher than might have been conventional at the start, were required to control his symptoms, and did not contribute in any significant fashion to death [para.6.12];

(9) Mr Packman died of natural causes, and any deficiencies on the part of medical staff probably made very little difference to the eventual outcome [para.7.2];

(10) The death certificate ought to have read: 1a gastrointestinal haemorrhage, 2 pressure sores and morbid obesity [para. 6.13].

The Report of Dr Marshall

48. Dr Marshall is a consultant in the Department of Gastroenterology at the Horton Hospital in Oxford. He has prepared a report dated 1 April 2005. His conclusions may be summarised as follows:

(1) Mr Packman was likely to have suffered a significant gastrointestinal haemorrhage approximately three days after his transfer to GWMH [p.7];

(2) It does not appear that Dr Barton made an attempt to ascertain why he had become so acutely unwell [p.9];

(3) A transfer for endoscopic therapy ought to have been considered. Whether such therapy would have been carried out would have depended on how Mr Packman responded to resuscitative measures, such as the administration of intravenous fluids [p.10];

(4) Mr Packman would have represented a high risk for surgery. It would have been difficult to justify the potential mortality of elective surgery in his case. Had endoscopic therapy failed to stop the bleeding, emergency surgery would have been the only way to save life, although this would have involved a high probability of death [p.10].

The Legal Framework

49. 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.

50. 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.

51. 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.)

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

53. 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*.

54. 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.*'

55. 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.*'

56. 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.'

57. 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'.

58. 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.

59. 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).

60. 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.

61. 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.

62. 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.

63. 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.*'

64. 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

65. Mr Packman was admitted to QAH on 6 August 1999, after suffering a fall at home. He was morbidly obese, and was suffering from deep pressure sores. His condition improved, and on 23 August 1999 he was transferred to GWMH.

66. On 26 August, Mr Packman suffered a massive gastrointestinal haemorrhage. He complained of feeling unwell, and was examined by Dr Barton. She diagnosed a

myocardial infarction, with an alternative diagnosis of a gastrointestinal haemorrhage. Dr Barton decided that that Mr Packman was too ill to be transferred to an acute unit, and that he should be treated instead symptomatically at GWMH.

67. Dr Barton prescribed oramorph, and, later, the administration of diamorphine and midazolam via a syringe driver. The doses administered via the syringe driver were subsequently increased at various times on the authorisation of Dr Barton and Dr Reid.

68. Mr Packman died at 1.50 p.m. on 3 September.

Summary of the Experts' Opinions

69. The experts agree that on 26 August Mr Packman suffered a significant gastrointestinal haemorrhage. His condition was serious, and constituted a medical emergency.

70. The essential difference between Dr Wilcock and Dr Black concerns the quality of Dr Barton's decision not to transfer Mr Packman to an acute unit. This was an important decision, as it amounted to a decision not to explore the possibility of emergency procedures, such as endoscopic therapy or surgery, and to provide only symptomatic treatment.

71. Dr Wilcock's view is that Mr Packman may have been suffering from a potentially treatable and reversible condition, and that he ought to have been transferred urgently. He states that Dr Barton's decision that Mr Packman was not well enough to be transferred was negligent. On the other hand, Dr Black's opinion is that, given Mr Packman's other conditions, Dr Barton's decision was within the boundaries of a reasonable clinical decision. He states that the chances of Mr Packman surviving any treatment were very small, and that, in fact, his prognosis even prior to 26 August was 'terrible'.

72. These different opinions are reflected in the view the experts have taken in respect of the administration of oramorph, diamorphine and midazolam. Dr Wilcock's opinion is that the drugs were inappropriate and excessive. On the other hand, Dr Black states that they were necessary to control Mr Packman's symptoms.

73. In relation to causation, Dr Wilcock's view is that Dr Barton's negligent decision of 26 August and the inappropriate and excessive use of diamorphine and midazolam

contributed more than minimally to Mr Packman's death. Dr Black's view, however, is that Mr Packman died of natural causes, and that the treatment provided by medical staff probably made very little difference. In his opinion, the drugs administered did not contribute to death in any significant fashion.

Discussion

74. 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.

75. The essential question in this case is whether Dr Barton's decision not to transfer Mr Packman to an acute unit was negligent. Dr Wilcock's opinion is that it was negligent. Dr Black, however, states that it was with the boundaries of a reasonable clinical decision. In light of this conflicting medical opinion, it is clear to us that it could not be proved to the criminal standard that Dr Barton's decision was negligent. For the same reason, it is our opinion that negligence in the prescription and administration of the doses of oramorph, diamorphine and midazolam could not be proved.

76. Furthermore, it is our view that, even if Dr Barton's actions were found to be negligent, causation could not be proved to the criminal standard. Dr Black describes Mr Packman's prognosis, even prior to 26 August, as 'terrible'. He states that Mr Packman died of natural causes, and that the actions of medical staff probably made little difference to the eventual outcome. However, it is our view that even on Dr Wilcock's analysis alone, causation could not be proved. He is only able to say that Mr Packman could have had a potentially treatable and reversible condition. In this regard, Dr Marshall confirms that any surgery carried with it a high probability of death.

77. Dr Reid did not participate in Dr Barton's decision of 26 August. After Dr Barton had taken that decision, Dr Reid did not see Mr Packman until 1 September. In our view, a

case of negligence could not be established on those facts. In respect of his role in increasing the doses of diamorphine and midazolam, our view, for the reasons given above in the case of Dr Barton, is that negligence could not be proved to the criminal standard.

Conclusions

78. 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.

David Perry QC

Louis Mably

27 October 2006

6 King's Bench Walk
London
EC4Y 7DR