STATEMENT OF DR JANE BARTON - RE: ELSIE LAVENDER

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mrs Elsie Lavender. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mrs Lavender.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal bartel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients.

Signed Code A

4. Whilst the demands on my time were probably slightly less in 1996 than the position which then pertained in 1998 and beyond, certainly even by 1996 there had been a significant increase in dependency, increase in bed occupancy, and consequent decrease in the ability to make notes of each and every assessment and review of a patient. These difficulties clearly applied both to me and the nursing staff at the time of our care of Mrs Lavender. Similarly I had by this stage felt obliged to adopt the policy of pro-active prescribing to which I have made reference in my previous statement to you, given the constraints and demands on time.

5. Mrs Lavender aged 83 was transferred to Daedalus Ward at GWMH on 22nd February 1996 under the care of consultant Geriatrician Dr Althea Lord. Her Past Medical history was of diabetes for over 40 years, and she had been registered blind since 1988. She had apparently lived alone since the death of her husband and had a son living in Warsash who would do her shopping. She had fallen down the stairs at home two weeks previously and been admitted to a medical bed in Royal Naval Hospital Haslar with general weakness and immobility. She was referred to Dr Jane Tandy consultant Geriatrician at Portsmouth Healthcare Trust by her consultant physician, Surgeon Commander Taylor although I do not have the benefit of the referral letter nor any of her Haslar notes. Dr Tandy had seen her on ward A4 at Haslar and dictated a letter to Surgeon Commander Taylor on 16th February 1996.

6. Dr Tandy had recorded that she had examined Mrs Lavender. She felt the most likely problem was a brain stem stroke which had led to the fall. In addition, she had noted Mrs Lavender had insulin dependent diabetes mellitus, was registered blind, was now immobile and had atrial fibrillation.

There was weakness in both hands and Mrs Lavender had been unable to stand, though was able to do so with physios. She was 'a bit battered' and had pain across her shoulders and down her arms. She still required 2 people to transfer her. She had longstanding stress incontinence and mild iron-deficiency anaemia. Dr Tandy had confirmed the atrial fibrillation on examination, but had heard no murmurs. Code A She had made mention of further investigation of her iron deficiency anaemia and her stroke but had agreed to take her over to Daedalus ward for "rehab" as soon as possible.

7. To assist with the transfer, one of the nursing staff on Ward A4 completed a nursing referral form on 21st February recording that Mrs Lavender's main problem was now immobility. She confirmed the pain in the arms and shoulders, and recorded that Mrs Lavender had ulcers on both legs. At that stage all pressure areas were said to be in tact although her buttocks were very red. The referral form also set out the various medications Mrs Lavender was receiving at the time of discharge to GWMH.

8. I then admitted Mrs Lavender to Daedalus Ward the following day. Unfortunately, given the very considerable interval of time I now have no real recollection Mrs Lavender, but my entry in her records for the assessment on her admission reads as follows:

"22-2-96 Transferred to Daedalus Wd GWMH
PMH fall at home top to bottom of stairs
laceration on head
leg ulcers
severe incontinence needs a catheter
IDDM needs Mixtard Insulin bd

regular series B.S.
transfers with 2
incontinent of urine
help to feed and dress. Barthel 2
Assess general mobility
? suitable rest home if home found for cat"

9. A nurse apparently recorded that Mrs Lavender had a barthel score of 4, but the difference with my assessment is of no real significance - Mrs Lavender was clearly profoundly dependent. A Waterlow pressure sore score on admission was recorded at 21, a score of 20 or more being 'very high risk'. Mrs Lavender's prognosis in view of her condition, being blind, diabetic, with a brain stem stroke and being immobile was not good, but the hope was that we might be able to rehabilitate her.

10. Following the information in the referral form in relation to Mrs Lavender's medication, I prescribed Digoxin for her atrial fibrillation, Co-amilofruse (a Frusemide and Amiloride combination) for congestive cardiac failure, Insulin Mixtard for her diabetes to be given in the morning if the blood sugar was above 10 and the same medication at night at a slightly different dose, again if her blood sugar was above 10. I also prescribed Ferrous Sulphate for her anaemia, Becomethasone as an asthma preventer, and Salbutamol as an asthma reliever.

11. I do not know now if Mrs Lavender was receiving pain relieving medication whilst at Haslar, but in view of the pain she was experiencing on admission, I also prescribed Dihydrocodeine, two 30mg tablets, 4 times a day.

12. I saw Mrs Lavender again the following day, probably in the morning, and would have reviewed her condition again. My note on this occasion reads as follows:

"23-2-96 Catheterised last night 500ml residue
blood & protein Trimethoprim"

13. The nursing note for the previous day in fact recorded that 750mls of urine had been catheterised, but the important feature was that the subsequent urine test revealed the presence of blood and protein in the urine, suggestive of a urinary tract infection. I therefore prescribed an appropriate antibiotic, Trimethoprim, on a precautionary basis in case of infection.

14. Bloods had been taken on 22nd February, and the nursing notes for the following day suggest that the platelet level was found to be abnormal and that the blood sample was too small. I was apparently informed of this and was to review the position in the morning.

15. The nursing notes record that I did see Mrs Lavender again the following morning, Saturday 24th February, and that her pain was not controlled by the Dihydrocodeine. The nursing notes show that she had a red and broken sacrum. I therefore prescribed Morphine Sulphate, 10mgs twice a day, in addition to the Dihydrocodeine. Although I did not normally see patients at GWMH over weekends, when others were usually on duty, I may have been on duty the previous night, and would have been concerned to attend to Mrs Lavender if she was in pain at the time.

16. The nursing notes suggest that in consequence of the Morphine Sulphate Mrs Lavender had a comfortable night, but had deteriorated again by the following evening. It was said that she appeared to be in more pain, screaming "my back" when moved, though she was uncomplaining when not. Mrs Lavender's son apparently wanted to see me. The nursing notes also indicate that the sacral area was now weak and blistered and that there were red sore and broken areas.

17. I would have reviewed Mrs Lavender's condition again on the Monday morning, 26th February. In view of the fact that the previous dosage of Morphine Sulphate had become insufficient for Mrs Lavender's pain, I increased the dose to 20mgs twice a day, again with the Dihydrocodeine continuing. I believe Mrs Lavender's bottom was very sore, and I was concerned that she should have a Pegasus mattress in the hope of reducing pressure sores. I was probably made aware of the fact that Mrs Lavender's son wanted to see me and arranged to return to GWMH at 2pm for that purpose.

18. The nursing notes record that I saw Mr Lavender and his wife at the hospital that afternoon. I have no recollection of this meeting, but I anticipate he was understandably concerned at the fact that his mother had been suffering in pain over the weekend. I think that by this stage Mrs Lavender's appetite was poor. I would probably have explained that pain relief was becoming more difficult, that there was skin breakdown, and that his mother was deteriorating.

19. Sadly it is the case that in elderly frail people with pre-existing illness, such as Mrs Lavender, significant events such as a major fall with transfer to one

hospital and then another can in themselves have a very serious deleterious effect on their health, leading to death.

20. It may be the case that in the circumstances I indicated to Mrs Lavender's son that his mother might be dying, this simply being a feature of what can happen to elderly people in such circumstances, with the trauma of stroke, a major fall, and transfer to one hospital and then another. I believe I would have discussed the options for pain relief with Mrs Lavender's son and probably explained that it might become necessary to use a syringe driver and administer Diamorphine if the pain continued to be inadequately controlled. I think I would have explained that it was possible the administration of proper pain relieving medication might have the incidental and undesired effect of hastening death.

21. I believe Mrs Lavender's son was concerned that his mother should have adequate, proper pain relief, including medication administered via syringe driver if necessary, so that his mother was free from pain.

22. In any event, my note for 26th February in Mrs Lavender's notes reads as follows:

> "26-2-96 not so well over w/e
> family seen and well aware of prognosis
> and treatment plan
> bottom very sore - needs Pegasus mattress
> institute sc analgesia if necessary"

23. I think that following my discussion with Mrs Lavender's son, I wrote up a proactive prescription for further pain relief should Mrs Lavender experience uncontrolled pain when I was not immediately available. I prescribed Diamorphine in a dose range of 80 - 160mgs, together with Midazolam 40 - 80mgs and Hyoscine 400 - 600mcgs. I would have anticipated that the nursing staff would contact me in such an event, so that I could then have authorised administration as necessary within that dose range.

24. I believe that I would have seen Mrs Lavender again the following morning, though I have not made an entry in her records. The nursing notes record that bloods were taken. An area, I believe on Mrs Lavender's sacrum, was now said to be blackened and blistered.

25. I would have seen Mrs Lavender again the following day, 28th February, but again I did not make an entry in her notes on this occasion. The nursing notes show that the black areas - on the sacrum - were covered with Inadine. It appears that over the period 26th - 28th February Mrs Lavender had required no insulin in the morning and 20 units in the evening, suggesting poor nutritional intake.

26. Again, although I do not believe I had an opportunity to note it, I would have seen Mrs Lavender on 29th February, and 1st March, to review her condition. Sadly, I think she was slowly deteriorating over this period. The nursing notes suggest that on 29th February, Mrs Lavender's blood sugar was elevated and that I was contacted, ordering a quick acting insulin to be administered. I would not then have seen her again until the following Monday, 4th March.

27. Unfortunately, Mrs Lavender was again suffering in pain by 4th March. The drug chart and the nursing notes show that I therefore increased the Morphine Sulphate, in the form of Oramorph slow release tablets, to 30mgs twice a day. I think the Dihydrocodeine was still continued at this stage.

28. I would have reviewed Mrs Lavender again the following morning, and it was clear that the pain relief was again inadequate. The nursing notes record that Mrs Lavender's pain was now uncontrolled. She had had a very poor night and was said to be distressed. She was now not eating or drinking and had deteriorated over the last few days. In the circumstances I felt that it was necessary now to set up subcutaneous analgesia via syringe driver and to administer Diamorphine together with Midazolam in order to relieve Mrs Lavender's pain and distress. I recorded the medication on her drug chart, with the Diamorphine in a range of 100 - 200mgs over 24 hours, Midazolam in a range of 40 - 80mgs over the same period, and Hyoscine at 400 - 800mcgs.

29. The syringe driver was then set up at 9.30am that morning, with the Diamorphine and the Midazolam at the lower end of the range, 100mgs and 40mgs respectively. It was not necessary to administer Hyoscine at that stage as there were no secretions. I considered these doses appropriate in view of the fact that Mrs Lavender's pain was now uncontrolled and she was reported to be in distress. In spite of the previous increases, it had become necessary to increase the medication still further. A further reasonable increase to the level prescribed by me was now necessary to ensure that Mrs Lavender was now free from pain and distress in circumstances in which it was clear that she had continued to deteriorate and was now likely to be

dying. This medication was given solely with the aim of relieving that pain and distress.

30. My note on this occasion in Mrs Lavender's medical records reads as follows:

> "5-3-96 Has deteriorated over last few days
> not eating or drinking
> In some pain ∴ start sc analgesia
> Let family know"

31. As suggested in my note and confirmed by the nursing records, Mrs Lavender's son was contacted by telephone and the situation explained to him.

32. The medication appears to have been successful in reliving the pain and distress. The following day the nursing notes indicate that the pain was well controlled and the syringe driver was renewed at 9.45am. I reviewed Mrs Lavender again that morning and my note reads as follows:

> "6-3-96 Further deterioration
> sc analgesia commenced
> comfortable and peaceful
> I am happy for nursing staff to confirm death"

33. As indicated, Mrs Lavender was now comfortable and peaceful. It was apparent that the medication had been successful in relieving the significant pain and distress which she had suffered. Aware that she was dying, I indicated that I was happy for nursing staff to confirm death and that it

would not be necessary for a duty doctor to be asked to attend for this purpose.

34. It appears then that Mrs Lavender died in the course of the evening of 6th March, and she was found to have passed away peacefully shortly before 9.30pm.

Code A

Signed handed to DI Yates.

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