STATEMENT OF DR JANE BARTON - RE: ROBERT WILSON

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, Mr Robert Wilson. 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 Mr Wilson.

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 Barthel 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. I confirm that these comments are indeed a fair and accurate summary of the position in 1998 when I was involved in the care of Mr Wilson.

4. Unfortunately, at this remove of time I have no recollection of Mr Wilson. With the benefit of the notes however, it is apparent that Mr Wilson was a 74 year old gentleman who was admitted to the Queen Alexandra Hospital on the 21st September 1998 following a fall at home during which he had sustained a fractured greater tuberosity of the left humerus. Mr Wilson had been admitted the previous year with epigastric pain which was diagnosed as left lobar pneumonia and alcoholic gastritis with grossly abnormal liver enzymes. He was found to have a small bright liver compatible with alcohol liver disease, and indeed it seemed that he had been consuming excessive alcohol for a number of years. In the course of this admission in 1997 Mr Wilson was treated with antibiotics and diuretics but was unco-operative about diet. He was discharged after three weeks with a planned follow up in out-patients.

5. It appears that Mr Wilson spent the night of the 21st September 1998 on the A & E ward. He complained of pain, and the relevant A & E record shows that he received 10mgs of morphine intravenously at 9pm that evening.

6. Mr Wilson was then assessed in the fracture clinic the following day. He was reported as not being keen to undergo surgical intervention, and following this he was admitted to Dickens Ward in the Elderly Medicine Department of the Queen Alexandra Hospital. It appears that on admission Mr Wilson's analgesia was not sufficient, and intravenous Morphine, 2 - 5mgs was prescribed, together with 30mgs of Codeine Phosphate 6 hourly as required.

7. Although not seemingly recorded on the prescription chart, a nursing entry records that the medication was subsequently altered so that the Morphine was given by a subcutaneous injection, with the addition of the Codeine Phosphate.

8. A Barthel score assessment was made on the 22nd September following his admission, a score of 5 being recorded.

9. Although there appears to be no entry in the prescription charts, the medical notes record that on 24th September Mr Wilson was given 5mgs of Diamorphine, though an examination following that administration the area from the shoulder to the elbow was said to be very painful. Indeed, the nursing records show that an initial 2.5mgs of Diamorphine was given with little effect, seemingly requiring a further 2.5mgs about half an hour later.

10. It seems that Mr Wilson may have had oedema, and on 24th September diuretics in the form of Frusemide and Spironolactone were prescribed. On 25th September Mr Wilson was recorded as still being in pain, and indeed he appears to have continued to have been throughout much of his stay on Dickens Ward in pain in spite of the administration of Morphine and Codeine Phosphate from time to time. On 1st October for example his left arm was said to be "painful +++ on movement", though he had no apparent pain at rest, and that continued generally. On the 4th October he was said to be still in great pain, and the humerus was elevated slightly on the pillow to help reduce the swelling.

11. On the 11th October the pain was said to remain "quite bad in his L arm", and then again on the 12th the nursing notes record that he remained "in a lot of pain when being cared for".

12. It appears on the 29th September Mr Wilson had become very dehydrated and his renal function had deteriorated. His diuretics were stopped and he was commenced on IV fluids. A medical entry that day records that Mr Wilson had impaired renal function, that his liver function was abnormal and he had alcoholic hepatitis. It was also recorded that Mr Wilson was "not for resuscitation in view of poor quality of life and poor prognosis". I do not know who made this entry in the records, but clearly one of the medical team considered that Mr Wilson was significantly unwell with a poor prognosis, to the extent that resuscitation would not be appropriate.

13. Mr Wilson's arm became swollen through oedema. Consultant Surgeon, Mr Hand appears to have reviewed Mr Wilson at a clinic on the 6th October and reported to Dr Durrant the GP that the left arm was grossly swollen, Mr Hand suspecting that this was secondary to immobilisation as well as fluid retention. On the 8th October it is also recorded that his ankles were very oedematous. On 9th October diuretics were recommended in view of the gross oedema, with Bendrofluazide being added.

14. A Barthel score was recorded as only 3 on the 2nd October, by 6th October this had risen to 5.

15. It appears that Mr Wilson had become depressed in consequence of stopping alcohol, and on the 2nd October referral was made to Dr Lusznat, Consultant in Old Age Psychiatry. The note of referral in the medical records stated specifically that he was "very withdrawn and depressed".

16. Dr Lusznat carried out an assessment on the 8th October and recorded her impression that Mr Wilson was suffering with early dementia, possibly alcohol related, together with depression. She prescribed Trazodone as an anti-depressant. In a subsequent letter to Dr Grunstein, Consultant in Elderly Medicine, Dr Lusznat stated that physically Mr Wilson was obese with his left arm in a sling and his left hand still grossly swollen and bruised. She also noted that there was also marked oedema of both legs. In relation to his mental state she recorded that he was subjectively low in mood and objectively easily tearful. Although he had no active suicidal ideas or plans, he had said that there was no point in living. Dr Lusznat confirmed her impression that Mr Wilson had developed an early dementia which could well be alcohol related although alternatively this might be an early Alzheimer's disease or vascular type dementia. Further, on her assessment record Dr Lusznat noted that Mr Wilson had a lot of pain in his left arm, and admitted feeling low Code A He wanted to go home.

17. Unfortunately, it seems that Mr Wilson had an unrealistic expectation of his position. The records show that an assessment was carried out the following day, 9th October and it was felt Mr Wilson required help with all the activities of daily living, generally by two people. Specifically his "conception of discharge" home was said to be "totally unrealistic", and he was felt to be too much at risk at that time to be managed at home.

18. On the 11th October a further Barthel assessment was carried out, producing a Barthel score of 7.

19. It appears that Mr Wilson's condition remained essentially unchanged. Attempts were made without success for him to have a convalescent

bed, and arrangements were then made for him to be transferred to the GWMH. Mr Wilson was seen on a ward round on the 13th October and it was agreed that he still needed both nursing and medical care. It was felt that a short spell in a long-term NHS bed would be appropriate. He was still very oedematous and his albumin was very low. Frusemide was added to his diuretics and renal function was to be reviewed. The nursing notes also record that he continued to require special medical/nursing care given his oedematous limbs were at high risk of breakdown, and indeed his right foot was apparently already having started to breakdown.

20. A referral form was completed on the 13th October with Mr Wilson recorded as continuing to be in a lot of pain, and indeed the prescription chart shows he had been receiving Codeine Phosphate over the previous days. The referral form also confirmed that Mr Wilson's legs were very oedematous with high risk of breakdown, and secondary to cardiac failure and low protein.

21. Mr Wilson was then transferred to Dryad Ward at the GWMH the following day, 14th October. I believe I assessed Mr Wilson on his admission, and my note in his records reads as follows:-

"14-10-98 Transfer to Dryad Ward continuing care 75
HPC # humerus L 27-8-98
PMH Alcohol problems
Recurrent oedema
CCF
needs help c ADL
hoisting
continent
Barthel 7
Lives c wife Code A
plan gentle immobilisation"

22. As will be apparent I inadvertently recorded the date of the fracture as the 27th rather than the 21st September. Although I also recorded the Barthel score as 7, assessment done the same by the nursing staff in fact gave a score of only 4. My notation "CCF" meant that I understood Mr Wilson to have congestive cardiac failure, apparent from his significant oedema, and indeed confirmed by the referral form which had specifically recorded cardiac failure. I do not know what records would have been available to me at the time, but I anticipate some form of records would have came with the patient on transfer.

23. Following my assessment I wrote up prescriptions on Mr Wilson's drug chart, mirroring the medication which had been recorded on the referral form. Specifically, I prescribed Thiamine 100mgs once a day - a vitamin given for nutrition due to alcoholism, multi vitamins once a day for the same purpose, Senna and Magnesium Hydroxide for constipation probably brought on by the opiate medication given for pain relief Frusemide 80mgs in the morning and Bendrofluazide 25mgs once a day both as diuretics to reduce the oedema, together with Spiranolactone 50mgs twice a day as a diuretic which increases the efficacy of the Frusemide. I also prescribed Trazodone 50mgs once a day for Mr Wilson's depression, and Paracetamol as recorded on the referral letter.

24. Although the referral letter made no mention of the codeine phosphate which had clearly been given to Mr Wilson over the previous days, I had felt it appropriate to provide further pain relief of medication beyond the Paracetamol in circumstances in which the referral letter made clear that Mr Wilson continued to have a lot of pain in his arm. Accordingly I prescribed Oramorph, 10mgs in 5mls at a dose of 2.5mgs - 5mls as needed, 4 hourly.

Code A

25. The nursing notes confirm Mr Wilson's admission, with a history of the fractured humerus, the long history of heavy drinking and left ventricular failure, with chronic oedematous legs. The nursing notes also record that following my assessment Mr Wilson was given 10mgs of Oramorph for pain control.

26. The prescription charts also contain prescriptions for Diamorphine in a dose range of 20 to 200mgs subcutaneously, together with Hyoscine 200/800mcgs and Midazolam 20 to 80mgs via the same route. I do not know when I wrote this up but I anticipate it may have been at the time of my assessment on Mr Wilson's admission. I anticipate I would have been concerned to ensure that there was a pro-active regime of pain relief and medication available in case of deterioration and with the potential for Mr Wilson to become inured to the opiate pain relief which was clearly necessary at that stage. It would have been my expectation in the usual way that the nursing staff would endeavour to make contact with me or the duty doctor before commencement of that medication - if Mr Wilson's medical condition warranted it and indeed it would be commenced at the bottom end of the dose range.

27. I anticipate that I would have seen Mr Wilson again the following day, 15th October, though clearly I have no recollection of this. I have not made an entry in his clinical notes but did I record a further prescription for Oramorph, with 10mgs to be given 4 hourly at 6am, 10am, 2pm and 6pm and a further 20mgs at 10pm in the hope of ensuring that Mr Wilson did not experience pain and distress in the course of the night.

28. The nursing note for the 15th October confirmed that Oramorph was commenced 4 hourly for pain in Mr Wilson's left arm. Mrs Wilson was then seen by Sister Hamblin who apparently explained that her husband's condition was poor. 20mgs of Oramorph was apparently given at midnight with good effect but it appears that Mr Wilson then deteriorated over night becoming 'very chesty' with difficulty in swallowing medications.

29. I believe I was absent from the Hospital on Friday 16th October. I think I attended at a meeting in Portsmouth at the Health Authority in the morning and would not have been contactable. It is clear though from the records that one of my partners, Dr Knapman, came to see Mr Wilson on 16th October in my absence. Dr Knapman has recorded that Mr Wilson had declined overnight with shortness of breath and that on examination he was 'bubbling' and had a weak pulse. He was said to be unresponsive to spoken orders. Dr Knapman recorded oedema in the arms and legs and suspected that Mr Wilson had suffered a silent myocardial infarction. He increased the dose of Frusemide in an attempt to reduce the oedema.

30. From the nursing records it appears that Mrs Wilson was informed of her husband's deterioration, and later that day Mr Wilson was said to have a very bubbly chest. A syringe driver was then commenced with 20mgs of Diamorphine and 400mgs of Hyoscine. It is not clear if the diamorphine was commenced following discussion with Dr Knapman or any other doctor then on duty, or indeed if it might have been discussed with me. It is possible that nursing staff might have made contact with me if I had been available later on 16th October, but equally Dr Knapman or one of my other partners would have been available on duty.

31. The 20mgs of Diamorphine was in effect broadly commensurate with the Oramorph which had been administered, 50mgs of Oramorph having been given the previous day. In view of the reported difficulty Mr Wilson had in swallowing medications, a switch to the equivalent subcutaneous medication appears to have been sensible, together with the Hyoscine to help reduce or 'dry' the chest secretions.

32. A nursing note later on the 16th October records the commencement of the Diamorphine and that the reason for the driver was explained to the family, with Mrs Wilson being informed of her husband's continued deterioration. Later that evening, at approximately 10.30pm, Mr Wilson was recorded as being a little "bubbly" with more secretions during the night, but it was also said that Mr Wilson had not been distressed and appeared to be comfortable.

33. It appears that the following morning, 17th October, the Hyoscine was increased to 600mcgs as pharyngeal secretions had been increasing overnight. The Diamorphine was maintained at 20mgs. It appears that my partner Dr Peters then saw Mr Wilson in the course of the day, recording in the notes that he was comfortable but there was a rapid deterioration. Dr Peters was probably on duty that weekend. Dr Peters also noted that the nursing staff could verify death if that proved necessary. Clearly Dr Peters' expectation was that Mr Wilson might die shortly. It appears that in the course of the day the Diamorphine was then increased to 40mgs, and Hyoscine to 800mcgs, with the addition of 20mgs of Midazolam. I do not know if that increase might have been with reference to Dr Peters either when Dr Peters visited or otherwise, or indeed separately with reference to me.

34. The effect of secretions which were reported to be increasing, can be very unpleasant for a patient, producing a sensation of inability to breath, and the administration of a drug such as Diamorphine can assist in relieving the significant agitation and distress which can be experienced from such a sensation, and indeed reduce oedema from cardiac failure. This may have been a factor in the decision to increase the Diamorphine. The nursing note immediately preceding the reference to the increase in Diamorphine refers to suction being required very regularly to remove copious amounts of secretions. Further, there may well have been a concern that Mr Wilson might become tolerant of the opiates and that increase might be required accordingly.

35. Fortunately, although noisy secretions continued at night, it seems then the medication was indeed successful in relieving any distress. Specifically the secretions were said not to be disturbing him, and he appeared comfortable.

36. Although Dr Peters has not made a separate entry in the medical records the following day, 18th October, it seems that Dr Peters attended again at the hospital, there being a ~~significant~~ specific Code A entry in the nursing records that Mrs Wilson had remained overnight and that Dr Peters spoke with her. There was said to have been a further deterioration in Mr Wilson's already poor condition. The syringe driver was apparently renewed at 2.50pm with an increase in the Diamorphine to 60mgs, Midazolam to 40mgs, and Hyoscine at 1200mcgs. That latter prescription was in excess of the dose range I had previously authorised, and Dr Peters made a further specific prescription as a verbal order to enable that to be given.

37. Sadly, it appears that Mr Wilson's condition continued to deteriorate and the nurses later recorded that he died peacefully at 11.40pm in the presence of members of his family.

19-5-05

Signed Code A and handed to Code A.

Code A