GOSPORT.

Mr Robert Wilson (deceased)

1) Mr Iain Wilson is the son and he is the family's representative on behalf of the late Mr Robert Wilson.

Background

2) Mr Wilson was transferred from Queen Alexandra Hospital to the Hospital on 14 October 1998. Those responsible for Mr Wilson's ongoing medical care, including Dr Barton, owed him a duty of care.

3) The chronology is as follows : -

Date	Event
21.09.98	Admitted Queen Alexandra Hospital. Fracture of left humeral head. Refuses operation. Kept overnight. Liver function significantly abnormal. 20:45 hours: 10mg morphine IV.
22.09.98	Transferred to care of elderly team. Impaired renal function. Not fit for op. Given, co-codamol; codeine phosphate; paracetemol.
23.09.98	5mg morphine - for resuscitation. Blood results - abnormal liver function.
24.09.98	2.5mg morphine twice. Pain improved.
25.09.98	Codeine phosphate. Co-dydramol 2 tabs x 4 per day.
27.09.98	Started on intravenous fluids. Pain remained bad in the arm.
29.09.98	Able to lift arm without pain.
30.09.98	Co-dydramol stops; replaced with paracetamol alone. Pain in neck and arm.
01.10.98	Left arm was painful +++ on movement.
02.10.98	Arm painful on movement. Would require long term care.
03.10.98	2- 5mg; receives 2.5mg morphine.
04.10.98	23.10 hours: 2.5mg intramuscular (IM).
05.10.98	02:00 hours: 2.5mg morphine.
06.10.98	RW decides against operation - but unsuitable for surgery.
07.10.98	Brighter, more talkative, eating and drinking more.
08.10.98	Seen by consultant in old age psychiatry. Started on Trazodone, sedative anti-depressant. Some depression and mildly impaired short term memory codeine phosphate at night.
11.10.98	Pain quite bad.
12.10.98	Barthel 7: Rehab suggested in a lot of pain when being cared for.

13.10.98 Oedematous limbs. High risk of tissue breakdown. In cardiac failure with low protein. Nursing notes - no complaints of pain.

O/ night Peaceful night. No complaints of pain.

14.10.98 Transfer letter: He still had a lot of pain in his arm and difficulty moving it and oedematous legs due to heart failure and low protein at risk of breaking down.

14.10.98 Transfer to Dryad:
Continuing care, fractured humerus, alcohol problem, current oedema, CCF
Plan - gentle mobilisation
S/ B Dr Barton: Morphine solution 5 - 10mg every 4 hourly prn
Oromph: 10mg
14:45 hours: 10mg
23:45 hours: 10mg "for pain relief."

15.10.98 Oromorph 10mg every 4 hours
10.00 am
2.00 pm
6.00 pm
10.00 pm - 20mg

Pain in left arm.
SN Hamblin - condition is poor.

O/ night Condition deteriorated overnight. Very chesty and difficulty in swallowing medications.

16.10.98 S/ B Knapman. Declined overnight with shortness of breath. O/ E bubbly, weak pulse, unresponsive to spoken orders oedema++ in arms and legs. Diagnosis ?silent MI ?decreased liver function
16:10 hours: Syringe driver commenced.
16:30 hours: On syringe driver. Prescription written by Dr Barton.
Nursing: Bubbly chest
Oromoprh
6.00 am
10.00 am
2.00 pm
Diamorphine
16:10 hours 20mg

17.10.98 Hyoscine increased
Diamorphine
05.15 hours: 20mg
15:50 hours: 40mg
Midazolam
15:50 hours: 20mg

18.10.98 Diamorphine
14:50 hours 60mg
Midazolam
14:50 hours 40mg
Nursing - further deterioration in already poor condition. Syringe driver renewed.

23:40 hours: Mr Wilson died

Dr Barton's actions

4) The evidence on which breach of duty is maintained and which was heard at the inquest is the expert evidence of : -

   (a) Professor Black. At the inquest he stated that there was no justification in the medical records for use of oramorph on 14 and 15 October 1998.

   (b) Professor Baker's evidence, read to the jury : -

      (i) Page 12: On the information contained in the medical records the commencement of oramorph was not adequately justified; and

      (ii) Page 15: Even if Mr Wilson did have pain from the fracture that was not controlled by paracetemol, regular doses of 10mg oral morphine would not have been the appropriate treatment. Other non-opiate or weak opiate medication should have been used first. If these medications had failed adequately to reduce the pain, a low dose of morphine (2.5 - 5mg) as had been used in the early days of Mr Wilson's admission might have been reasonable.

   (c) Dr Wilcock, both in his report and in his evidence at the inquest, as to his view on the safety of the levels of morphine prescribed on 15 October 1998: -

      (i) Report, page 37: Mr Wilson was prescribed doses of oral morphine initially prn and subsequently regularly, likely to be excessive to his needs. Mr Wilson subsequently received doses of diamorphine over the last 48 hours of his life that were likely to be excessive to his needs;

      (ii) Pages 38 and 43: In his evidence at the inquest and having been taken to a passage in his report at page 44, "*This was to a degree that disregarded the safety of Mr Wilson by unnecessarily exposing him to receiving excessive doses of diamorphine.*" Dr Wilcock agreed that that the dosage of oramorph on 14 and 15 October 1998, "*...disregarded the safety of Mr Wilson by unnecessarily exposing him to receiving excessive doses of* oramoph."

      (iii) All three experts (Black/ Baker/ Wilcock) criticised the dosage of medication prescribed to Mr Wilson on his admission to Dryad ward on 14 October 1998 in the light of his presenting symptoms. This criticism extends beyond the fact of there being no entry in the medical records to justify the type and level of prescription. Those entries that there are, do not justify the prescription or level of dosage of oramorph and are to be compared with the approach adopted by Queen Alexandra Hospital before transfer.

5) Evidence as to whether Mr Wilson's shoulder fracture would heal is contained in the medical records; see references to expectation of arm healing, pages 21 and 77 and in the expert report of Dr Wilcock, pages 28 – 29. Movement was likely to aggravate the pain until the fracture would have began to heal, a process that can take several weeks and would not be fully complete for 12 weeks, although there is wide variation. Nevertheless it would have been anticipated that Mr Wilson's pain would improve so that he was pain-free when the limb was at rest, followed by a progressive improvement in the movement-related "incident" pain.

Dr Barton's actions

6) Dr Barton chose to : -

(i) Manage Mr Wilson's condition on transfer to Dryad ward on 14 October 1998 in such a way that was inappropriate to that condition?

(ii) Administer and give dosages of oramorph to Mr Wilson which were inappropriate to his needs on 14 and/ or 15 October 1998?

(iii) Pre-prescribe diamorphine, hyoscine and midazolam on 14 October 1998 which was inappropriate to Mr Wilson's needs?

7) Dr Barton's prescription of the level of dosage of oramorph was reckless in that there was a serious risk in prescribing oramorph but also that it was prescribed and at a high initial dose that was unsafe regardless, and/ or that the serious risk of hepatic coma was not properly appreciated, in the light of the following evidence taken as a whole : -

(i) The contrast between the approach to pain relief medication up to and including 13 October 1998 as recorded in the medical records and the approach adopted on transfer to Dryad on 14 October 1998, both in relation to immediate need and prospective need; and

(ii) Dr Barton's knowledge that : -

(a) Mr Wilson had serious liver disease;

(b) Morphine carried risks to those with liver disease of inducing hepatic coma;

(c) Mr Wilson had not had oramorph at that level of dosage or frequency at Queen Alexandra Hospital;

(d) Mr Wilson's pain had been managed by paracetemol and one-off dosages of codeine phosphate at Queen Alexandra Hospital.

(iii) The absence in the clinical records for 14 and 15 October 1998 of entries noting a : -

a. Pain assessment;

b. Review of the medication once prescribed;

c. Review of Mr Wilson's noted deterioration, in the nursing records and in Mr Iain Wilson's statement and its possible causes;

(iv) Sister Hamblin's statement that Mr Wilson had been transferred for terminal care;

(v) The absence of a rationale for pre-prescribing on 14 October 1998 diamorphine, hyoscine and midazolam;

(vi) The assumption that Mr Wilson was in terminal decline and that this informed the approach to his care;

(vii) Dr Barton's review on 15 October 1998 and the regularity with which oramoprh was prescribed on that day;

(viii) The absence of consultant review in October 1998 and since April 1998;

(ix) The view of Dr Barton that in spite of the pressures in October 1998 being the same as those she identified in early 2000 (when she resigned) she did not consider that the patients on Dryad were exposed to risk;

(x) Dr Barton was in overall charge and determined prescribing. She attended on 15 October 1998 and she was in a position to review the effects of the medication and to review the 4 hourly prescription;

(xi) The long-standing nursing staff knew of Dr Barton's approach.

Causation

8) The evidence that Dr Barton's actions caused Mr Wilson's death is as follows : -

9) Professor Black, in his report and in his evidence before the jury : -

i) In his report at paragraph 6.11: *"It is my view that the regular prescription and dosage of oramorph was unnecessary and inappropriate on 15 October and in a patient with serious hepatocellular dysfunction was the major cause of deterioration, in particular in mental state, on the nights of 15 and 16. In my view it is beyond reasonable doubt that these actions more than minimally contributed to the death of Mr Wilson";*

ii) In his evidence before the jury (day 6) changing his written conclusion, "*In my view this treatment was negligent and more than minimally contributed to the death of Robert Wilson"* to, "*...more than likely contributed to the death'"*;

10) Professor Baker's evidence which was read to the jury : -

a) Page 15: *"Although Mr Wilson did have congestive cardiac failure...his death would have been hastened by opiate administration and the path to death may well have been initiated by the commencement of oramorph on 14.10.98";*

b) Page18: *"Bearing these qualifications in mind, in my opinion, Mr Wilson did fall into the category of patients who might have left hospital alive if the oramorph had not been commenced on his transfer to Dryad ward";*

11) Dr Wilcock in his evidence to the jury (day 14) when questioned on the cause of death was invited to comment on the conclusions as to cause of death reached by Professors Black and Baker. He stated that were it not for his concerns about the effect of the pulmonary oedema, "*issue of oedema making it difficult to state anything beyond reasonable doubt re cause of deterioration",* his conclusions would have been similar to Professor Black's (see above).

12) Therefore the dosage of oramorph which Dr Barton chose to prescribe materially contributed to Mr Wilson's death.

Mr Arthur Cunningham (deceased)

1) Mr Charles Farthing is the step-son and family's representative of the late Mr Arthur Dennis Brian Cunningham.

Background

2) Mr Cunningham was admitted to hospital for rehabilitative care. On 21.09.98 he was seen by Dr Lord at the Dolphin Day hospital who admitted him to Dryad Ward at the Hospital with a view to more aggressive treatment on the sacral ulcer.

3) At the time of Mr Cunningham's admission, the consultant geriatrician whose care he was under had set out a clear care plan. She : -

    i) Admitted him for more intensive therapy to his ulcer;

    ii) Recommended a high protein diet to help improve his nutrition and help wound healing;

    iii) Asked the nursing home to keep his bed open for the next three weeks at least.

4) This care plan was not followed. Dr Barton decided to treat Mr Cunningham as though terminally ill from the moment of his arrival.

5) At the Dryad Ward on 21.09.98, Mr Farthing was told that Mr Cunningham would die. Mr Cunningham did not receive the high protein diet to help improve his nutrition and help wound healing as had been recommended. Once he had become unresponsive, no hydration or other infusion was provided.

6) The reason it was not followed was that Dr Barton took her own view from that of Dr Lord in relation to Mr Cunningham's survival. Her personal assessment and examination led her to take "a different view" to Dr Lord in relation to Mr Cunningham's survival prospects.

7) Dr Lord stated at the inquest hearing that recommended treatment can be altered without further consultant input being required if there is a change in the patient's condition. Dr Lord's assessment was made on 21.09.98. Dr Barton's assessment was also made on 21.09.98.

8) There had been no change in Mr Cunningham's condition in between the two assessments. In the absence of a change in his condition and in the absence of further consultant input, Dr Barton decided that she would not provide curative treatment to Mr Cunningham.

9) On 21.09.98, the consultant geriatrician had prescribed 2.5mg - 10mg of morphine "as required". On 21.09.98 on his arrival at the Dryad Ward, Mr Cunningham was fully conscious.

10) On 21.09.98 at 20:15 hours Mr Cunningham received 10mg of oramorph. At 22:00 hours he was sedated.

11) At 23:10 hours that evening the regime for opiate analgesics moved from a regime where they were to be administered on an as required basis, to a regime where they were administered continuously via a syringe driver. The medical records do not show any evidence of adequate assessment of the : -

    i) nature or origin of symptoms being treated;

ii) need for the increases;

iii) effect of the medication on Mr Cunningham.

12) Dr Barton's assertion at the inquest that Mr Cunningham was in agony is not born out in the medical records.

13) Over the course of 6 days, s/c 24 hours doses of diamorphine increased from 20mg to 80mg and midazolam increased from 20mg to 100mg. There is insufficient information in the medical notes to explain the increases which require to be justified.

14) On 23.09.98 Mr Farthing found his step father totally unconscious. Dr Barton accepted that consideration was never given to the possibility that the deterioration in Mr Cunningham's condition may have been due to excessive opioid analgesia.

Dr Barton's actions

15) In circumstances where there is no, alternatively no adequate, assessment of the nature of the symptoms and/ or the propriety of the continuation of opiate analgesia, and/ or the effect of the medication on Mr Cunningham, Dr Barton was in breach of her duty to provide proportionate symptom relief.

16) In relation to the breaches of duty : -

a) Given his need for treatment, age and frailty, Mr Cunningham was at a heightened risk of death;

b) Dr Barton knew : -

i) that excessive doses of diamorphine could cause respiratory depression, loss of consciousness and death, delirium, confusion, agitation;

ii) the principles of the analgesic ladder;

iii) of the need for particular caution in the administration of strong opioids to the elderly;

iv) that it was not appropriate to run the risk of adverse consequences inherent in administering doses in excess of the recommended starting dose, unless there was no other way of controlling the symptoms;

v) of concerns at Gosport in 1991 as to the risk of premature deaths caused by diamorphine.

c) There is no satisfactory explanation for omitting to follow Dr Lord's care plan and omitting to monitor the affects of the opiate and sedative analgesia.

Causation

17) Dr Lord considered that it was appropriate to keep Mr Cunningham's place in the nursing home open for at least three weeks. There was no reference to respiratory difficulties and no signs of pneumonia in Dr Lord's thorough assessment. Six days later Mr Cunningham died of bronchopneumonia, which occurs as a secondary complication of opiate and sedative induced respiratory depression.

18) In the absence of a change in circumstance it is submitted that Dr Lord's three week time estimate was based upon an assumption that Mr Cunningham would be treated in

accordance with the recommended care plan. In the event Mr Cunningham was dead within the week.

19) If Mr Cunningham been treated in accordance with the care plan and in the absence of the analgesic and sedative medication, he would have lived for a longer period than he did. Dr Barton's actions materially contributed to Mr Cunningham's death on 26.09.98.