
DRAFT REPORT
regarding
GEOFFREY PACKMAN (BJC/34)

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AT THE REQUEST OF: Hampshire Constabulary

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1. SUMMARY OF CONCLUSIONS

Mr Packman was a 67 year old man with obesity impairing his mobility, swelling of his legs and leg ulcers admitted to the Queen Alexander Hospital because of cellulitis (infection of the skin) affecting his left leg and groins. He also had pressure sores over his buttocks and thighs. He improved with treatment with antibiotics. He passed loose black stools, suggestive of melaena (blood in the stool) on a couple of occasions, but his haemoglobin was stable, excluding a significant gastrointestinal bleed. He was transferred to Dryad Ward for rehabilitation.

During his admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal; there was a lack of clear, accurate and contemporaneous patient records, inadequate assessment of Mr Packman's condition; a lack of consultation with colleagues and the use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs.

Mr Packman became acutely unwell on the 26th August 1999. A blood test revealed a large drop in his haemoglobin which made a significant gastrointestinal bleed likely. This is a serious and life-threatening medical emergency which requires urgent and appropriate medical care. The commonest underlying cause, a peptic ulcer, can however, be cured. Mr Packman should have been transferred without delay to the acute hospital. However, Mr Packman was not transferred; the blood test result was not obtained or acted upon and he went on to receive doses of diamorphine and midazolam which were not obviously justified and likely to have been excessive to his needs.

In short, 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 when he became unwell with a gastrointestinal bleed. He was not appropriately assessed, resuscitated with fluids, transferred or discussed with the on-call medical team. The use of regular morphine and subsequent use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs were inappropriate. 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, negligibly or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

2. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be suboptimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

3. ISSUES

- 3.1 Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day?
- 3.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case?
- 3.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

4. BRIEF CURRICULUM VITAE

Dr Andrew Wilcock MB ChB, FRCP, DM, Reader in Palliative Medicine and Medical Oncology, University of Nottingham and Honorary Consultant Physician, Nottingham City Hospital NHS Trust.

Trained in general medicine, including experience in health care of the elderly (acute medicine and rehabilitation) prior to specialising in Palliative Medicine, working in Specialist Palliative Care Units in Nottingham and Oxford. Appointed to present post as Senior Lecturer in 1995. Promoted to Reader in 2001. Carries out research in pain, breathlessness and exercise capacity. Regularly lectures on national and international courses. Palliative care prescribing advisor to the British National Formulary (2002-). Expert reviewer for Prodigy national palliative care guidelines for general practitioners. Joint author of the international Palliative Care Formulary that has sold over 90,000 copies, and the 3rd edition of Symptom Management in Advanced Cancer, with Dr Robert Twycross. Previously Chair of the Mid-Trent Cancer Services Network Palliative Care Group, Nottingham

Cancer Centre Palliative Care Group, inaugural Secretary for the Science Committee of the Association for Palliative Medicine of Great Britain and Ireland and member of the National Institute for Clinical Excellence Lung Cancer Guidelines Development Group.

Operates the international Palliative Medicine mailbase mailing list and co-owns and edits www.palliativesdrugs.com that publishes the Palliative Care Formulary on the internet. With 20,000 members it is the largest Palliative Care resource of its kind. Provisional Member of the Expert Witness Institute.

5. DOCUMENTATION

This Report is based on the following documents:

- [1] Full paper set of medical records of Geoffrey Packman, including the medical certificate of cause of death.
- [2] Operation Rochester Briefing Document Criminal Investigation Summary.
- [3] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.
- [4] Hampshire Constabulary Summary of Care of Geoffrey Packman.
- [5] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'
- [6] Portsmouth Health Care NHS Trust Policies:

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- i) Control of Administration of Medicines by Nursing Staff Policy (January 1997).
 - ii) Prescription Writing Policy (July 2000).
 - iii) Policy for Assessment and Management of Pain (May 2001).
 - iv) Compendium of Drug Therapy Guidelines, Adult Patients (1998).
 - v) Draft Protocol for Prescription Administration of Diamorphine by Subcutaneous Infusion, Medical Director (December 1999).
 - vi) Medicines Audit carried out by the Trust referred to as Document 54 on page 52 in the Chi Report (reference 6).
- [7] General Medical Council, Good Medical Practice (July 1998).
 - [8] British National Formulary (BNF). Section on Prescribing in Terminal Care (March 1999).
 - [9] British National Formulary (BNF). Section on Prescribing in the Elderly (March 1999).
 - [10] Statement of Dr Jane Barton as provided to me by Hampshire Constabulary (undated).
 - [11] Statement of Dr Jane Barton RE: Geoffrey Packman, 17th November 2005.
 - [12] Draft Report regarding Statement of Dr Jane Barton RE: Geoffrey Packman (BJC/34), Dr A Wilcock, 26th January 2006.
 - [13] Draft overview of Geoffrey Packman (BJC/34), Dr A Wilcock, 5th November 2005.
 - [14] Draft report regarding Geoffrey Packman, Dr Jonathan Marshall, 1st April 2005.

6. CHRONOLOGY/CASE ABSTRACT

Events at Queen Alexander Hospital, 6th–23rd August 1999

Mr Packman, a 67 year old man who lived with his wife and daughter, was admitted on the 6th August 1999 to Queen Alexander Hospital following a fall at home. Due to his obesity he was unable to get up and two ambulance crews were called to assist (page 42 of 283). He was initially seen in Accident and Emergency and then Anne Ward where he was clerked by the Senior House Officer (SHO) who noted his five year history of lower leg oedema (swelling) that had got worse over the past six months; bilateral leg ulcers for one month; increasing erythema (redness) of the groin for three weeks which had become uncomfortable; increasing weakness and difficulty mobilising for one week (page 44 of 283). Mr Packman's past medical history included hypertension (high blood pressure) since 1985 and arthritis (unspecified). He was receiving doxazosin 4mg once a day, felodipine mr 5mg once a day and bendrofluazide 5mg once a day, possibly all for his hypertension, although the latter (a diuretic, 'water tablet') is also given for oedema. Systemic enquiry revealed a poor urinary stream, constipation for one week and no problems with chest pain or shortness of breath. Mr Packman's wife was undergoing tests for possible breast cancer. He was a non-smoker. District nurses visited three times a week to apply dressings to his legs and normally he was able to mobilise around the house and occasionally outside with the use of a stick (page 44 of 283). On examination he was obese, had an elevated temperature (37.6°C), an irregular heart rate of 80 beats per minute, fine crackles in the mid zones of his chest bilaterally, a soft, non-tender abdomen and erythema of both

groins particularly on the left which leaked clear fluid. Both legs were swollen particularly the left which was also erythematous. There was bruising on his buttocks in the shape of a toilet seat. The SHO summarised Mr Packman's main problems as leg oedema, cellulitis (infection in the subcutaneous tissues of the skin) in the groin and left lower leg, immobility due to his obesity/oedema/infection and atrial fibrillation (irregular heart rhythm) (page 45 of 283). Investigations were undertaken (blood tests, blood cultures, urine analysis, chest x-ray, electrocardiograph (ECG), swabs from his groin and leg ulcers) and treatment commenced with intravenous antibiotics to treat the infection, and his dose of diuretics increased by switching the bendrofluzide to furosemide 80mg once a day (pages 45 and 174a of 283). The results of the investigations were in keeping with cellulitis: a raised white cell count of $25.7 \times 10^9/L$, 90% neutrophils (page 213 of 283); a C-reactive protein (CRP) of 191mg/L, (normal range $<5\text{mg/L}$; page 202 of 283); haemolytic streptococcus, a bacteria known to cause cellulitis, grown from the sores in his groin and buttocks (pages 227 and 229 of 283) and an elevated aspartate aminotransferase at 194IU/L (normal 12–40IU/L; page 202 of 283). There was also renal impairment; urea and creatinine were elevated 14.9mmol/L (normal 3–7.6mmol/L) and 173micromol/L (normal 60–120micromol/L; page 202 of 283) respectively. Other results revealed a marginally low albumin (a protein) at 36g/L (normal range 37–50g/L), a normal haemoglobin (15.7g/dl; page 213 of 283) and negative blood and urine cultures (pages 221 and 231 of 283). An ECG was reported as showing atrial fibrillation, a common arrhythmia which causes the heart to beat irregularly, but at a satisfactory

rate of 85 beats per minute (pages 45 and 185 of 283). Mr Packman was catheterised because of urinary incontinence (page 144 of 283).

Mr Packman was reviewed later the same day by a more senior doctor (a registrar) who listed Mr Packman's problems as cellulitis of the left leg, chronic leg oedema, poor mobility, morbid obesity, hypertension and possible atrial fibrillation. He agreed with the plan to treat the cellulitis with intravenous antibiotics (flucloxacillin and penicillin G) and because of Mr Packman's immobility, obesity and cellulitis, also commenced low molecular weight heparin (enoxaparin (clexane)) to thin the blood and reduce the risk of a deep vein thrombosis in the leg. The registrar also suggested a repeat ECG rhythm strip, which subsequently confirmed atrial fibrillation (pages 48 and 185 of 283; although I am unable to comment given the quality of the copy) and, as the felopidine and doxazosin may have been exacerbating Mr Packman's oedema, to consider other drugs to treat his hypertension. Mr Packman was deemed not appropriate for cardiopulmonary resuscitation in the event of a cardiorespiratory arrest because of his 'pre-morbid state and multiple medical problems' (page 46 of 283).

The medication chart indicates that during his stay on Anne Ward, Mr Packman received the antibiotic benzylpenicillin 1.2G intravenously four times a day from 6-11th August 1999, after which it was continued as an oral equivalent, penicillin V 500mg four times a day until 18th August 1999 (pages 174a and 177 of 283). Similarly, the antibiotic flucloxacillin 1G was given intravenously four times a day from the 6-9th August 1999, after which it was continued orally as flucloxacillin 500mg four times a day until the 18th August 1999 (pages 174a and 177 of 283). The antihypertensive

doxazosin 4mg once a day was continued unchanged (page 174a of 283) but the felodipine was reduced and subsequently discontinued on the 19th August 1999 (page 174a of 283). The diuretic furosemide 80mg once a day and the heparin enoxaparin 40mg twice a day were continued throughout his stay (pages 174a, 177 and 179 of 283). Paracetamol 1G was given at 20.10h on the 6th August and 07.15h on the 7th August as once only, nurse prescribed doses, probably to reduce his temperature as there was no mention of pain (page 130 of 283); thereafter it was prescribed regularly 1G four times a day and continued throughout his stay, although intermittently doses were declined (pages 174, 174b, 177 and 179 of 283).

Gaviscon, an antacid, generally given for the relief of dyspepsia (indigestion) was prescribed p.r.n. 'as required'; three doses were taken on the 8th and one dose each on the 9–12th and 14th August 1999 (page 174 of 283).

During his stay on Anne Ward, Mr Packman improved. His temperature and cellulitis began to settle and he was switched to oral antibiotics (pages 48 and 49 of 283). Dr Reid reviewed Mr Packman on the 9th August 1999, who recorded more oedema in the left than the right foot and more arthritis in the left than the right knee and hip, although this was mild (page 48 of 283). Mr Packman's weight was recorded as 148.6kg on 12th August 1999 (page 121 of 283). On the 13th August 1999, blood test results had improved; white blood cell count and CRP had fallen and his renal function returned to normal (pages 196, 200, 211 of 283). Following discussion with Mrs Packman, because of Mr Packman's immobility, pressure sores and social

circumstances, the plan was to transfer him to Dryad Ward for rehabilitation (pages 50, 108, 121, 122 of 283).

According to his observation chart, some time on the evening of the 11th August, Mr Packman's blood pressure was measured as he was 'feeling dizzy'; it was 'normal' for him at 170/90 but his pulse was not recorded and I can find no other mention of this episode (page 159 of 283). An entry on the comments sheet on the 11th August 1999 at 13.45h reports loose black stools (suggestive of melaena, which is blood in the stool, see technical issues; page 133 of 283). Mr Packman opened his bowels several times between the 11–13th August, with no mention of melaena (pages 134 and 135 of 283). An entry made by Dr Tandy on the 13th August 1999 noted 'black stools overnight - nil today, says bowels looser than usual. No pain. Abdomen soft. Bowel sounds normal. PR (digital examination of the rectum) normal brown stool. Chase haemoglobin to rule out bleed. ?Antibiotic related diarrhoea. Stool chart' (pages 52, 53 of 283). Mr Packman's haemoglobin was checked and was essentially stable; 13.5g/dL (12th August) 12.9g/dL (19th August), 12.9g/dL (20th August), (pages 209, 211, 215 of 283).

Blood tests carried out on the 14th August 1999, revealed normal thyroid function tests, that the aspartate aminotransferase had returned to normal (40IU/L), but that his albumin had fallen to 29g/L (normal 37–50g/L; pages 196 and 198 of 283).

On the 15th August Mr Packman was incontinent of loose faeces (page 136 of 283). An entry dated 16th August 1999 noted that Mr Packman had pressure sores over his buttocks, sacrum and thighs that required daily

dressings and that he was faecally incontinent (page 51 of 283). An entry dated 18th August 1999 reported that he was stable, and that his wounds looked better, and the antibiotics were discontinued on the 19th August (page 51 of 283). A communication sheet entry on the 19th August 1999 at 06.00h noted that Mr Packman twice passed small amounts of black tarry stools (pages 119 and 137 of 283). A later entry the same day reported bowels open small amount with no mention of melaena (page 138 of 283). An entry dated 20th August 1999 notes no further black motions, no nausea, epigastric pain or tenderness (page 53 of 283). Blood test results on the 20th August revealed a stable haemoglobin at 12.9g/dL and an improved albumin at 34g/L (pages 192 and 209 of 283).

Mr Packman's Barthel score had improved from 0 to 6 representing improvements in continence of bowels, ability to undertake his own grooming (washing face, cleaning teeth etc.) feeding himself independently and being able to transfer with major help from having been unable to transfer (page 163 of 283). Nevertheless, he remained in bed, using a monkey bar to raise himself off the bed and otherwise being moved with a hoist (page 148 of 283). The sores in his groin had improved (page 149 and 150 of 283) but the sacral pressure sore persisted, with dressings needing frequent changing due either to being sodden with exudate or soiled with faeces (page 150 of 283).

Events at Dryad Ward, 23rd August 1999 until 3rd September 1999.

23rd August 1999

An entry was made in the medical notes on 23rd August 1999, which I assume was done on Dryad ward, although this should be clarified (page 54 of 283). The clerking doctor noted that Mr Packman's ongoing problems were obesity, arthritis in his knees, immobility, pressure sores and constipation. They noted that Mr Packman was 'on a high protein diet, ? melaena 13th August 1999, haemoglobin stable' but was better in himself, with a good mental test score and no pain. There was little to find on examination bar his obesity, swollen legs and pressure sores (page 54 of 283).

The nursing summary notes recorded that Mr Packman had been 'transferred from Anne Ward following an episode of immobility and sacral sores. Catheterised. On profile bed, hoist only. Able to feed himself. Mrs Packman is awaiting a decision re mastectomy at Queen Alexander Hospital tomorrow' (page 62 of 283). Several nursing care plans were produced: 'Requires full assistance to settle at night' (page 78 of 283); 'Due to immobility...prone to constipation' (page 82 of 283); 'Urinary catheter' (page 84 of 283); 'Pressure sore areas' (page 96 of 283).

The drug chart reveals he was continued on regular doxazosin 4mg once a day, furosemide 80mg once a day, enoxaparin 40mg twice a day, paracetamol 1G four times a day; commenced on magnesium hydroxide 10ml twice a day (a laxative), subsequently taken intermittently; two doses on the 24th, one dose on the 25th, two doses on the 28th, 29th and one

dose on the 30th (page 170 of 283) and p.r.n. 'as required' gaviscon (undated but most probably on the 23rd August)(pages 168, 170 of 283).

24th August 1999

A handling profile noted in the section for pain 'needs to be controlled' (page 90 of 283). This is at odds with the medical notes entry for the 23rd August 1999 that states 'no pain' (page 54 of 283). Pain is not mentioned anywhere else. His bowels were well open (no melaena specified) and swabs taken from his pressure sores for microbiology (pages 82 and 97 of 283).

Blood test results revealed a haemoglobin of 12g/dL and a white cell count of $12.2 \times 10^9/L$ (Page 207 of 283); a marginally raised urea 8.9mmol/L (normal 3.0–7.6mmol/L) and a reduced albumin 31g/L (normal 37–50g/L). Both forms were signed with the initials 'JAB' (pages 190 and 207 of 283). Note: the biochemistry results form given as page 190, differs in my two files, one having a more complete set of results for the 24th August 1999. Temazepam 10–20mg was prescribed p.r.n. and he took 10mg at 22.10h (page 168 of 283).

25th August 1999

Mr Packman was noted to have 'bowels open medium, formed, leaking some fluid' and later 'several loose bowel actions throughout the afternoon and evening - 7–8. Some fresh blood present, ? due to medication - same stopped. For review later' (pages 82 and 83 of 283). The nursing summary notes recorded that Mr Packman had been passing fresh blood PR ? due to

the enoxaparin (clexane). A verbal order from Dr Beasley was to withhold the 18.00h dose and review with Dr Barton in the morning. Mr Packman was also vomiting and metoclopramide 10mg IM was given at 17.55h (page 171 of 283).

Mr Packman took temazepam 20mg at 22.05h and loperamide 4mg (for diarrhoea) as a one off dose at a time I can not decipher (page 168 of 283). He was also prescribed loperamide 2mg four times a day regularly on the daily review prescriptions section, and appeared to have received this at 06.00h, 12.00h and 18.00h on 25th August 1999.

26th August 1999

The nursing summary notes recorded 'fairly good morning, no further vomiting - Dr Ravi contacted re enoxaparin (clexane). Advised to discontinue and repeat haemoglobin today and tomorrow. Not for resuscitation. Unwell at lunchtime, colour poor, complaining of feeling unwell. Seen by Dr Barton this afternoon - await result of haemoglobin. Further deterioration - complaining of ? indigestion - pain in throat, not radiating - vomited again this evening. Verbal order from Dr Barton diamorphine 10mg stat - same given at 18.00h. Metoclopramide 10mg given IM. Mrs Packman informed will visit this evening (page 62 of 283).

The medical notes record 'called to see, pale, clammy, unwell. Suggest ? myocardial infarction (MI). Treat stat diamorphine and oramorph overnight. Alternative possibility gastrointestinal (GI) bleed but no haematemesis. Not well enough to transfer to acute unit. Keep comfortable. I am happy for nursing staff to confirm death (page 55 of 283). The entry in the nursing

summary notes at 19.00h recorded 'Dr Barton here. For oramorph four hourly. Wife seen by Dr Barton, explained Mr Packman's condition and medication used' (page 62 of 283).

The drug chart showed that he received diamorphine 10mg at 18.00h prescribed as a verbal order in the once only section (page 168 of 283). The prescription was repeated below this one, but it does not appear to have been given. (page 168 of 283) Oral morphine solution (Oramorph) was commenced regularly 10–20mg every four hours with 20mg at night which Mr Packman continued until 10.00h on the 30th August 1999 (page 172 of 283). Regular oral morphine solution 10mg every 4 hours was also prescribed in the daily review prescription, which appears to be an error and unnecessary duplication; none appears to have been prescribed from this section however (page 171 of 283). Diamorphine 40–200mg and midazolam 20–80mg SC/24h were also prescribed on the 26th August 1999 (page 171 of 283).

A full blood count revealed a significant fall in Mr Packman's haemoglobin to 7.7g/dL. A comment on the form reads 'many attempts were made to phone these results, no answer from Gosport War Memorial Hospital switchboard'. The results are signed with the initials JAB (page 205 of 283).

27th August 1999

The nursing summary entry noted 'some marked improvement since yesterday. Seen by Dr Barton this am - to continue with oramorph four hourly - same given tolerated well. Some discomfort this afternoon – especially when dressings being done. Wife has visited this afternoon and

is aware that condition could deteriorate again. Still remains poorly' (page 63 of 283).

Mr Packman's pressure sore dressings were renewed to all areas 'some improvement since Wednesday especially to the areas on the left buttock. Area on right buttock remains offensive and some exudates (page 97 of 283). Mr Packman night was recorded as 'oramorph given as prescribed. Comfortable night, not complaining of any chest pain' (page 79 of 283).

28th August 1999

Medical notes entry noted 'Remains poorly but comfortable so please continue opiates over weekend' (page 55 of 283). Nursing summary noted 'Remains very poorly – no appetite has refused all food. Wife visited – very distressed as she is having surgery this coming week' (page 63 of 283). The entry for the night noted 'Oramorph given as prescribed. Condition remains poorly and variable. Drinking well. Dressings remain intact' (page 63 of 283). An entry in the nursing care plan for 'requires full assistance to settle at night' noted 'Oramorph given as prescribed, condition variable, drinking well, appears hydrated. Slept long periods' (page 79 of 283).

29th August 1999

Nursing summary entry for night, noted 'Slept for long periods. Oramorph given as prescribed (page 63 of 283). The nursing care plan for 'requires full assistance to settle at night' noted 'Quite sleepy. Medication given as prescribed. Is complaining of left sided abdominal pain ?bowel or ?' (page 79 of 283).

30th August 1999

The nursing summary notes recorded 'This morning complaining of left abdominal pain', then 'Condition remains poor. Syringe driver commenced at 14.45h with diamorphine 40mg, midazolam 20mg. No further complaints of abdominal pain – very small amount of diet taken – managing mainly puddings. Recatherised this afternoon, draining (see also pages 55 and 85 of 283). When possible encourage fluids. Dressings also renewed' (page 63 of 283).

The drug chart confirms a syringe driver containing 40mg of diamorphine and 20mg of midazolam was commenced at 14.45h (page 171 of 283). However, the midazolam 20mg appears dated the 26th August 1999 (page 171 of 283).

His pressure sores were redressed. The small pressure sore on his left buttock was much cleaner; an area of slough was removed from the pressure sore on the lower right buttock exposing a large crater one inch deep which was redressed (page 98 of 283).

An entry in the nursing care plan for 'requires full assistance to settle at night' noted 'appeared to have a peaceful and comfortable night. No faecal incontinence until mane (morning) and then it was a large amount of black soft faeces' (page 79 of 283).

31st August 1999

Nursing summary noted 'Appeared to have a comfortable and peaceful night. This morning has passed a large amount of black faeces. The nursing summary for the night noted 'Comfortable night continues to pass

tarry black faeces' (page 63 of 283). This was repeated in the nursing care plan for 'Due to immobility...prone to constipation' (page 83 of 283).

Mr Packman's pressure sores on his left buttock were reported to be producing a copious amount of exudate (page 98 of 283).

An entry in the nursing care plan for 'requires full assistance to settle at night' noted 'Peaceful night. Incontinent of black tarry faeces+++ (a lot), nil taken by mouth, remains hot' (page 79 of 283).

1st September 1999

A medical notes entry made by Dr Reid notes 'Rather drowsy, but comfortable, passing melaena stools, abdomen huge, but quite soft, pressure sores over buttock and over the posterior aspect of both thighs. Remains confused. For T.L.C. (tender loving care) – stop furosemide and doxazosin. Wife aware of poor prognosis' (page 55 of 283).

The diamorphine dose in the syringe driver was increased to 60mg/24h at 19.15h (page 171 of 283). The dose of midazolam was also increased to 40mg/24h at 15.45h and 60mg/24h at 19.15h (page 171 of 283).

Nursing summary entry notes 'Dr Reid here. To continue', then 'Syringe driver renewed at 19.15h with diamorphine 60mg and midazolam 60mg as previous dose not controlling symptoms. Dressings renewed this afternoon. Mrs Packman had visited this afternoon and is aware of poor condition. Mrs Packman being admitted to E1 Ward at QA tomorrow for surgery. Please contact her son in the event of Mick's death. No night calls please' (page 64 of 283). The nursing summary nocte (night) entry reported 'Incontinent of black tarry faeces on settling. Peaceful night all care given. Syringe driver

satisfactory. Syringe driver reprimed' (page 64 of 283). The black stools were also recorded in the nursing care plan for 'Due to immobility...prone to constipation' (pages 82 and 83 of 283).

The nursing care plan relating to Mr Packman's pressure sores noted that they were contaminated with faeces and so redressed (page 98 of 283) and slough removed from the large pressure sore on his left buttock (page 100 of 283).

2nd September 1999

The nursing summary entry noted 'diamorphine increased to 90mg, midazolam 80mg (page 64 of 283). The drug chart notes this was at 18.40h (page 171 of 283). Hysocine (hydrobromide) was prescribed in a dose range of 800microgram-2g (an incorrect upper dose range) although never given (page 172 of 283).

An entry in the nursing care plan for 'Due to immobility...prone to constipation' noted 'some slight faecal soiling' (page 83 of 283) and the care plan related to his catheter noted 'some drainage but debris present' (page 85 of 283). An entry in the nursing care plan for 'requires full assistance to settle at night' noted 'Incontinent of black tarry faeces on settling. Nursed on side. Peaceful night. Strong radial pulse, open eyes when spoken to' (page 81 of 283).

3rd September 1999

A medical and nursing notes entries were made confirming death at 13.50h (pages 55 and 64 of 283). The cause of death was given as '1a Myocardial

infarction', with an approximate interval between onset and death of five days.

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Syringe drivers, diamorphine, midazolam and hyoscine hydrobromide

A syringe driver is a small portable battery-driven pump used to deliver medication subcutaneously (SC) via a syringe, over 24h. Indications for its use include swallowing difficulties or a comatose patient. In the United Kingdom, it is commonly used in patients with cancer in their terminal phase in order to continue to deliver analgesic medication. Other medication required for the control other symptoms, e.g. delirium, nausea and vomiting can also be added to the pump.

Diamorphine is a strong opioid that is ultimately converted to morphine in the body. In the United Kingdom, it is used in preference to morphine in syringe drivers as it is more soluble, allowing large doses to be given in very small volumes. It is indicated for the relief of pain, breathlessness and cough. The initial daily dose of diamorphine is usually determined by dividing the daily dose of oral morphine by 3 (BNF 37, March 1999). Others sometimes suggest dividing by 2 or 3 depending on circumstance (Wessex protocol). Hence, 60mg of morphine taken orally a day could equate to a daily dose of 20 or 30mg of diamorphine SC. It is usual to prescribe additional doses for use 'as required' in case symptoms such as pain breakthrough. The dose is usually 1/6th of the 24h dose. Hence for someone receiving 30mg of diamorphine in a syringe driver over 24h, a breakthrough dose would be 5mg. One would expect it to have a 2-4h

duration of effect, but the dose is often prescribed to be given hourly as required. As the active metabolites of morphine are excreted by the kidneys, caution is required in patients with impaired kidney function.

Midazolam is a benzodiazepine, a diazepam like drug. It is commonly used in syringe drivers as a sedative in patients with terminal agitation. Sedation can be defined as the production of a restful state of mind. Drugs that sedate will have a calming effect, relieving anxiety and tension. Although drowsiness is a common effect of sedative drugs, a patient can be sedated without being drowsy. Most practitioners caring for patients with cancer in their terminal phase would generally aim to find a dose that improves the patients' symptoms rather than to render them unresponsive. In some patients however, symptoms will only be relieved with doses that make the patient unresponsive. A typical starting dose for an adult is 30mg a day. A smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The BNF (BNF 37, March 1999) recommends 20–100mg SC over 24h. The Wessex protocol suggests a range with the lowest dose of 5mg a day. The regular dose would then be titrated every 24h if the sedative effect is inadequate. This is generally in the region of a 33–50% increase in total dose, but would be guided by the severity of the patients symptoms and the need for additional 'as required' doses. These are generally equivalent to 1/6th of the regular dose, e.g. for midazolam 30mg in a syringe driver over 24h, the 'as required' dose would be 5mg given as a stat SC injection. The duration of effect is generally no more than 4h, and it may need to be given more frequently. As an active metabolite of

midazolam is excreted by the kidneys, caution is required in patients with impaired kidney function.

Hyoscine hydrobromide is an antimuscarinic drug most commonly given to reduce excessive saliva or retained secretions ('death rattle'). It also has anti-emetic, antispasmodic (smooth muscle colic) and sedative properties. Repeated administration can lead to cummulation and this can occasionally result paradoxically in an agitated delirium, highlighted in both in the BNF and the Wessex protocol (page 41). It is usually given in a dose of 600–2400microgram SC over 24h (BNF 37, March 1999) or 400–600microgram as a stat SC dose. The Wessex protocol gives a dose range of 400–1200microgram over 24h.

The titration of the dose of analgesic or sedative medication is guided by the patients symptom control needs. The number and total dose of 'as required' doses needed over a 24h period are calculated and this guides the increase necessary in the regular dose of the drugs in the syringe driver in a way that is proportional to the patients needs. The ideal outcome is the relief of the symptoms all of the time with no need for additional 'as required' doses. In practice, this can be difficult to achieve and the relief of the symptoms for the majority of the time along with the use of 1–2 'as required' doses over a 24h period is generally seen as acceptable.

ii) The principle of double effect

The principle of double effect states that:

'If measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable provided the doctor's intention is to relieve the distress and not kill the patient.'

This is a universal principle without which the practice of medicine would be impossible, given that every kind of treatment has an inherent risk. Many discussions on the principle of double effect have however, involved the use of morphine in the terminally ill. This gives a false impression that the use of morphine in this circumstance is a high risk strategy. When correctly used (i.e. in a dose *appropriate* to a patient's need) morphine does not appear to shorten life or hasten the dying process in patients with cancer. Although a greater risk is acceptable in more extreme circumstances, it is obvious that effective measures which carry less risk to life will normally be used. Thus, in an extreme situation, although it may occasionally be necessary (and acceptable) to render a patient unconscious, it remains unacceptable (and unnecessary) to cause death deliberately. As a universal principle, it is also obvious that the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care.

iii) *Melaena.*

Melaena refers to black 'tarry' faeces that are associated with gastrointestinal haemorrhage. The black colour is caused by oxidation of the iron in haemoglobin during its passage through the ileum and colon. Bleeding originating from the lower gastrointestinal tract is generally associated with the passage of bright red blood. Only blood that originates from a high

source such as the small intestine, or bleeding from a lower source that occurs slowly enough to allow for oxidation, is associated with melaena. Thus, melaena is most often associated with haemorrhage in the stomach or duodenum and the most common cause of melaena is a peptic ulcer. If the source of bleeding is suspected to be in the upper gastrointestinal tract, an endoscopy is usually performed to diagnose the cause.

IV) Not for resuscitation

The medical notes record that Mr Packman was 'not for resuscitation' and Dr Barton refers to this in her statement. In my experience and opinion, the meaning of 'not for resuscitation' is quite specific. A medical judgement has been made that in the event of a patient's heart or breathing stopping *unexpectedly* (a cardiorespiratory arrest), there is little or no chance of cardiopulmonary resuscitation being successful (i.e. it would be medically futile) and thus should not be attempted. The decision not to resuscitate will be influenced by the presence of progressive life-threatening illness or other significant medical problems. This status does not however, mean that the patient is automatically excluded from receiving appropriate treatment for other medical problems that may arise. Thus, for example, patients with far advanced cancer, who may be admitted seriously unwell with an infection, given that cardiopulmonary resuscitation is likely to be futile, a 'not for resuscitation' decision is generally made. This does not however, prevent them from receiving appropriate treatment for their infection, even with intravenous antibiotics or fluids if necessary, when this is appropriate to their overall situation.

8. OPINION

Events at Queen Alexander Hospital, 6th–23rd August 1999

Mr Packman was a 67 year old man with obesity which limited his mobility and contributed to a several year history of swelling of his legs which in turn predisposed him to leg ulcers. Following three weeks of increasing redness of the groins he became less well with increasing weakness, leading to a fall which precipitated his admission to the Queen Alexander Hospital on the 6th August 1999. The main reason for his deterioration was cellulitis of the left leg ± groins. There were also pressure sores over his buttocks and thighs and he was noted to have atrial fibrillation (an irregular heart rhythm). He received appropriate treatment with intravenous then oral antibiotics and an increased dose in his diuretics and subsequently he and his blood test results improved. At 13.45h on the 11th August 1999 it was noted that he passed loose black stools, suggestive of melaena, blood in the stool. Sometime in the evening of 11th August 1999, Mr Packman complained of feeling dizzy and his blood pressure was checked and was normal for him at 170/90. It would be usual practice for the nursing staff to report melaena to the medical staff and it is a little surprising to find the first mention of melaena in the medical notes was two days later on the 13th August 1999 in an entry made by Dr Tandy. However, she undertook an appropriate assessment of Mr Packman including a digital rectal examination which revealed normal brown stool on the glove; his full blood count was checked and was found to be essentially stable. This would exclude a significant bleed. Although it is reported that Mr Packman had no abdominal pain, it is of note that he intermittently took Gaviscon, a treatment for indigestion,

between the 8–14th of August 1999. Mr Packman again passed small amounts of black tarry stools on the 19th August 1999; there was no nausea, epigastric pain or abdominal tenderness and his haemoglobin remained stable.

Although Mr Packman's Barthel score improved, he remained in bed requiring a hoist to be moved. His pressure sores persisted and he was transferred to Dryad Ward on the 23rd August 1999 for rehabilitation. In my opinion there are no issues relating to the standard of care or treatment proffered to Mr Packman during his admission to Anne ward and I note that Dr Marshall has no concerns regarding the management of his melaena.

Events at Dryad Ward, 23rd August 1999 until 3rd September 1999.

Infrequent entries in the medical notes during Mr Packman's stay on Dryad Ward make it difficult to closely follow his progress over the last twelve days of his life. There are five entries prior to the confirmation of death, taking up just over one and a half pages in length. In summary in approximate chronological order, Mr Packman was admitted to Dryad Ward for rehabilitation, his ongoing problems were noted to be obesity, arthritis in the knees, immobility, pressure sores and constipation. The episode of possible melaena on the 13th August 1999 was clearly noted and that his haemoglobin was stable. It was also reported that Mr Packman was better in himself with a good mental test score and no pain. The drug chart reveals he was continued on the same drugs as he received on Anne Ward bar the introduction of regular magnesium hydroxide (a laxative). On the 24th August 1999, a nursing handling profile noted in the section for pain

that it 'needed to be controlled'. This is at odds with the medical notes entry above and pain is not mentioned anywhere else. On the 25th August 1999, Mr Packman experienced seven to eight loose bowel actions throughout the afternoon and evening and fresh blood was observed. He also vomited and required an intramuscular anti-emetic. Dr Beasley, the general practitioner on-call for Dryad Ward that evening was contacted by the nursing staff whose decision was to withhold the 18.00h dose of enoxaparin and for Mr Packman to be reviewed by Dr Barton in the morning. Enoxaparin is designed to interfere with the clotting ability of the blood and thus would exacerbate any bleeding problems and it was reasonable to stop it. However, I can find no record that Mr Packman's heart rate or blood pressure were measured by the nursing staff or requested by Dr Beasley, which would help to inform the medical decision made. For example, a rapid heart rate \pm a low blood pressure would potentially indicate a significant bleed and an immediate medical review in my opinion would have been indicated.

On the 26th August 1999, Mr Packman was reported to have had a fairly good morning with no further vomiting. Dr Ravi (who Dr Barton identifies as a locum consultant geriatrician) was contacted regarding the enoxaparin. He agreed with its discontinuation and asked that Mr Packman's haemoglobin be checked on the 26th and 27th August 1999. The nursing notes record that Mr Packman complained of feeling unwell at lunchtime and had a poor colour and that he was seen by Dr Barton and the plan was for to await the result of his haemoglobin. There was no entry in the medical notes regarding Dr Barton's assessment and no record that even

the basic observations of heart rate and blood pressure were taken. At approximately 18.00h on the 26th August 1999, Mr Packman complained of indigestion-like pain in his throat and vomiting. A verbal order was taken from Dr Barton for a stat dose of diamorphine 10mg and anti-emetic was also given. Dr Barton reviewed Mr Packman at 19.00h, noting that he was pale, clammy and unwell, but no basic observations (e.g. temperature, heart rate, blood pressure) or results of a medical examination (e.g. heart sounds, chest, abdomen) were recorded. Dr Barton considered that Mr Packman had had a myocardial infarction, but this was based on the history alone with no supporting evidence from an electrocardiograph (ECG). Dr Barton's plan was to treat Mr Packman with the stat dose of diamorphine and then regular oral morphine solution overnight, 10mg every four hours with 20mg at night. In my experience, it is usual to give patients who have had a myocardial infarction diamorphine as required, 'p.r.n.', but I have never seen oral morphine solution given regularly.

Dr Barton reported Mr Packman to be 'not be well enough' to transfer to the acute unit. I do not understand this comment. If Mr Packman was at home when he became this unwell, he would have been admitted to a hospital with appropriate facilities by emergency ambulance. Hence, a transfer via an emergency ambulance could have been arranged for Mr Packman. The fact that Mr Packman was not for resuscitation would not in my opinion have excluded him from receiving the most appropriate treatment and if his needs could not be met at Dryad Ward then emergency transfer to the acute hospital setting should have been undertaken. Instead Dr Barton recorded 'keep comfortable' and that she was 'happy for nursing staff to

confirm death'. In addition to the diamorphine and the oral morphine solution, Dr Barton also prescribed diamorphine 40–200mg and midazolam 20–80mg SC over 24h p.r.n.

Dr Barton also considered the alternative possibility of a gastrointestinal bleed but appeared to rule this out on the basis that there was no haematemesis. My understanding is that the absence of haematemesis does not rule out the possibility of a gastrointestinal bleed and in my opinion, a gastrointestinal bleed was much more likely given Mr Packman's pain, indigestion, melaena and falling haemoglobin. All of this information was/could have been available to Dr Barton on the evening of the 26th August 1999. In particular, the fall in haemoglobin from 12g/dl on the 24th August 1999 to 7.7g/dl on the 26th August 1999 was revealed by the blood test undertaken, analysed and reported on the 26th August 1999. A note on the report states that the lab gave up attempting to notify the ward, as it was unable to get through to Gosport War Memorial Hospital switchboard. Nevertheless, given that Dr Barton's plan from earlier that day was to await the results of the haemoglobin and that Dr Barton considered that a gastrointestinal bleed was at least a possibility, I would have thought it reasonable for her to have made attempts to obtain the results via the on-call service.

On the 27th August 1999 there was an 'marked improvement' in Mr Packman's condition and he was seen by Dr Barton but no entry was made relating to this assessment, and as far as I can ascertain, the results of the blood test taken on the 26th August were either not obtained or acted upon, a further blood test as per Dr Ravi's plan not taken, Mr Packman's changing

condition not discussed with Dr Ravi or another consultant and he was not transferred to the acute hospital. Instead the plan was to continue with the regular morphine even though he was no longer complaining of the pain in his throat. The same can be said for the 28th August 1999.

On the 30th August 1999 (probably a Bank holiday) Mr Packman complained of left sided abdominal pain. A syringe driver was commenced at 14.45h containing diamorphine 40mg and midazolam 20mg/24h. This was a new pain, yet there is no indication that Mr Packman was either discussed with or was assessed by the on-call doctor prior to the commencement of the syringe driver. Thus it is unclear if a syringe driver containing diamorphine and midazolam was indicated or appropriate.

On the 31st August 1999 Mr Packman passed a large amount of melaena and the diagnosis of a gastrointestinal bleed should not have been in doubt. There is no evidence to suggest that his basic observations were taken or that he was assessed by a doctor. On the 1st September 1999, Mr Packman was noted by Dr Reid to be passing melaena stools, comfortable but drowsy and confused. This could have been due to Mr Packman's progressive anaemia and/or the dose of diamorphine may have been excessive for his needs. Dr Reid indicated that Mr Packman was for TLC (tender loving care). At 15.45h the dose of midazolam was increased to 40mg/24h without apparent reason. Subsequently, the diamorphine was increased to 60mg/24h and the midazolam increased to 60mg/24h at 19.15h as 'previous dose not controlling symptoms'. However, there is no explanation of what these symptoms were and if the increase was discussed with the on-call doctor.

On the 2nd September 1999, the diamorphine was increased to 90mg/24h and the midazolam to 80mg/24h without explanation. Hyoscine hydrobromide was also prescribed with an up limit of 2g. This is incorrect by a factor of 1000 as the upper limit should be 2mg. However, hyoscine hydrobromide was never given. An entry in the nursing care plan for the night time reports peaceful night, strong radial pulse, open eyes when spoken to.

Mr Packman was confirmed dead at 13.50h on the 3rd September 1999. The cause of death was given as myocardial infarction with an approximate interval between onset and death of five days. In my opinion, the circumstances of Mr Packman's deterioration and death were more in keeping with a gastrointestinal haemorrhage rather than a myocardial infarction, particularly given the fall in haemoglobin and melaena stool.

Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day?

The medical care provided by Dr Barton and Dr Reid to Mr Packman following his transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (General Medical Practice, General Medical Council, July 1998, pages 2-3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination

- in providing care you must keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs
- in providing care you must be willing to consult colleagues.

Specifically:

- i) There was insufficient assessment and documentation of Mr Packman's clinical condition when he became less well on the afternoon of the 26th August 1999.
- ii) There was insufficient assessment and documentation of Mr Packman's clinical condition when he became acutely ill on the evening of the 26th August 1999.
- iii) Mr Packman was considered to have experienced either a myocardial infarction or a gastrointestinal haemorrhage, yet advice was not sought from other colleagues nor was he transferred to an appropriate place of care.
- iv) Mr Packman received regular oral morphine that may have been excessive to his needs and prescribed a syringe driver, as required, with upper dose ranges of diamorphine and midazolam likely to be excessive to his needs.
- v) Over the days that followed, there was a continued lack of an appropriate medical assessment of Mr Packman's condition; the results of blood tests that would have indicated a gastrointestinal bleed were either not obtained or acted upon.

vi) Mr Packman received increasing doses of diamorphine and midazolam that were likely to be excessive to his needs.

If the care is found to be suboptimal what treatment should normally have been proffered in this case?

Issue i (lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate and contemporaneous patient records).

Mr Packman was reported to be feeling unwell with a poor colour (generally indicates pallor) at lunchtime on the 26th August 1999. The nursing notes record that he was seen by Dr Barton but there is no entry in the medical notes relating to this. It is unclear what assessment was made of Mr Packman and even whether the most basic of observations were undertaken (e.g. temperature, heart rate and blood pressure). The nursing notes record only that the plan was to await the result of the haemoglobin level checked that day. When a patients' clinical condition changes for the worse, a thorough medical assessment should be carried out to ascertain the possible cause(s) and to identify if they are reversible with appropriate treatment. The assessment would consist of the history, examination and appropriate investigation.

Issue ii (lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate and contemporaneous patient records).

Dr Barton was contacted about Mr Packman when he developed his indigestion-like pain at 18.00h on the 26th August 1999 and requested that diamorphine 10mg be given by intramuscular injection. This stat dose was

appropriate given that a delay was anticipated in her getting to the hospital and the dose appropriate given Mr Packman's pain (it was considered to be a myocardial infarction), size and age. It is unclear how long it took Dr Barton to get to the hospital, but it was recorded that she was there at 19.00h.

When a patients' clinical condition changes for the worse, a thorough medical assessment should be carried out to ascertain the possible cause(s) and to identify if they are reversible with appropriate treatment. The assessment would consist of the history, examination and appropriate investigation. Dr Barton's entry in the medical notes recorded Mr Packman's appearance as pale, clammy and unwell. This suggests he was 'shocked'; a situation where a low cardiac output leads to a low blood pressure. However, basic observations such as his temperature, heart rate and blood pressure are not recorded nor is there a documented physical examination. These should have been undertaken, particularly as Dr Barton considered that Mr Packman had a serious underlying cause of being unwell, either a myocardial infarction or a gastrointestinal bleed.

There appears to have been no attempt to confirm the diagnosis of myocardial infarction; I understand there was limited access to an ECG machine out of hours at Dryad, but no attempts appear to have been made to obtain one subsequently or blood tests taken for cardiac enzymes.

Given that Dr Barton considered that a gastrointestinal bleed was a possibility, it would have been reasonable for her to have made attempts to obtain the result of the haemoglobin checked that day from the on-call pathology service. This would have revealed the fall in the haemoglobin to

7.7g/dl and made a diagnosis of gastrointestinal haemorrhage the more likely possibility.

Issue iii (providing treatment that serves the patients needs; willing to consult colleagues).

Gastrointestinal haemorrhage is a medical emergency and Mr Packman should have been thoroughly assessed and cared for in a clinical environment set up to respond to such an emergency (similarly, if he was having a myocardial infarction). I am led to believe that Dryad Ward was (understandably) limited in its ability to respond to such medical emergencies. For example, they lacked the ability to provide intravenous fluids, antibiotics or blood transfusions. Hence, I understand that the policy was to transfer patients who became acutely medically unwell to the acute hospital setting when this was appropriate. I see no reason for this not to have been appropriate for Mr Packman; he had been transferred to Dryad Ward for rehabilitation, had no known underlying life-threatening illness, death was not anticipated and a 'not for resuscitation' status should not have excluded him from receiving appropriate treatment for medical problems that arose. Whilst the cause of Mr Packman's gastrointestinal bleed is unknown, one of the commonest causes is a peptic ulcer which can be cured with appropriate treatment. Thus, Mr Packman may have had a potentially treatable and reversible medical condition, which presented with a serious complication (gastrointestinal bleeding) that should have been managed as a medical emergency. This would have included:

- obtaining intravenous access

- taking blood for a full blood count, clotting and cross-matching for blood transfusion
- correction of fluid losses and restoration of blood pressure
- caring for him in an clinical environment that can respond to such an emergency.

It is my understanding that Dryad Ward was not able to provide Mr Packman with such care and thus, in my opinion, he should have been transferred to the acute hospital setting. Whilst I appreciate it is not ideal to transfer medically unstable patients from one hospital to another, given the lack of even basic resuscitative measures at Gosport War Memorial Hospital, there was, in effect, little alternative and in this context, I do not understand Dr Barton's comment that Mr Packman was not well enough to transfer to an acute hospital. The lack of ability to medically stabilise a patient can not be a reason not to attempt a transfer at all, otherwise, logically, ill patients would not be able to be taken from home to hospital. Instead, patients who become unwell at home, are taken to hospital by an emergency ambulance, and in my opinion, transfer by emergency ambulance could have been arranged for Mr Packman. Even if one adopted the view of Dr Barton that he was too unwell to transfer, then there were subsequent opportunities to transfer him. For example, he was reported as showing 'some marked improvement since yesterday' on the 27th August 1999 and he lived for another eight days. Further, despite Dr Barton's assessment that Mr Packman was so unwell that he could not be transferred, there is nothing documented to suggest that she sought advice

regarding appropriate management of Mr Packman from the on-call physicians/geriatricians or the cardiologists.

Issue iv (prescribe only the treatment, drugs, or appliances that serve patients' needs).

If Mr Packman was distressed by severe pain related to a peptic ulcer (or myocardial infarction) then the prescription of morphine parenterally was reasonable. Although generally 5mg would be given, 10mg can be used in heavier patients. The repeated use of this dose, p.r.n. for the relief of severe pain, would also be reasonable. In her statement, Dr Barton concludes (point 24) that the diamorphine was additionally justified on the basis that Mr Packman had a large pressure on his sacrum and thighs which would have been causing him significant pain and discomfort. In my opinion, this is not a robust conclusion; there was no mention of Mr Packman being in pain due to his pressure sores at the Queen Alexander Hospital (where his only analgesic was paracetamol), in the medical clerking on his transfer to Dryad Ward or in the nursing care plan relating to his pressure sores. One nursing summary entry a day later on the 27th August 1999, records 'some discomfort this afternoon - especially when dressings being done.' The significance of this is unclear; a discomfort is generally used to describe a mild pain, the site of the discomfort is unspecified and there is no mention of discomfort or pain on changing his dressings that day in the nursing care plan relating to his pressure sores. In my experience, I have never seen oral morphine solution subsequently prescribed regularly for patients considered likely to have had either a

myocardial infarction or a gastrointestinal haemorrhage and the use of regular oral morphine solution was, in my opinion, inappropriate. The oral morphine solution was prescribed as a range 10–20mg four times a day and 20mg at night; one of the problems of prescribing drugs as a range is that it can be difficult to know what dose patients actually received, when the bigger or smaller dose should be given and who should decide this. Thus, it is unclear from the prescription chart and nursing summary notes what dose of morphine Mr Packman actually received during the daytime.

Similarly, the prescription of diamorphine and midazolam in a syringe driver p.r.n., on the 26th August 1999, in my opinion, was not justified; the dose range of diamorphine 40–200mg and midazolam 20–80mg/24h would have exposed Mr Packman to doses likely to have been excessive for his needs. A dose of an opioid which is excessive to a patient's needs is associated with an increased risk of drowsiness, delirium, nausea and vomiting and respiratory depression.

It is unusual that drugs to be given by syringe driver are prescribed p.r.n. particularly in a wide dose range. This is because of the inherent risks that would arise from a lack of clear prescribing instructions on why, when and by how much the dose can be altered within this range and by whom. For these reasons, prescribing a drug as a range, particularly a wide range, is generally discouraged. Doctors, based upon an assessment of the clinical condition and needs of the patient usually decide on and prescribe any change in medication. Dr Barton in her statement notes that the prescription for the diamorphine and midazolam were on an anticipatory basis in case they were required in due course and that it was not her intention that they

be administered at that time (point 29). However, there are no instructions on the prescription chart that would provide a safeguard in this respect.

If there were concerns that a patient may experience, for example, episodes of pain, anxiety or agitation, it would be much more usual, and indeed seen as good practice, to prescribe appropriate doses of morphine/diamorphine, diazepam/midazolam and other drugs that could be given intermittently p.r.n. orally or SC. This allows a patient to receive what they need, when they need it and guides the doctor in deciding if a regular dose is required, or, if already taking a regular dose, how it should be titrated.

Issue v (lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate and contemporaneous patient records).

Over the days that followed, there was a continued lack of an appropriate medical assessment of Mr Packman's condition; no attempts were made to obtain an ECG or blood tests taken for cardiac enzymes; the results of blood tests that would have indicated a gastrointestinal bleed were, despite numerous opportunities were either not obtained or acted upon. Although requested by Dr Ravi, I can find no haemoglobin result for the 27th August 1999.

Issue vi (lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate and contemporaneous patient records; prescribe only the treatment, drugs, or appliances that serve patients' needs).

On Monday 30th August 1999 at 2.45pm a syringe driver was set up containing diamorphine 40mg and midazolam 20mg SC/24h. A nursing care plan queried whether Mr Packman's left sided abdominal pain was related to his bowels or some other cause. However, no medical assessment was undertaken and thus the cause of the pain and the appropriateness of the use of these two drugs in a syringe driver are unclear. There was no annotation in the nursing or medical notes to suggest that a doctor was involved in this decision, contrary to Dr Barton's stated intention (Statement of Dr Jane Barton) and illustrates the lack of a safeguard in the prescription of these drugs, in these doses, by syringe driver.

Generally, the total 24h oral dose of morphine is divided by three or occasionally by two to determine an appropriate dose, i.e. diamorphine 20-30mg/24h would generally be considered an appropriate conversion for Mr Packman and in this regard a dose of diamorphine 40mg/24h represents a 33-100% increase. In her statement, Dr Barton states that Mr Packman would have 'started to have become inured (tolerant) to the opiate medication' and an increase of this nature was in her view entirely appropriate to ensure that his pain was well controlled (point 35). In my experience and my opinion, rapid tolerance to opioids (he had been on oral morphine for four days) is not a plausible explanation in itself to justify an increase in Mr Packman's opioid dose.

Despite Mr Packman passing a large amount of black faeces on the morning of the 31st August 1999 there was no medical assessment documented.

On the 1st September 1999, Dr Reid noted that Mr Packman was drowsy, had been passing melaena stools and was confused. It is unclear if Dr Reid was aware of the haemoglobin result from the 26th August 1999 but he appeared to consider at that time Mr Packman suitable for TLC (tender loving care) only. The confusion and drowsiness may have been due to the diamorphine, midazolam or his medical condition, as he was likely to have been becoming progressively more anaemic.

Although noted to be comfortable by Dr Reid, the midazolam was increased at 15.45h to 40mg/24h (from 20mg/24h; increase of 100%) with no mention of why this increase was indicated or discussed with a doctor. Later that evening, the dose of diamorphine was increased to 60mg/24h (from 40mg/24h) and midazolam to 60mg/24h (from 40mg/24h) at 19.15h because 'previous dose not controlling symptoms.' However, there is no mention of what these symptoms were or that the increase was discussed with a doctor. The diamorphine increase was 50% and the midazolam dose was effectively trebled within 24h. It is difficult to assess the appropriateness of these increases. The medical and nursing notes do not suggest Mr Packman was in pain or distress. This is another reason why the use of smaller p.r.n. doses of diamorphine and midazolam is helpful; frequent use (e.g. ≥ 2 extra doses per 24h) suggests the need to titrate the regular medication upwards and also guides the magnitude of the required increase.

Mr Packman was noted to have had a peaceful night. However, the diamorphine was increased to 90mg/24h (from 60mg/24h; a 50% increase) and the midazolam to 80mg/24h (from 60mg/24h; a 33% increase) at

18.40h on the 2nd September 1999. There is no mention of pain or distress in the nursing or medical notes and the justification for the further increase in dose is unclear.

If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

Both Dr Barton and Dr Reid had a duty to provide a good standard of medical practice and care. In this regard, Dr Barton and Dr Reid fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2-3) with particular reference to a lack of clear note keeping, adequate assessment of the patient, providing treatment that could be excessive to the patients' needs and willingness to consult colleagues.

Mr Packman was admitted for rehabilitation and it was not anticipated that he was likely to die. Although Dr Barton considered a myocardial infarction more likely than a gastrointestinal haemorrhage, the latter would have been confirmed as the more likely if the haemoglobin result was obtained that evening or the following day. A gastrointestinal haemorrhage (or a myocardial infarction) is a serious medical emergency and requires appropriate and prompt medical attention. The cause of Mr Packman's gastrointestinal bleed is unknown. However, as the most common cause is a peptic ulcer which can be cured with appropriate treatment, it is possible that Mr Packman's deterioration was due to a potentially reversible cause that could have been managed by transfer to the acute hospital for appropriate resuscitation with intravenous fluids, blood transfusion and

further investigation. This view is in keeping with the opinion of a gastroenterologist, Dr Jonathan Marshall (report of 1st April 2005).

Dr Barton considered Mr Packman too unwell to move. In this regard it seems odd that a patient becoming acutely unwell at Gosport War Memorial Hospital would be at a disadvantage compared to if they had become acutely unwell at home. I see no reason that a patient could not be transferred by emergency ambulance if this was in their best interests. When possible they should be medically stabilised beforehand, but the lack of ability to do this should not be the reason not to attempt transfer at all. Even if one accepted the view that Mr Packman was too unwell to move, advice should have been sought on his management from the on-call physicians/geriatricians or cardiologists.

In short, 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 course of action.

Morphine and diamorphine are safe drugs when used correctly. The key issue is whether the use and the dose of diamorphine and other sedatives are *appropriate* to the patients' needs. Although some might invoke the principle of double effect (see technical issues), it remains that a doctor has a duty to apply effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose of strong opioid that was *appropriate* and not excessive for a patient's needs. The stat doses of diamorphine could be seen as appropriate for the relief of severe pain. However, 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, negligibly or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

9. LITERATURE/REFERENCES

- British National Formulary 37 (March 1999).
Prescribing in Terminal Care, pages 11–14
Prescribing for the elderly, pages 15–16
- Good Medical Practice, General Medical Council July 1998, pages 2–3
- Palliative Care Handbook, Guidelines on Clinical Management, Third Edition 'Wessex Protocol' Salisbury Palliative Care Services May 1995.

10. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____