SUMMARY OF EVIDENCE

CASE OF ROBERT WILSON

Background/Family Observations

Robert WILSON was born on Code A in Code A and at 15 years of age joined the Navy serving for 22 years. During this time he met his wife who was a Wren although in 1982 after 32 years of marriage they divorced after having seven children one of whom was adopted.

He remarried in 1985 and lived with his wife in Fareham and Sarisbury Green. He fully retired at 65 years but would smoke 80 cigarettes a day Code A He gave up smoking after being admitted to Queen Alexandra Hospital following a suspected heart attack in 1997 Code A

Code A

In September 1998 whilst his wife was away Mr WILSON collapsed in his bedroom and was admitted to the Queen Alexandra Hospital, at first he appeared extremely ill, had a fracture to his left shoulder and had lost the will to live. After time Mr WILSON improved considerably and after approximately 3 ½ weeks it was decided he would go to the Gosport War Memorial Hospital for rehabilitation.

On Monday 11th October 1998 Mr WILSON was transferred to the Gosport War Memorial Hospital. The trip was via a mini-bus and took an hour and a half. On his arrival he was clearly tired out. He was seen by a lady doctor who stated that she would give him something to calm him down from the trip. Mr WILSON was lucid at this time.

The following day Mr WILSON was found with food all over him and incomprehensible when spoken to. When Mrs WILSON asked to see someone in authority she was told by the Ward Sister 'your husband is dying'. Later that evening Mr WILSON went into a coma from which he did not recover. He was being given drugs to remove his pain by some sort of drip.

Mr WILSON died at about 2340 hrs on Sunday 18th October 1998.

Given the fact that Mr WILSON had gone to the Gosport War Memorial Hospital for rehabilitation how come he slipped into a coma so quickly and why was he put on Diamorphine.

Mr WILSON's death certificate shows a cause of death as congestive cardiac failure, Code A Code A and was signed by Dr PETERS.

Medical History of Robert WILSON

Robert WILSON a 74 year old gentleman in 1998 attended Queen Alexandra Hospital, Portsmouth A&E Department on the 21st September 1998 with a fracture of the left femoral head and tuberosity.

Mr WILSON had suffered many years before with Malaria and Diphtheria Code A

Code A

When he attends A&E it is originally intended to offer him an operation on his arm, which he refuses. However, he is kept in A&E overnight for observation. It becomes apparent by the next day that he is not well, is vomiting and he is needing Morphine for pain. His wife is on holiday and it is not thought possible for him to go home so he is transferred on 22nd September to the Care of the Elderly team at the Queen Alexandra Hospital.

The day after admission he is no longer thought fit enough to have an operation on his arm, although he would now be prepared to. Code A Code A He has abnormal blood tests on admission including a mild anaemia of 10.5 with a very raised mean cell volume of 113 and his platelet count is reduced at 133. Five days later his haemoglobin has fallen to 9.7 and the platelet count has fallen to 123. There are no further full blood counts in the notes, although his haemoglobin was normal with haemoglobin of 13 in 1997.

Code A

Code A

Code A

His physical condition in hospital deteriorates at first. He is noted to have considerable pain for the first 2 – 3 days, he is found to have extremely poor nutritional intake and has eaten little at home. Code A He is communicating poorly with the nursing staff and is restless at night on 30th September. His Barthel deteriorates from 13 on 23rd September to 3 on the 2nd October, his continued nutritional problems are documented by the dietician on 2nd October. In the nursing cardex he is vomiting, he has variable communication problems, he is irritable and cross on 1st October. On 4th October his arm is noted to be markedly

swollen and very painful and it is suggested he needs Morphine for pain. The following day he knocks his arm and gets a laceration.

There is ongoing communication with his family which is complicated by inter-family relationships between his first wife's family and his current wife. The plan by 6th October is that he will need nursing home care when he leaves hospital and his Barthel at this stage is 5. However on the 5th the nursing cardex note that he is starting to improve although, he remains catheterised and has been faecally incontinent on occasion.

On 7th October is now more alert and is now telling the staffs that he wishes to return home. The nursing staff notes that he is now much more adamant in his opinions. However on 8th he had refused to wash for 2 days. He is then reviewed at the request of the medical staff by a psycho-geriatrician. The opinion is that he has early dementia, Code A and depression. He is noted to be difficult to understand with a dysarthria. He is started on Trazodone as an antidepressant and as a night sedative, he is still asking for stronger analgesics on 8th October. The letter also mentions rather sleepy and withdrawn ..... his nights had been disturbed.

On the 9th October an occupational therapy assessment is difficult because he is reluctant to comply and a debate occurs about whether he is capable of going home. By the 12th October his Barthel has improved to 7 so Social Services say that he no longer fits their criteria for a nursing home and he should now be considered for further rehabilitation (21). The nursing cardex notes that his catheter is out he is eating better but he still gets bad pain in his left arm. His arms, hands and feet are noted to be significantly more swollen on 12th October. His weight has now increased from 103 kgs on 27th September to 114 kgs by 14th October. However his Waterlow score remains at "high risk" for all his admission. A decision is made to transfer him for possible further rehabilitation, although the medical review on 13th October states in view of the medical staff and because of his oedematous limbs, he is at high risk of tissue breakdown. He is also noted to be in cardiac failure with low protein Code A Code A He currently needs 24 hour hospital care.

Gosport War Memorial Hospital

On 14th October he is transferred to Dryad Ward and the notes say "for continuing care". The notes document the history of fractured humerus, Code A current oedema and heart failure. No examination is documented. The notes state that he needs help with ADL, he is incontinent, Barthel 7, he lives with his wife and is for gentle rehabilitation.

The next medical notes are on 16th October and state that he had declined overnight with shortness of breath. On examination he is reported to have a weak pulse, unresponsive to spoken orders, oedema plus plus in arms and legs. The diagnosis is "? silent MI, ? Code A and the treatment is to increase the Frusemide. The nursing cardex for 14th October confirms he was seen by Dr BARTON, that Oramorphine 10 mgs was given and he was continent of urine. On 15th October the nursing notes state commenced Oramorphine 10 mgs 4 hourly for pain in left arm, poor condition is explained to wife. On 16th on the nursing cardex he is "seen by Dr KNAPMAN am as deteriorated overnight, increased Frusemide". However the nursing care plan states for 15th October, settled and slept well, Oramorphine 20 mgs given 12 midnight with good effect, Oramorphine 10 mgs given 06.00 hours. Condition deteriorated overnight, very chesty and difficulty in swallowing medications. Then on 16th it states has been on syringe driver since 16.30

hours. As will be seen from the analysis of the drug chart, Mr WILSON received the Oramorph at midnight on 15th and then 06.00 hours Oramorph on 16th. The first clinical deterioration is on the night of 15th – 16th October not the night of the 14th – 15th October.

The next medical note is on 19th October which notes that he had been comfortable at night with rapid deterioration and death is later recorded at 23.40 hours and certified by Staff Nurse COLLINS. The nursing cardex mentions a bubbly chest late pm on 16th October. On the 17th Hyoscine is increased because of the increasing oropharyngeal secretions. Copious amounts of fluid are being suctioned on 17th. He further deteriorates on 18th and he continues to require regular suction. The higher dose of Diamorphine on the 18th and Midazolam is recorded in the nursing cardex.

Dr Jane BARTON

The medical care provided by Dr BARTON to Mr WILSON 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, Good Medical Practice, October 1995, (pages 2–3)

Dr BLACK reports

There is weakness in the documentation of his condition, in particular on the admission to the Gosport War Memorial Hospital on 14th October, and on the15th October when the regular oral strong opiate analgesia is commenced. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must provide clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatments provided". The lack of clinical examination on admission and on the day of 15th October when the decision was made to start regular strong oral opiate analgesia represents poor clinical practice to the standards set by the General Medical Council.

In Dr BLACK's opinion he further comments:-

It is my belief that the prescription of a total of 50 mgs of Oramorphine on the 15th October following the 20 mgs that were given on the 14th October was not an appropriate clinical response to the pain in Mr WILSON's left arm. In my view this dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th-16th October, in particular, his rapid mental state deterioration. In my view this treatment was negligent, and more than minimally contributed to the death of Mr Robert WILSON on 19th October.

Dr WILCOCK reports

Mr Wilson was a 74 year old man who was admitted to hospital after falling over and fracturing the greater tuberosity of his left humerus. He had multiple serious medical problems; Code A Code A , heart failure and Code A . Other

problems included early dementia, depression and a high level of dependency. Although the care he received at Queen Alexander Hospital led to Mr Wilson being mentally more alert and returned his Code A to normal, he continued to become increasingly oedematous despite the re-introduction of his diuretic therapy which was considered due to heart failure. The pain he experienced from his fracture progressively improved as anticipated and during his time at Queen Alexander Hospital, his daily analgesic requirements reduced from the equivalent of 20mg to 3mg of oral morphine. Nevertheless, given the time it takes for a fracture to heal, it was not surprising that pain on movement was still present at the time of his transfer. There are no concerns regarding the care proffered to Mr Wilson at the Queen Alexander Hospital.

On transfer to Dryad Ward, the care proffered to Mr Wilson by Dr Barton and Dr Knapman 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 (Dr Barton and Dr Knapman) and providing treatment that could be excessive to the patients needs (Dr Barton). No pain assessment was carried out on Mr Wilson, but his only regular analgesic, paracetamol, was discontinued and prescribed p.r.n. (as required). Instead of his usual codeine 15–30mg p.r.n., approximately equivalent to morphine 1.5–3mg, he was prescribed morphine 5–10mg p.r.n. for pain relief. He received two doses of 10mg (a total of 20mg/24h) and the next day commenced on regular morphine 10mg every 4h and 20mg at night. In total he received 50mg of morphine in this 24h period, representing a larger dose than that he received in the initial 24h after his fracture. This is against the general expectation that pain from a fracture would have been improving over time and, without a clearly documented pain assessment, it is difficult to justify. However, the impact of this dose of morphine on Mr Wilson is impossible to judge because he deteriorated rapidly in the early hours of the 16th October 1998. The nature of his rapid decline and subsequent death were in keeping with worsening heart failure with or without a sudden event such as a heart attack. This, combined with his Code A could easily have precipitated his terminal decline. His reduced level of consciousness could have been due to a hepatic coma precipitated by the morphine or by a reduced level of blood oxygen secondary to the excess fluid on the lungs (pulmonary oedema) due to the heart failure. Later that day a syringe driver was commenced containing diamorphine 20mg/24h and increased over the next 48h to 60mg/24h, equivalent to oral morphine 120–180mg/24h. This increase in dose appears difficult to justify, as Mr Wilson was not reported to be distressed by pain, breathlessness or the secretions and was likely to be excessive for his needs. However, because heart and Code A failure could also have led to a reduced level of consciousness, in my opinion, it is difficult to state with any certainty that the doses of morphine or diamorphine he received would have contributed more than minimally, negligibly or trivially to his death

Dr Jonathan MARSHALL a specialist Gastroenterologist states:-

Mr Wilson entered a terminal phase at or around the 16th October 1998. There is an entry in the notes that he had declined overnight with SOB (shortness of breath). On examination at that time he had a weak pulse, was unresponsive to spoken commands and had oedema ++ in arms and legs.

The impact of regular morphine administration to Mr Wilson is likely to have hastened his decline. It's sedative effects would worsen Code A which he undoubtedly had

throughout his hospital stay and would cause rapid deterioration as indeed happened between the 14th and the 18th October.

Mr Wilson's received 10mg of morphine on 14th October and then was commenced on 10mg morphine 4 hourly from then on. No dose reductions appear to have been made as recommended by standard prescribing guides. Doses escalated upwards until syringe drivers containing diamorphine 40mg with hyocine and midazolam 20mg were administered [278]. These are 'terminal care' doses from which recovery could not be expected Code A Code A

The impact of regular morphine administration to Mr Wilson is likely to have hastened his decline. It's sedative effects would worsen Code A which he undoubtedly had throughout his hospital stay and would cause rapid deterioration as indeed happened between the 14th and the 18th October.

Interview of Dr Jane BARTON

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified a registered medical practitioner in 1972. In addition to her GP duties she took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 19th May 2005 Dr BARTON, in company with her solicitor, Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Robert WILSON at the Gosport War Memorial hospital.. The interviewing officers were Code A Code A

The interview commenced at 0902 and lasted for 28 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/6.

This statement dealt with the specific issues surrounding the care and treatment of Robert WILSON

Expert response to the statement of Dr BARTON

Dr BLACK reports having read Dr BARTON's statement it does not effect the conclusions in his report.

Professor BAKER who conducted a statistical study of the mortality rates at Gosport War Memorial Hospital which is included in the generic case file has also commented upon the care of Mr Robert WILSON at the GWMH and reports as follows:-

I have studied the copies of the records provided to me by Hampshire Constabulary in order to consider three issues – the certified cause of death, the prescription of opiates and sedatives, and whether Mr Wilson fell into the category of patients who might have left hospital alive.

With respect to death certification, I have concluded that the certificate was inaccurate in that Mr Wilson did not have Code A He probably did have heart failure, although I believe the initiation of opiate medication was an important factor in leading to death.

With respect to the prescription of opiate drugs, I have concluded, on the evidence available to me, that the initiation of opiate medication on transfer to Dryad ward was inappropriate; I have also concluded that the starting dose was too high. The prescription of hyoscine and midazolam was justified by the use of opiates.

With respect to leaving hospital alive, I have concluded that Mr Wilson was in the category of patients who might have left hospital alive if he had not been commenced on opiate medicate on transfer to Dryad ward.