# SUMMARY OF EVIDENCE

# CASE OF GEOFFREY PACKMAN

## Background/Family Observations

Geoffrey PACKMAN was born in Derbyshire on Code A. He was known as Mick, he had three sisters and always worked in office jobs. He met his future wife Betty whilst working in local government in Derbyshire and they married in July 1956.

In 1964 Mick and Betty adopted their son Mark and in 1967 they adopted their daughter Victoria (known as Vicky). At this time Mick was working in insurance in London and in 1969 the family moved to Emsworth in Hampshire.

At this time Mick was fit and healthy; he was on the Committee of the Sea Cadets and would attend the annual camp. He would also 'run the line' for his son's football team. Whilst on an annual camp he injured his knee and his mobility decreased. Due to this his legs started to swell and he began to put on weight.

In 1983 Mick had a falling out at work and became a taxi driver for a local company. In order to do so he had a medical and was found to have high blood pressure and weighed 17/18 stone. In 1985 he started his own business with a friend but after a couple of years the business collapsed and Mick retired, he was 57 years old. During his time as a taxi driver he put on a considerable amount of weight.

By 1998 Mick was virtually housebound. He did not drink alcohol but drank fizzy drinks and liked sweets and crisps. He would sit in his chair in the lounge and listen to classical music. He even started up a music club and friends would visit and listen to music with him. He continued to put on weight and his legs would constantly weep fluid, he couldn't walk properly and had to lean on the furniture and walls to get around the house. For the last 2 or 3 years of his life he had a health visitor who came in and changed the dressings on his legs three times a week.

On 6th August 1999 Mick got stuck on the toilet at home. Four people were needed to get him off the toilet and downstairs. He was admitted via the A & E Department at Queen Alexandra Hospital to Ann Ward. He made good progress his legs dried up and he looked the best he had for years. He was happy, chatty, eating and drinking properly and keen to get home. After two to three weeks he was transferred to Dryad Ward at Gosport War Memorial Hospital for recuperation and rehabilitation.

The family visited on a daily basis and initially he was fine. He was eating and drinking properly, never complained of any pain and was in good spirits.

After a couple of days Mrs PACKMAN whilst visiting Mick was taken to one side by a lady doctor who said in a very abrupt manner, "Your husband is going to die and you have to look after yourself now". It wasn't explained to her why or when this would happen.

At about this time Mrs PACKMAN also received a call from the hospital telling her that Mick had had a heart attack. On visiting him he told her that he hadn't had a heart attack just that he had a bout of indigestion that he always suffered from.

Two or three days after this conversation Mick deteriorated and became 'spaced out'. His eyes were glazed, his head would nod and he had to be propped up in bed. When awake he could still talk but had to be fed. He then became unconscious, he was on diamorphine but no one explained why.

On 3rd September 1999 Mr PACKMAN died. The cause of death on the death certificate was given as heart attack.

**Medical history of Geoffrey PACKMAN.**

Geoffrey Packman was a sixty eight year old gentleman who was admitted as an emergency on the 6th August 1999 to Portsmouth Hospitals NHS Trust following an attendance at A&E.

He had suffered from gross (morbid) obesity for many years, he had also had venous leg ulceration for at least five years, he was hypertensive and had a raised prostatic specific antigen, suggesting prostatic pathology.

Following a fall at home he was completely immobile on the floor and two ambulance crews were needed to bring him to accident and emergency. He was currently receiving District Nursing three times a week for leg ulcer management. He had become increasingly immobile complicated by the fact that his wife who lived with him and provided care was being investigated for breast cancer. The admission clerking showed that he not only had leg ulcers but he had marked cellulitis, was pyrexial and in atrial fibrillation. Cellulitis was both in his groin and the left lower limb. He was totally dependent needing all help with a Barthel of 0. His white cell count was significantly raised at 25.7, his liver function tests were abnormal with an AST of 196 and his renal function was impaired with a urea of 14.9 and a creatinine of 173. These had all been normal earlier in the year. He was treated with intravenous antibiotics in a special bed.

He appeared to make some progress and on 9th August his cellulitis was settling. A Haemolytic Streptococcus sensitive to the penicillin he had been prescribed was identified. On 11th August the nursing cardex stated that there appeared to have been a deterioration of his heel ulcers with a "large necrotic blister on the left heel". His haemoglobin on 12th August was 13.5.

On 13th August white count was improved at 12.4, his U's and E's were normal and the notes recorded a planned transfer to the Gosport War Memorial Hospital on 16th August.

Later on the 13th black bowel motion is noted but the doctor who examines him records a brown stool only. It is not clear whether he has had a gastro intestinal bleed. On 16th August no comment is made on the possible gastrointestinal (G.I) bleed, but on 20th August his

haemoglobin is noted to be 12.9 no further black stools have been reported so he is planned for transfer on 23rd August. Albumin at this stage is now reduced at 29.

On 17th August sacral sores are now noted in the nursing cardex which by the 20th are now recorded as "deep and malodorous".

He is transferred to the Gosport War Memorial Hospital on 23rd August. A reasonable history and examination is undertaken which notes that there was a history of possible melaena, the clinical examination recorded suggests that he is stable. Blood tests are requested for the next day. The drug chart suggests that his weight is 148 kgs but it is not clear if this is an estimate or a measurement. He is very dependent with a Barthel of 6 and a Waterlow score of 18, putting him in high risk. His haemoglobin on 24th is 12. The nursing cardex on the 24th notes the multiple complex pressure sores on both the buttocks and the sacrum (96-100).

On 25th August the nursing cardex reports that he is passing blood rectally and also vomiting.

On 26th August a doctor (Dr Barton) is asked to see him and records that he is clammy and unwell. The notes suggest that he might have had a myocardial infarction and suggests treating him with Diamorphine and Oramorphine overnight. It records that as an alternative there might be a G.I. bleed but this is recorded as unlikely because he has not had haematemesis. It also notes that he is not well enough to transfer to an acute unit and he should be kept comfortable, including "I am happy for the nursing staff to confirm death". His Clexane (an anticoagulant given to prevent pulmonary embolus) is now stopped. The nursing cardex on the same day records further deterioration throughout the day with pain in his throat and records a verbal request for Diamorphine. A full blood count is taken (this fact is not recorded in the notes) but the result is filed in the notes recording a haemoglobin markedly reduced at 7.7. It also states "many attempts were made to phone Gosport War Memorial Hospital but no response from switchboard". These significant results are not commented on at any stage in the nursing or clinical notes.

On 27th August the nursing notes record some improvement in the morning but discomfort in the afternoon especially with dressings. On 28th August both the medical and the nursing records are noted to be very poorly with no appetite. Opiates are to continue over the weekend. 29th August he is sleeping for long periods and on 30th he is still in a very poor clinical condition but eating very small amounts of diet. He is re-catheterised the same day.

On 31st he is recorded as passing a large amount of blood rectally and on the 9th September he is reviewed by a consultant Dr Reid who notes that he is continuing to pass melaena stool, there are pressure sores across the buttocks and posterior aspects of both thighs, he is now significantly confused. Dr Reid records that he should be for TLC only and that his wife is now aware of the poor prognosis. Nursing notes note that the dose of drugs in the syringe driver should be increased; the previous doses were not controlling his symptoms. The nursing notes of the 2nd September record the fact the Diamorphine is again increased on the 2nd to 90mgs and on 3rd September he dies at 13.50 in the afternoon.

**<u>Dr Jane BARTON</u>**

The doctor responsible on a day to day basis for the treatment and care of Geoffrey PACKMAN was a Clinical Assistant Dr Jane BARTON. The medical care provided by Dr

BARTON 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 (Good Medical Practice, General Medical Council, October 1995, 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 including, where necessary, an appropriate examination.
- in providing care you must keep clear, accurate, and contemporaneous patients 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.

The medical records were examined by two independent experts. Dr Robert BLACK in his review of Dr BARTON's care reported specifically:-

Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

There are a number of weaknesses in the clinical care provided to Mr Packman:

- gastro-intestinal haemorrhage is suspected in Portsmouth but although never disproven, he is continued on his anticoagulant.

- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.

- on assessment on 25th August a further bleed does not lead to further medical attention.

- on 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.

- a difficult clinical decision is made without appropriate involvement, of senior medical opinion.

- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.

- a higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is my opinion that Mr Packman died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

Dr Andrew WILCOCK reports:-

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.

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.

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.

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.

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.

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

Dr BLACK further states

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.

Dr Jonathan Marshall a specialist Gastroenterologist specifically reports that :-

Mr PACKMAN was likely to have experienced a significant GI bleed approximately 3 days after transfer to GWMH. He was assessed as being unwell and was managed with escalating doses of opiate analgesia until he died on 3-9-99.

He further states that transfer for endoscopic therapy should have been considered in Mr PACKMAN's case, although this can only take place after resuscitative measures have been taken such as I/V fluids, oxygen etc. Endoscopic therapy allows accurate diagnosis of the site and cause of bleeding. It also allows further procedures to try and stop the bleeding and is 'bread and butter' emergency gastroenterology available in any endoscopic unit.

The critical determinant would be how fit Mr Packman was after resuscitative measures for the ambulance transfer to endoscopy.

'*Do not resuscitate*' orders refer specifically to not commencing cardiopulmonary resuscitation if the heart stops. Mr Packman was in this 'DNR' category reasonably (high chance of technical futility) but not in a group in whom no resuscitation is attempted if they simply becomes *unwell.*

**Interview of Dr Jane BARTON.**

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified as 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 17th November 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 Geoffrey PACKMAN at the Gosport War Memorial Hospital. The interviewing officers were DC YATES and DC QUADE.

The interview commenced at 0914hrs and lasted for 27 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/11. This statement dealt with the specific issues surrounding the care and treatment of Geoffrey PACKMAN.

On Thursday 6th April 2006 Dr Barton was interviewed a further nine times throughout the course of the day where a series of questions were put to her in essence challenging her medical management of Mr PACKMAN. Dr BARTON made 'no comment' to any of the questions.