SUMMARY OF EVIDENCE

CASE OF ELSIE LAVENDER

Background/Family Observations

Elsie Hester LAVENDER nee BRYANT was born on Code A She married at the age of 22 and had one child Alan William LAVENDER. She became a widow in 1989 and had one brother who died in 1993/4. She continued to live alone in the family home in Gosport until she died at the Gosport War Memorial Hospital on 6th March 1996 at the age of 84 years.

Mrs LAVENDER was diagnosed as suffering with diabetes in 1982 and was insulin dependant; her only other medical conditions were that she had slight rheumatism and was partially blind due to the diabetes. Apart from this she was a strong, healthy and independent woman who coped with her housework, washing and was very family orientated. She did have a home help and a nurse would assist with her insulin regime twice a day. She had been admitted to hospital on a couple of occasions when she became 'hypo' but the hospital would stabilise her and send her home.

In February 1996 Mrs LAVENDER had a fall at home and was found by her home help, Frances DOHINI, and was taken to Haslar Hospital. It was several days later before the family was informed she had suffered a brain stem stroke, although she was sat up in bed from the start. Mrs LAVENDER was in pain not only from the stroke but from the fall as well albeit she had not fractured any bones but had cut her head.

Mrs LAVENDER remained in Haslar for two or three weeks and made excellent progress so much so that her Occupational Therapist and physiotherapist were preparing her for home. She had learned to walk with the assistance of a frame and an adjustable walking stick was being arranged. She was talking to others coherently and understanding what was being said to her.

Mrs LAVENDER was transferred to Daedelus Ward at Gosport War Memorial Hospital for rehabilitation and was placed in a room on her own. She easily passed a mental test conducted by a nurse just after she arrived.

Her son Adam LAVENDER and his wife visited daily and after two or three days spoke with Dr BARTON. Adam LAVENDER asked Dr BARTON when his mother would be going home as he would have to get rid of the cat if she was going to get a warden controlled flat.

Dr BARTON replied, "You can get rid of the flat" and added, "You do know that your mother has come here to die".

Mr LAVENDER was stunned as he believed his mother was at the War Memorial Hospital for rehabilitation and he could not believe the cold and callous way Dr BARTON had broken the news to him. He felt as if his mother's death had been predetermined.

Shortly after this conversation Mrs LAVENDER was placed on a syringe driver and her health quickly deteriorated. On one occasion she appeared unconscious and smelt awful.

On 6th March 1996 Mr LAVENDER received a call from the Gosport War Memorial Hospital informing him that his mother had died. Her death certificate was certified by J A BARTON BM and gave the cause of death as cerebralvascular accident diabetes mellitus.

Mrs LAVENDER was an elderly lady and at that time was one of the longest standing insulin dependant people. She appeared to be making a full recovery from the stroke, was alert, lucid and only had a little pain in her shoulder. It was not until her final day that Mr LAVENDER was told that diamorphine was being administered through the syringe driver.

Police Investigation

Following the publicity in respect of the Police investigation of the case of Gladys RICHARDS who died at the Gosport War Memorial hospital in, a number of relatives of other patients who died at the same hospital reported to the Police that they had concerns in respect of the medical treatment of their relatives and requested Police investigations. Amongst these relatives were those of Mrs LAVENDER.

The medical records of Mrs LAVENDER were obtained by the Police, copied and submitted to the key clinical team for review. The key clinical team considered that Mrs LAVENDER'S treatment at the Gosport War Memorial hospital was negligent and the cause of death was unclear.

As a result of the key clinical team's findings the medical records of Mrs LAVENDER have been examined by Police in order to identify all persons who were concerned in her medical and nursing treatment. All medical and nursing staff identified have made statements explaining those entries, in the medical records of Mrs LAVENDER, made by them or to which they made some contribution.

Case papers and the medical records of Mrs LAVENDER have been analysed by a further set of independent experts, Dr's WILCOCK and BLACK.

Medical history of Elsie LAVENDER.

(The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes, 'M' in front are the microfilm notes).

The Gosport notes record that Mrs LAVENDER was an insulin dependent diabetes mellitus since the1940's (53). She is referred to the Diabetic Service because of more troublesome hypoglycaemia in 1984 (65). In 1985 she is known to have a mild peripheral neuropathy (73).

By 1988 she has very poor eyesight (47M). She is also documented to have high blood pressure in 1986 (29).

Elsie LAVENDER was admitted to Haslar hospital on 5th February 1996 through A&E having had a fall at home (H15, H16). She is recorded as having right shoulder tenderness (H25) is moving all four limbs and her cervical spine is thought to be normal, written as (CX spine√) (H16). The notes record that x-rays were taken of her skull and both shoulders (H24). In a subsequent neurological examination, she is noted to have reduced power 3/5, cannot move her right fingers and has an extensor right plantar (H24). A Barthel on the 5th (H631) is recorded as 5/20.

Her past medical history is noted as insulin dependent, diabetes mellitus for 54 years (age 29) appendicectomy and a hysterectomy. She is noted to have previous collapses in the past (H47) but without weakness, although her clerking in 1995 (H48) suggested that she might have had some sensory loss and a mild diabetic peripheral neuropathy. Her Barthel in 1995 was 14/20 (H495) and she was able to mobilise at that stage with a walking stick (H497). She had diabetes, eye disease, was registered blind in 1988 (H 97). She had hypoglycaemic episodes going back many years (H 71) and pneumonia in 1985 (H317).

On transfer to the ward, both her legs are noted to be weak 4/5 (H35) no sensory loss is noted. The notes also state she does not normally go upstairs and her bed is downstairs (H29). However, her son stated that a large pool of blood was found at the top of the stairs (H37). She apparently goes out once a week with her son is forgetful but not confused (H39).

Following admission, she is seen by a physiotherapist (157) who notes pain in both shoulders, can only stand with two people and is now having to be fed, washed and dressed, when previously independent.

No further neurological examination is recorded by the Haslar medical team and she is referred to Dr Lord on 13th February (H159). Dr Lord sees her and confirms that she still has bilateral weakness of both arms and legs (H163) and finds that her left plantar is extensor (H163) confirmed in his letter (H253) but is not sure about the right plantar which has previously been found to be extensor.

The importance of this finding is that it suggests that she has a bilateral neurological event in the brain or brain stem somewhere above the lumbar spine.

Dr LORD records "probable brain stem CVA"..... "she has had her neck x-rayed, I assume it was normal" (H167).

Dr LORD notes her mild anaemia of 9.7 with an MCV of 76.5 (H17) and says that she will consider investigation into anaemia later (H164). Abnormal blood tests are also available in the notes on 9th February (H609) an albumin of 32, a Gamma GT 128 and Alkaline Phosphatase of 362. No investigations are done to determine whether these are a hepatic effect of her diabetes or a mixture of problems with the raised alkaline phosphatase potentially coming from a fracture.

On the 20th February Mrs LAVENDER is again seen by a physiotherapist (H165), her bilateral shoulder pain is again documented and she needs two to transfer. Reviewing her drug charts (H684 and H690) she receives regular analgesia comprising Co-proxamol and Dihydrocodeine all through her admission.

Events at Gosport War Memorial Hospital.

The medical notes in Gosport (45M) 22nd February 1996 state that she "fell at home from the top to the bottom of the stairs and had lacerations on her head". It also states that she has severe incontinence and leg ulcers. Once in Gosport there is no rigorous clerking of the patient and no examination recorded. In some of the nursing cardex there is a series of assessments confirming that this lady is highly dependent. She has no mobility and bed rest is maintained all through her stay (100 -101). She has leg ulcers both legs (107 - 109). She is catheterised throughout, although there is no suggestion that she had a catheter prior to her admission to hospital (111). She has a sacral bed sore noted; "a red and broken sacrum on 21st February" (115) and this progresses to a black and blistered bed sore on the 27th February (115). She is thought to be constipated on an assessment, and then continually leaks faeces throughout her admission (119).

Barthel is documented at 4/20 on 22nd February (165) (i.e. grossly dependent). Her mental test score is normal 10/10 on the same date (165). Lift handling score (171) also confirms high dependency.

Investigation tests reported on 23rd February 1996 find that she has a normal haemoglobin of 12.9 with a slightly reduced mean cell volume of 75.6 and gross thrombocytopenia (a low platelet count) of 36,000 (57M). The report on the film (58M) shows that this is a highly abnormal full blood count with distorted red blood cells and polychromasia. A repeat blood film is suggested. This is repeated on 27th February (57M) and thrombocytopenia is now even lower at 22,000. The urea is normal at 7.1 on 23rd February but has increased and is abnormal at 14.6 on 27th February (187). Her alkaline phosphatase is 572 (over 5 times the upper limit of normal) her albumin is low at 32 (187). No comment is made on

any of these significantly abnormal blood tests in any of the Gosport notes, though the low platelet count is noted in nursing summary on 23rd February (151). The platelet count had been normal at 161 on admission to the Haslar (H17).

An MSU (59M) sent on 5th February showed a heavy growth of strep faecalis there are no other MSU or other blood culture results in the notes.

Medical progression (documented on pages 45M and 46M) is of catheterisation and treatment for a possible U.T.I on 23rd February. On 26th February, a statement that the patient is not so well and the family were seen regarding progress. Nursing cardex reports (153) a meeting with the son occurred on the 24th February and state "son is happy for us just to make Mrs Lavender comfortable". "Syringe driver explained".

The medical notes on 5th March say deteriorated further, in some pain, therefore start subcutaneous analgesia. On 6th March "analgesia commenced, comfortable overnight I am happy for the night staff to confirm death". It is then confirmed at 21.28 hours on 6th March.

The nursing care plan first mentions significant pain on 27th February (95) and describes pain on most days up until 5th March where the pain is uncontrolled and the patient is distressed, at which point a syringe driver is commenced (97).
Morphine slow release (MST) (67M) was started at 10 mgs bd on the 24th February and is given until 26th February when MST 20 mgs bd (145) is started, this continues until the 3rd March. On 4th March Oramorph 30 mgs bd is written up and given during 4th March (139). On 5th March Diamorphine is written up 100 – 200 mgs subcut in 24 hours (137). 100 mgs is prescribed and started at 08.30 in the morning, together with Midazolam 40 mgs (137) (61M). Midazolam had been written up at 40 – 80 mgs subcut in 24 hours. Diamorphine and Midazolam pump is filled at 09.45 hours (61M) on 6th March together with another 40 mgs of Midazolam.

The notes document (for example page 65M) Dr Lord was the consultant responsible for this patient although the patient only appears to have been seen medically at any stage by Dr Barton, and a different consultant Dr Tandy saw the patient in the Haslar Hospital.

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Elsie DEVINE was a Clinical Assistant, Dr Jane BARTON. As such her role in caring for patients is governed by Standards of Practice and Care as outlined by the General Medical Council. This advice is sent to all doctors on a yearly basis and includes the following statements

Good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination.

In providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed.

Good clinical care must include – taking suitable and prompt action necessary.

Referring the patient to another practitioner, when indicated.

In providing care you must – recognise and work within the limits of your professional competence...

Prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patient's health and medical needs.

In reviewing the medical records of Mrs LAVENDER it is apparent that Dr BARTON has not made entries in the medical records when she has visited her patient. There is lack of explanation as to the treatment being offered to Mrs LAVENDER and the reasoning behind the various prescriptions of drugs. Ranges of drugs are prescribed which appear to fall outside recognised parameters.

Expert analysis

Dr Andrew WILCOCK

The medical records were examined by two independent experts. Dr Andrew WILCOCK in his review of the standard of care afforded to Mrs LAVENDER reported specifically:-

i) The notes relating to Mrs LAVENDER's transfer to Daedalus Ward are inadequate. On transfer from one service to another, a patient is usually re-clerked highlighting in particular the relevant history, examination findings and planned investigations to be carried out.

ii) The cause of Mrs LAVENDER's urinary retention was not assessed.

iii) Mrs LAVENDER was treated for a urinary tract infection with the antibiotic trimethoprim. Neither a diagnostic urine specimen nor a check urine specimen (to see if the infection had cleared) were sent for microbiology. It is therefore unclear if the urinary tract infection was successfully treated or not. This should have been considered when Mrs Lavender was noted to be 'not so well' (see point v).

iv) There is a lack of medical notes relating to the pain or its assessment and the commencement of morphine (MST 10mg) twice a day on the 24th February 1996.

v) On the 26th February 1996 the medical notes report Mrs LAVENDER to be 'not so well over weekend'. There is a lack of detail that explains in what way she was not so well. There are no records that an appropriate history, examination or investigations had been undertaken to try and determine the reason for Mrs LAVENDER feeling less well. Instead, without any assessment of the pain, the MST was increased to 20mg twice a day and a syringe driver prescribed to be used 'as required' that contained diamorphine and midazolam in doses that would be excessive to Mrs LAVENDER's needs.

vi) Blood tests from the 27th February 1996 revealed a low platelet count and deteriorating kidney function. There is no mention of this in the medical notes, and no action was taken.

vii) On the 29th February 1996 there is no mention in the medical notes that Mrs LAVENDER's blood sugars were high requiring additional doses of insulin. The fact that this could have been due to an untreated infection does not appear to have been considered. Despite entries in the nursing care plan and summary sheets relating to Mrs LAVENDER's pain there is no mention of this in the medical notes.

viii) The nursing care plan reports leakage of faecal fluid. There is no mention of this problem in the medical notes or consideration of the possible significance of this symptom given Mrs LAVENDER's history of trauma.

ix) The morphine was increased again on the 4th March 1996. There is no pain assessment or entry in the medical notes that relates to this increase.

x) The entry in the medical notes of the 5th March reports that Mrs LAVENDER had deteriorated over the last few days. It is not clear in what way she had deteriorated. There is no history or examination that considers the possible reasons for her decline.

xi) Mrs LAVENDER's pain appeared poorly controlled on the night of the 4th March but there is no assessment of the pain in the medical notes prior to a syringe driver containing diamorphine 100mg and midazolam 40mg being commenced. The doses of diamorphine and midazolam used in response to Mrs LAVENDER's worsening pain, are excessive for her needs, even if it were considered that her pain was morphine responsive and she was dying from natural causes.

Dr David BLACK

Dr BLACK is an expert in Geriatric medicine. His review of the standard of care afforded to Mrs LAVENDER reported specifically:-

i) Mrs Elsie LAVENDER provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.

ii) The major problems in this lady's case are the apparent lack of medical assessment and the lack of documentation. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical care must include – taking suitable and prompt action necessary"... "referring the patient to another practitioner, when indicated"..... "in providing care you must – recognise and work within the limits of your professional competence...."..... "prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs". The major gaps in the written notes, as documented in my report, represent poor clinical practice to the standards set by the General Medical Council. In this case, I believe that the overall medical care received between Haslar and Gosport Hospital was negligent in that an inadequate assessment and diagnosis of this lady's conditions was made. If it was, it was never recorded. The lack of any examination at Gosport, the lack of any comment on the abnormal blood test make it impossible to decide if the care she subsequently received was sub optimal, negligent or criminally culpable. It seems likely to me that she had several serious illnesses, which were probably unlikely to be reversible, and therefore, she was entering the terminal phase of her life at the point of admission to Gosport Hospital. However, without proper assessment or documentation this is impossible to prove either way.

iii) The initial symptomatic management of her terminal illness was appropriate. The prescription of the Diamorphine on the 26th February (never given) and the excessive doses of medication used in the final 36 hours was, in my view, sub optimal drug management. These may have been given with the intention of shortening life at the final phase of her terminal illness. However, I am unable to prove beyond reasonable doubt this did hasten death by anything other than a short period of time (hours to a few days).

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 24th March 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 Elsie LAVENDER at the Gosport War Memorial hospital. The interviewing officers were DC Christopher YATES and DC Geoff QUADE.

The interview commenced at 0917hrs and lasted for 22 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/4.

This statement dealt with the specific issues surrounding the care and treatment of Elsie LAVENDER.

Expert response to statements of Dr BARTON