Operation ROCHESTER.

Key Points June 2006.

Robert Caldwell WILSON. Born Code A

Robert Wilson served 22 years in the Navy leaving in 1964. He was married with 7 children before divorcing in 1981 he had suffered malaria and diphtheria.

His ex wife describes his latter days as being an alcoholic it was not uncommon for him to drink 17 pints of beer in a day, by 1997 he is said to have been drinking a bottle of whisky a day.

Medically Mr WILSON was first noticed to be abusing alcohol at the time of an endoscopy in 1994.

In 1997 he was admitted to hospital with a fall demonstrating markers of serious alcoholic liver disease with a poor long term prognosis

On the 21st September 1998, Mr WILSON collapsed in his bedroom suffering a fracture to left shoulder. He was admitted to the Queen Alexandra Hospital where he refused to be operated upon. His physical condition initially deteriorated with alteration in mental state, renal impairment and subsequent gross fluid retention.

His wife was away on holiday at the time and unable to care for him, as a consequence Mr WILSON was transferred to the care of the elderly team at the Q/A hospital on 22nd September 1998.

Mr WILSON was clearly unwell. By the 22nd September he agreed to an operation but no longer thought fit enough.

He was recognised to have been an extremely heavy drinker with considerable oedema and abdominal distension his blood tests were found to be abnormal, he was suffering from mild anaemia, impaired renal function and was vomiting within 24hrs of admission probably due to alcohol withdrawal.

His physical condition deteriorated and he was noted as being in considerable pain during the first 2-3 days of his admission. He was noted as being in poor nutritional condition, irritable and suffering communication problems.

Regular Co-dydramol starts on 25th September until 30th September when it is replaced by 4 times a day regular Paracetamol which continues until his transfer.

In summary, his pain relief for the last week in the Queen Alexandra is 4 times a day Paracetamol and occasional night time dose of Codeine Phosphate.

By the 4th October 1998, his arm had become markedly swollen and it was suggested that he needed morphine for the pain.

By the 6th October 1998 it was recognised that he would need nursing home care, it had been noted the previous day that his condition was starting to improve although he remained catheterised and faecally incontinent.

On the 7th October 1998 it was noted that Mr WILSON was more alert and telling staff that he wished to go home, he was assessed by a psycho-geriatrician who's opinion was that that he had early dementia which may be alcohol related and depression. Mr WILSON was prescribed and administered 'Trazodone' as an antidepressant and as a night sedative he is still asking for stronger analgesics on 8th October. Mr WILSON was noted as sleepy and withdrawn and suffered disturbed nights.

On the 9th October an occupational therapy assessment was described as difficult because he is reluctant to comply and it was debated whether Mr WILSON was capable of going home .

By the 12th October Mr WILSONS Barthel score had improved to a level (7) that Social Services took the view that he no longer fitted their criteria for a nursing home and he should be considered for further rehabilitation.

The nursing notes comment that his catheter was out he was eating better but still suffered 'bad pain' in his left arm. His arms, hands and feet were noted to be significantly more swollen on 12th October, but his weight had increased from 103 kgs on 27th September to 114 kgs by 14th October 1998.

A decision was made to transfer Mr WILSON for possible further rehabilitation, although a medical review on 13th October stated that because of his oedematous limbs, he was at high risk of tissue breakdown. He was also noted to be in cardiac failure with low protein and at very high risk of self neglect and injury should he take alcohol again. He was assessed as requiring 24 hour hospital care.

On 14th October 1998 Mr WILSON was transferred to Dryad Ward at Gosport War Memorial Hospital, for 'continuing care'.

Mr WILSON was seen by Dr BARTON who prescribed Oramorphine 10 mgs.

On 15th October the nursing notes state that Oramorphine 10 mgs was commenced 4 hourly for pain in the left arm and that Mr WILSONS poor condition was explained to wife.

On 16th October the nursing notes comment that Mr WILSON was 'seen by Dr Knapman a/m as deteriorated overnight, increased Frusemide'.

This position seems to be contradicted by the nursing care plan which 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 that Mr WILSON had been on syringe driver since 16.30 hours.

Analysis of the drug chart indicates that 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.

Nursing notes mention a 'bubbly chest' late pm on 16th October and 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 (266). The higher dose of Diamorphine on the 18th and Midazolam is recorded in the nursing cardex (266).

The next medical note is on 19th October noting that Mr WILSON had had a comfortable night but had rapidily deteriorated.

Death was recorded at 23.40 hours on the 18th October and certified by Staff Nurse Collins.

<u>Case assessed by a multi-disciplinary clinical team 2004.</u>

<u>Robert WILSON.</u> 74. Died 18th October 1998 four days after admission to Gosport War memorial Hospital, he is recorded as having a high alcohol intake and poor nutritional status. He was admitted with a fracture of the left humerus.

During his last days on Dickens ward, he was on regular paracetomal and codeine as required needing one dose of codeine most days. On transfer to dryad, he received 2 doses of oramorph and was then put on a moderate dose of oramorph every 4 hours with paracetomal as required. Liver and kidney problems make the body more sensitive to the effects of oramorph. He had both of these problems. He deteriorated, and was converted to a syringe driver at a dose, which was a close conversion from the oramorph dose.

Over the next 2 days the dose was increased without obvious indication. Death was presumably from overdose of opiates, in a man with a poor opiate metabolism, and reduced tolerance.

Unless the decision had been taken to treat pain 'regardless' then this was negligent. The initial dose of Morphine was inappropriate in a person with known alcoholic liver disease. A rapid increase in body weight was documented in notes, with no apparent clinical response.

Dr Jane BARTON from caution interview with police on 19th May 2005.

Within a prepared statement Dr BARTON commented that she had no recollection of Mr WILSON due to the remove of time. However with the benefit of referral to notes she was able to comment on his medical history and admission to the Queen Alexandra hospital on 21st September 1998 with a fracture to the left humerus.

In particular Dr BARTON referred to Mrs WILSON condition on 29th September 1998, impaired renal function, liver function abnormal and suffering alcoholic hepatitis. It had also been recorded that Mr WILSON was 'not for resuscitation in view of poor quality of life and poor prognosis'.

On the 14th October 1998 Mr WILSON was transferred to Gosport War Memorial Hospital Dryad ward being assessed by Dr BARTON on admission. She had noted that he had been transferred for continuing care having suffered a fractured left humerus. In summary she noted Mr WILSON's alcohol problems, recurrent oedema and congestive cardiac failure.

Following her assessment she wrote Mr WILSONS prescriptions on his drug chart mirroring the medication recorded on his referral form consisting of vitamin nutrition for alcoholism, drugs for constipation, diuretics to reduce oedema, drugs for depression, parecetamol analgesia and increased pain relief Oramorph due to continued pain in his arm.

Additionally Dr BARTON wrote up a proactive regime of Diamorphine, Midazolam and Hyoscine, pain relief and medication available in case of deterioration of the patient.

It was her expectation that in the usual way nursing staff would endeavour to make contact with her or the duty doctor before commencement of the medication which would be at the bottom end of the dose range.

Dr BARTON prescribed further Oramorph on 15th October 1998, subcutaneously given his difficulty in swallowing medication.

Diamorphine was commenced on 16th October 1998 the reason being explained to the patients wife, she was also informed of his continued deterioration.

On the 17th October the patient was seen by Dr PETERS who recorded that Mr WILSON was comfortable but there was a rapid deterioration. He added that nursing staff could verify death if necessary.

There followed an increased dosage of Diamorphine, Hyoscine and Midazolam which might have been done with reference to Dr PETERS note, or with reference to Dr BARTON.

Dr BARTON commented that the patient suffered increasing secretions producing a sensation of inability to breath, diamorphine can assist in relieving agitation and distress and reducing oedema from cardiac failure. Furthermore there may have been a concern that Mr WILSON might become tolerant to opiates and according the increase might be required.

On the 18th October 1998 Dr PETERS attended speaking to Mrs WILSON and authorising an increase in Hyoscine beyond the range prescribed by Dr BARTON.

Mr WILSON continued to deteriorate and the nurses recorded that he died peacefully at 1140pm in the presence of members of his family.

Expert Witness Dr Andrew WILCOCK (Palliative medicine and medical oncology) comments:-

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; alcohol-related cirrhosis leading to liver failure and encephalopathy, heart failure and kidney failure. 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 kidney function 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 liver failure, 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 liver 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.

Expert Witness Dr David BLACK (Geriatrics) comments:-

Mr Robert WILSON a 74 year old gentleman with known severe alcoholic liver disease who was admitted with a complex and painful fracture of the left upper humerus. His physical condition deteriorates at first in hospital, with alteration in mental state, renal impairment and subsequent gross fluid retention.

He then starts to improve and is transferred to the Gosport War Memorial Hospital for further assessment and possible rehabilitation or continuing care. He is started on regular oral strong opiate analgesia for pain in his left arm and rapidly deteriorates and dies within 5 days of admission.

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.

It is Dr BLACK's 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.

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 Dr BLACK's view this treatment was negligent, and more than minimally contributed to the death of Mr Robert WILSON on 19th October.

Professor Richard BAKER (Clinical Governance)

Studied the records provided 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 the expert concluded that the certificate was inaccurate in that Mr Wilson did not have renal failure, and had liver dysfunction but not failure. He probably did have heart failure, although the expert believed the initiation of opiate medication was an important factor in leading to death.

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

Dr BAKER had referred in a previous report commissioned by the Chief Medical Officer to the potential of patients leaving hospital alive, he 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.

In the experts opinion, Mr Wilson had liver dysfunction but not full blown failure. His liver dysfunction did not cause death. In the presence of other life-threatening conditions, the liver dysfunction may impair the ability to recover, and it would have been reasonable to mention on the death certificate that Mr Wilson had chronic liver disease. The cause of his liver disease – alcohol – was not mentioned on the certificate.

Mr Wilson did not have renal failure. He did have abnormal blood test results after his admission to hospital, but these improved with re-hydration. Mr Wilson probably did have cardiac failure. There may have been other conditions as well. Haemoglobin estimations during his admission to Queen Alexandra Hospital had indicated mild anaemia. If this condition had deteriorated, the heart failure would also have become worse. However this was rather unlikely since he was being closely observed in Queen Alexandra Hospital and signs of increasing anaemia would almost certainly have been recognised. Evidence of bleeding would have been noted if it had occurred. There is no convincing evidence in the records to confirm a diagnosis of myocardial infarction such as history of chest pain, raised cardiac enzymes or ECG evidence. One could also speculate about possible occurrence of some unsuspected condition.

However, despite all these speculations, it has to be acknowledged that his decline was associated with the regular administration of morphine, and was responded to by administration of diamorphine by syringe driver.

The reason for commencing Oramorph is not recorded in the medical notes [179]; in particular, the reasons for not using a non-opiate drug for pain relief are not given. Even if Mr Wilson did have pain from the fracture that was not controlled by paracetamol, regular does of 10mg of oral morphine would not have been the appropriate treatment. Other non-opiate or weak opiate medication should have been used first. If these medications had failed to adequately reduce

the pain, a low dose of morphine (2.5-5mg) as had been used in the early days of his admission might have been reasonable. Although Mr Wilson did have congestive cardiac failure, therefore his death would have been hastened by opiate administration and the path to death may well have been initiated by the commencement of Oramorph on 14/10/98.

It is important to note that the general standard of completion of death certificates is unsatisfactory. For example, in a review of 1000 counterfoils of certificates in one teaching hospital in 1999-2000, only 55% of certificates had been completed to a minimally accepted standard (Swift and West, 2002). Of the remaining certificates, 25% had incomplete data, in 11% the part II section had been used inappropriately, and 9% were illogical or inappropriate. In her third report from the Shipman Inquiry, Dame Janet Smith observed: *A further problem with the current system is that the quality of certification is poor. Doctors receive little training in death certification.* (paragraph 17, page 4, Shipman Inquiry). The standard of completion of the death certificate in Mr Wilson's case should therefore be regarded as fairly typical. Although Mr Wilson did not have renal failure, the history of recent abnormal renal function tests prompted use of this diagnosis; the mention of liver failure was probably a convenient way of describing the impaired liver function.

Expert Witness Dr Jonathon MARSHALL (Gastroenterologist)

Mr WILSON was suffering with chronic liver failure due to alcoholic cirrhosos in 1997.

Mr WILSON entered terminal phase on or about 16th October 1998 there was a clearly marked deterioration between 12th/13th of October and the 16th.

The management of Mr Wilson's liver condition following the time of initial admission was not perfect but reasonable. He should have received Pabrenex to prevent *Wernickes'* encephalopathy in addition to lactulose to treat *hepatic* encephalopathy.

Mr Wilson was assessed by a psychogeriatrician who did not detect any of the classical signs of Wernickes' encephalopathy. During most of his admission as well Mr Wilson was generally alert and so the omission of lactulose or other anti-encephalopathy treatment cannot be cited as a major omission. In real-life I suspect Mr Wilson would have refused to take lactulose for presumed encephalopathy because of its taste and laxative effects.

Mr Wilson was clearly an un-well man whose life expectancy was short. His previous record demonstrates that he would have been likely to return to drinking on discharge from hospital. The administration of high doses of morphine whilst an in-patient on Dryad however must be considered reckless. Warnings about morphine usage in the context of liver disease are readily available in standard prescribing guides such as those cited from the BNF.

No attempt appears to have been made to justify the use of opiates in this at risk patient group. There also does not appear to have been any attention paid to appropriate dose reduction and/or monitoring in Mr Wilson's case.

The outcome was predictable in the clinical context of cirrhosis and escalating opiate dosage that Mr Wilson could not have survived.

The impact of regular morphine administration to Mr WILSON is likely to have hastened his decline. Its sedative effects would worsen hepatic encephalopathy which he undoubtedly had throughout his hospital stay, and would cause rapid deterioration as indeed happened between the 14th and 19th October./

Mr Wilson's cause of death is given as (1) Congestive Cardiac Failure (2) Renal failure and (3) Liver failure. The experts understanding was that this was a clinical diagnosis as opposed to a post-mortem finding.

Congestive cardiac failure was unlikely to be the primary cause of death in Mr Wilson's case. Mr Wilson had oedema and the *commonest* cause for oedema is as a consequence of heart failure. However oedema also occurs in cirrhotic liver disease and in the experts view this was far more likely cause of oedema and ultimate demise than heart failure.

Mr Wilson had cirrhosis and therefore cause of death (3) 'liver failure' was reasonable. Mr Wilson had signs of *chronic* liver failure throughout his hospital stay including oedema and probable hepatic encephalopathy. The experts view is that he died of *acute chronic* liver failure precipitated by opiate medication.

Renal failure is a common secondary consequence of liver failure.

While there is limited evidence to support a diagnosis of 'renal failure' it is a common complication of liver disease. Mr Wilson is likely to have had the 'hepatorenal syndrome.' This means reversible renal failure as a direct consequence of the liver failure. If the liver injury can in some way be reversed then the renal failure will correct.

<u>Evidence of other key witnesses.</u>

Code A first wife of Robert WILSON, describes husband as a fit active navy man until 1964. However was a heavy smoker 60-80 a day and would drink heavily regularly 17 pints a day. Divorced in 1981.

Saw Mr WILSON when admitted to Queen Alexandra Hospital, he had refused painkillers was lucid and able to speak clearly. Next visited on his second day at Gosport War Memorial Hospital. He was in a coma and she was told by the nurse that he had travelled badly. Did not see him against prior to death.

Gillian KIMBERLEY second wife of Robert WILSON married in 1885. WILSON retired at 65 in quite good health. A heavy smoker 40 a day. Drank half a bottle of scotch a day. He was 5'6' tall and about 12 stone. Sufferd suspected heart attack in Febraury 1997 hospitalised for 3 weeks and stopped smoking.

Husband suffered a fall in September 1998 whilst she was staying with relatives in Plymouth. She visited him 6 days later. He was transferred to Gosport on 14th October for rehabilitation. Seemed OK prior to transfer.

On arrival a female Doctor said she would give him something to calm him down from the trip. The following day he looked dreadful was a mess with food all over him and incomprehensible. Spoke with the ward sister who told her bluntly that he was dying. He could die at any time but they were not giving him longer than a week. Has always had concerns about Roberts death.

Iain WILSON son of deceased. Father a heavy smoker form the age of 11 but quit five years prior to death. Drank a bottle of whisky a day after giving up smoking.

When initially admitted to Queen Alexandra hospital with fractures left shoulder he was told by a doctor that his father had given up the will to live.

The evening prior to leaving the Queen Alexandra hospital Mr WILSON was happy sat up in bed, having a joke and aware of his surroundings. Nurse said they new he was on the road to recovery because he was arguing with them.

Father transferred to Gosport War memorial hospital on the 14th October by minibus a 90 minute journey. Saw father following day on the bed in an almost paralysed state, distressed and confused. Saw father on 16th almost in coma and on syringe driver.

Mr WILSON concerns:-

- Why did he go downhill so quickly after leaving Q/A?
- Why was he placed on diamorphine when earlier had been refusing painkillers?
- If he was ill why move for rehabilitation, and why not by ambulance?
- What was the cause of renal and liver failure?

Code A daughter of deceased - family history and visits made to father at Q/A and Gosport War memorial Hospital.

Code A step - son of deceased. Background and hospital visits. Unhappy with fathers treatment at Gosport War Memorial Hospital and challenged staff. Tried to meet doctor in charge but unable to do so despite several attempts.

Code A Daughter of deceased. Family history and visit to Gosport War memorial hospital on 17th/18th October 1998.

Code A Son of deceased. Background, visted father at Queen Alexandra hospital September 1998, seemed to be well and looked after, clean and tidy was in a wheel chair following fall but seemed lucid and happy with where he was, spoke about going home.Next saw father the day prior to his death. Totally shocked at his decline.

Code A Daughter of deceased. Family background.Visted Dryad ward 14th or 15th October, father was completely unconscious, did not register that she was in the room.

Code A Eldest son of deceased. Background. Visited once at Gosport War Memorial Hospital was not conscious, seemed poorly and clearly heavily sedated.

Anthony MOWBRAY General Practitioner retired. Mr WILSON a patient at his Sarisbury Green practice. In March 1997 prescribed drugs and multi-vitamins for oedema (fluid on the legs) ascites (fluid abdominal cavity) and liver failure. Patient felling better by April 1997. May 1997 troubled by swelling to right leg, in July 1997 he was taking small amounts of alcohol, told to take more exercise. Blood tests consistent with high alcohol dependency.

Timothy TAYLER Doctor, Sarisbury Green practice. Saw Mr WILSON in July 1996 noted abnormal liver function and alcohol excess. Commissioned liver tests . Saw again in August 1996, test indicated abstinence from alcohol and improving liver.

Dierdre DURRANT General Practitioner saw Mr WILSON in November 1993 suffered inflammation of the stomach due to alcohol abuse. Failed return to see doctor in 3 weeks as requested.

Christopher HAND Doctor Queen Alexandra Hospital. Examined Mr WILSON for his fractured left humerus 21st September 1998. WILSON refused an Operation.

Christian BIRLA Doctor Queen Alexandra Hospital. Explains an entry re 'resuscitation' status on 23rd September 1998. Having observed Mr WILSON between 23rd and 29th September 1998 she decided that due to his physical condition (he was an alcoholic) he would not be resuscitated if he stopped breathing at any point. General re condition of Mr WILSON whilst at QAH and analgesia applied.

The BNF notes that if a patient's liver is damaged caution has to be exercised in the administration of opiates.

Mrs WILSON'S state of physical health was such through alcohol abuse that if his health deteriorated to the extent that he were to die, it would not be unexpected in the near future.

Arumugam RAVINDRANE Consultant Physician specialist registrar Dickens Ward, Queen Alexandra Hospital 1998. Examined Mr WILSON 25th September 1998, noted dehydrated and drowsy. Renal function slightly better by 30th September. Stopped all sedatives but continued fluids. By 2nd October 1998 Mr WILSON still very sleepy, indications of malnutrition and diseased liver. Stopped I/V fluids and gave high protein drinks.

Listed patient for long term continuing care. Wrote a letter to psychiatrist indicating his alcoholism liver disease, clinical depression and withdrawn attitude.

9th October 1998 noted gross oedema but eating well, Barthel index 5 which was low indicating very poor mobility. Asked for nursing home placement with social services.

Last enrty in notes dated 13th October 1998 stating Mr WISLON needed both nursing and medical care. In danger of falling and risk would remain until fully mobilised. His special needs included attending to swollen arm.

Does not recall Mr WILSON but having read notes he was unwell, he may have stabilised and maintained some level of health, equally he could have died suddenly or quickly due to his condition. His liver function was abnormal.

Kathryn TAYLOR-BARNES Senior House Officer Queen Alexandra Hospital 1998 examined Mr WILSON 24th September 1998. Examined fractured shoulder and checked for further damage. Produced five point plan to ensure proper management. Content that diamorphine 5mg was adequate for pain relief.

Rosie LUZNANT Consultant in old age psychiatry. On 8th October wrote entry in medical notes, presented with a low mood, a wish to die and disturbed sleep. Believed to be suffering from early dementia and depression.

Mini mental state examination score of 24/30. (30/30 is good memory. 5/30 is poor memory)

Wrote to referring doctor GRUNSTEIN on 15th October

Claire DYSON Nurse, working Dickens Ward Queen Alexandra Hospital 28th September 1998 was first day as a trained nurse. Made several entries in the patient's daily living notes between 28th September and 6th October 1998.

Ruth CLEMON Nurse Dickens Ward, Queen Alexandra Hospital head of nursing team. Made entries in nursing notes between 24th September 1998 and 13th October 1998, final entry 13th October reads 'Reviewed by medical team, continues to require special medical/nursing care as oedematous limbs at high risk of breakdown (right foot already about to break down) this is due to increased oedema secondary to cardiac failure and low protein. Also high risk of self neglect and injury if starts to take alcohol again. Needs to have 24hr hospital care until arm healed.

On 24th September Mr WILSON in severe pain addressed with diamorphine slow either intravenous or subcutaneous 2-5mgs. Morphine given 3 times during initial 24hrs.

Nicola HAYNES Entries to nursing notes between 23rd September 1998 and the 1sr October 1998 whilst at Queen Alexandra Hospital.

Collette BILLOWS Nurse.. entries to medical notes including transfer on 13th October 1998.

Althea LORD Consultant Geriatrician. Had no contact with the patient at Dryad Ward, was on leave from 12th October to 23rd October.

Ewenda Jay PETERS GP Forton Road Medical Centre, GOSPORT, employed as clinical assistance at Royal HASLAR Hospital, GOSPORT 1995 – 2000 and provided cover for Dr BARTON at Gosport War Memorial Hospital. Made entry on medical notes 18th October 1998 reading 'comfortable but rapid deterioration nursing staff or night sister to verify death if necessary'.

On 18th October increased the patients dosage of Hyoscene an anti nausea drug also used to dry up secretions

Anthony Charles KNAPMAN GP Forton Road Medical centre. Provided cover for Dr BARTON at Gosport War Memorial Hospital.

Made entry in Mr WILSON's medical notes on 16th October 1998 'decline overnight with shortness of breath, fluid in chest, weak pulse, oedema arms and legs, silent MI/, indicates that he may have had a heart attack or deterioration of his liver.

Dr KNAPMAN prescribed Mr WISLON an increase in Frusemide a diuretic due to his fluid retention, the only drug written up by Dr KNAPMAN.

Dr KNAPMAN did not feel that drugs written up by Dr BARTON were excessive.

Gillian Elizabeth HAMBLIN Senior sister Dryad Ward responsible for the 24hr care of the patients on the ward. Dr BARTON would visit the ward each morning 0730hrs Monday to Friday to see every patient before returning to her own practice.
Dr BARTON prescribed the drugs required by each patient.
Nurse HAMBLIN has no doubts about the use of syringe drivers.
Following admission Nurse HAMBLIN has written the following diagnosis.
Broken left upper arm.
Congestive cardiac failure.
Renal failure.
Liver failure.
Treatment /recommendation syringe driver 16.10.1998.
The diagnosis obtained through her review of the medical records.

Nurse HAMBLIN noted from the notes that Mr WILSON suffered multiple organ failure and she made the prognosis that he was being admitted for terminal care at Dryad Ward.
At 1550hrs on 17th October Nurse HAMBLIN increased dose of Diamorphine to 40mgs and Hyoscine increased to 800 mcgs.She added 20 mcgs of Midazolam.
On 18th October Diamorphine increased from 40mg to 60mg to control pain, multi organ failure and fractured arm. Midazolam increased 20-40mg due to patient suffering liver failure.

Nurse HAMBLIN Further statement cannot recall conversation with nurse Shirley HALLMAN who was her senior nurse on Dryad WARD. Reiterated that the dosage increases in diamorphine to Mr WILSON were necessary to deal with his pain and anxiety, this was not always recorded in the notes but was self evident. Would always inform a doctor of the change, sometimes afterwards.

Lynne BARRETT Staff nurse Dryad Ward. Discusses training and use of syringe drivers and background re ward procedures. Made single entry on Mr WILSONS notes.

Debra BARKER Staff nurse Dryad Ward. Witnessed use of diamorphine on patient WILSON 16th and 18th October via syringe driver.

Irene DORRINGTON Staff nurse Dryad Ward. Administered Oramorph to Mr WILSON 14TH October and witnessed Nurse MILNER administer Oramorph on 15th and 16th October prescribed by Dr BARTON.

Marjorie WELLS Staff nurse Dryad Ward, administered Oramorph to Mr WILSON ON 15TH October .

Jeanette FLORIO Nurse Employed Daedalus ward occasionally covered Dryad. On 17th October administered 20mg of Diamorphine to Mr WILSON.

Margaret PERRYMAN Nurse Dryad Ward, witnessed staff nurse FLORIO administer 20mg Diamorphine on 17th October 1998.

Freda SHAW Staff nurse Dryad Ward. Witnessed Oramorph oral solution administered by Nurse HAMBLIN on 15th October 1998. Explains other general nursing note entries.

Sandra MILNER Staff nurse Sultan Ward providing cover for Dryad. Administered Oramorph 20mg 15th October 1998 and 10mg on 16th October.

Siobhan COLLINS Staff nurse Dryad Ward. Explains the 'five rights' procedure for syringe driver use. Only involvement with Mr WILSON was to verify death at 2340hrs on 18th October 1998.

Shirley HALLMAN Staff nurse Dryad Ward. Administered Diamorphine and Oramorph to Mr WILSON, does not believe dosage excessive in her experience.

Carol ARNOLD Healthcare support worker. Witnessed administration 10mg ramorph 15th October 1998.

Jacqueline SPRAGG. Produces cause of death certificate stub 23170 re Robert WILSON.

Code A Tape recorded interviews Dr BARTON 19th May 2005.

D.M.WILLIAMS
Det Supt 7227
8th June 2006.