EPAQT OF INDEPENDENT REVIEW PANEL.

REPORT OF THE INDEPENDENT REVIEW PANEL

ESTABLISHED BY

PORTSMOUTH HEALTHCARE NHS TRUST

TO INVESTIGATE A COMPLAINT BY:

Code A

Panel Members

Mrs Jane Quincey	Chairperson
Mr David Lee	Associate Convenor
Mr Richard Tickner	Purchaser Representative

Clinical Assessors

Dr Jane Orr	GP Camberley
Dr Andrew White	Consultant Geriatrician Worthing
Mrs Bridie Castle	Nursing Assessor

Panel held on

22nd May 2001

Report produced on

10th August 2001

Summary of the Complaint

Code A Mrs Elsie Devine dob Code A was admitted to Gosport War Memorial Hospital, on 21st October 1999. She had previously been a patient at the Queen Alexandra Hospital Portsmouth and was suffering from a kidney infection.

Code A was unable to visit every day as she was at

Code A

On 19th November, Mrs Devine's condition worsened, and her Code A was telephoned. Code A was not telephoned by the hospital.

When Code A arrived at the hospital during the evening of 19th November, she was very shocked to find Code A terminally ill; she had not known that this was the case. Mrs Devine died on 21st November.

Code A wrote to the Portsmouth Healthcare Trust on 6th January 2000 complaining that she had not been informed of the seriousness of Code A condition, at the way she had been treated by the medical staff at the War Memorial Hospital, and with a list of specific questions about Code A treatment.

Mr Max Millett, Chief Executive, answered this letter on 4th February; he gave answers to all Code A questions. Code A remained dis-satisfied and requested a meeting with Dr Ian Reid, the Consultant in charge and with hospital administrative staff. This meeting took place on 23rd March 2000 and an apology was made to Code A Code A

Further correspondence between the Trust and Code A ensued and another meeting took place on 19th May 2000. However, Code A remained seriously concerned about the events surrounding the death of Code A and in July 2000 requested an Independent Review.

Terms of Reference for the Independent Review Panel

Code A remains dissatisfied with the clinical care provided for Code A Mrs Elsie Devine, prior to her death, and with the associated communication from the Trust.

The Panel was asked to consider:

1. The adequacy of the communication between the Trust Code A
2. The appropriateness of the clinical response to Mrs Devine's medical condition.

Consideration by the Independent Review Panel.

The panel was established in April 2001. The panel members had copies of all relevant documents including letters between the complainant and the Trust and the clinical notes of the late Mrs Devine.

The panel also had copies of the following:

Dr David Jarrett, Lead Consultant Geriatrician, written clinical advice.

A written statement by Dr Ian Reid, Medical Director of Portsmouth Healthcare Trust and Consultant Geriatrician, taken on 17th May.

An interim written report by Mrs Bridie Castle, a Registered General Nurse.

Oral evidence was heard from:

The complainant and Code A

From the following NHS staff:

Dr Jane Barton GP, Clinical Assistant, Dryad Ward.

Gill Hamblin, Ward Sister, Dryad Ward.

Freda Shaw, Staff Nurse, Dryad Ward.

Term of reference Number One:

To consider the adequacy of the communications between the Trust Code A Code A

Code A Evidence. Code A

Code A began by reading a statement to the panel in which she clearly explained the reasons for her complaint.

Code A explained that Code A had lived with her for twenty years and was a much loved member of a close knit family. In September 1999, Mrs Devine was admitted to Queen Alexandra Hospital with a kidney infection, cystitis and mild confusion. The latter was probably because she was anxious about her first stay in hospital.

When the time came to discharge Mrs Devine from the QAH, various options were discussed with the family. Code A

Code A

Code A home either, due to a last minute decision by Mrs Devine's Code A There were further discussions with Jan Severs from Social Services and as St Christopher's Hospital in Fareham and a nursing home were ruled out, the family decided that Mrs Devine should go to the War Memorial Hospital as Mr Devine lived near by.

Mrs Devine was unhappy at the War Memorial Hospital in spite of daily visits by Code A Code A and other family members. On one occasion Mr Devine was told that Code A refused to take her medication; this was because she thought she was being given sedatives. On another occasion a relative visited and asked if she could take Mrs Devine for a walk in the hospital garden, and when this was refused, Mrs Devine was very upset. Code A felt that Code A was bathed and had her hair washed excessively for an agitated old lady and this added to her distress.

On Thursday 18th November Mrs Devine was given a Fentanyl patch without herself or her family being told.

On Friday 19th November, Mrs Devine was found wandering in a corridor in a confused and agitated state. Code A was telephoned, which Code A Code A felt was inappropriate, as she was not a close family member. Furthermore the hospital staff imparted no sense of urgency. However, when Mr Devine visited at lunchtime, he met with Dr Barton who told him his mother had renal failure and had 36 hours to live. He telephoned Code A in London immediately, who left London and arrived at the hospital at around 3.30 p.m. in order to be with Mrs Devine. Code A had not asked to see a doctor. When Dr Barton arrived this was the first time Code A Code A had met her.

On arrival, Dr Barton failed to introduce herself, but asked the family to follow her in what Code A and Code A felt was a very hostile way. Code A was very

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shocked when Dr Barton said that she had not been contacted sooner because they did not want to add to her already considerable burden of worry. Code A felt it was inappropriate for that decision to be made for her. Dr Barton also told Code A that she would be writing renal failure as the cause of death on the death certificate Code A Code A noted that on Mrs Devine's medical record that when Dr Barton had administered the morphine drive, she wrote that she would be happy for her staff to confirm death when this happened. This however was not said to Code A Dr Barton then left and Code A never saw her again. Code A also stated that there was some confusion over the date of Mrs Devine's last blood test. Dr Barton said that it was on the 11th November, whereas in a later statement Mr Max Millett said that it was on 16th November and the result was known on 18th November.

Further causes of worry for Code A were that Dr Cranfield had told her that she would be informed if there were any changes in her mother's condition and this had not happened; that although it had taken two nurses to calm her mother on 19th November after an injection of chlopromazine this was not considered an emergency, and that at 9.25 am on 19th November her mother had been given a morphine driver and the hospital knew she was dying. Yet the family was not told and was allowed to go on with their lives unaware of this.

Code A finished her statement by telling the panel of the grief and unhappiness that had been caused to the family because of the manner of her mother's death. None of her questions had yet been answered satisfactorily and she had been unable to come to terms with what had happened.

The Panel then put questions to Code A

She was asked how her mother had been at home before being admitted to hospital and she answered that she was a normal active 88 year old. She was an independent woman who liked to do as much as possible for herself, although this sometimes worried the family as she had a bad knee, and could be forgetful on occasions. Mrs Devine also had poor eyesight. After several falls Mrs Devine had two cataract operations, one of which was done privately and one on the National Health Service. She attended a day centre regularly and had friends whom she visited. She was able to look after her own finances.

When the panel asked Code A when she realised that her mother was very ill, she replied "Never" and that she and her family were only made aware that her mother was dying on 19th November when Code A telephoned her.

Code A was then asked about her visiting her mother in hospital. She told the panel that she usually visited every Thursday. The last time she visited was on Thursday 11th November and this visit was frustrating. Her mother was having a bath and it was some time before she returned and they were able to speak together. Mrs Devine told her daughter that she was very unhappy in the hospital and asked to be taken home. However, although slightly forgetful, she was able to make conversation and talk about her visitors.

The following Thursday Code A were unable to visit as they were at the Hammersmith Hospital with Code A so they decided to visit on Sunday 21st November instead. Code A said that she was not sure whether her mother had expected her usual Thursday visit, and that if she had, this may have contributed to Mrs Devine's worry and agitation.

By the time Code A arrived at the hospital on 19th November, in response to her Code A phone call, her mother was unconscious and she was never able to speak to her again. Thus the last time she was able to speak with her mother was on Thursday 11th November.

The panel then asked Code A if she was with her mother when she was admitted to the War Memorial Hospital. She replied that she wasn't, but as Mrs Devine was transferred from the Queen Alexandra Hospital, she had assumed that the records would go with her. Code A said that her mother was at the Gosport War Memorial hospital only for respite care and was not a health risk. These records showed her to be the Next of Kin and a direct contact number to the Hammersmith hospital was on the records.

Code A then told the panel that although she had visited regularly and her Code A had visited daily, they had not been told that their mother was on a syringe driver, and that her medication was not discussed with the family. None of the family had noticed a deterioration in Mrs Devine's condition.

Code A was then reminded of the action that the Trust had taken and that an apology had been given. Code A replied that she did not feel that an apology was good enough, and that if she had made serious errors at work she could have lost her job or been seriously reprimanded. She went on to say that she thought that the staff working on Dryad ward that day, must have a conscience about the events. She asked how it could have been that her mother was treated in that way and the family disregarded. They were a close and caring family and could not understand what had happened on that day.

Mrs Castle explained to Code A that apologies are always offered sincerely and that following events such as these, action plans are drawn up and implemented. Mrs Castle added that nurses are genuinely affected by events such as these and they want to ensure that no other family has a similar experience. She stressed the importance of people like Code A coming forward when they were unhappy with any part of the service that they or their relatives may have received. Code A replied that she was here today to make sure that that the same thing never happened to anyone else.

Dr Barton's evidence: (accompanied by Dr Althea Lord)

Dr Barton began by explaining her work pattern.

She is a local full time GP and also worked on a sessional basis as a Clinical Assistant for Portsmouth Health Care Trust and had done so for twelve years. She resigned from this post in July 2000, but still works for the Trust admitting patients to GP beds and covering casualty.

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She worked on Dryad ward at Gosport War Memorial Hospital, which is a continuing care ward with 19 patients. Some patients died on the ward, some would be discharged home and others to a nursing home. She said there were 4/5 admissions a week. Dr Barton said her GP practice also covered out of hours GP service using HealthCall and she was rostered on 1 night in 10.

A typical work day was to arrive at Dryad ward at 7.30 am to check on existing patients; carry out GP duties during the rest of the morning and return to Dryad ward at lunchtime to admit new patients. In the afternoon she resumed her GP duties and returned to Dryad ward in the evening. Additionally she accompanied the Consultants, Dr Reid and Dr Lord on each of their weekly ward rounds.
Dr Barton then outlined her understanding of Mrs Devine's case.

From the medical and nursing notes, Dr Barton recalled that Mrs Devine was admitted to Dryad ward on 21st October 1999 with mild dementia, a form of nephritic syndrome, her renal function was failing and she had an under active thyroid. She was continent and was transferring from her bed to a chair with the help of one person. Her Bartel was 8 and her Mini Mental Test score was 9/30. This is quite low and therefore indicated mild dementia.

From talking with Mrs Devine's Code A Dr Barton established that Mrs Devine was unable to continue living with her mother because she had become too frail and demented. Code A

Dr Barton then told the panel about the way in which she communicated with Mrs Devine's family.

The Panel asked Dr Barton if subcutaneous fluids were routinely given on Dryad ward. She replied that they were not often given. When asked whether it was considered for Mrs Devine to be transferred back to the Queen Alexandra Hospital to receive fluids, she explained that it had been considered, but was not thought appropriate because of Mrs Devine's mental state.

Dr Barton said that the nurses would have discussed this option with Mrs Devine's Code A after the ward round by Dr Reid on 15th November, but that these discussions had not been recorded in the notes. She was also aware that Code A had said that he had no recollection of these discussions.

On Friday 19th November, she thought the family ought to know that Mrs Devine was very unwell and asked the nursing staff to contact Mrs Devine's Code A and let them know about the situation. This they did and Code A arrived at lunchtime and met with Dr Barton. She explained that Mrs Devine's condition had deteriorated and that he should let the rest of the family know how seriously ill she was. Dr Barton offered to return later in the evening to meet with the rest of the family.

Dr Barton said that when she arrived at the hospital that evening Mrs Devine's family, who, from their looks and body language seemed very hostile and angry, met her. She anticipated a difficult meeting. She knew that another family member had died at St Christopher's Community Hospital in Fareham, and that Code A had complained

about the care provided at Queen Alexandra's Hospital. Dr Barton was asked if she had "angry relatives" flagged up in her mind before the meeting; she said that she did.

Dr Barton explained to the family the Mrs Devine had deteriorated and had had to be sedated. She said the family was shocked, as was she, about this deterioration. She then went off duty for the weekend. Dr Barton pointed out that if she had not returned to the hospital that evening, the family would have not seen a doctor until Monday.

Dr Barton then went on to say how it was her usual practice to try to establish a relationship with key family members of her patients. However, she had been unable to do this in the case of Mrs Devine, because of the family circumstances and Mrs Devine's rapid deterioration. She explained that she would have liked to have discussed the use of opiates with the family before they were given, but this had not been possible, as it had been clinically necessary to give them immediately. She said she did explain about the opiates and the syringe driver on the evening of 19th November, but the family was too shocked to take in what they were being told.

Dr Barton thought that at the end of her talk with the family the Staff Nurse, Freda Shaw, would have asked the family if they had understood what they had been told. She herself felt that it had not been a good meeting, but she had hoped that it would have been the beginning of a relationship with the family and not the end.

The panel asked Dr Barton about her statement to the family that Mrs Devine had "36 hours to live". She replied that in the 25 years she had been practising medicine, she had never predicted the timing of death. It would be inappropriate and wrong. She said that she had hoped Mrs Devine would improve, but she did not know whether she would improve or die.

When asked about her understanding of the roles of Code A in relationship to their mother's illness and hospitalisation, she said she thought that Code A was the Contact/Carer and that Code A was the next of kin. Dr Barton said that she had understood that Code A had asked the nursing staff not to bother Code A Dr Barton said she felt comfortable dealing with Code A as he visited his mother every day, was seen in the ward a lot and had been in contact with Social Services. She had met with Code A Code A on a regular basis and he was always perfectly amicable. She had the impression that he was not aware of how ill his mother was and that she was deteriorating. She surmised that he might have conveyed that impression to Code A Code A

Finally Dr Barton said that she had not been aware that there had been a contact number for Code A in London in the notes.

Sister Gill Hamblin's Evidence: (accompanied by Dr Althea Lord)

Sister Hamblin outlined her role in the care of Mrs Devine.

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She has worked at Gosport War Memorial Hospital for twelve years and for nine of those as a Ward Sister. She said that Dryad ward is a twenty-bed ward and that patients stayed there until they died, went to a nursing home, rest home or their own home.

Sister Hamblin said she was not on duty when Mrs Devine was admitted, but from the beginning she had been agitated, confused and inclined to wander. She was an independent person, who although rather unsteady on her feet, had not wanted to be helped. The nursing staff had done their best to accommodate her wishes; for instance giving her a bath at 7.00 pm if that was what she wanted.

On 15th November, the day of Dr Reid's ward round, Mrs Devine deteriorated. Because of this, she had expected Dr Barton to arrange to see Code A in order to explain the turn of events. Sister Hamblin had not been aware of any discussions concerning Mrs Devine's possible transfer back to the Queen Alexandra Hospital.

Sister Hamblin said it was she who had telephoned Code A at about 8.45 am on 19th November. She telephoned her at work because they had no work telephone number for Code A on record. She also thought it was appropriate to telephone her as she had regularly visited Mrs Devine with Code A and seemed to be involved in decision making. Code A told Sister Hamblin on the telephone that her Code A was planning to come in at lunchtime and that she would try to reach him in order to tell him to come earlier if he was needed. Sister Hamblin replied that there was no urgency just then and that Dr Barton would not be returning to the hospital until after her morning surgery, so that a lunchtime visit would be appropriate.

When Code A and Dr Barton arrived at lunchtime, he was told of the morning's events. The syringe driver and the medications his mother had received were explained to him. Dr Barton and Sister Hamblin asked Code A if would like them to contact Code A and he said that he would not. From Code A admission, Code A had been adamant that the hospital should not contact Code A and that he would do this.

Sister Hamblin said that Code A were regularly in touch with the staff of Dryad ward and that Code A often came to visit with Code A She also said that despite Code A being recorded on the notes as first contact, Code A had made it clear Code A and that she shouldn't be contacted directly. Sister Hamblin said that it was a failing that Code A instructions were not recorded in writing. They have now changed their practice so that such instructions are always recorded.

Sister Hamblin was asked about procedures for documenting conversations with relatives of patients and said that as a result of this complaint, practice had changed. She had been on her own with Code A when he asked her not to contact Code A Now, wherever possible, staff do not talk to relatives and carers on their own but in pairs. All conversations – even informal ones – are recorded.

Sister Hamblin said that the nursing staff regularly discussed his mother's condition with Code A, but with hindsight think they should have contacted Code A

However, the nursing staff sensed some tension between Code A particularly in relation to Code A She added that they did not realise that Code A was not fully in the picture until 19th November. She thus concluded that had not realised the seriousness of his mother's condition and therefore did not convey this to his sister.

When Mrs Devine talked to the ward staff about going home, she knew that a nursing home was probably her only option. She didn't talk about her home life or say that she wanted to go home.

The Panel asked why Mrs Devine's hair was washed twice in three days and replied that this was what Mrs Devine had requested.

Sister Hamblin said that she had never met Code A as she had not been on duty when she visited.

Staff Nurse Freda Shaw's Evidence: (accompanied by Dr Althea Lord.)

Staff Nurse Shaw said that when she arrived on duty on the afternoon of Friday 19th November, she was told that Mrs Devine's condition had deteriorated and that she was very poorly. She was also told that Dr Barton had seen Code A and that Code A Code A was on her way from London.

When Code A and her family arrived, Staff Nurse Shaw telephoned Dr Barton who told her that she would come to see the family after afternoon surgery. When Dr Barton arrived it was she who took the family to see her.

Staff Nurse Shaw said that she was present during the meeting with Dr Barton and Code A and the rest of her family. As it was now a long time ago, she could not recall exactly what was said, or Code A emotional state. However, she was sure that the family would have been told what had happened that day. After Dr Barton left Staff Nurse Shaw remembers asking Code A if she had understood what she had been told. Code A recalls that she did and that she was going to sit with her mother.

Mrs Devine was not one of Staff Nurse Shaw's patients. There were two nursing teams on the ward and Mrs Devine was a patient of the other team. However, she does recall Mrs Devine being confused and often being dressed early in the morning, although not washed. The staff left her to bath until she requested it.

Staff Nurse Shaw had seen Code A on the ward, but had never spoken with him. However, all the nurses knew that Code A kept in touch with the ward staff and that Code A was in London with Code A

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Term of Reference Number 2.

To consider the appropriateness of the clinical response to Mrs Devine's medical condition.

Code A Evidence. Code A

Code A again began by reading the panel a written statement.

Code A stated that when she arrived at the hospital with her family at around 3.30 p.m. on 19th November, the Ward Sister met them and took them to the Ward. She said, "I'm afraid she won't know you love" Code A took her mother's hand and began talking to her. Mrs Devine squeezed her Code A hand and the Ward Sister said, "She does know you" and "They can go on for weeks like that" Code A said that her mother's eyes were closed but appeared to be flickering and that her breathing seemed laboured and she struggled for air.

The family visited again on the following day, Saturday 20th November and left at 11.30 p.m. Her condition was much the same as the previous day, but her hand squeeze was not as strong.

On the following day, Sunday 21st November, the family visited again, and this time there was no response from Mrs Devine when her hand was squeezed. Code A had to leave at 11.00 a.m Code A By this time Code A was too distraught to speak and Code A asked the nursing staff to advise her of any changes in her mother's condition. She intended to return the following day, but she received a phone call at 8.20 p.m to say that her mother had died.

On Monday 22nd November Code A collected the Death Certificate from the hospital. However, the Coroner would not accept renal failure as the cause of death, and Code A returned the death certificate to Dr Barton who added Chronic Glomerulephritis to the death certificate. When she handed the death certificate to Code A she said, "Code A is not happy with us is she?" Code A said that she understood Glomerulephritis could not be diagnosed without a biopsy and this caused her to doubt Dr Barton's professional competence.

The panel then asked and answered questions with Code A

Dr Orr explained that the rules governing what Coroners will accept on death Certificates change frequently and that 'renal failure' may be considered too vague for some Coroners. She went on to say that a scan had shown scarring on Mrs Devine's kidneys and that this can lead to kidney failure. Dr Orr said that Mrs Devine had multiple myeloma, but Code A said that this was not the case as Dr White had said that she did not. Dr Orr then asked Code A what her profession was and Code A Code A replied that this was not relevant.

Dr White said that a biopsy is not necessary or appropriate all the time, as there are risks to the procedure which would outweigh the benefits to an elderly person. Code A

Code A asked if renal failure due to Glomerulephritis is life threatening; Dr White explained that it could be because the patient becomes more prone to infection.

Code A then said that her mother's medical notes had been a 'shambles', and if her mother had been aggressive, why had they not been told? Additionally an assumption had been made that Mrs Devine was taking fluids orally and there was no evidence that her fluid intake/output was monitored and there was no fluid chart. Therefore a decision was made not to give Mrs Devine intravenous fluids without discussion with the family.

Code A told the panel about an incident when her mother was a patient at the Queen Alexandra Hospital. Her mother had been confused and agitated and on one occasion when Code A visited, other patients told her that her mother had not been eating or drinking and that no one seemed to care. She asked her mother about this and Mrs Devine said that she had. However, when Mrs Devine tried to pick up a cup of fluid, her hand was shaking so that the contents were spilt. The medical staff apologised and an intravenous drip and fluid chart were set up. Code A said that the doctor drew her to one side and said that she was entitled to make a complaint about the nursing staff, although he could not.

Code A then went on to question her mother's medication that had been given at the Gosport War Memorial Hospital, without discussion with the family.

Why had Mrs Devine been started on a 50mg dose of Chlorpromazine? She understood old people should be started on a lower dose.

Why had Mrs Devine been given a Fentanyl patch, which she understood was to treat chronic pain, when there was no evidence in the notes that her mother was in any pain? She understood that whilst wearing a patch no other drugs should be administered for 48 hours and that confusion and hallucination can be side effects.
Why was this not discussed with the family?

Why was Mrs Devine given a morphine driver less than an hour later than the chlopromazine and while still wearing a Fentanyl patch, which Code A understood should not be given to people with kidney infections and people over 65?

Why had Mrs Devine been given Thioridazine, which should not be given to people with kidney disease, and there are known side effects? Also, why was Mrs Devine taking Trimethorprime?

Why were the family not told that their mother was in renal failure and that she had been started on a syringe driver? Code A had not understood that her mother was dying and that morphine was the treatment.

The medical records showed that Mrs Devine had a Creatinine level of 360, and Code A Code A asked how this linked in. She thought this could be because of her mother's lack of fluid intake.

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Why, if Mrs Devine's kidneys were failing, did she continue to be given diuretics to get rid of the fluid in her legs, when she was not receiving enough fluid?

Finally Code A said that her clinical concerns were that the combination of drugs that her mother was taking contributed to her early death. Furthermore, the family was not told what drugs Mrs Devine was taking. Code A realised that her mother would eventually die, but thought that she had been "helped along the way".

Code A concluded that she specifically wanted the "truth" about the events of Friday 19th November.

This concluded Code A evidence.

Dr Barton's Evidence: (Accompanied by Dr Althea Lord)

The panel asked Dr Barton how dementia had been diagnosed and she replied that Mrs Devine had had a CAT scan in October 1999 whilst at the Queen Alexandra Hospital, and this had shown ventricular disease. When asked if she had been aware of any formal diagnosis prior to October 1999, she replied that she wasn't.

Dr Barton said that Mrs Devine was medically stable when she was admitted to the War Memorial hospital, and seemed to improve at first. However, she had deteriorated on the Thursday and Friday before Dr Reid's ward round on 15th November; something which the nursing staff had also mentioned.

Dr Barton said that the notes stated that Dr Reid saw Mrs Devine on 25th October 1999 and found that she also had normachrome anaemia. He saw her again on 1st November when he found her more confused, agitated and demented. Dr Barton said that a patient like this is very difficult to manage on a slow stream ward.

On 11th November, Mrs Devine's urine test – MSU – had showed protein, but no growth. On this date it was also noted that her general and mental state had deteriorated and that her condition was more serious. Dr Barton confirmed that the test she requested had not been written up in the notes.

On Monday 15th November, Dr Reid found Mrs Devine to be even more aggressive and restless. A mid-stream urine test was requested and the results suggested a urinary tract infection. She was given antibiotics and a small dose of Thioridazine for her agitation. She was referred to Dr Rosie Luznat. The notes show that a locum saw Mrs Devine on 18th November and it was agreed that she should be placed on the waiting list for Mulberry ward, which is an elderly mental health ward at Gosport War Memorial Hospital.

On Thursday 18th November, Mrs Devine was not well. Her renal function was deteriorating, her protein was low and she was not eating or drinking well. A subcutaneous fluid infusion was not appropriate, as she would be likely to pull it out. Therefore a Fentanyl skin patch was started instead.

On Friday 19th November the nursing staff found Mrs Devine early in the morning in a distressed state in the corridor. She was given Chlorpromazine, which took four hours to work, and a subcutaneous infusion of Diamorphine and Midazolam were started.

Dr Barton confirmed that there was nothing written in the medical notes on 11th and 12th November, even though antibiotics were started at this time.

The Panel asked Dr Barton to expand on the reason for prescribing the Fenatyl patch for pain management. Dr Barton said that it had been difficult to tell from Mrs Devine's agitated and restless state whether or not she was in pain, and they had limited options for making her comfortable. When Mrs Devine had been found early in the morning on 19th November holding onto bars in the corridor, she had been verbally and physically aggressive. The nursing staff had said that it was difficult to get near to Mrs Devine because she was lashing out at them when they tried to do so.
Mrs Devine had refused oral medications and intramuscular was not appropriate at that time. Dr Barton said she had had previous success with a Fenatyl patch and felt this was the best treatment for Mrs Devine. Although Mrs Devine may not have been strictly in physical pain, she was obviously in mental pain, which can be as distressing and damaging as physical pain. This needed relieving in the same way as physical pain does. Dr Barton confirmed that the patch had been removed before the other drugs took effect, but in any case it is not correct that other drugs should not be given while a patient has a Fenatyl patch. The Fenatyl patch would not have been an added cause of Mrs Devine's condition.

The panel then asked Dr Barton why she had prescribed a syringe driver. Dr Barton explained that that she wanted to avoid frequent intramuscular injections which could hurt and upset Mrs Devine. The driver administered drugs at a slow steady rate with a low disturbance to Mrs Devine.

Dr Barton was then asked why she started Mrs Devine on 40 mg of both Diamorphine and Midazolam. She replied that usually she would start a patient at between 10 and 20 mg, depending on their size and if they did not have opiates in their system. As Mrs Devine had shown resistance to the Fenatyl patch, she felt 40mg would be appropriate.

Dr Barton was asked why Mrs Devine was continued on Frusemide and Amiloride, when she was in fact dying. She said that the Frusemide was stopped on 17th November, and that she received nothing orally after 19th November, when she was thought to be dying.

Dr Barton was also asked whether Mrs Devine had been prescribed sleeping pills. She was prescribed Temazepam on 11th-12th November, because she was probably not sleeping, and the other drugs she was taking would not induce sleep.

Dr Barton confirmed that at the time the syringe driver was set up, she did believe that Mrs Devine was dying, but that she did not attempt to estimate a time scale for her passing. She also confirmed that she had written in the notes that she was happy for the nursing staff to confirm death over the weekend, in order not to have to call out a doctor. This is normal practice and not because she expected Mrs Devine to die that weekend.

Dr Barton was asked why there had not been a post mortem. She replied that with the benefit of hindsight a post mortem would have been useful. However, she had been able to sign the death certificate with what she believed to be the cause of death, and that the family had accepted this.

This concluded Dr Barton's evidence.

Sister Gill Hamblin's Evidence (Accompanied by Dr Althea Lord)

Sister Hamblin had been on duty on the morning of 19th November. She said that Mrs Devine had been up and dressed at 5.30 am and had been trying to pull another patient out of bed. She had been much more agitated than usual and none of the nurses had been able to get near her as she kept pushing them away. She grabbed one nurse by the wrist and pushed her into a bookcase and another she pushed across the room. The nurses then persuaded her to sit in an armchair and they called Dr Barton. The nursing staff were concerned that Mrs Devine would hurt herself and others, as although small she was a strong lady. Dr Barton prescribed 50mg of Chlorpromazine to be given intramuscularly at 8.30 am. It took four nurses to give the injection.

After the injection two nurses stayed with Mrs Devine and walked around the ward with her until she sat in an armchair. By 12.00 she had relaxed sufficiently to be transferred to a bed and was able to take fluid. She eventually settled by 12.30 pm.

Sister Hamblin said that Mrs Devine didn't sleep very much as she wandered around the ward at night. She was therefore probably tired and that is why the sedative was given. It was a problem deciding what to give Mrs Devine, as she would have pulled out any subcutaneous drips. This is why a driver in the shoulder where she couldn't reach it, rather than in the abdomen was agreed on.

Sister Hamblin confirmed that Mrs Devine received 40mg of Diamorphine and 40mg of Milazodam on 19th November. She had had a Fentanyl patch the previous day She said that this is what she needed, as the nursing staff were unable to make her comfortable.

When asked about the drug dosage, Sister Hamblin said that Dr Barton would normally start patients on a dose of 5-10 mg and that 40mg was an unusually high dose. However, she would always query drugs and doses prescribed by a doctor if she were worried and would expect other qualified nursing staff to do the same. She said that on this occasion because of Mrs Devine's condition, she felt the dosage was appropriate. At the time of Mrs Devine's illness medication was written in the care plan. Since this complaint the nurses on the ward now use a Diamorphine infusion and pain control chart.

This concluded Sister Hamblin's evidence.

Staff Nurse Freda Shaw's Evidence: (Accompanied by Dr Althea Lord.)

The panel asked Staff Nurse Shaw about the procedure for interpreting variable prescription doses. She said that as there was no doctor on duty at weekends, nurses were given a range so that they could increase doses if they thought it necessary. Each patient was discussed during the handover of duty. If a patient was particularly distressed or in pain or discomfort, this could indicate an increase in dosage when the next medication was given. Staff Nurse Shaw said she had personally made dosage decisions when a doctor had not been available.

Staff Nurse Shaw said that when she came on duty on 19th November at 2.15pm, Mrs Devine was sedated and sleeping and a subcutaneous infusion had been given.

The Panel asked Staff Nurse Shaw if she would question drug or dose prescriptions with a doctor. She said she would do this if necessary and also with a ward colleague. The Panel also asked about fluid charts. Staff Nurse Shaw said that they are used when possible, but nurses don't always fill them in. This is because it is difficult when patients are mobile, can go to the toilet unaided and help themselves to drinks, to monitor fluid intake and output accurately.

Staff Nurse Shaw finally said that since this complaint, nursing staff document much more in the patient's records and that at the end of their shifts spend time writing up notes.

This concluded Staff Nurse Freda Shaw's evidence.

Further Evidence from Dr Althea Lord.

Dr Lord asked to clarify some points to the Panel.

It is policy that notes from Portsmouth hospitals follow patients to Community hospitals. However, psychiatric notes are held separately and community hospitals only receive a summary.
The years 1998 and 1999 were a time of considerable change for Dryad ward. It went from being a ward, which provided continuing care for patients until they died, to providing 4-6 weeks respite care for patients until they were discharged. This meant that the culture of the ward changed from one, which was quite stable, to one with a high turnover of patients with complicated medical problems, more ward traumas and a lot more pathology. She said that an average continuing care ward received 50 patients a year; in 1998/1999, Dryad ward received 255 patients. Without the staff realising, the workload increased, and with hindsight more medical and nursing input was needed.

Dr Lord said that as the ward was so busy, staff found it particularly difficult to deal with patients like Mrs Devine who had both physical and psychological problems. She added that when patients deteriorated as quickly as had Mrs Devine, the medical and nursing staff were sometimes left feeling that they had not been able to maintain enough contact with the family.

This concluded Dr Lord's additional evidence.

FINDINGS

Term of Reference 1: The adequacy of the communication between the Trust and Code A Code A

The panel found that:

There is no evidence, either oral or written that the seriousness of Mrs Devine's condition and her rapid deterioration between 15th and 19th November 1999, was conveyed to Code A or to Code A

There is no written evidence to show that the seriousness of Mrs Devine's condition on the morning of 19th November was effectively conveyed to the most appropriate family member.

There is no written evidence which demonstrates that Mrs Devine's medical treatments were discussed with the family.

The Panel understands that the nursing staff acknowledges that there were insufficient recordings of the discussions with family members and that this has now been rectified. All discussions, both formal and informal are now recorded.

There was inadequate communication between the nursing and medical staff and there is no evidence of a decision being taken about who would tell Mrs Devine's family of the seriousness of her condition. There was no process in place for the staff to agree who should discuss issues with the family. Assumptions were made about whose responsibility it was, and thus no one did it.

It is clear from the admission records that Code A was named as the next of kin, and Code A was named as the contact. However, as Code A was able to visit more often, he had more contact with the nursing staff. Consequently, although Code A Code A was named as next of kin, she was not the first person contacted on the morning of 19th November.

The communication between the Queen Alexandra Hospital and the Gosport War Memorial hospital about Mrs Devine's condition was inadequate in this case. Although the notes were forwarded, a telephone call would have been helpful.

It is unfortunate that the Trust did not hold an early meeting to answer Code A questions about her mother's care and medical treatment. A letter is not always the best way of resolving a difficult and distressing situation, and a meeting could have given answers in layman's terms. The Panel acknowledges that it is common practice to call an early face to face meeting; and it is very unfortunate that this was not done.

The Panel acknowledges that there was a willingness in the Trust to put things right and that they have worked hard to do so. As a result their practice has improved

Term of Reference 2: The appropriateness of the clinical response to Mrs Devine's medical condition.

The panel found that:

The staff at Gosport War Memorial Hospital was not aware of the family's concerns about Mrs Devine's fluid intake while she was a patient at the Queen Alexandra Hospital, despite the fact that her notes from the Queen Alexandra Hospital were available.

The dosage of drugs given to Mrs Devine was appropriate for an elderly patient in her condition. Although 40 mg of Diamorphine and 40 mg of Midazolam are quite high doses, it was necessary to give this amount because of Mrs Devine's extreme agitation and lack of response to previous medication.

The clinical response to Mrs Devine's care was appropriate, although discussion with the family concerning the best medication for her would have made the situation easier for the family.

RECOMMENDATIONS

1. The seriousness and poor prognosis of acute confusion should be conveyed to the relatives. This is because although acute confusion of a frail elderly person can be as dangerous as an acute physical condition, this is not always understood.

2. The management of patients can be individual and complex. Therefore this should be discussed with the family at the earliest opportunity, so that their expectations and feelings can be taken into account.

3. The Trust should review their admission document, so that it is quite clear to staff, relatives and patients who should be informed of any developments or change in the condition of the patient.

4. Clear guidelines for nursing staff should be set up so that:

a. All conversations between relatives and professionals are documented.
b. A member of the nursing staff should be nominated to be responsible for telling the relatives if there is any change in the patients' condition.

1

SIGNED

Jane Quincey

Code A

Date 14th August 2001

Richard Tickner

Code A

Date 20 August 2001

David Lee

Code A

Date 15th August 2001

Report regarding the late Mrs. Elsie Devine ex patient on Dryad Ward Gosport War Memorial Hospital Portsmouth NHS Trust.

Complainant: Code A
Code A **of Mrs. Devine**
following an independent review of this case
12th June 2001

by Mrs. Bridie Castle
Clinical Services Manager
BHB Community Healthcare NHS Trust

BACKGROUND

Mrs Devine was transferred to Drayd ward on the 19th October 1999 following her admission to Queen Alexandra Hospital due to acute confusion following a Urinary Tract Infection. She was transferred to Dryad ward because at that time Code A with whom she lived was unable to have her back home. On her admission her diagnosis was Chronic Renal Failure, Dementia and hypothyroidism.

From the 9th November 1999 the first biochemical deterioration was noticed. From then onwards her condition was deteriorating significantly. On the 18th November 1999 she was commenced on a Fentanyl patch 25mgs. On the 19th November 1999 she became extremely aggressive. 50mgs of chlorpromazine was administered intramuscularly. The transdermal patch was discontinued and a syringe driver was set up with 40mgs of Diamorphine and 40mgs of Midazolam to be delivered subcutaneously over a period of 24 hours.

Mrs. Devine's Code A had been visiting his mother daily for the past four days. Code A of Mrs. Devine has stated that she was not aware that her mother's condition had been deteriorating. On the 19th November 1999, Dr Barton who has been looking after Mrs Devine met with Code A Code A Mrs Devine's Code A

Mrs Devine sadly passed away on the 21st November 1999.

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TERMS OF REFERENCE

The Convenor has recommended that the terms for reference for the review should be as follows:

1. To consider the adequacy of the communications between the Trust and Code A

2. To consider the appropriateness of the clinical response to Mrs Devine's medical condition.

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COMMUNICATION:

The Trust has admitted that they did not communicate effectively with Code A

The Trust has apologised several times for this problem. Representatives of the Trust has met with the family of Mrs Devine to explore their concerns and has responded in writing acknowledging their failure in communication.

I cannot see how it will help the family or the Trust to explore this issue all over again.

I am satisfied that the Trust's investigation with regards to this issue was thorough and fair.

CLINICAL RESPONSE:

- Fluid Administration

It is noted that Mrs Devine's first sign of deterioration in her condition began from the 9th November 1999 and from then onwards followed further deterioration in her general condition. She became increasingly confused and agitated. It is difficult to manage patients who suffer from these clinical features.

It is unlikely that Mrs Devine would have kept an intravenous or subcutaneous fluid intervention. It is also unlikely that she would have tolerated a naso gastric tube. The Doctor has made a decision on the basis of Mrs Devine's general condition. However, such a decision is best made in consultation with the family and this did not happen.

The Trust has admitted that their communication with the family was problematic. The Trust has investigated this issue thoroughly and responded in writing to Code A I am satisfied that the investigation was fair and the Trust has apologised.

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- Treatment and Death certification:

The condition of the patient would dictate the treatment to be administered. A list of drugs used for Mrs Devine was declared to Code A

It is noted that time and again the complainant made allegation 'decision to terminate her mother's life'. This allegation is inappropriate and the Trust has addressed this issue and made it clear with regards to its position to euthanasia.

Dr Judith Stevens, consultant Nephrologist had diagnosed Mrs Devine as suffering from chronic glomerulonephritis. Dr David Jarrett, the lead consultant Geriatrician mentioned that this condition does not necessarily need a biopsy to be diagnosed.

The Trust has looked into these issues in a thorough manner and has taken reasonable steps to provide adequate answers to Code A Code A In view of the certification of death, there does not seem to be any dispute that Mrs Devine died of renal failure and the coroner's request for a precise diagnosis was given as chronic glomerulonephritis, which Mrs Devine had been suffering from.

CONCLUSION

Following the independent review on the 22nd May 2001 and having listened carefully to Code A expressing their very sincere concerns about the care Mrs. Devine received in the last stages of her life on Dryad Ward. Also having listened to the medical and nursing staff involved in the clinical care of the late Drs. Devine on Friday 19th November 1999 my conclusions are as follows:

The drugs given to Mrs. Devine were not contraindicated either by using in the combinations stated or with her medical condition.

On the morning of Friday 19th November 1999, Mrs. Devine was wandering, agitated, acutely confused, disoriented and frightened. In a frail, elderly person this is a very serious medical condition and may be as dangerous as a heart attack but it does not form part of the public perception of a serious or life threatening illness. For this reason, she clearly required a large dose of strong medication, as she was a danger to both herself and people around her. The fact that she was still responding to Code A (by squeezing her hand at the sound of her voice) that day and the next day suggested the medications she was given was reasonable and was in the best interest of the patient to keep her comfortable.

In conclusion, the Panel found that the drugs, doses and devices used to make Mrs. Devine comfortable on 19th November were an appropriate and necessary response to an urgent medical situation.

However, it is important to stress that many valuable lessons have been learned from this complaint and appropriate action plans have been devised for the staff of Dryad ward therefore enhancing a higher quality and standard of nursing practice for the patients who come under their care.

The Trust has admitted its failure to communicate with the relatives effectively. All other issues raised by Code A have been investigated thoroughly by the Trust. Code A allegation of 'the decision to terminate her mother's life' is inappropriate.

Mrs. Devine/BC/maj

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Independent Medical Report
on the appropriateness of the clinical response to the
Late Mrs Devine's medical condition while at
Gosport War Memorial Hospital in November 1999

Mrs Devine was transferred to Gosport War Memorial Hospital from Queen Alexandra Hospital, Portsmouth. She had been admitted to the latter with acute confusion and a Urinary Tract Infection on a background of mild memory impairment. She also had mild chronic renal failure.

Mrs Devine became very confused, verbally aggressive and restless from the 15th November 1999 and at times required four nurses to look after her. Acute confusion in frail elderly people is a serious medical emergency, whatever the underlying cause, and can lead to death. The management of a person with acute confusion should be to reduce the confusion and agitation by non pharmacological and pharmacological (drugs) means in order to avoid the patient causing themselves or others harm, look for an underlying cause for the confusion, if appropriate and then treat the underlying cause for the confusion, if appropriate. Mrs Devine received the following drugs to manage her confusional state:

1. THIORIDAZINE (a major tranquilliser) 10 mg by mouth once or twice a day from the 11th November to the 17th November 1999.

2. She had a FENTANYL PATCH 25 mcg started on the 18th November removed lunchtime 19th November 1999. . (Fentanyl is a synthetic strong opiate analgesic similar to Morphine. A 25 mcg patch is used once every three days and is equivalent to a 24 hour dose of 90 mg of Morphine orally).

3. CHLORPROMAZINE intramuscular injection 50 mg 8.30 am on 19th November 1999 (Chlorpromazine is a major tranquilliser).

4. A continuous subcutaneous infusion of DIAMORPHINE 40 mg and MIDAZOLAM 40 mg was started at 9.25 am on the morning of the 19th November 1999. (Diamorphine is a strong opiate analgesic and Midazolam is a drug for sedation). 40 mg of subcutaneous Diamorphine over 24 hours is equivalent to approximately 120 mg of oral morphine over 24 hours.

At the time of administration (late 1999) all these drugs, and the doses thereof, in my view were acceptable given the clinicial situation. None of them were contraindicated in elderly people or elderly people with mild chronic renal failure.

It is clear from speaking to Dr. Barton, Sister Hamblin and Staff Nurse Shaw on the 22nd May 2001, that despite the Thioridazine, Fentanyl and Chlorpromazine Mrs Devine remained extremely agitated and confused and therefore the decision to start a

Continued.. /2

Independent Medical Report Mrs Devine Continued..

subcutaneous infusion of Diamorphine and Midazolam was appropriate. Considering Mrs Devine's extreme agitation and the lack of response to the drugs prior to starting the subcutaneous infusion a dose of 40 mg of Diamorphine and 40 mg Midázolam over 24 hours was appropriate. Mrs Devine was comfortable following starting the subcutaneous infusion until she died some forty eight hours later. Following the interview with Sister Hamblin and Staff Nurse Shaw, both of whom have extensive experience in the nursing care of frail elderly patients I am confident that they would have queried any drugs or doses of drugs should they have felt uncomfortable administering them.

I feel that if the seriousness of Mrs Devine's condition and the management of that condition from the 15th November 1999 had been adequately conveyed to Code A she would not have needed to complain about the care provided for her late Mother.

Code A

Dr. Andrew White FRCP
Consultant Physician
Department of Medicine for the Elderly

OPERATION ROCHESTER

BACKGROUND

NOTE

Overview

1. This note accompanies our ten individual advices in respect of an investigation conducted by the Hampshire Constabulary known as Operation Rochester.

2. The investigation concerned the deaths of a number of elderly patients at the Gosport War Memorial Hospital ('GWMH'), in Hampshire. All of the deaths occurred in the 1990s.

3. The ten cases on which we have been asked to advise are as follows (in the order in which we were provided with papers):

(1) Elsie Devine
(2) Code A
(3) Elsie Lavender
(4) Ruby Lake
(5) Arthur Cunningham
(6) Enid Spurgin
(7) Robert Wilson
(8) Geoffrey Packman
(9) Helena Service
(10) Sheila Gregory.

4. In particular, we have been asked to consider whether, in respect of the above mentioned cases, the evidence which has been gathered by the Hampshire Constabulary discloses any offences of gross negligence manslaughter.

5. The principal subject of the police investigation was Dr Jane Barton, now aged 57, a local General Practitioner, who worked on a part time basis at GWMH as a Clinical Assistant. In respect of all of the above cases, Dr Barton was the doctor who cared for the patient on a day to day basis. In that capacity, she was responsible for conducting clinical assessments and prescribing medication.

6. The investigation also examined the conduct of Dr Barton's colleagues, in particular Dr Richard Reid, now aged 55, a Consultant Geriatrician, who was involved in the cases of Mr Packman and Mrs Spurgin.

The Police Investigation

7. The investigation conducted by Hampshire Constabulary into events at GWMH has been extremely thorough. We have been provided with an extensive volume of material in respect of each case. This material has included medical records, reports from medical experts, interviews with Dr Barton and Dr Reid, and witness statements taken from the families of the deceased and the medical staff at GWMH and other hospitals.

8. We should say that the investigation, which has been carried out over a number of years, has been exemplary. We are satisfied that all the relevant material relating to events at GWMH has been identified, obtained and, where necessary, subjected to the scrutiny of independent medical experts.

9. We have been greatly assisted by the way in which the investigation has been conducted. In coming to our conclusions, we have, of course, had regard to all of the material which the police have obtained.

The Experts

10. The evidence in respect of each of the ten cases has been reviewed by two independent medical experts: Dr Andrew Wilcock, a Reader in Palliative Medicine and Medical Oncology at the University of Nottingham and an Honorary Consultant Physician of the Nottingham City Hospital NHS Trust, and Dr Robert Black, a Consultant Physician in Geriatric Medicine at Queen Mary's Hospital in Kent, and an Associate Member of the General Medical Council.

11. In summary, two principal issues of concern have been identified. The first involves the inappropriate and excessive administration of medication, most notably diamorphine by the medical staff at GWMH. The second involves the failure of the medical staff to carry out adequate clinical assessments of patients.

12. Where it has been necessary to obtain further specialist opinions, additional medical reports have been provided by practitioners with the relevant expertise.

13. It is important to note that, as is evident from the content of our advices, there have been a number of significant differences of opinion between Dr Wilcock and Dr Black, and in fact the other experts who have prepared reports, in respect of the central issues identified by the investigation.

Legal Analysis

14. In considering each of the above cases, we have set out a summary of the relevant events, the significant conclusions of the various experts, and a legal analysis. Having regard to those matters, we have then analysed whether the evidence reveals the commission of the offence of gross negligence manslaughter.

15. In conducting this analysis, we have of course had regard to the evidential test in the Code for Crown Prosecutors, and in particular paragraphs 5.2 and 5.3:

> '*5.2 Crown Prosecutors must be satisfied that there is enough evidence to provide a "realistic prospect of conviction" against each defendant on each charge. They must consider what the defence case may be, and how that is likely to affect the prosecution case.*'

5.3 *A realistic prospect of conviction is an objective test. It means that a jury or bench of magistrates or judge hearing a case alone, properly directed in accordance with the law, is more likely than not to convict the defendant of the charge alleged. This is a separate test from the one that the criminal courts themselves must apply. A court should only convict if satisfied so that it is sure of a defendant's guilt.'*

David Perry QC

Louis Mably

27 October 2006

6 King's Bench Walk
London
EC4Y 7DR