Statement number: S329U

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STATEMENT PRINT

Surname: BLACK

Forenames: DAVID ANDREW

Age: 50 Date of Birth: Code A

Address: Code A Postcode: Code A

Occupation: CONSULTANT PHYSICIAN GERIATRIC MEDICINE

Telephone No.: Code A

Statement Date: 09/05/2006

Appearance Code: Height: Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

SUMMARY OF CONCLUSIONS

Norma WINDSOR , at the time of her death, was a 69 year old lady who suffered from ischaemic heart disease with a proven myocardial infarction, follicular lymphoma and chronic lymphatic leukaemia, problems with her gastrointestinal tract and finally a massive pleural effusion developing shortly before her death.

Her GP admits her to the Gosport War Memorial Hospital on the 24th April 2000 where a clinical examination is either not undertaken or not recorded. She is recorded as being persistently hypotensive and unwell by the nursing staff over a number of days until her final admission on 5th May to St. Mary's Hospital. At that time she is very seriously ill and despite active and appropriate intensive care dies shortly after. A major problem in assessing this case is the poor documentation in

Gosport Hospital, in particular in the medical notes making a retrospective assessment of her progress difficult. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patients and drugs or other treatments provided". The lack of documentation of examination possibly undertaken at the Gosport War Memorial Hospital or accurate information on changes in her clinical status represents poor clinical practice. However, I believe her death was by natural causes.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1 Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case?

2.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

3. CURRICULUM VITAE

Name Professor David Andrew Black

Address **Code A**

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Telephone	Code A
DOB	Code A
Place	WINDSOR, England.
GMC	Full registration. No Code A
Defence Union	Medical Defence Union. No: Code A

EDUCATION	Leighton Park School, Reading, Berks.	1969-1973
	St John's College, Cambridge University.	1974-1977
	St Thomas' Hospital, London SE1	1977-1980

DEGREES AND QUALIFICATIONS

BA, Cambridge University	1977
(Upper Second in Medical Sciences)	
MB BChir, Cambridge University	1980
MA, Cambridge University	1981
MRCP (UK)	1983
Accreditation in General (internal) Medicine	
and Geriatric Medicine	1989
FRCP	1994
MBA (Distinction) University of Hull.	1997
Certificate in Teaching	2001
NHS/INSEAD Clinical strategists program	2003

SPECIALIST SOCIETIES

British Geriatrics Society

British Society of Gastroenterology

British Association of Medical Managers

PRESENT POST

Dean Director of Postgraduate Medical and Dental Education

Kent, Surrey and Sussex Deanery.	2004-present
Consultant Physician (Geriatric Medicine)	1987-present
Queen Mary's Hospital, Sidcup, Kent.	
Associate member General Medical Council	2002-present

PREVIOUS POSTS

Associate Dean.	
London Deanery.	2004
Medical Director (part time)	1997-2003
Queen Mary's Hospital	
Operations Manager (part time)	1996-1997
Queen Mary's Hospital, Sidcup, Kent	
Senior Registrar in General and Geriatric Medicine	
Guy's Hospital London and St Helen's Hospital	
Hastings.	1985-1987
Registrar in General Medicine and Gastroenterology	
St Thomas' Hospital, London.	1984-1985
Registrar in General Medicine	
Medway Hospital, Gillingham, Kent	1983-1984
SHO rotation in General Medicine	
Kent & Canterbury Hospital, Canterbury	1982-1983
SHO in General Medicine	
Kent & Sussex Hospital, Tunbridge Wells	1981-1982
House Physician, St Thomas' Hospital	1981
House Surgeon, St Mary's Portsmouth	1980

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DA Black, IM O'Brien

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The impact of the NSF on everyday Clinical Care. Conference on Clinical governance in elderly care . RCP May 2001

The Geriatricians view of the NSF. BGS Autumn Meeting 2001

The Organisation of Stroke Care. Physicians and managers working together to develop services. Professional training and clinical governance in geriatric medicine. All at Argentinean Gerontological Society 50th Anniversary meeting. Nov 2001

The future of Geriatric Medicine in the UK. Workshop: American Geriatrics Society May 2002

Liberating Front Line Leaders. Workshop: BAMM Annual Meeting June 2002

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Medical Aspects of Intermediate Care. London Conference on building intermediate care services for the future. Sept 2002

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4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Norma WINDSOR (BJC/560 3R/A)

[2] Operation Rochester Briefing Document Criminal Investigation Summary.

[3] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[4] Commission for Health Improvement Investigation Report on
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5. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence).

5.1 Norma WINDSOR was a 69 year old lady at the time of her death on 7th May 2000 in the Intensive Care Unit of Portsmouth Hospitals NHS Trust.

5.2 Mrs WINDSOR had a history going back to an operation in 1979 of vagotomy and pyloroplasty for duodenal ulcer disease. In 1998 she was noted to have an abnormal blood count with lymphadenopathy, was referred for a haematological opinion and an original diagnosis of chronic lymphatic leukaemia (CLL) was made (363). Shortly after that she was treated with Chlorambucil and she came out in a skin rash (271). Meanwhile in 1998 she had been admitted to hospital acutely with a myocardial infarction (452), had a positive exercise test (157) and was referred for an angiogram in May 1999 (408). In July she was added to the waiting list for the angiogram (406).

5.3 In 1999 she saw a Dermatologist for her skin rash, it was not clear if this was urticaria or bullers pemphigoid (91). She was eventually treated with steroids and the rash improved over time (316) (364). In the meantime she had a bone marrow which confirmed chronic lymphatic leukaemia with lymph node involvement (129).

5.4 In 2000 a cardiologist decided that despite her severe coronary artery disease, she was not fit for surgery because of "a high chance of thrombosis and stroke". In 2000 she is diagnosed to have a post nasal drip (61).

5.5 In early 2000 she was seen in the Gastrointestinal (GI) clinic having been referred from the haematologist because of a fall in haemoglobin. The notes in the clinic are missing, at first she is thought to be referred because of diarrhoea related to previous GI surgery (233-4). However when the notes re-appear it is decided to do further investigations for possible blood loss and an upper GI endoscopy and colonoscopy are booked (328). Around the same time, she has further haematological investigation and a second bone marrow (787) and she is now thought to have a follicular lymphoma rather than pure chronic lymphatic leukaemia. A decision is made to treat her again with both Prednisolone and Chlorambucil (336) as it was thought that her skin rash was not related to previous Chlorambucil. In March 2000 she is on Prednisolone and Chlorambucil and is noted to be significantly more cheerful (334). A review of her steroid usage shows that she receives several months of steroids up to December 1999 for her skin rash (372). She is off the steroids by February

and is discharged by dermatology (338). Her steroids are then restarted by the haematologists and she is feeling very much better when she is in the clinic 2 weeks later. On the 19th April she is on Prednisolone 10 mgs daily and Chlorambucil 5 mgs. A decision is made to suspend this treatment for the moment (508). Finally on the 18th April the booked upper and lower gastro intestinal investigations are performed (896-875). Her blood pressure is 135/70 prior to the investigations and the two documented blood pressures after are 85/48 and 100/60. She is also noted to be breathless at rest but discharged home. The investigations are reported as showing no significant abnormality, apart from a hiatus hernia (622,600,624). Finally her creatinine on 22nd March was normal at 100 micro mls per litre (632).

5.6 She is admitted into a GP bed by her GP Dr KNAPMAN on 27th April and the medical notes (514) state that she has weakness, exhaustion and depression and a recent bout of diarrhoea and vomiting (514). Her previous past medical history is noted as is her medication of Citalopram, Isosorbide Mononitrate, Aspirin, Nitrolingual Spray, Quinapril and Atenolol. No examination is recorded and the plan is stated to be two weeks to help regain her usual state of health.

5.7 The nursing notes record on 28th April (15) that she is seen by the GP Dr KNAPMAN and her blood pressure is to be monitored. However, there are no medical notes that day and no further medical notes to the 2nd May (514). The nursing notes on 29th May document a blood pressure of 100/60 and that there had been diarrhoea 3 times that morning. On 30th (15) she continued to have offensive stools, feeling unwell, cold, clammy to the touch, feels hot. She was light headed and standing blood pressure of 90/50, a pulse of 68 and temperature of 36.

5.8 On the 1st May the nursing cardex again (15) records a low blood pressure and a telephone conversation with a Dr PEVES who says to only give half the normal dose of Atenolol (50 mgs). During the night she is tearful. It appears that over this period of time she had been taking minimal food intake (30).

5.9 On the 2nd May she is seen by Dr KNAPMAN who records her low blood pressure at 95/60, stops the Atenolol and prescribes Co-proxamol for back ache. Again no examination is recorded, if it has been undertaken, apart from the blood pressure.

5.10 A different doctor who I believe to be Dr GREEN the Consultant Haematologist comes to see her on 3rd May; she had been due in outpatients. He finds her miserable, not eating, says that she is vomiting. This is not observed by the nurses but he wonders if she is depressed and he makes a physiotherapy referral. The nursing notes of 4th May (15-16) show that she is retching, her blood pressure is lower at 80/60 and she is asking for her husband. The family are concerned during the day and she has further diarrhoea during the night.

5.11 On 5th May she is unwell at 1030 am (16), cold and clammy, blood pressure unrecordable, weak and thready pulse, her GP is called and comes at 1150 am (16). He records that her blood pressure is low at between 80-90/40-50 and asks for her to be transferred to St. Mary's Hospital. However it is not until 1739 that a bed becomes available (16).

5.12 Her drug chart from the admission of the 27th April (20) (49-53) confirms that she was receiving Quinapril, Isosorbide Mononitrate, Ranitidine, Atenolol (stopped on 1st May) Aspirin, Co-proxamol and Buccastem.

5.13 She arrives at St Mary's Hospital at 1845 is cold, clammy and dyspnoeic. The on-call medical team is asked to see her urgently at 1930 (517-524), the examination finds that she is in extremis, pulse 120, no recordable blood pressure and signs of a large right pleural effusion. A chest x-ray confirms a massive right pleural effusion. The diagnosis is thought to be a combination of septic shock and a large pleural effusion, she is in acute renal failure with a urea of 37.3 and a creatinine of 462 (525). She had a normal creatinine of 77 on 26th April (525). She is severely acidotic at 7.17 (525) she passes a large mucus stool and is resuscitated and finally a decision is made for transfer to ITU (531). An emergency investigation of the pleural effusion is non diagnostic (546). She receives inotropes, steroids, diuretics (562) and the chest is drained (581).

5.14 Although referred at 2.30 am the emergency ambulance does not pick her up until 4.30 am (0430) and she arrives in the ITU at 5 am (0500) (136).

5.15 During the course of 6th May she is treated with very intensive medical treatment and at first there is a small improvement in cardiac output. However, she deteriorates later in the day, the family are spoken to at 1030 (544) and she is then put on a ventilator for respiratory distress.

5.16 She receives three very small doses of morphine before her death of 1 mg, ½ mg and ½ mg as sedation after intubation (563). She finally dies of cardiogenic shock at 0255 on 7th May. Her death certificate says:

1a: Cardiogenic Shock
1b: Ischaemic Heart Disease
2 : Chronic Lymphatic Leukaemia

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Norma WINDSOR. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Norma WINDSOR, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2 Norma WINDSOR was a 69 year old lady at the time of her death who had a considerable number of problems in the two years up until her death. She is first diagnosed as having chronic lymphatic leukaemia in 1998 which often has quite a good prognosis with an indolent course, although complications such as lymphoma, infections and bone marrow failure can all complicate management. However, in 1998 she has a significant myocardial infarction and is found to have severe four vessel disease requiring coronary angiography and surgery. Unfortunately because of her haematological problems, the risks of having surgery are thought to be too high versus the risks of not having surgery. Her problems are also complicated in 1999 by a blistering skin eruption which does eventually settle with steroids.

6.3 Alongside this she has had problems with her gastrointestinal tract including diarrhoea which might be related to her previous GI surgery but with a falling haemoglobin a decision is made to do further (appropriate) investigations. In January 2000 after further haematological investigations, it is thought that she really has the follicular lymphoma with features of CLL rather than pure CLL. A

decision to restart her on the Prednisolone and Chlorambucil is made. At first she seems to make good progress between February and March, although by 19th March (508) when seen in the Haematology Clinic things are not right again. She is getting headaches all the time, she feels sick all the time and cannot eat. She then has her gastrointestinal investigations on the 18th April after which she is documented to be both breathless and hypotensive. This is thought to have been her normal state, so she is discharged home. Finally her GP admits her to hospital in a GP bed on 27th April.

6.4 If an examination is undertaken by Dr KNAPMAN on 27th or 28th when he saw her, it is not recorded in the notes. When eventually admitted as an emergency on 5th May she is found to have had a very large pleural effusion. It seems unlikely that any competent clinician would have missed this diagnosis if it had been both present on the 27th April and if the patient had been examined.

It seems to me likely it was present on 27th April as she was breathless and unwell and documented to be hypotensive from the moment of her admission. It seems to me that Dr KNAPMAN did not put himself in a position to make an early diagnosis of this lady's problems.

6.5 Mrs WINDSOR's continued ill health on the ward is documented in the nursing notes from 28th April - 5th May (15-16). This includes her having retching and diarrhoea. The nursing cardex does record minimal food intake (30).

6.6 Finally it is realised on 5th May that she is very seriously ill, although even then, there does appear to be no great haste to admit her to hospital. The GP sees her at 1145 and she is finally admitted to hospital and gets to St Mary's at 1845.

6.7 At this stage she is desperately unwell, in acute renal failure in hypovolaemic and cardiogenic shock and despite intensive and appropriate therapy she dies early on the morning of 7th May.

6.8 There is no doubt that she died of natural causes. Cardiogenic shock on the background of ischaemic heart disease and chronic lymphatic lymphoma, all appear appropriately on the death certificate. However the reason that she deteriorated after being seen in March in the Haematology Clinic when she was feeling much better, and her admission on 27th April with a massive pleural

effusion is totally unclear. Without a post mortem it is pure supposition as to the pathological processes.

7. OPINION

7.1 Norma WINDSOR at the time of her death was a 69 year old lady who suffered from ischaemic heart disease with a proven myocardial infarction, follicular lymphoma and chronic lymphatic leukaemia, problems with her gastrointestinal symptom and finally a massive pleural effusion developing shortly before her death.

7.2 Her GP admits her to the Gosport War Memorial Hospital on the 27th April 2000 where a clinical examination is either not undertaken or not recorded. She is recorded as being persistently hypotensive and unwell by the nursing staff over a number of days until her final admission on 5th May to St. Mary's Hospital. At that time she is very seriously ill and despite active and appropriate intensive care dies shortly after. A major problem in assessing this case is the poor documentation in Gosport Hospital, in particular in the medical notes making a retrospective assessment of her progress difficult. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patients and drugs or other treatments provided". The lack of documentation of examination possibly undertaken at the Gosport War Memorial Hospital or accurate information on changes in her clinical status represents poor clinical practice. However, I believe her death was by natural causes.

8 LITERATURE/REFERENCES

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3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.

4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.

5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129

6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.

9. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.

2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.

3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.

4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.

5. Wherever I have no personal knowledge, I have indicated the source of factual information.

6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.

8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

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10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signed: D BLACK

Signature witnessed by: