SUMMARY OF CONCLUSIONS

Mrs Elsie Lavender was an 84 year old lady admitted to the Haslar Hospital on 5th February 1996 following a fall and then transferred to Gosport War Memorial Hospital on 26th February 1996. She had long-standing problems with diabetes, a peripheral neuropathy, poor eyesight and registered blind. After admission she is found to be doubly incontinent, totally dependent with a probable quadriplegia, constant pains down her shoulders and arms and is found to have serious and unexplained abnormalities in various blood tests.

In the Gosport War Memorial Hospital, she fails to make any improvement, deteriorates with a bed sore that eventually becomes black and blistered. She receives pain relief and palliation for her deteriorating physical condition including subcutaneous Diamorphine and Midazolam and dies on 6th March 1996.

The expert opinion is:

> Mrs Elsie Lavender provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.
>
> The major problems in this lady's case are the apparent lack of medical assessment and the lack of documentation. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical care must include – taking suitable and prompt action necessary"... "referring the patient to another practitioner, when indicated"..... "in providing care you must – recognise and work within the limits of your professional competence...."..... "prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs". The major gaps in the written notes, as documented in my report, represent poor clinical practice to the standards set by the General Medical Council. In this case, I believe that the overall episode of medical care provided between Haslar and Gosport Hospital was negligent in that an inadequate assessment and diagnosis of this lady's conditions was made. If it was, it was never recorded. The lack of any examination at Gosport, the lack of any comment on the abnormal blood test make it impossible to decide if the care she subsequently received was sub optimal, negligent or criminally culpable. It seems likely to me that she had several serious illnesses, which were probably unlikely to be reversible, and therefore, she was entering the terminal phase of her life at the point of admission to Gosport Hospital.

However, without proper assessment or documentation this is impossible to prove either way.

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

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

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Address	Code A
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DOB	23rd March 1956
Place	Windsor, England.
Marital status	Married with 2 children.
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 Marys 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 Marys 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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4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Elsie Lavender

[2] Full set of medical records of Elsie Lavender on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

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

[5] Hampshire Constabulary Summary of Care of Elsie Lavender

[6] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).

[7] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

[8] Medical report prepared by Dr James Gillespie

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

5.1. The Gosport notes record that Mrs Lavender was a insulin dependent diabetes mellitus since the1940's (53). She is referred to the Diabetic Service because of more troublesome hypoglycaemia in 1984 (65). In 1985 she is known to have a mild peripheral neuropathy (73). Her weight in 1988 is 85 kgs (73) and in 1987 her weight is 89 kgs (77). By 1988 she has very poor eyesight (47M). She is also documented to have high blood pressure in 1986 (29).

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

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

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

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

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

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

Dr Lord records "probable brain stem CVA"..... "she has had her neck x-rayed, I assume it was normal" (H167).
I was unable to find any x-ray request recorded in the notes for a cervical spine, nor any reports of an x-ray of a cervical spine or indeed reports on the x-rays that were recorded as being requested (i.e. the skull and shoulder x-rays).

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

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

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

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

5.5. Investigation tests reported on 23rd February 1996 find that she has a normal haemoglobin of 12.9 with a slightly reduced mean cell volume of 75.6 and gross thrombocytopenia (a low platelet count) of 36,000 (57M). The report on the film (58M) shows that this is a highly abnormal full blood count with distorted red blood cells and polychromasia. A repeat blood film is suggested. This is repeated on 27th February (57M) and thrombocytopenia is now even lower at 22,000. The urea is normal at 7.1 on 23rd February but has increased and is abnormal at 14.6 on 27th February (187). Her alkaline phosphatase is 572 (over 5 times the upper limit of normal) her albumin is low at 32 (187). No comment is made on any of these significantly abnormal blood tests in any of the Gosport notes, though the low platelet count is noted in nursing summary on 23rd February (151). The platelet count had been normal at 161 on admission to the Haslar (H17).

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

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

happy for us just to make Mrs Lavender comfortable". "Syringe driver explained".

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

5.9. The nursing care plan first mentions significant pain on 27th February (95) and describes pain on most days up until 5th March where the pain is uncontrolled and the patient is distressed, at which point a syringe driver is commenced (97). On 6th March pain is controlled.

5.10. **Drug management in Gosport.** I shall concentrate on the use of analgesia. Throughout the patient received appropriate doses of insulin, Co-amilofruse (a diuretic), Digoxin, Iron and steroid inhalers up unto the last twelve hours. She also received a course of Trimethoprim (an antibiotic) between 23rd and 27th February.

5.11. Morphine slow release (MST) (67M)was started at 10 mgs bd on the 24th February and is given until 26th February when MST 20 mgs bd (145)is started, this continues until the 3rd March. On 4th March Oramorph 30 mgs bd is written up and given during 4th March (139). On 5th March Diamorphine is written up 100 – 200 mgs subcut in 24 hours (137). 100 mgs is prescribed and started at 08.30 in the morning, together with Midazolam 40 mgs (137) (61M). Midazolam had been written up at 40 – 80 mgs subcut in 24 hours. Diamorphine and Midazolam pump is filled at 09.45 hours (61M) on 6th March together with another 40 mgs of Midazolam.

5.12. When admitted into hospital Dihydrocodeine PRN for pain had been written up together Hyoscine. Diamorphine 80 – 160 mgs subcut in 24 hours was written up on 26th February together with Midazolam 40 – 80 mgs in 24 hours subcut, but these drugs were never prescribed (141).

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

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 Elsie Lavender. Also whether there were any actions or admissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Mrs Lavender, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2. In particular I have discussed:
a) Her medical conditions
b) Whether she had become terminally ill during her admission
c) Whether the treatment that was then provided was appropriate.

6.3. Mrs Lavender had a number of serious underlying medical conditions. The most serious of which was her insulin dependent diabetes mellitus going back to the 1940's complicated by hypoglycaemia's, which had led, to falls on previous occasions, peripheral neuropathy which may also contribute to falls and with a combination of diabetes and other processes she had become registered blind. She also had documented frailty prior to admission, for example, already having moved her bed downstairs with an exercise tolerance of 10 yards with a stick. Her son was documented to do her shopping (11). However, she was still living alone, was only documented to have stress incontinence (11) and was cognitively intact (MTS 10/10) (165).

6.4. She was then admitted to Haslar Hospital having had a fall, which was from the top to the bottom of the stairs. No explanation is given as to how she was at the top of the stairs, if she was already set up with her bed downstairs at home. Following this she is documented both at the assessment at Haslar Hospital and then on admission to Gosport Hospital as being severely dependent. She cannot use her arms properly, her hands and wrists are noted to be weak and she cannot stand and walk, she is so incontinent she needs a catheter and she has continual faecal leakage. Barthel is 4/10. I believe this lady was misdiagnosed and had quadriplegia from a high cervical Spinal cord injury secondary to her fall. This diagnosis appears to have been missed by all the doctors who saw her. Although the A&E notes in Haslar state "cervical spine normal" (H18), presumably on clinical, not x-ray, grounds. Also Dr Tandy mistakenly believes she had her neck x-rayed and it was normal (H163). No-one checks this statement is correct.

6.5. Other on-going serious medical problems have also not been explained. She has a documented low platelet count on admission to Gosport, which on repeat is extremely low and at a level that makes life threatening bleeding at any time quite probable. The blood film is also highly abnormal which suggests that there is now some systemic illness going on, probably involving this lady's bone marrow. In the absence of infection or a likely drug culprit, then cancer involving the bone marrow would be a possibility. She also has a very rapidly rising alkaline phosphatase, which suggests either liver, or bone pathology. No other information is now available that would help me clarify this further.

I would have expected that these very abnormal blood tests would have been reviewed and commented on by the doctor in charge of the case. There is no point in undertaking investigations if the results are ignored. The blood results appear to be complex to interpret and I would have expected a clinical assistant or General Practitioner to have taken advice from the consultant in charge of the case as to their relevance and whether further action was required. If further discussion did take place or the results were properly looked at, this is simply not recorded in the notes.

6.6. Other evidence that this lady was frail and ill is provided by the pressure sore which appears to deteriorate during admission and a low albumin documented on admission.

6.7. In my view this lady received a negligent medical assessment in both Haslar and Gosport. In particular she was not examined on admission to Gosport, or if she was it was not documented in the notes. Thus no medical explanation beyond the "possible brain stem CVA" is made. This would not explain all her physical symptoms, or her profound neurological deficit. Also no medical diagnosis was made for pain that she continually complained of down her arms, which again would fit with a high cervical Spinal cord fracture or similar injury. Also, no attempt was made to determine why this lady had a very low platelet count and rising alkaline phosphatase. Without making an adequate medical assessment it is impossible to plan appropriate management. The lack of an adequate medical assessment and adequate documentation make it very difficult to be certain as to what treatment should normally have been given.

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 investigation".... "In providing care you must , keep clear, accurate, legible and contemporaneous patient records, which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". The major gaps in the written notes as described above represents poor clinical practice to the standard set by the General Medical Council.

6.8. There can be no doubt though that the family, Dr Barton and the nursing staff all recognised this lady was seriously ill. Although the doctors fail to come to a diagnosis and therefore could not determine whether there was any treatable underlying problem. Evidence for this is that there was already discussion, within 2 days of admission, with the family about prognosis for recovery and how best to manage her illness. A syringe driver was already being discussed with the family on 24th February. Indeed all the markers of illness I have found, suggest this lady was very seriously ill.

6.9. Even if a high cervical Spinal cord fracture had been diagnosed, the potential for neurosurgical intervention in an elderly lady with diabetes is low and treatment with prolonged immobilisation has a very high mortality rate in itself. The unexplained low platelet count also suggests other significant serious pathology, which was never diagnosed, and on top of this we have somebody who needs all care and has leg ulcers and pressure sores. In my view, there were only two options open at this stage, **a)** to get a further specialist opinion or **b)** treat symptomatically and provide palliative care.

6.10. In view of the complexity of the medical problems, it would have been wise and appropriate to have obtained a further specialist opinion, probably from the consultant in charge of the case before deciding this lady was definitely terminally ill. I can see no evidence in the notes that this was considered.

If there was a failure to obtain further specialist opinion I believe this would be poor clinical practice to the standards set by the General Medical Council.

It was appropriate though to provide pain relief for someone who was both apparently in pain and distressed with loss of totally bodily function. To start MST at a normal low dose on the 24th February was appropriate.

6.11. If the pain was not resolved, increasing the dose to 20 mgs bd on both the 26th February adding the Oramorph 30 mgs bd on 4th March were all appropriate symptomatic responses.

6.12. An unusually large dose of Diamorphine (80 – 160 mgs subcut in 24 hours) is written up on the 26th February on the PRN (as required prescriptions) section of the drug chart. Midazolam 80 mgs subcut is also written up PRN. Although never prescribed, there is no justification in the notes for why such an apparently large dose of Diamorphine was written to be given if needed.

6.13. I have little doubt this lady was moving to a terminal phase of her illness by the 5th March. There had been no improvement in her quadriplegia, she remained faecally incontinent, the nursing cardex documents increasing pain, her platelet count has fallen further and her urea has doubled to 14.6 (187). At this stage a decision to start Diamorphine 100 mgs once a day subcutaneously and 40 mgs once a day Midazolam is made.

6.14. Midazolam is widely used subcutaneously in doses from 5 – 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 40 mgs for 24 hours, which is within current guidance, although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours. (Palliative Care. Chapter 23 in Brocklehurst Text Book of Geriatric Medicine, 6th Edition 2003).

6.15. The Diamorphine was specifically prescribed for pain and is commonly used for pain in terminal care, Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. The dose of Diamorphine actually prescribed was 100 mgs in 24 hours. At that time Mrs Lavender was receiving 60 mgs a day of Oramorphine. Diamorphine subcutaneously is usually given at a maximum ratio of 1:2 (i.e. up to 30 mgs of Diamorphine in 24 hours for 60 mgs of Oramorphine). (Wessex Guidelines). However her pain was not controlled and it would be appropriate to give a higher dose of the Diamorphine. Conventionally this would be 50% greater than the previous days; (Wessex Guidelines) some people might give up to 100%. Thus a starting dose of Diamorphine of 45 – 60 mgs in 24 hours would seem appropriate. Mrs Lavender actually was prescribed a minimum dose of 100 mgs of Diamorphine, in my view excessive.

6.16. Diamorphine is compatible with Midazolam and can be used in the same syringe driver. It is documented above though that she

received a high dose of Midazolam and an excessive, and in my view, inappropriately large dose of Diamorphine. Together these drugs are likely to have caused excessive sedation and respiratory depression. However there is no evidence in the notes to prove these complications occurred.

6.17. Mrs Lavender is documented to be comfortable on the 6th and dies approximately 36 hours after the Midazolam and Diamorphine pumps were started.

The prediction of how long a terminally ill patient will live is virtually impossible and even Palliative Care experts show enormous variation (Higginson I J and Costantini M. Accuracy of Prognosis Estimates by 4 Palliative Care teams: A prospective cohort study. BMC Palliative Care 2002 1:1.)

6.18. The doses of Midazolam and Diamorphine used were in my opinion excessively high and may have been prescribed with the intention of deliberately shortening the terminal phase of her life. However, I can not find evidence to satisfy myself the standard of "beyond reasonable doubt", they had the definite effect of shortening her life in more than a minor fashion of a few hours to a few days.

7. OPINION

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

7.2. The major problems in this lady's case are the apparent lack of medical assessment and the lack of documentation. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical care must include – taking suitable and prompt action necessary"... "referring the patient to another practitioner, when indicated"..... "in providing care you must – recognise and work within the limits of your professional competence...."..... "prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs". The major gaps in the written notes, as

documented in my report, represent poor clinical practice to the standards set by the General Medical Council. In this case, I believe that the overall episode of medical care provided between Haslar and Gosport Hospital was negligent in that an inadequate assessment and diagnosis of this lady's conditions was made. If it was, it was never recorded. The lack of any examination at Gosport, the lack of any comment on the abnormal blood test make it impossible to decide if the care she subsequently received was sub optimal, negligent or criminally culpable. It seems likely to me that she had several serious illnesses, which were probably unlikely to be reversible, and therefore, she was entering the terminal phase of her life at the point of admission to Gosport Hospital. However, without proper assessment or documentation this is impossible to prove either way.

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

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
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.

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.

Signature:_____ Date: _____