

Copy JB/PS/11

## STATEMENT OF DR JANE BARTON

### RE: GEOFFREY PACKMAN

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).
2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Geoffrey Packman. Unfortunately, at this remove of time I have no recollection at all of Mr Packman. As you are aware, I provided you with a statement on the 4<sup>th</sup> November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mr Packman.
3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998.

I confirm that these comments are indeed a fair and accurate summary of the position then, though if anything, it had become even more difficult by 1999 when I was involved in the care of Mr Packman.

4. Mr Geoffrey Packman was a 67 year old man who lived at home with his wife and daughter in Emsworth. It appears that he was visited regularly at home by the District Nurse who in February of 1999 noted that he had a large red weeping area on the shin of his right leg. A Doppler's test was performed, being an ultrasound measurement of the pressure in the veins of the legs. Mr Packman's GP appears to have referred him to Consultant Urologist Mr Chiverton at some point after April 1999. The GP referred in his letter to symptoms of prostatism and a raised PSA. He said that Mr Packman had had a negative mid-stream urine test, but rectal examination, presumably to assess the size of the prostate, had been virtually impossible because of Mr Packman's huge size and inability to lie properly on his side. The GP noted that Mr Packman was grossly obese, and indeed a subsequent measurement of his weight was recorded at 146 kg - in excess of 23 stone.
5. Mr Packman was noted to have a raised random blood sugar and was also due to have a glucose tolerance test to exclude diabetes mellitus.
6. At the end of June his GP then made a further referral, this time to Consultant Dermatologist Dr Keohane in relation to Mr Packman's leg ulceration. Mr Packman had apparently been attending the District Nurse's leg ulcer clinic for many months, and had hugely oedematous legs. The District Nurse had drawn the GP's attention to a large granulomatous raised area on the back of his right calf, and Dr Keohane's advice was requested. At this stage it seems that Mr Packman was being visited by the District Nurse 3 times a week in order

to dress the leg ulceration, that he had recently become immobile and his condition had worsened. Mr Packman was seen in the dermatology clinic on 30<sup>th</sup> June 1999, the Senior House Officer reporting back that Mr Packman had bi-lateral severe oedema with some leg ulceration secondary to venous hypertension. Mr Packman was to be brought in for further Doppler's testing.

7. On 6<sup>th</sup> August 1999 Mr Packman was then admitted to the Queen Alexandra Hospital having suffered a fall. He was unable to mobilise and 2 Ambulance crews were called to assist. It was noted on admission that the GP and the District Nurse were unable to cope with Mr Packman at home. The diagnoses at that stage were bi-lateral leg oedema, with ulcers on the left leg, obesity, and it was noted that he was simply not coping.
8. In the course of clerking-in on 6<sup>th</sup> August, it appears that Mr Packman was suspected to be in atrial fibrillation. An ECG was arranged which showed atrial fibrillation at a rate of 85. Blood tests revealed that he has a white cell count of 25,000, an ESR of 31, and a CRP of 194. He was felt to have cellulitis in the groin and left lower leg, he was commenced on antibiotics, and his diuretic medication was changed to Frusemide. His past medical history was noted to consist of the bi-lateral leg oedema, which he had apparently had for 5 years, hypertension which had been treated since 1985, and arthritis.
9. It appears that about the time of admission Mr Packman was recorded as having a large black blistered area on his left heel in addition to the leg ulceration.

10. Following assessment his problems were recorded as cellulitis of the left leg, chronic leg oedema, poor mobility, morbid obesity, raised blood pressure and possible atrial fibrillation. In relation to the latter, and prior to the performance of the ECG, anticoagulants were suggested if atrial fibrillation was confirmed, and the possibility of left ventricular dysfunction was also raised. Shortly thereafter Mr Packman was commenced on Clexane 40mgs twice daily.
11. At this stage Mr Packman's creatinine level was noted at 173, with urea at 14.9, suggesting that the insult due to the infection in his legs was resulting in compromise of his renal function.
12. It was also noted on 6<sup>th</sup> August that "in view of pre-morbid state + multiple medical problems [Mr Packman was] not for CPR in event of arrest". A Barthel score stated to have been assessed on 5<sup>th</sup> August (presumably 6<sup>th</sup> August in error) was recorded as zero, indicating that Mr Packman was completely dependant.
13. Mr Packman was reviewed by the Specialist Registrar the following day, 7<sup>th</sup> August, who agreed, presumably on the basis of what was felt to be Mr Packman's poor condition at that stage, that he was not be resuscitated in the event of arrest. It was suggested that his anti-hypertensive medication should be changed to an ACE inhibitor in view of the oedema, and he was considered for a beta-blocker in view of his atrial fibrillation. His diuretic was changed lest it cause dehydration. Mr Packman was given Flucloxacillin 500 mgs 4 times daily, supplemented by Penicillin V 500 mgs 4 times a day to combat the cellulitis.

14. Although steps were apparently taken to prevent the development of pressure sores, on 8<sup>th</sup> August Mr Packman was noted to have sores to the sacrum, being described as "Grade 3". I believe this would have been a reference to a wound classification system, Grade 3 suggesting that there was full thickness skin loss involving damage of subcutaneous tissue.
15. Over the next few days it appears that Mr Packman's cellulitis improved, but the overall assessment of his suitability of resuscitation did not change - on 11<sup>th</sup> and again on 13<sup>th</sup> August it was again specifically noted that he was not for resuscitation - recorded as "Not for 555".
16. On 13<sup>th</sup> August Mr Packman was reviewed by a Consultant Geriatrician Dr Jane Tandy. She noted that he had had black stools overnight. The following day a nursing note records that when the dressings on the pressure sores were renewed, the wounds to the left buttock and right lower buttock and thigh were very sloughy and necrotic in places, and very offensive smelling. Clearly by that time, Mr Packman had developed significant pressure sores.
17. A Barthel score measured on 14<sup>th</sup> August again recorded a score of zero indicating his complete dependence.
18. It appears that by 15<sup>th</sup> August a decision had been made that Mr Packman should be transferred to the Dryad Ward at the GWMH. A note in the nursing records indicates that Staff Nurse Hallman at GWMH had indicated that we were not in a position to take Mr Packman at that time. This is likely to have been an indication that there were no beds available, and that we would have been under considerable pressure in consequence of the high bed occupancy.

19. An entry in Mr Packman's records for 20<sup>th</sup> August by the Specialist Registrar indicates that Mr Packman was due for transfer to the GWMH on 23<sup>rd</sup> August. The Specialist Registrar also noted that Mr Packman remained not for resuscitation. A Barthel score measured on 21<sup>st</sup> August again recorded a score of zero indicating his complete dependence.
20. Mr Packman was then admitted to the GWMH on 23<sup>rd</sup> August 1999. There is a clerking-in noted contained within his records, but I do not recognise the handwriting or signature of the doctor who assessed him on this occasion. His problems were noted to be obesity, arthritis, immobility and pressure sores. The episode of melaena on 13<sup>th</sup> August was noted, with his haemoglobin being stable. At that stage he was said to be in no pain. Cardiovascular and respiratory systems were thought to be normal. The clinician admitting Mr Packman also prescribed medication in the form of Doxazosin 4 mgs daily for hypertension, Frusemide 80 mgs once a day as a diuretic for Mr Packman's oedema, Clexane 40 mgs twice a day for DVT prophylaxis and atrial fibrillation. Paracetamol 1gm 4 times daily for pain relief, Magnesium Hydroxide 10 mls twice daily for constipation, together with Gaviscon for indigestion and cream for his pressure sores.
21. On this occasion, a Barthel score of 6 was recorded for 23<sup>rd</sup> August, suggesting that, although Mr Packman might have improved to a degree, he was still significantly dependent.
22. I anticipate that I would have reviewed Mr Packman the following day as part of my assessment of all the patients on the ward, though it appears that I did not have an opportunity to make any entry in his medical

records on this occasion. The prescription chart shows that I prescribed Temazepam for Mr Packman on a PRN basis - as required - at a dose range of 10-20 mgs. 10 mgs of Temazepam was then given on the night of 24<sup>th</sup> August, with a night nursing record then indicating that he slept for long periods.

23. I anticipate that I would have reviewed Mr Packman the following day, 25<sup>th</sup> August, though again I did not have an opportunity to make an entry in his records. It appears that Mr Packman then was noted to have passed blood per rectum, and Dr Beasley was contacted, Dr Beasley presumably being on duty out-of-hours. He advised that the Clexane should be discontinued. Dr Beasley also appears to have prescribed Metoclopramide by way of verbal order, which I later endorsed, together with Loperamide. The Metoclopramide was apparently given at 5.55 pm with good effect. The dressings on the pressure sores were removed on 25<sup>th</sup> August and were noted to be contaminated with faeces.
24. I do not know if I reviewed Mr Packman on the morning of 26<sup>th</sup> August. He was noted by the nurses to have had a fairly good morning. Sister Hamblin has recorded that Dr Ravi, locum Consultant Geriatrician, was contacted and he confirmed that the Clexane should be discontinued and the haemoglobin repeated. Again, Mr Packman was noted to be "not for resuscitation". Sister Hamblin may have contacted Dr Ravi if I was unavailable that morning. The nursing record goes on to indicate that Mr Packman then deteriorated at about lunchtime, that his colour was poor and that he complained of feeling unwell. I was called to see him, my entry in his records on this occasion reading as follows.

\*26-8-99      Called to see pale clammy unwell  
                  suggest ? MI. treat stat diamorph

and oramorph overnight

Alternative possibility GI bleed but no

haematemesis

not well enough to transfer to acute unit

keep comfortable

I am happy for nursing staff to confirm death."

As my note indicates, I was concerned that Mr Packman might have suffered a myocardial infarction, and accordingly I decided to administer opiates in the form of Diamorphine for pain and distress consequent on the possible myocardial infarction, at a dose of 10 mgs intramuscularly. In addition, I would have been conscious that he had large pressure sore areas on his sacrum and thighs which would have been causing him significant pain and discomfort. I prescribed 10 mgs Diamorphine intramuscularly to be given immediately, which is recorded on the drug chart as a verbal instruction. An alternative diagnosis which I recorded was that Mr Packman had had a gastro intestinal bleed.

25. My impression when I assessed Mr Packman on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to an acute unit was quite inappropriate. Any such transfer was very likely to have had a further deleterious affect on his health.
  
26. The nursing note for 26<sup>th</sup> August indicates that we were to await blood test results. There was then a further deterioration later in the day, with Mr Packman complaining of indigestion and a pain in his throat, which was not radiating.



27. The blood count taken on 26<sup>th</sup> August subsequently showed that Mr Packman's haemoglobin had dropped to 7.7 grams, a substantial drop from the 12 grams which had been recorded 2 days earlier.
  
28. It appears that I re-attended to see Mr Packman at 7.00 pm on 26<sup>th</sup> August. Concerned that he should have further appropriate medication to relieve his pain and distress, I prescribed Oramorph 10-20 mgs 4 times a day together with 20 mgs at night. 20 mgs of Oramorph was later given at 10.00 pm.
  
29. I also wrote up prescriptions for Diamorphine 40-200 mgs subcutaneously over 24 hours, together with 20-80 mgs of Midazalam via the same route on an anticipatory basis, concerned that further medication might be required in due course to relieve Mr Packman's pain and distress. It was not my intention that this subcutaneous medication should be administered at that time. The nursing record also indicates that I saw Mr Packman's wife, explaining her husband's condition and the medication we were using. I anticipate I would have indicated to Mrs Packman that her husband was very ill indeed, and in all probability that he was likely to die.
  
30. I would have reviewed Mr Packman again the following morning, and indeed the nursing record confirms that I attended to see him then. Sister Hamblin has recorded that there had been some marked improvement since the previous day and that the Oramorph was tolerated well and should continue to be given, though Mr Packman apparently still had some discomfort later that afternoon especially when the dressings were being changed. In spite of the earlier improvement, Mr Packman was said to remain poorly. 10 mgs of Oramorph were administered 4 hourly, together with a further 20 mgs

at night as prescribed, so that Mr Packman received a total of 60 mgs that day, though this was seemingly not enough to remove his pain and discomfort when his dressings were being changed. The nursing records indicate that he appeared to have a comfortable night.

31. I reviewed Mr Packman again the following morning, and on this occasion I made a note in his records which reads as follows:

\*28-8-99      Remains poorly but comfortable  
                  please continue opiates over weekend."

32. The nursing record indicates that Mr Packman remained very poorly with no appetite. However, the Oramorph again appears to have been successful in keeping Mr Packman comfortable at night.
33. I do not believe I would have seen Mr Packman on Sunday 29<sup>th</sup> August. The nursing record indicates that he slept for long periods, but that he also complained of pain in his abdomen. The sacral wounds were said to be leaking a lot of offensive exudate.
34. I do not know if I would have seen Mr Packman again the following morning, Monday 30<sup>th</sup> August, that being a Bank Holiday. I have no way of knowing now if I was on duty then. If I did see him as part of my review of all the patients on the two wards, I did not have an opportunity to make a specific entry in his records on this occasion. A Barthel score was recorded as 4. The nursing record indicates that Mr Packman's condition remained poor, and later that day - at 2.45 pm the syringe driver was set up to deliver 40 mgs of Diamorphine and 20 mgs Midazolam subcutaneously. I anticipate that Mr Packman would have continued to experience pain, and clearly in view of the significant sacral

sores, it was highly likely that he would have been experiencing further significant discomfort.

35. In view of his poor condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying. Mr Packman had received 60 mgs of Oramorph daily over the preceding 3 days, and the administration of 40 mgs of Diamorphine subcutaneously over 24 hours did not represent a significant increase. Mr Packman would have started to have become inured to the opiate medication, and an increase of this nature was in my view entirely appropriate to ensure that his pain was well controlled. Indeed, the nursing record goes on to state that there were no further complaints of abdominal pain and Mr Packman was able to take a small amount of food.
36. I anticipate that the nursing staff would have liaised with me prior to the commencement of the Diamorphine and Midazolam and that this would have been set up on my instruction, directly if I had been at the Hospital, or otherwise by phone.
37. On the morning of 31<sup>st</sup> August Mr Packman was recorded as having had a peaceful and comfortable night, though he then passed a large amount of black faeces that morning.
38. I believe I would have seen Mr Packman again that morning, though again I did not have an opportunity to make an entry in his records. I anticipate his condition would have been essentially unaltered, and that he would have remained comfortable. Similarly, I would probably have seen Mr Packman again on the morning of 1<sup>st</sup> September but would have been unable to record this. I anticipate that his condition was again

unchanged. 5 separate pressure sore areas were noted by the nurses. A Barthel score of only 1 was recorded.

39. Mr Packman was reviewed the same day by Consultant Geriatrician Dr Reid. Dr Reid noted that Mr Packman was rather drowsy but comfortable. He had been passing melaena stools. His abdomen was noted to be huge but quite soft, and Dr Reid also recorded the presence of the pressure sores over the buttocks and across the posterior aspects of both thighs. He noted that Mr Packman remained confused and was for "TLC". The Frusemide and Doxazosin were to be discontinued, and Mr Packman's wife was said to be aware of his poor prognosis.
40. The entry by Dr Reid that Mr Packman was to have "TLC" - tender loving care - was clearly an indication that Dr Reid also considered Mr Packman to be terminally ill. Dr Reid had the opportunity to review the medication which Mr Packman was receiving at the time, and clearly felt it appropriate.
41. Sister Hamblin recorded later in the nursing records that the syringe driver was renewed at 7.15 pm with 60 mgs of Diamorphine and 60 mgs of Midazolam subcutaneously as the previous dose was not controlling Mr Packman's symptoms. It appears therefore that Mr Packman was experiencing yet further pain and discomfort. I anticipate that the nursing staff would have contacted me and that I authorised this moderate increase in his medication in order to alleviate the pain and distress.

42. That night, Mr Packman was noted to be incontinent of black tarry faeces, but otherwise he had a peaceful night and the syringe driver was said to be satisfactory.
43. I believe I would have reviewed Mr Packman again the following day, 2<sup>nd</sup> September. The nursing records show that his medication was again increased, the Diamorphine to 90 mgs and the Midazalam to 80 mgs subcutaneously. I anticipate again that Mr Packman would have been experiencing pain and distress, and that I and the nursing staff were concerned that the medication should be increased accordingly to ensure that he did not suffer pain and distress as he died. That night, Mr Packman was said to remain ill, but was comfortable and the syringe driver was satisfactory.
44. Sadly, Mr Packman passed away on 3<sup>rd</sup> September 1999 at 1.50 pm. My belief was that death would have been consequent on the myocardial infarction.
45. The Oramorph, Diamorphine and Midazalam were prescribed and in my view administered solely with the aim of relieving Mr Packman's pain and distress, ensuring that he was free from such pain and distress as he died. At no time was any medication provided with the intention of hastening Mr Packman's demise.