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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: REID, RICHARD IAN

Age if under 18: O.21 (if over 18 insert 'over 18') Occupation: CONSULTANT ELDERLY MEDICINE

This statement (consisting of 31 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signed: R I REID Date: 26/11/2004

I am Doctor Richard Ian REID and I reside at the address detailed overleaf.

Further to my earlier statement regarding Elsie DEVINE , I wish to add the following:-

I have been shown the below listed documents by Detective Constable Code A

1. Exhibit BJC/16/PG/274&275
2. Exhibit BJC/16/PG/276
3. Exhibit BJC/16/PG/277&278
4. Exhibit BJC/16/PG/279&280

The above four documents form the prescription sheet of Mrs Elsie DEVINE whilst she was an inpatient on Dryad Ward of Gosport War Memorial Hospital .

I have been allowed by DC Code A to properly examine these documents and to reassemble them into their original format.

Exhibit BJC/PG/277&278 forms the basis of the document.

Exhibit BJC/PG/279&280 would have originally been attached to the edge of the previous document creating one long folding card or booklet.

Exhibit BJC/16/PG/276 is a stick on extension to the above documents which would have been

affixed to exhibit BJC/16/PG/277&278 on page 278.
Exhibit BJC/16/PG/274&275 is a further extension of the document which would have originally been affixed above exhibit BJC/16/PG/276.

I have been asked to explain the content of the above documents and provide an explanation of each drug detailed on them, to give an account from these documents of what the dose rate of each drug was, as shown on the prescription sheet and finally to comment on the use of each drug prescribed.
I first wish to state that I am not the author of any of the notes or writing on these documents.

My name appears at the top of page 277 beside the word 'Consultant'. From my examination of these documents, together with my examination of the clinical notes as referred to in my earlier statement, I am able to say that none of the drugs listed on the prescription sheets was prescribed by me or prescribed on my advice or instruction. There is however one possible exception to this, that being the drug 'Amiloride' - a drug used to treat fluid retention or heart failure.

This drug was prescribed on 1st November 1999 (01/11/1999) by Dr BARTON. It is possible that Dr BARTON consulted me regarding the prescribing of this drug in Mrs DEVINE's case or that Dr BARTON prescribed it on my instruction.

These documents would have been available to me and would almost certainly have been examined by me on each of the occasions that I conducted a ward round of Dryad Ward during the period that Mrs DEVINE was on the ward. Namely on 25th October 1999 (25/10/1999), the 1st November 1999 (01/11/1999) and finally on 15th November 1999 (15/11/1999).

I feel that these documents are best explained by detailing each drug in turn by date order.

As previously stated Mrs DEVINE was admitted to Dryad Ward, Gosport War Memorial Hospital on 21st October 1999 (21/10/1999) from the Queen Alexandra Hospital .

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On 21st October 1999 (21/10/1999) Dr BARTON has prescribed a regular dose of:-
Thyroxine 100 micrograms daily.

This drug is for the treatment of hypo-thyroidism which is an under active thyroid gland which if severe and untreated could cause confusion.

In my experience I would say that this would be a very common treatment dose for persons suffering from this complaint. This dosage is monitored by carrying out blood tests.

Mrs DEVINE would have taken this drug in tablet form. There are no major side effects of this drug.

I note from the prescription charts that Mrs DEVINE took this drug from 22nd October 1999 (22/10/1999) until 17th November 1999 (17/11/1999). I can only assume that Mrs DEVINE's condition after this time had become such that she was no longer able to take this drug orally or was refusing to take drugs orally.

On 21st October 1999 (21/10/1999) Dr BARTON also prescribed a regular dose of Frusemide 40 mg tablets, one daily. This drug is used in the treatment of fluid retention and heart failure and also other conditions. The dosage prescribed is the most usual starting dose of this drug. This drug was administered from 22nd October 1999 (21/10/1999) until 17th November 1999 (17/11/1999). The use of these two drugs together is quite compatible.

On 21st October 1999 (21/10/1999) Dr BARTON also prescribed on an 'as required' basis the drug Temazepam 10mg tablets, one at night.

This drug is a 'sleeping tablet' and one 10mg tablet is the normal starting dose for this drug.

The drug was administered on one occasion only to Elsie DEVINE. This was at 0115 hours on 11th November 1999 (11/11/1999).

Given the history on admission to Dryad Ward of 'confusion' and the fact that changes of environment/hospitals can increase 'confusion', particularly at night, I do not feel it was unreasonable to have prescribed this drug on an 'as required' basis on her admission to Gosport War Memorial Hospital.

It must be borne in mind that nursing staff at not permitted to administer drugs without them first being prescribed by a doctor.

Gosport War Memorial Hospital operated with only a 'Clinical Assistant', Dr Jane BARTON and therefore there was no resident medical cover in the form of a doctor available on site 24 hrs a day.

It was therefore in my opinion good practice to prescribe on an 'as required' basis a sleeping pill for this patient.

This would allow the nursing staff to administer the drug if required without consulting a doctor.

On 21st October 1999 (21/10/1999) on admission to the Gosport War Memorial Hospital I note that Dr BARTON has also prescribed in the 'as required' section the drug 'Oramorph ' at a strength of 10mgs in 5mls in a dose of 2.5 - 5mls 4 hourly as required. This drug is an oral morphine drug in solution and the dose prescribed in milligrams is 5-10mg.

This is the usual recommended starting dose for this drug.

This drug is usually used in the treatment of pain.

This drug, according to the prescription sheets was never administered to Elsie DEVINE.

Given that there is no resident doctor at Gosport War Memorial Hospital I feel that it would be entirely reasonable to prescribe on an 'as required' basis a simple 'analgesic' (painkiller) which

the nursing staff could then administer if required.

In the absence of any documented pain being reported in the case of Elsie DEVINE I feel that this prescription was inappropriate at this stage. This is because 'analgesics' can be divided into 3 levels/groups of which 'Oramorph' falls into the strongest level/group.

On 1st November 1999 (01/11/1999) I note that Dr BARTON has prescribed the drug 'Amiloride' 5mg tablets, one daily. This drug is used to treat fluid retention or heart failure.

This is the usual recommended starting dose of the drug and is at the lower end of the starting range.

This drug was administered from 2nd November 1999 (02/11/1999) to the 18th November 1999 (18/11/1999).

The use of this drug is entirely compatible with 'Frusemide' and Thyroxine.

This drug was possibly discussed with me prior to prescription as stated earlier in this statement.

There are two reasons that possibly led to the prescription of this drug. The first being that Mrs DEVINE's fluid retention was increasing namely her legs were swelling.
The second being that 'Frusemide' can have the effect of lowering potassium levels in the blood whereas 'Amiloride' can have the effect of raising potassium levels in the blood. Therefore it can be useful to use these two drugs in combination. 'Amiloride' can, in some cases, cause a worsening of kidney function and requires monitoring if given. This can be achieved by blood tests.

On 11th November 1999 (11/11/1999) I note that Dr BARTON prescribed 'Trimethoprim' 200mg tablets, one daily for a period of 5 days.

'Trimethoprim' is an antibiotic which is commonly used for the treatment of urinary tract

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infections. This is in my opinion an entirely correct dose and length of treatment.

This drug is compatible with the other prescriptions taken daily by Mrs DEVINE at this time.

I note that Mrs DEVINE completed the course of treatment involving this drug on the 15th November 1999 (15/11/1999).

Caution should be taken when administering this drug to patients suffering from impaired kidney function.

However failing to treat a urinary tract infection can also have adverse consequences on kidney function. Therefore there is a need to monitor.

On 11th November 1999 (11/11/1999) Dr BARTON prescribed on an 'as required' basis 'Thioridazine' 10 mg tablets, one three times daily.

'Thioridazine' is a drug used in the treatment of 'restlessness', 'agitation' and 'confusion'.
The drug has a tranquillizing and sedative effect.
The dose prescribed in Mrs DEVINE's case was at the very bottom end of the dosage range.

This drug was administered on ten occasions between 11th November 1999 (11/11/1999) and 17th November 1999 (17/11/1999) to Mrs DEVINE. She received the prescribed dose on each occasion. These were as follows:-

1. 0830 hrs on 11th November 1999 (11/11/1999)
2. 1330 hrs on 12th November 1999 (12/11/1999)
3. 0825 hrs on 13th November 1999 (13/11/1999)
4. 1800 hrs on 13th November 1999 (13/11/1999)
5. 0825 hrs on 14th November 1999 (14/11/1999)
6. 1945 hrs on 14th November 1999 (14/11/1999)

7. 0830 hrs on 15th November 1999 (15/11/1999)

8. 2130 hrs on 15th November 1999 (15/11/1999)

9. 0845 hrs on 16th November 1999 (16/11/1999)

10.1740 hrs on 17th November 1999 (17/11/1999)

No more than 2 tablets were given in any one day. The prescribed limit being three tablets.

This drug is compatible with the other prescribed drugs that Mrs DEVINE was taking on a daily basis.

On 15th November 1999 (15/11/1999) I carried out a ward round at Dryad Ward, Gosport War Memorial Hospital. On Mrs DEVINE's clinical notes of that day I noted the use of this drug to treat Mrs DEVINE's 'aggression' and 'restlessness' (see exhibit BJC/16/PG/154&155). I have also referred to its use in my earlier statement and mentioned that I felt it was important that, when a new drug was prescribed, that the reasons for this were recorded on the medical notes.

This does not appear to have been done in this case.

I would consider that the dose prescribed of 'Thioridazine' was wholly appropriate at that time in the treatment of Mrs Elsie DEVINE's 'aggression' and 'restlessness'.

On 18th November 1999 (18/11/1999) Dr BARTON prescribed 'Fentanyl TTS', 25 micrograms as a self adhesive skin patch on a 'regular basis'- every third day. 'Fentanyl' is a drug used in the treatment of pain.

This drug was administered in 'patch' form at 0915 hours on 18th November 1999 (18/11/1999).

The drug once administered in 'patch' form does take a period of time before it is fully effective.

This period can be up to 24 hours.

According to the prescription sheet the Fentanyl patch was removed at 1230 hours on 19th November 1999 (19/11/1999). The recommended sites to place Fentanyl patch are on dry healthy hairless skin on the chest, back or upper arm. I have not seen on the medical notes of Elsie DEVINE where the Fentanyl patch was sited in her case.
I have been asked why an 'analgesic' (painkiller) of the strength of Fentanyl has been prescribed and administered to a patient who according to their medical record have not made any complaint of pain.

This is best explained as follows:-

It is often the case that an elderly patient who is very confused and/or distressed may not be able to communicate that they are in pain and may also not display any symptoms or signs of pain other than their confusion, restlessness and aggression.
In the first instance these symptoms are treated with a sedative drug which in this case had been commenced on 11th November 1999 (11/11/1999) by administering 'Thioridazine' in tablet form.

On 18th November 1999 (18/11/1999) it has been noted on Mrs DEVINE's clinical notes by the locum staff psychiatrist that despite taking Thioridazine Mrs DEVINE had become more restless and aggressive and that she was also refusing to take medication.

In my opinion the continued distress, restlessness and aggression being displayed by Mrs DEVINE could be an indication of pain that she was suffering and was unable to communicate.

At this stage, in my opinion, there would be three possible courses of action:-

1. To increase the dosage of 'sedative'.
2. Cease sedative and place on analgesic (painkiller).
3. Administer a combination of both sedative and painkiller.

From my reading of the prescription sheet, Dr BARTON appears to have taken the second

option of prescribing the analgesic (painkiller) in the form of a 'Fentanyl patch'.

I also note that Mrs DEVINE on 18th November 1999 (15/11/1999) was refusing to take her oral medication which would explain the use of the Fentanyl patch as opposed to an orally taken analgesic (painkiller).

To have continued with sedation in Mrs DEVINE's case would have involved, increased dosages of sedation which would probably have involved having to receive several injections daily which in turn could cause Mrs DEVINE to suffer further distress.

With regard to the decision by Dr BARTON to apply a 'Fentanyl patch' on 18th November 1999 (18/11/1999) I would not have expected Dr BARTON to consult me prior to making that decision unless she had concerns herself about doing it.

Dr BARTON is a very experienced doctor who has considerable experience in the treatment of elderly patients and elderly patients who are dying.

The primary concern in these circumstances would be the comfort of the patient and in particular to relieve any distress and pain they were suffering.

On 19th November 1999 (19/11/1999) Dr BARTON prescribed 'Chlorpromazine', 50mg to be given by intramuscular injection.

This prescription was made in the 'once only' section and was administered at 0830 hours on 19th November 1999 (19/11/1999) by a member of the nursing staff. Chlorpromazine is a sedative/tranquiliser. The dosage of 50mgs given to Mrs Elsie DEVINE is at the upper end of the normal range of dosage.

This dosage and drug is compatible with the 'Fentanyl patch' that Mrs DEVINE was wearing at the time. The administering of Chlorpromazine is consistent with Mrs DEVINE's continued 'confused' and 'aggressive state'.

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On 19th November 1999 (19/11/1999) I note from Mrs DEVINE's clinical notes exhibit BJC/16/PG/156/157 that Dr BARTON has made an entry in which she refers to a marked deterioration of Mrs DEVINE's condition overnight with confusion and aggression and a marked decline in her kidney function. She also notes a further deterioration of Mrs DEVINE's condition that morning.

In this note Dr BARTON mentions the application of the Fentanyl patch the previous day.

She notes that despite its use Mrs DEVINE's condition was continuing to deteriorate.

She notes:
'Needs sub-cutaneous analgesia with Midazolam'.

In my opinion this may be translated as follows:-
'In Dr BARTON's opinion Mrs DEVINE needed a sub-cutaneous infusion of a painkiller and a sedative'. A sub-cutaneous infusion would probably be a reference to the drugs being administered by means of a syringe driver.

The note then reads:
'Son seen and aware of condition and diagnosis'.
'Please make comfortable'
'I am happy for nursing staff to confirm death'.

In my opinion the last section of this note indicates that Dr BARTON had formed the opinion that Mrs Elsie DEVINE was terminally ill and that the overriding priority was to relive symptoms and therefore her instructions were to ensure Mrs DEVINE was comfortable and free from distress.

It is my opinion that Dr BARTON should have made entries on Mrs DEVINE's clinical notes regarding the prescription of:
1. Fentanyl patch on 18/11/99 (18/11/1999)

2. The Chlorpromazine on 19/11/99 (19/11/1999)

Both are powerful drugs and also represent an important change in Mrs DEVINE's condition and treatment. It would therefore have been best practice to have noted these changes and reasons for the changes on Mrs DEVINE's clinical notes at the time of prescription.

On 19th November 1999 (19/11/1999) Dr BARTON prescribed Diamorphine 40-80mgs every 24 hours on a regular basis by sub-cutaneous infusion (via syringe driver).

Together with;
Midazolam 20-80mgs every 24 hours on a regular basis by sub-cutaneous infusion (via syringe driver). These two drugs would have been mixed together, both drugs being in a liquid form, both drugs are completely compatible with being mixed together and administered over a 24 hour period by means of syringe driver.
Diamorphine is an opiate drug used in the treatment of pain.

It is a very strong analgesic (painkiller) which is frequently used in the care of terminally ill patients who are in pain or are distressed or both.

The dose of Diamorphine prescribed by Dr BARTON was 40-80mgs in a 24 hour period.

Mrs DEVINE had been wearing a 25 microgram Fentanyl patch for the previous 24 hours.

A 25 microgram Fentanyl patch is probably the equivalent to between 30 mgs and 60mgs of Diamorphine over a 4 hour period. Both Fentanyl and Diamorphine are opiates.

The prescription of 40mg of Diamorphine over a 24 hour period was therefore the correct replacement dose for the Fentanyl patch.

However the Fentanyl patch was not removed from Elsie DEVINE until 1230 hours on 19th November 1999 (19/11/1999). Fentanyl remains in the system of a patient for between 12 to 24

hours after the patch is removed.

Mrs DEVINE's treatment with Diamorphine began at 0925 hours on 19th November 1999 (19/11/1999) whilst she was still wearing the Fentanyl patch. Therefore Mrs DEVINE is likely to have received more than the equivalent of 40mgs in the first 24 hours of her treatment with Diamorphine.

However it should be noted that Fentanyl had not relieved Mrs DEVINE's distress and that the prescribed Diamorphine dosage was 40-80mgs. It is extremely unlikely that this dosage was exceeded.

The drug Midazolam is a sedative in liquid form which is completely compatible for use with Diamorphine. It is prescribed to treat restlessness in patients who are terminally ill and who are unable to take sedation by mouth or are refusing to do so.

The dose prescribed by Dr BARTON was 20-80mgs in a 24 hour period.

The normal starting dose for Midazolam is 10-20 mgs in a 24 hour period.

From my examination of the prescription sheets I note that sub-cutaneous infusion commenced at 0925 hours on 19th November 1999 (19/11/1999).

This would have been set up by a senior member of the nursing staff. I note that the starting dose of Diamorphine administered was 40mgs in a 24 hour period.

This was repeated at 0735 hours on 20th November 1999 (20/11/1999) and again at 0715 hours on 21st November 1999 (21/11/1999).

In the case of the drug Midazolam a dose of 40mgs was administered at 0925 hours 19th November 1999 (19/11/1999) over a 24 hour period and was repeated at 0735 hours on 20th November 1999 (20/11/1999) and again at 0715 hours on 21st November 1999 (21/11/1999).

A sub-cutaneous infusion usually refers to the continuous administration of a drug through a needle inserted just under the skin and involves the use of a syringe driver.
A syringe driver is a medical device which in simple terms is an electrically powered syringe that has a motor which depresses the plunger of the syringe very slowly. This enables a patient to be administered an even dose of the drug throughout a 24 hour period. Other than the first insertion of a needle this equipment avoids the need for a patient to be given multiple injections. This therefore avoids causing the patient distress. In the case of Elsie DEVINE it is my opinion that the use of a syringe driver to administer the drugs Diamorphine and Midazolam was appropriate in the circumstances. This is because Mrs DEVINE had already received Fentanyl (an opiate) sub-cutaneously in the form of a skin patch and because Mrs DEVINE was refusing oral medication. Mrs DEVINE at the time required two nurses to be solely looking after her because of her agitation and distress.

With regard to the doses of the drugs Diamorphine and Midazolam the administering of the Fentanyl patch and the 50mgs of chlorpromazine I have the following observations:

Regarding the Fentanyl patch in my opinion it may have been a more appropriate alternative to have administered individual sub-cutaneous injections of small doses of Diamorphine over 24 hours to assess its effect on Mrs DEVINE so that a clearer idea could be obtained of the dose of Diamorphine to be administered over a period of 24 hours via a syringe driver in order to relieve Mrs DEVINE's symptoms.

This however would involve multiple injections that may have caused further distress and may not have led to a relief of her symptoms.

Regarding the starting dose of 40mgs of Diamorphine over a 24 hour period in my opinion this is unlikely to have taken account of the application of the Fentanyl patch 24 hours before. It would probably have been more prudent to have started with a dose of 20-30 mgs of Diamorphine.

The administering of 40mgs of Diamorphine in the first 24 hours could have led to over sedation but the administration of 20-30mgs might well not have relieved Mrs DEVINE's distress.

Regarding the sedatives administered to Elsie DEVINE on 19th November 1999 (19/11/1999) I have the following observations.

At 0830 hours on 19th November 1999 (19/11/1999) Mrs DEVINE received an intramuscular injection of 50mgs of Chlorpromazine. This dose is at the upper limit of the dosage range for an initial injection.

I would expect to see some effect on a patient administered this drug, in a period of half to one hour.

The effect of this drug I would expect to last from anything from three to six hours.
(However I have limited expertise in this field).

It is of some concern that when Mrs DEVINE was administered Midazolam at 0925 hours on 19th November 1999 (19/11/1999) via syringe driver the Chlorpromazine may not have reached its maximum effect.

It should however be borne in mind that the Midazolam was being administered as a slow infusion over a 24 hour period.

This could also have led to some over sedation of Mrs DEVINE during the first few hours of the Midazolam infusion.

With regard to the dose of 40mgs of Midazolam over a 24 hour period I have concerns that the administered starting dose was of 40mgs when the prescription sheet shows that Dr BARTON prescribed a dose of 20-80 mgs over a 24 hour period.

In my opinion 20mgs of Midazolam over a 24 hour period would have been a more appropriate starting dose.

I can see nothing on the medical notes of Elsie DEVINE to show the reason for administering 40mgs of Midazolam. The drugs Diamorphine and Midazolam were administered together by syringe driver by a member of the nursing staff.

In the main drugs are administered to a patient by the nursing staff following prescription by a doctor.

When writing a prescription with a range of 20mg - 80mg of a drug I would expect that, initially the lowest dose would be administered to assess its effect on the patient unless there were very good reasons for giving a higher dose.

In that instance I would expect a note to be made on the medical record of the patient giving the reasons for administering the higher dose.

I can see 'no note' on the medical records of Elsie DEVINE explaining the reason for her being administered the higher starting dose of 40mg of Midazolam on 19th November 1999 (19/11/1999).

In my opinion Dr BARTON's note of 19th November 1999 (19/11/1999) on Mrs DEVINE's clinical notes exhibit BJC/16/PG/156&157 together with the prescription sheets is an indication of a change in course of treatment of Elsie DEVINE to palliative care.

I would not expect DR BARTON to consult me prior to making this decision, unless, she had concerns about doing so.

Palliative care in this case would mean relieving Mrs DEVINE symptoms of confusion, restlessness, aggression and distress on a background of rapidly declining renal function by using a combination of analgesia (painkillers) and sedatives.

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It is well recognised that administering strong analgesics and sedatives in this situation may hasten death in the course of relieving suffering and making a patient comfortable.

The most common side effects of administering Diamorphine to a patient are:-
Nausea, vomiting, constipation and drowsiness.

Large doses produce:
Respiratory depression - slow and shallow breathing.
Hypotension - low blood pressure
The most common side effects of the drug Midazolam are:-
Drowsiness and respiratory depression.
These side effects may hasten death.

In my opinion the variable dose on prescription by Dr BARTON of the drugs Diamorphine and Midazolam was to allow the nursing staff the discretion to increase the dosage of each drug should the initial dose not control or relieve the symptoms displayed by Mrs DEVINE, particularly as there was no on site 24 hour doctor cover. No increase of dosage of either Diamorphine or Midazolam from the initial starting doses was made in the case of Mrs DEVINE.

Mrs DEVINE died at Dryad Ward, Gosport War Memorial Hospital during the evening of 21st November 1999 (21/11/1999).

Taken by: **Code A**