GENERAL MEDICAL COUNCIL

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DR JANE BARTON

APPENDIX: GUIDANCE TO PROFESSOR DAVID BLACK IN PREPARING COMPREHENSIVE REPORT ON TREATMENT AT GOSPORT WAR MEMORIAL HOSPITAL

In preparing a comprehensive report in relation to the medical treatment of (A) Leslie Pittock, (B) Elsie Lavender, (C) Eva Page, (D) Alice Wilkie, (E) Gladys Richards, (F) Ruby Lake, (G) Arthur Cunningham, (H) Robert Wilson, (I) Enid Spurgin, (J) Geoffrey Packman and (K) Elsie Devine, Professor Black is kindly asked to address the matters set out below.
Please Professor Black please provide a single generic report covering paragraphs one to twenty-four below and then a separate short addendum statement for each patient.

PRINCIPLES OF MEDICAL CARE

Pain Relief

1. Explain the principles of prescribing and administering medication for pain relief, if appropriate by reference to the British National Formulary. Explain the nature and purpose of opioid analgesics, and how they fit within the range of analgesic medication available. Explain the Analgesic Ladder and the 'step-by-step' principle of prescribing analgesia. Explain the principles governing assessment and review of a patient's condition and the appropriate administration of pain relief. Assess the dangers of failing to follow the correct approach.

2. Explain the different methods by which opioid medication may be administered (ie orally, parenterally) and when each is appropriate. When is it appropriate to use a syringe driver? Are there any inherent dangers of using syringe drivers? Assess the dangers of failing to follow the correct approach.

3. Explain the process of obtaining the equivalent doses of orally-administered Morphine and parenterally-administered Diamorphine, if appropriate by reference to the British National Formulary.

4. Explain whether, and if so when, it may be appropriate to administer opioid analgesia parenterally in combination with sedative drugs. What level of monitoring is required in such cases. Explain the nature and purpose of

Midazolam, when and how it may be administered. Assess the dangers of failing to follow the correct approach.

Elderly Patients

5. Explain the significance of old age in relation to prescribing and administering medication for pain relief, if appropriate by reference to the British National Formulary. Assess the dangers of failing to follow the correct approach.

Medical Assessments

6. Explain the principles governing the requirement to make adequate medical assessment of a patient, by reference to any appropriate standards including GMC Guidelines. Assess the dangers of failing to follow the correct approach.

7. Explain the principles governing when and how it is appropriate to seek advice in this respect from colleagues, specialists or other sources of information.

Medical Records

8. Explain the principles governing the requirement of keeping adequate medical records in relation to the assessment and treatment of a patient, by reference to any appropriate standards including GMC Guidelines. Assess the dangers of failing to follow the correct approach.

9. Explain the use of drug charts (for example in Gosport War Memorial Hospital) and the principles governing how they should be used. Assess the dangers of failing to follow the correct approach.

Standards and Guidelines

10. Produce in evidence any relevant sections of the British National Formulary, for example the sections dealing with (a) Pain Relief, (b) Prescribing for the Elderly and (c) Syringe Drivers.

11. Produce in evidence any relevant sections of the Palliative Care Handbook Guidelines on Clinical Management, 3rd Edition (1995) – the "Wessex Protocols."

12. Produce in evidence any relevant GMC Guidelines.

13. Produce in evidence any other written materials which are of particular significance to appropriate medical practice in relation to the matters set out above.

MATTERS SPECIFIC TO GOSPORT WAR MEMORIAL HOSPITAL

14. If possible explain the nature of the position of 'Clinical Assistant' – the position of Dr Jane Barton at Gosport War Memorial Hospital in the period in question. Comment generally on the responsibilities she had. (If you consider this to be more properly dealt with by Trust Management please so indicate).

15. Explain how the drug chart in a hospital such as Gosport War Memorial Hospital should work. What do the terms 'written up,' 'prescribed' and 'administered' mean in this regard? Whose responsibility is it to ensure the drug chart is properly kept?

16. If a drug was written up PRN, for how long would this arrangement go on? When would or should the position be reassessed?

COMMON POINTS TO BE ADDRESSED IN RELATION TO EACH PATIENT

17. In the 'Summary of Conclusions' section for each patient, any failing identified should be particularised. For example, if there has been a failure to maintain adequate medical records, the matters that should have been recorded should be particularised.

18. In the "Summary of Conclusions' section for each patient, the significance of any failing identified should be set out. For example, if an excessive amount of opioid analgesia has been prescribed, the dangers of such a course of action should be made clear.

19. For each patient, set out in bullet-point format in chronological order the drugs prescribed, written up and administered and by whom it was done in each case.

20. Wherever a medical note of significance can be attributed to a particular doctor, it should be.

21. Set out the nature of Dr Barton's responsibility for each patient.

22. Failings attributable to Dr Barton must be clearly identified. Where failings are attributable to persons other than Dr Barton, this must be clearly identified. It must be clear where Dr Barton personally was at fault and where she was not.

23. Comment on the adequacy of the drug chart in each case. Was the drug chart used appropriately? Were any drugs 'written up' but not used? Were any drugs 'written up' but actually prescribed later? Was sufficient guidance given in each case by Dr Barton as to the administration of drugs? Was sufficient

guidance given in each case by Dr Barton as to when it would be appropriate to commence a syringe driver?

24. Comment on the appropriateness of prescribing a range in dose of drugs such as Diamorphine and Midazolam by syringe driver in each case that this practice appears – for example the prescription of Diamorphine 20-200mg/24hr PRN. Is this good practice? Are there any inherent dangers? Does it provide adequate guidance in terms of the dose of the drug actually to be administered? Who decides in such a case what the dose actually to be administered is? In each case, was there any justification for the top range of the dose prescribed, taking into account the age and personal circumstances of the patient in question?

MATTERS SPECIFIC TO EACH PATIENT

Leslie Pittock

25. **Age.** Mr Pittock's age at the time of his death should be checked.

26. **Page numbers.** References to the page numbers in the medical/nursing records should be added, as with the other reports.

27. **Pain assessment.** Do the medical notes reveal whether any assessment of pain was undertaken? If pain was assessed, were any efforts made to deal with the underlying causes? Set out in detail what the medical and nursing notes disclose in relation to the nature and degree of pain experienced by Mr Pittock. Do these matters have any significance for determining the purpose for which opiates were prescribed in this case?

28. **Agitation and opiate medication.** Was any assessment undertaken to determine the possible causes of Mr Pittock's agitation? Should such an assessment have been undertaken? Should it have included any consideration of whether drugs such as Diamorphine were a contributing factor? Should any review have been undertaken of the dose of opiate medication prescribed in this context? Was any consideration given to lowering the dose of Diamorphine?

29. **Use of syringe driver.** Was the use of a syringe driver appropriate in Mr Pittock's case? Was he able to take medication orally? Clarify from the medical and/or nursing notes who was responsible for commencing the syringe driver on 15/1/96.

30. **Sertraline and Lithium Carbonate.** Comment on the discontinuance of Sertraline and Lithium Carbonate on 12/1/96, particularly in terms of any effects on Mr Pittock's condition.

31. **Nozinan**. Comment on the appropriateness of the prescription of Nozinan on 18/1/96 and 20/1/96.

32. **Seeking advice.** Would it have been appropriate in this case for Dr Barton to have sought advice from any other source on the appropriate treatment for Mr Pittock? Do the records disclose any attempt to do so? Comment on the significance of any failing in this regard.

Elsie Lavender

33. **Age.** Mrs Lavender's age at the time of her death should be checked.

34. **Dr Lord/Dr Tandy.** Clarify which doctor examined Mrs Lavender on 16/2/96 (after referral on 13/2/96).

35. **Date of transfer**. Clarify the date of transfer to Daedalus Ward.

36. **Purpose of transfer to Daedalus Ward.** Clarify the purpose of Mrs Lavender's transfer to Daedalus Ward. Was this purpose appropriately taken into account upon Mrs Lavender's transfer? Comment on the significance of the purpose of transfer in assessing the appropriate treatment in Mrs Lavender's case.

37. **Pain assessment.** Expand upon the efforts apparent from the records to perform an appropriate pain assessment in Mrs Lavender's case. What efforts were made to identify, assess and address the causes of pain? What is required by the Wessex Guidelines in this respect? What course of action was appropriate? Comment upon Dr Barton's actions in this regard.

38. **Deterioration and opioid medication.** Should any consideration have been given to whether the use of opioid analgesia was contributing to Mrs Lavender's deteriorating condition on Daedalus Ward? What steps were appropriate in this regard? Should any review of the prescription or dose of opioid medication have been undertaken?

39. **Treatment of underlying medical conditions.** What efforts were there to treat Mrs Lavender's underlying medical conditions? What assessment took place of Mrs Lavender's urinary retention and the success of treatment for a urinary tract infection? What assessment and treatment took place in relation to her low platelet count, deteriorating kidney function, high blood sugars and leakage of faecal fluid? What advice or assessment was sought from colleagues or specialists in this regard? Comment on the significance of the approach adopted.

40. **Assessment of 24/2/96**. Clarify what basis Dr Barton had on 24/2/96 to provide a prognosis to Mrs Lavender's son on that day. What diagnoses had been

made? Comment on the significance of the outcome of the meeting between Dr Barton and Mrs Lavender's son that day.

41. **Midazolam.** Clarify the conclusion (at current paragraph 6.18) that the dose of Midazolam was too high. Is this correct? If so, an explanation as to why the dose was too high should be reflected in the report. Comment also upon the range of Midazolam prescribed in this case, particularly in respect of a patient who has not previously received opiates.

Eva Page

42. **Drug chart.** Clarify the correctness of the entry at current paragraph 5.11 of report – currently refers to a single dose of Oramorphine 5mg on 28/3/98 – should it refer to Diamorphine on 2/3/98? Clarify also whether it is possible to identify the date upon which the prescriptions for Diamorphine and Midazolam by syringe driver were written. Also, clarify in relation to paragraph 5.11 whether the Fentanyl was administered by patch or otherwise.

43. **Pain assessment.** Clarify whether there is any indication of the symptoms of lung cancer and/or pain experienced in Mrs Page's case. What pain assessment was carried out? What was the purpose of prescribing opiate analgesia in this case?

44. **Seeking advice.** Clarify whether expert psychogeriatric advice was sought and/or obtained in relation to the control of anxiety and stress in Mrs Page's case. Comment on the appropriateness of this course of action.

45. **Medical Records.** Do the medical records adequately set out the reason for the prescription of opiate medication on Mrs Page's admission to Dryad Ward?

46. **Drug combination.** Clarify whether it was appropriate in Mrs Page's case to commence Diamorphine and Midazolam in combination. Whether there was any justification for it and the potential harmful effects. What significance has the previous prescription of Fentanyl in this regard? What were the likely effects of this medication? Were the reasons for the administration of these drugs adequately recorded?

Alice Wilkie

47. No report has yet been produced by Professor Black in relation to Alice Wilkie. The following matters should be addressed in the forthcoming report, in addition to the general issues to be considered in respect of each patient set out above.

48. **Medical/pain assessment.** What evidence is there of pain on behalf of Mrs Wilkie? Was appropriate pain assessment carried out? Were appropriate efforts

made to address the underlying causes of pain? What medical assessment was carried out between 10/8/98 and 21/8/98?

49. **Prescription of opioid analgesia**. What was the basis of the decision to prescribe opioid analgesia? Were less powerful analgesics used first? Was the prescription of opioid analgesia appropriate? Comment on the dose prescribed and administered. Comment on the method of administration of the drugs in question. Was Mrs Wilkie able to take medication orally? Did adequate review of the dose of Diamorphine take place?

50. **Drug combination**. Was the prescription of Diamorphine and Midazolam in combination appropriate in Mrs Wilkie's case? What were the likely effects of the drugs administered on Mrs Wilkie?

51. **Medical records.** Were the medical records in Mrs Wilkie's case adequate? Were the reasons for the prescription and dose of opioid analgesia appropriately recorded?

Gladys Richards

52. **Date of transfer.** Clarify the date of Mrs Richards' transfer to Gosport War Memorial Hospital. Paragraph 5.6 may require correction.

53. **Drug chart.** Clarify the date of the prescription of Diamorphine 20-200mg – paragraph 5.9 currently suggests it was on 4/8/98 and should refer to 14/8/98. Also, paragraph 7.2 refers to a prescription on 17/8/98 – should this be 18/8/98?

54. **Purpose of transfer.** Clarify the purpose of Mrs Richards' transfer to Gosport War Memorial Hospital. Was this purpose appropriately taken into account upon Mrs Richards' transfer? Comment on the significance of the purpose of transfer in assessing the appropriate treatment in her case.

55. **State of health at date of transfer.** Clarify Mrs Richards' state of health at the time of her transfer to Gosport War Memorial Hospital. Comment in this regard on the significance of the fact that she was deemed well enough to undergo two operations on her right hip. Was Mrs Richards suffering from any life-threatening disease at the time of her transfer? Were these matters appropriately taken into account at the time of her receipt at Gosport War Memorial Hospital?

56. **Pain assessment – first transfer.** Was an adequate pain assessment carried out in Mrs Richards' case in relation to her first transfer to Gosport War Memorial Hospital? What do the medical and nursing records show in relation to whether she was in pain? What conclusions were reached by those treating Mrs Richards in this regard? Were these conclusions appropriate? Were appropriate

steps taken to identify and address any underlying causes of pain? What is the significance of behavioural disturbance in this regard?

57. **Pain assessment – second transfer.** Was an adequate pain assessment carried out upon Mrs Richards' return to Gosport War Memorial Hospital on 17/8/98? Were appropriate steps taken to identify and address any underlying causes of pain?

58. **Opiate medication – first transfer.** Was it appropriate to prescribe oral opiates and subcutaneous Morphine on Mrs Richards' initial admission to Gosport War Memorial Hospital? Could Mrs Richards take medication orally at that time?

59. **Drug sensitivity**. Comment upon any particular sensitivity that Mrs Richards had to Oramorphine and Midazolam. If such sensitivity did exist, did and should this have had any effect on the prescribing of opiate medication and benzodiazepines?

Ruby Lake

60. **Transfer to Gosport War Memorial Hospital.** Comment upon Mrs Lake's progress or deterioration prior to her transfer to Gosport War Memorial Hospital on 18/8/98. Comment in this regard on the significance of her cardiac enzyme measurements on 10/8/98 and 12/8/98. What was her condition on the day of transfer? Was her condition at the time adequately taken into account upon her receipt at Gosport War Memorial Hospital?

61. **Medical assessment.** What medical/pain assessment was appropriate on 19/8/98? Was an appropriate assessment conducted? Were adequate steps taken to identify and address any underlying medical condition and/or the causes of pain?

62. **Prescription of Oramorphine.** Clarify whether adequate justification is recorded for the prescription of Oramorphine on 19/8/98. Was such prescription appropriate?

63. **Prescription of Diamorphine and Midazolam.** Clarify whether adequate justification is recorded for the prescription of Diamorphine and Midazolam from 19/8/98. Was the prescription of these drugs appropriate, on the evidence available? Is it apparent whether the prescription was carried out before or after the chest pain of 19/8/98 was apparent?

64. **Syringe driver**. Clarify whether the medical records provide any justification for the use of the syringe driver in Mrs Lake's case? Were there any indications that Mrs Lake could not take medication orally? Is there any indication on the

face of the records of a diagnosis of myocardial infarction and/or cardiogenic shock?

Arthur Cunningham

65. **Date.** Correct the date given at paragraph 6.27 of the present report – "by 29th he is clearly delirious."

66. **Conclusions.** The 'Summary of Conclusions' should clearly set out whether it is the dose of Diamorphine or the dose of Midazolam which is criticised, or both, as well as the dates upon which the dose was excessive.

67. **Medical notes.** Comment generally on the adequacy of the medical notes in relation to Mr Cunningham's time on Dryad Ward.

68. **Note by Dr Barton.** Comment upon the entry in the medical records by Dr Barton on 25/9/98 – see page 837 of 928.

69. **Pain assessment.** Was an adequate pain assessment carried out in Mr Cunningham's case? Were appropriate efforts made to assess and address the underlying causes of pain?

70. **Morphine prescription.** Comment on the administration of Morphine 10mg at 22.20 on 21/9/98. Was this appropriate? Do the medical records provide an adequate justification?

71. **Syringe driver.** Comment on whether it was appropriate to commence the syringe driver on 21/9/98. Was the decision justified? Was adequate justification for this decision set out in the medical notes? What indication do the notes contain as to whether Mr Cunningham was able to take medication orally?

72. **Medical re-assessment.** In the light of the difficulty in controlling Mr Cunningham's symptoms, should any re-assessment of possible contributing factors to his condition have taken place? Should further information or advice have been sought from colleagues or any other source? Was this done?

73. **Deterioration and medication**. Should Mr Cunningham's deterioration by 23/9/98 have prompted any review of the doses of Diamorphine and Midazolam? Did this take place?

74. **Shortening of life.** Clarify the degree to which Mr Cunningham's like may have been shortened by the drug regime.

Robert Wilson

75. **Failure to obtain senior medical opinion.** Professor Black's criticism of the failure to obtain senior medical opinion on 16/10/98 should feature in the 'Summary of Conclusions' section.

76. **Hepatic Encephalopathy**. Explain further the condition of hepatic encephalopathy, particularly in relation to the likely effects of the administration of Oramorphine.

77. **Oramorphine**. Clarify by reference to the medical/nursing notes (page 263) the start date for Oramorphine – was it 14/10/98 rather than 15/10/98?

78. **Oral medication**. Clarify how it is known that by 16/10/98 Mr Wilson was unable to take oral medication.

79. **Prescription of Diamorphine and Midazolam.** Comment on the appropriateness of the prescription of Diamorphine and Midazolam on the day of transfer to Dryad Ward. Were the reasons for such a prescription adequately recorded? Was the prescription appropriate considering Mr Wilson's response to Oramorphine?

80. **Medical notes**. Do the medical notes adequately record the reason for commencing the syringe driver and Diamorphine on 16/10/98?

81. **Increase in dose of Diamorphine.** Professor Black's criticism of the increase in dose of Diamorphine and the addition of Midazolam from 17/10/98 should feature in the 'Summary of Conclusions' section.

82. **Consciousness.** What do the medical and nursing notes suggest in relation to the levels of pain, distress or discomfort suffered by Mr Wilson from 16/10/98. Do they reveal anything in relation to Mr Wilson's consciousness or unconsciousness from 16/10/98? Comment on the significance of these matters upon the appropriateness of increasing the dose of Diamorphine and Midazolam in Mr Wilson's case.

83. **Dr Peters.** Comment upon the involvement of Dr Peters in the treatment of Mr Wilson.

Enid Spurgin

84. **Diamorphine dose**. The dose of Diamorphine prescribed on 12/4/99 should be clarified – current paragraphs 5.17 and 6.9 are inconsistent (6.9 appears to be correct). Clarify also whether the criticism of the dose expressed at paragraph 6.9 refers to the dose *prior to* the reduction from 80mg to 40mg by Dr Reid.

85. **Pain assessment.** In the context of the criticism of the failure properly to assess Mrs Spurgin, expand upon the detail of the nursing notes in relation to any description of pain in Gosport War Memorial Hospital up to 7/4/99. What response was appropriate?

86. **Medical treatment.** Comment upon the adequacy of medical treatment of Mrs Spurgin and what measures may have been appropriate to treat her underlying medical conditions. Were adequate steps taken in this regard?

87. **Seeking advice.** Was it appropriate in Mrs Spurgin's case to seek advice and/or expert opinion from colleagues or other sources in relation to further treatment? Were appropriate steps taken in this regard?

88. **Response to vomiting**. Comment upon the appropriateness of the medical response to Mrs Spurgin's vomiting after the initial administration of Oramorphine – ie the substitution of Codydramol. Does this sequence reveal anything in relation to the appropriateness of the initial prescription of Oramorphine?

89. **Further medical assessment.** Was any further medical assessment conducted after Mrs Spurgin's deterioration on 11/4/99? Comment on the appropriateness of this course of action.

90. **Dr Reid**. Comment on the involvement of Dr Reid in the treatment of Mrs Spurgin and the appropriateness of Dr Reid's conduct.

Geoffrey Packman

91. **Date of review by Dr Reid.** This date is given at paragraph 5.12 of the current report as 9/9/99 – should this be 1/9/99?

92. **Blood count results.** Clarify whether the failure to obtain and act upon the result of Mr Packman's blood count is attributable to Dr Barton. Do the nursing notes reveal anything in this regard?

93. **Medical notes**. Comment generally on the adequacy of the medical notes relating to Mr Packman's time on Dryad Ward. Comment in particular on the adequacy of medical notes in relation to the prescription of medication on 26/8/99.

94. **Drug chart.** Comment on the multiple prescriptions written on 26/8/99 in conjunction with one another. Is this appropriate practice?

95. **'Not for resuscitation.'** Comment on the significance of the words 'not for resuscitation' in Mr Packman's medical notes. Do they have any significance in relation to the provision of other medical treatment to the patient?

96. **Condition on 26/8/99.** Explain the conditions which may have accounted for Mr Packman's presentation on 26/8/99. What do the blood test and the drop in haemoglobin levels reveal in this regard? What were the possible appropriate responses at this time, other than a decision to treat the patient symptomatically? Was successful treatment a possibility? Was Dr Barton's conclusion that Mr Packman was too unwell to be moved to an acute unit justified?

97. **Medical assessment**. Comment on the adequacy of medical assessment after 26/8/99.

98. **Verbal message to administer Diamorphine**. Comment on the appropriateness of the use of a verbal message to administer Diamorphine, as on 26/8/99.

Elsie Devine

99. **Fentanyl**. Expand upon the appropriateness of the prescription of a Fentanyl patch in Mrs Devine's case. What pain assessment had taken place? Had less powerful analgesia been considered or used? Was the dose appropriate?

100. **Initial medical assessment.** Comment on the adequacy of the initial medical assessment of Mrs Devine upon her transfer to Gosport War Memorial Hospital. Explain the significance for the treatment provided of the incorrect recording that Mrs Devine suffered from myeloma.

101. **Pain assessment.** Comment on the adequacy of any pain assessment conducted in relation to Mrs Devine. Were efforts made to identify and address any underlying causes?

102. **Later medical assessment**. In relation to the need to consider whether to treat Mrs Devine as terminally ill or referring her to the District General Hospital from 15/11/99 to 18/11/99, what do the medical records reveal in relation to such considerations and the reasoning for the approach adopted? Was the decision adequately considered and recorded?

103. **Fentanyl and deterioration**. Comment on the appropriateness of the response to Mrs Devine's deterioration on 19/11/99 following the administration of Fentanyl. Should consideration have been given to the possible contribution of Fentanyl to Mrs Devine's deterioration and to reducing the dose of opiate medication?

104. **Doses of Diamorphine and Midazolam.** Professor Black states that the doses were "higher than conventional guidance." Clarify whether they were excessive and what level of criticism should be attached.

105. **Chlorpromazine.** Comment on the appropriateness of the prescription of Chlorpromazine 50mg in Mrs Devine's case.