FFW/104/05.

HAMPSHIRE CONSTABULARY

OPERATION ROCHESTER

GOSPORT WAR MEMORIAL HOSPITAL

Code A

Volume 1

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Code A

Operation ROCHESTER.

Key points July 2006.

Code A

Code A was one of nine children raised in the Shaftsbury area of Dorset. In 1943 she married her husband Code A there was one child from the marriage. The couple retired to a caravan in Weymouth. Following Code A's death in Code A Mrs Code A moved to warden controlled premises in Gosport, Hampshire in 1990.

Mrs Code A suffered several chronic medical conditions during her lifetime including a heart attack in her 30's and a second similar attack in her 60's. She was a heavy smoker until ten years prior to her death suffering associated breathing problems for which she used an inhaler and had been admitted to hospital for a period of a month in 1989.

Additionally she suffered an under active thyroid and thin delicate skin that would damage very easily. She was an insomniac.

In 1995 Mrs Code A attended a geriatric day hospital under the care of a consultant geriatrician. A number of medical problems were identified including suffering headaches and heart problems.

She regularly attended her GP surgery in Gosport, four monthly between 1996 and 1999. Her GP Dr Code A recorded that she was suffering with chronic obstructive pulmonary disease which she had had for many years secondary to smoking, valvular heart disease and mild anxiety state leading to insomnia.

By December 1998 Mrs Code A was extremely unwell she was admitted to Haslar Hospital Gosport with chronic airways disease and left ventricular failure. Whilst in severe respiratory failure, she recovered enough to be declined social services intervention.

In February 1999 she was reviewed at outpatients for breathlessness, an X-ray of December 1998 confirmed that she was in heart failure.

On 15th August 1999 Mrs Code A was admitted to Haslar Hospital following a fall sustaining a fractured neck of the femur. The injury was dealt with by way of dynamic hip screw operation performed by Dr Code A without complication.

Her recovery was 'uneventful' she was described as unmotivated she suffered a swollen right leg, and was suffering chronic confusion and diarrhoea.

On 24th August 1999 consultant geriatrician Dr Code A decided to transfer her to Gosport War Memorial hospital, accordingly she was transferred on 3rd September 1999 at that time using a Zimmer frame, being catheterised and doubly incontinent, suffering asthma, heart failure and allergy to penicillin. Mrs Code A also remained confused.

Upon transfer to Dryad Ward Gosport War Memorial hospital a 20 bed ward, Mrs Code A was seen by Dr Code A who noted her condition as a fractured neck of the femur, history of hypothyroidism, asthma and cardiac failure. Dr Code A added that the plan was to get to know her and gentle rehabilitation. The record requested that nurses make her comfortable and added that Dr Code A was happy for nursing staff to confirm death.

Any pain present was satisfactorily controlled by co-dydramol twice a day and paracetamol.

On 6th September 1999 Mrs Code A is noted to have had a resolved left sided facial droop and tenderness to her right wrist. She was administered aspirin for her atrial fibrillation.

At this stage she was heavily dependent in terms of care and a high risk of suffering pressure sores.

Mrs Code A was then regularly reviewed both by Dr Code A and Consultant Dr Code A and was noted to be suffering poor appetite, agitation, variable confusion and with no significant improvement in mobility, she remained catheterised and faecally incontinent.

The lack of progress in rehabilitation continued, on the 1st November 1999 she vomited, between the 15th and 18th November 1999 she further deteriorated suffering chest infection and nausea. There followed a marked deterioration of her general condition nursing notes describing her as quite distressed and breathless.

Dr Code A authorised small doses of oral opiates to make the patient comfortable and recorded that she was happy for nursing staff to certify death.

The final drug chart from the 18th November until 22nd November showed that Oramorph (an oral opiate) was administered six hourly on the 18th/19th November, and Diamorphine 20mgs in 24hrs on 20th and 21st November 1999.

Mrs Code A further declined between the 19th and 22nd November 1999 and she died at 1720hrs on Code A her death being verified by Nurses Code A and Code A.

Dr Code A certified the cause of death as Bronchopneumonia.

Clinical team assessment.

Mrs Code A died 81 days after admission to Gosport War Memorial Hospital. She had suffered a fractured neck of the femur and other medical problems. The original aim was rehabilitation, but there was an early entry about keeping her comfortable. There was a suggestion of a stroke early in her stay at GWMH and she deteriorated. The decision was made to refer her to Nursing Home for care because she was unlikely to improve further. She then deteriorated with distress and breathlessness. The staff wondered about a chest infection but did not start antibiotics. Oromorph helped the distress and breathlessness, so she was started on a reasonably low dose of diamorphine through a syringe driver. Frusemide as a diuretic was given in case the breathlessness was due to fluid on the lungs. In the end the cause of death was not entirely clear (recorded as Bronchopneumonia) Should they have tried antibiotics or explained why they were not used? She probably would have died whatever was done from 15.11.1999.

Account Dr Code A from interview with police 25th August 2005.

Within a prepared statement Dr Code A outlined the medical history of the patient Mrs Code A prior to her admission to Gosport War memorial hospital on 3rd September 1999.

Dr Code A noted Mrs Code A 's condition and recorded that she was significantly dependent. In accordance with her usual practice she noted that she was happy for nursing staff to confirm death, this meaning that she wanted to ensure that nursing staff were aware that it was not necessary for a doctor to be called out if the patient were to die and a doctor were not available at the hospital at the time. Dr Code A had hoped that rehabilitation might prove possible but recognised the trauma of the fracture, the operation, the hospital transfer and her other medical problems there being a clear possibility therefore for deterioration in her condition.

Dr Code A prescribed medication in the form of Co-Dydramol and Oramorph for pain relief and a variety of other drugs to assist her with her other ailments.

In addition Dr Code A prescribed Diamorphine at a range of 20 – 200mgs, Hyoscine 200 -800 mcgs and Midazolam 20 -80 mgs to be available via syringe driver if necessary.

Dr Code A anticipates that she would have been available to review Mrs Code A S condition day by day each week, she was not able to make notes of routine assessment due to pressure of work however the consultant Dr Code A was making a weekly note following ward round assessment.

Dr Code A pointed out that the patient was reviewed by Consultant Dr Code A on the 13th/20th/27th September 1999, 4th/11th/18th/25th October 1999 and 1st/8th and 15th November 1999.

Dr Code A commented that Dr Code A would have reviewed the prescription chart when conducting his weekly ward round and would have been aware that Dr Code A had consistently written up drugs to be available 'as necessary'.

Dr Code A was abroad from 12th to 16th November 1999.

Dr Code A noted on examination of 15th November 1999 that Mrs Code A had become frailer being less well with a chest infection.

The nursing record of the 17th November showed that Mrs Code A continued to deteriorate being unwell distressed and breathless, as a consequence Dr Code A wrote up a prescription for Oramorph.

On the 18th November Dr Code A recorded the further deterioration, she was concerned that Mrs Code A might die and was anxious to speak to the Code A to warn her.

Dr Code A wrote up further prescriptions for Diamorphine, Hyoscine, Midazolam and Cyclizine, on the 19th November she became concerned that the patient was developing congestive cardiac failure.

In view of the continued deterioration it was appropriate to change from repeated administrations of Oramorph to Diamorphine via syringe driver.

Dr Code A recorded further deterioration on 22nd November 1999 and that the Diamorphine should continue.

The Diamorpohine and Oramorph that preceded it was prescribed by Dr Code A and administered solely with the intention of relieving the shortness of breath Mrs Code A was experiencing from what Dr Code A believed to be her cardiac failure and the anxiety and distress that Mrs Code A was suffering as a consequence.

Dr Code A concluded that at no time was the medication provided with the intention of hastening Mrs Code A 's demise.

<u>Expert Witness Dr Code A (Palliative medicine and medical oncology) will say:-</u>

Mrs Code A s decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of Diamorphine, the physical findings on the day of Mrs Code A s death would suggest that the dose she was receiving was

unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.

Expert Witness Dr Code A (Geriatrics) comments:-

Mrs Code A had a number of chronic diseases prior to her terminal admission following a fractured neck of femur. She had severe lung disease documented to going back to at least 1990, and in his view was extremely lucky to survive the admission in December 1998 at the age of 90 years. She also had documented heart failure, atrial fibrillation and heart cardiac valvular disease going back to at least 1995. It seems likely that she had cerebral vascular disease following the episode of diplopia in 1995 and the confusion that was subsequently documented is probably evidence of mild to moderate multiple infarct disease.

As is all too common, a very frail elderly lady had a fall and she suffered a fractured neck of femur. She was admitted to the Haslar Hospital for operative repair. There is always a very significant mortality and morbidity after fractured neck of femurs in old people, particularly in those who have had previous cardiac and other chronic diseases.

In the post operative period in Haslar she remained doubly incontinent of both urine and faeces and had considerable confusion, especially at night. She made very little rehabilitation progress. All of these are very poor prognostic signs at the age of 91.

She was subsequently assessed by the geriatric team and appropriately transferred to Gosport Hospital. The comment in the notes in Haslar, "will get home?" suggest that a consultant view was that even at this early stage, significant improvement was very unlikely, a view agreed by Dr Code A

When transferred to the Gosport War Memorial Hospital Mrs Code A was seen by Dr Code A who failed to record a clinical examination apart from some short statements about her past medical history and her functional history. However, Mrs Code A appeared to have been in a relatively stable clinical condition and no harm seemed to befall her as a result of this failure to examine her.

However, she was examined three days later by a different doctor when she had been noted to have a left sided facial droop and it seems quite likely that she had a further small stroke at this time as part of her multiple infarct disease.

Essentially she made no improvement in rehabilitation during her two months in Gosport War Memorial. She remained extremely dependent, eating very little and reliant on very considerable nursing input. There was ongoing discussion about the possibility of a long term nursing home

placement.

On 15th November she is noted to be quite unwell, the diagnosis was not entirely clear and Dr Code A wondered whether something was actually starting on 1st November when there was an episode of vomiting. The patient was examined and that examination is recorded in the notes. However, by 18th November, she had very rapidly deteriorated and Dr Code A made a record in the notes that because of her deterioration in general condition, oral opiates should be started in a small dose. Based on the nursing assessment of her distress and breathlessness, this was an appropriate response to someone who has an extremely poor prognosis, multiple chronic illnesses and making no significant progress after 3 months in hospital. A symptomatic response to this lady's problems was a reasonable clinical decision.

She received 5 mgs 6 hourly of Oramorphine on the 18th and 19th December, which Dr Code A believed to be an appropriate dosage and therapeutic regime. No improvement was made and she started on a Diamorphine pump at 20 mgs on 20th November. It would appear that the decision to start this was a nursing one, as no specific medical note was made on that day, however Dr Code A believed this to have been a reasonable decision for a patient who was dying.

Diamorphine was specifically prescribed for pain and is commonly used for pain /cardiac disease. However, it is also widely used for the distress and agitation that may be associated with terminal illness. Diamorphine can be mixed with Cyclizine (to prevent vomiting) in the same syringe driver. Diamorphine subcutaneously after Oramorphine is usually given a maximum ratio of 1 to 2 (for example up to 10 mgs of Diamorphine for 20 mgs of Oramorphine). On this occasion Code A had been receiving 20 mgs of Oramorphine a day on 18th and 19th where an absolute minimum dose of Diamorphine would have been 10 mgs in the syringe driver over the first 24 hours. However the increased to 20 mgs over 24 hours after 2 days of 20 mgs of Oramorphine would be within the range of acceptable clinical practice.

Seen on the 22nd, she was very ill with a rapid pulse, a rapid respiratory rate with a clear sounding chest. This suggests to Dr Code A that the agonal event may well have been a pulmonary embolus. However, this would not be surprising after a long period of poor mobilisation, following a fractured neck of femur.

A remaining concern regarding the clinical management was the anticipatory prescribing of strong opioid analgesia on both the first and second drug charts written between 3rd September and 17th November. Except where this would be useful as part on normal clinical management (for example after a heart attack), there appears to be no clinical justification for this prescribing pattern. However, although this may represent poor clinical practice, no harm came to Mrs Code A as a result of it.

The lack of clinical examination both on admission and more important Mrs Code A care deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above Dr Code A was satisfied that Mrs Code A 's death was of natural causes.

Evidence of other key witnesses.

Code A (Mrs Code A) Detailed medical history and background as known. His mother was heavy smoker, smoked 40 cigarettes a day. Following fractured hip in April 1999 mother was admitted to Queen Alexandra and then Gosport War memorial hospital. Seemed to be making progress but worsened after her bout of diarrhoea.

Code A (Code A Details family history, following her admission to Haslar hospital in 1999 Code A asked for a move to Gosport War Memorial hospital because she felt that she would receive rehabilitative treatment. Her Code A was initially very happy she thought the nurses were lovely and she made progress. Then declined, not eating or drinking much and staying in bed. On 20th November Mrs Code A was happy bright alert and lucid, did not complain of any pain. By 21st November she was lying on her side and appeared drowsy.

Code A (Code A General background information made several visits to Mrs Code A at GWMH. Was telephoned by a nurse on 22nd November to 'come in and say good-by', does not know why she died, she was a strong fit woman who had broken her hip.

Code A (great granddaughter) Background as above.

Code A (granddaughter) Background.

Code A (G.P retired) Code A in general practice at Bury Road Surgery, GOSPORT. Mrs Code A a patient since 1984. Initially attended infrequently but then every four months between 1996 and 1999.
Mrs Code A was on long term medication for an under active thyroid gland and a hypnotic as she was an insomniac. She was suffering fromchronic obstructive pulmonary disease secondary to smoking, valvular heart disease and mild anxiety leading to insomnia. As a result her routine medicine was:-
Thyroxine- For under-active thyroid.
Salbutomal, Beclaforte inhaler and Atrovent – for chronic obstructive pulmonary disease.
Zimovane-for insomnia.
Attended Mrs Code A 's home address 15th December 1998 breathless and could not lay down, diagnosed pneumonia in left lung and left ventricular failure and arranged admission to Queen Alexandra Hospital forthwith.

Code A (GP Retired) Gosport surgery.. saw Mrs Code A several times between 1986 and 1999 (22 occasions) for various ailments including, back pain, conjunctivitis, chest infections, sore mouth, dizziness, urinary tract infection, leg injury, falling and low pulse, headaches and lack of energy.

Code A (Consultant Orthopaedic Surgeon (retired)
On 16th August 1999 supervised the dynamic hip screw procedure to Mrs Code A s fractured neck of the femur, a routine operation with no complications. Then conducted 4 ward rounds between 18th and 31st August the patient progressed well and plan to transfer to GWMH for rehabilitation.

Code A (Senior House Officer Orthopaedics) post operative care Mrs Code A 25th August 1999 to 1st September 1999. Detailed notes indicate satisfactory progress in the patient over this period.

Code A (Clinical ward manager Haslar Hospital) Ward consisted of 20 beds with 20 staff on 24hr rota. Mr Code A wrote Mrs Code A s discharge letter of 3rd September 1999.

Code A (36 page statement) (Consultant Geriatrician)
Supervised Dr Code A at GWMH. Detailed notes of weekly ward rounds in respect of Mrs Code A from 13th September 1999 to 15th November 1999.
Felt it was inappropriate for Dr Code A to prescribe Diamorphine, Midazolam and Hyoscine on 3rd September 1999 in the absence of documented pain or distress and in the absence of documentation that Mrs Code A was terminally ill.
However it was appropriate for Dr Code A to prescribe opiates on 20th November 1999, it was common in patients in the terminal stages of life to clear secretions gathering in the upper airway and acceptable medical practice.
Dr Code A had once challenged Dr Code A about variable dosages, she was not happy about being challenged and gave any explanation that she was not always available for patients that develop severe pain or distress and nurses would be able to administer appropriate medication in a timely way to relieve pain and suffering.
Dr Code A trusted nurses to use discretion with variable doses appropriately. He did not recollect anything other than the minimum doses being administered.
Whilst cause of death was recorded as bronchopneumonia there was no specific record as such within the medical notes.
Whilst Dr Code A not keeping may have been poor due to pressures of work it was Dr Code A view that patients were being appropriately medically managed by her.

Code A (Consultant physician elderly medicine) Describes the process of consultant ward rounds conducted with Dr Code A. Conducted such a round with Dr Code A and Mrs Code A on 6th September 1999.

Code A (Consultant Radiologist) examined Mrs Code A s x-rays 7th September 1999 (taken 15.8.99) fractured femur, bones generally osteoporotic thin and brittle and degeneration to the wrist.

Code A (Nurse GWMH) History re syringe driver training/application. Employed Dryad Ward, wrote patient admittance summary in respect of Mrs Code A and patient care plan.

Code A (Clinical Manager Dryad Ward GWMH) responsible for 24hr care of patients Dryad Ward. Information re ward routines.
Administered Oramorph 17.11.99.
Completed drug register entries in respect of administration of Diamorphine and Oramorph.
Counter-signes death verification entry in respect of Mrs Code A

Code A (Nurse GWMH) Background re procedure/use of syringe drivers, ward rounds, and general entries on the nursing record pertaining to Mrs Code A Recorded that patient not very well distressed and breathless on 17.11.99 and unwell on 18.11.99. Witnessed nurse Code A administer Oramorph.

Code A (Carer GWMH) General nursing entries.

Code A (Nurse GWMH) Background re syringe drivers ward rounds and general nursing entries through Mrs Code A s tenure at GWMH. Administered 20mgs diamorphine to Mrs Code A on 21.11.99.

Code A (Nurse GWMH) Background re syringe driver procedure, ward round practices, various nursing note entries in respect of Mrs Code A including verification of death.

Code A (Nurse GWMH) General nursing note entries.

Code A (Nurse GWMH) General nursing note entry.

Code A (Detective Constable) Re interview Dr Code A 25th August 2005.

Code A
Detective Superintendent Code A
24th July 2006.

OPERATION ROCHESTER

Investigation Overview 1998-2006.

Background.

Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed during much of the period under investigation by the Fareham and Gosport Primary Care Trust. The hospital fell under the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002 when services were transferred to the local Primary Care Trust.

The hospital operates on a day-to-day basis by nursing and support staff employed by the PCT. Clinical expertise was provided by way of visiting general practitioners and clinical assistants, consultant cover being provided in the same way.

Elderly patients were generally admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Code A is a registered Medical Practitioner who in 1988 took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000.

Police Investigations.

Operation ROCHESTER was an investigation by Hampshire Police into the deaths of elderly patients at GWMH following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at levels or under circumstances that hastened or caused death. There were

further concerns raised by families of the deceased that the general standard of care afforded to patients was often sub-optimal and potentially negligent.

Most of the allegations involved a particular General Practitioner directly responsible for patient care Doctor Code A.

Two allegations (Code A) were pursued in respect of a consultant Dr Code A.

Of 945 death certificates issued in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Doctor Code A.

The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Dr Code A

The General Medical Council also heard evidence during Interim Order Committee Hearings to determine whether the registration of Dr Code A to continue to practice should be withdrawn. On each of the three occasions that the matter was heard the GMC was satisfied that there was no requirement for such an order and Dr Code A continued to practice under voluntary restrictions in respect of the administration of Opiate drugs.

<u>The First Police investigation.</u>

Hampshire Police investigations commenced in 1998 following the death of Code A Code A aged 91 years.

Mrs. Code A died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs. Code A two of her Code A Mrs. Code A and Mrs. Code A complained to the Hampshire Police about the treatment that had been given to their Code A at the GWMH. Mrs. Code A contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

The Reviewing CPS Lawyer determined that on the evidence available he did not consider a criminal prosecution to be justified.

Mrs. Code A then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs. Code A was upheld and a review of the police investigation was carried out.

Second Police Investigation

Hampshire Police commenced a re-investigation into the death of Code A on Monday 17th April 2000.

Professor Code A an elected member of the academy of experts provided medical opinion through a report dated 9th November 2000 making the following conclusions:

- "Doctor Code A prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Code A in a manner as to cause her death."

- "Mr. Code A, Ms. Code A and Ms. Code A were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs. Code A was unlawfully killed."

A meeting took place on 19th June 2001 between senior police officers, the CPS caseworker Code A, Treasury Counsel and Professor Code A.

Treasury Counsel took the view that Professor Code A's report on the medical aspects of the case, and his assertions that Mrs. Code A had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

Professor Code A provided a second report dated 10th July, 2001 where he essentially underpinned his earlier findings commenting:-

- "It is my opinion that as a result of being given these drugs Mrs Code A death occurred earlier than it would have done from natural causes."

In August 2001 the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Code A resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH as a result four more cases were randomly selected for review.

Expert opinions were sought of a further two medical professors Code A and Code A who were each provided with copies of the medical records of the four cases in addition to the medical records of Code A.

The reports from Professor Code A and Professor Code A were reviewed by the Police and a decision was taken not to forward them to the CPS as they were all of a similar nature to

the Code A case and would therefore attract a similar response as the earlier advice from counsel. A decision was then made by the Police that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor Code A and Professor Code A were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October 2001 the Commission for Health Improvement (CHI) launched an investigation into the management provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible at GWMH interviewing 59 staff in the process.

A report of the CHI investigation findings was published in May 2002 concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality patient care.

The CHI further reported that the Trust post investigation had adequate policies and guidelines in place that were being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer Sir Code A commissioned Professor Code A to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Professor Code A Immediately following the meeting nurse Code A (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

The documents were copies of memos letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including :-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol).
- Particular concerns regarding the conduct of Dr Code A in respect of prescription and administration of Diamorphine.

Nurse Code A S disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19th September 2002 the following decisions being made:-

- Examine the new documentation and investigate the events of 1991.
- Review existing evidence and new material in order to identify any additional viable lines of enquiry.
- Submit the new material to experts and subsequently to CPS.
- Examine individual and corporate liability.

A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

On 23rd September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients that had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns (including the five original cases)

In addition Professor Code A during his statistical review of mortality rates at GWMH identified 16 cases which were of concern to him in respect of pain management.

14 further cases were raised for investigation through ongoing complaints by family members between 2002 and 2006.

A total of 92 cases were investigated by police during the third phase of the investigation.

A team of medical experts (key clinical team) were appointed to review the 92 cases completing this work between September 2003 and August 2006.

The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

The terms of reference for the team were to examine patient notes initially independently and to assess the quality of care provided to each patient according to the expert's professional discipline.

The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1- Optimal care.
Category 2- Sub optimal care.
Category 3- Negligent care.

The cases were screened in batches of twenty then following this process the experts met to discuss findings and reach a consensus score.

Each expert was briefed regarding the requirement to retain and preserve their notations and findings for possible disclosure to interested parties.

All cases in categories 1 and 2 were quality assured by a medical/legal expert, Code A to further confirm the decision that there was no basis for further criminal investigation.

Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly were referred to the General Medical Council and Nursing and Midwifery Council for their information and attention.

Fourteen Category 3 cases were therefore referred for further investigation by police. Of the fourteen cases, four presented as matters that although potentially negligent in terms of standard of care were cases where the cause of death was assessed as entirely natural. Under these circumstances the essential element of causation could never be proven to sustain a criminal prosecution for homicide.

Notwithstanding that the four cases could not be prosecuted through the criminal court they were reviewed from an evidential perspective by an expert consultant Geriatrician Dr Code A who confirmed that the patients were in terminal end stage of life and that in his opinion death was through natural causes.

Accordingly the four cases ...Were released from police investigation in June 2006:-

- Code A

The final ten cases were subjected to full criminal investigation upon the basis that they had been assessed by the key clinical team as cases of 'negligent care that is to day outside the bounds of acceptable clinical practice, and cause of death unclear.'

The investigation parameters included taking statements from all relevant healthcare staff involved in care of the patient, of family members and the commissioning of medical experts to provide opinion in terms of causation and standard of care.

The expert witnesses, principally Dr Code A (Palliative care) and Dr Code A (Geriatrics) were provided guidance from the Crown Prosecution Service to ensure that their statements addressed the relevant legal issues in terms of potential homicide.

The experts completed their statements following review of medical records, all witness statements and transcripts of interviews of Dr Code A and Dr Code A the

healthcare professionals in jeopardy. They were also provided with the relevant documents required to put the circumstances of care into 'time context' The reviews were conducted by the experts independently.

Supplementary expert medical evidence was obtained to clarify particular medical conditions beyond the immediate sphere of knowledge of Dr's Code A and Code A.

A common denominator in respect of the ten cases was that the attending clinical assistant was Dr Code A who was responsible for the initial and continuing care of the patients including the prescription and administration of opiate and other drugs via syringe driver.

Dr Code A was interviewed under caution in respect of the allegations.

The interviews were conducted in two phases. The initial phase was designed to obtain an account from Dr Code A in respect of care delivered to individual patients. Dr Code A responded during these interviews through provision of prepared statements and exercising her right of silence in respect of questions asked.

During the second interview challenge phase (following provision of expert witness reports to the investigation team) Dr Code A exercised her right of silence refusing to answer any questions.

Consultant Dr Code A was interviewed in respect of 2 cases (Code A and Code A) following concerns raised by expert witnesses. Dr Code A answered all questions put.

Full files of evidence were incrementally submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.

- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

Additional evidence was forwarded to the CPS through the compilation of generic healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

The ten category three cases were:-

1. Code A Code A yrs. Admitted to GWMH 21st October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died Code A 1999, 32 days after admission cause of death recorded as Bronchopnuemonia and Glomerulonephritis.

2. Code A Code A yrs. Admitted to GWMH 22nd February 1996 with head injury /brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Died Code A 1996, 14 days after admission cause of death recorded as Cerebrovascular accident.

3. Code A Code A yrs. Admitted to GWMH 3rd September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died Code A 1999, 81 days after admission cause of death Bronchopnuemonia.

4. Code A Code A yrs. Admitted to GWMH 14th October 1998 with fractured left humerus and alcoholic hepatitis. Died Code A 1998 4 days after admission cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Code A yrs. Admitted to GWMH 26th March 1999 with a fractured neck of the femur. Died Code A 1999 18 days after admission cause of death recorded as cerebrovascular accident.

6. Code A yrs. Admitted to GWMH 18th August 1998 with a fractured neck of the femur, diarrhea atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Died Code A 1998 3 days after admission cause of death recorded as bronchopneumonia.

7. Code A yrs. Admitted to GWMH 5th January 1996 with Parkinsons disease he was physically and mentally frail immobile suffering depression. Died Code A Code A 1996 15 days after admission cause of death recorded as bronchopneumonia.

8. Code A yrs. Admitted to GWMH 3rd June 1997 with many medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died Code A Code A 1997 2 days after admission cause of death recorded as congestive cardiac failure.

9. Code A yrs. Admitted to GWMH 23rd August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died Code A 1999 13 days after admission cause of death recorded as myocardial infarction.

10. Code A yrs. Admitted to GWMH 21st September 1998 with Parkinson's disease and dementia. Died Code A 1998 5 days after admission cause of death recorded as bronchopneumonia.

Dr Code A provided extensive evidence in respect of patient care concluding with particular themes 'of concern' in respect of the final 10 category ten cases including:-

- *'Failure to keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues Including:-*

  Code A *– orthopaedic surgeon, microbiologist*

  Code A *– general physician, gastroenterologist*

  Code A *– general physician, cardiologist*

  Code A *– haematologist*

  Code A *– psychogeriatrician*

  Code A *– general physician/palliative care physician*

  Code A *– palliative care physician.*

Many of the concerns raised by Dr Code A were reflected by expert Geriatrician Dr Code A and other experts commissioned, the full details being contained within their reports.

There was however little consensus between the two principal experts Drs Code A and Code A as to whether the category 3 patients were in irreversible end stage terminal decline, and little consensus as to whether negligence more than minimally contributed towards the patient death.

As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that Doctors were negligent to criminal standard.

Whilst the medical evidence obtained by police was detailed and complex it did not prove that drugs contributed substantially towards death.

Even if causation could be proved there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of conviction.

Family group members of the deceased and stakeholders were informed of the decision in December 2006 and the police investigation other than referral of case papers to interested parties and general administration was closed.

Code A

Detective Superintendent Code A

Senior Investigating Officer.

16th January 2007.

Background/family observations

Code A was born on Code A She was one of nine children and lived just outside Code A, she married Code A on 4th June 1934 and had Code A Code A Apparently Mrs Code A became ill after childbirth and could not have anymore children after that. She was a small, slight lady. When Code A retired they moved to a caravan in Code A and then to Code A Code A died in Code A and Code A continued to live in the caravan alone until approximately 1990 when she moved into a warden assisted flat in Gosport.

Mrs Code A suffered a heart attack in her 30's and probably another one in her 60's. She was a heavy smoker and as a result suffered from emphysema which led to ongoing breathing problems for which she would use an inhaler. She stopped smoking 10 years prior to her death. She had an under active thyroid for which she took tablets and very thin, delicate skin that would bleed and bruise very easily, which the district nurse would attend to every week.

- In 1989 Mrs Code A was admitted to Haslar Hospital, with breathing problems, where she stayed for approximately one month.

In mid 1999 Mrs Code A fell and broke her hip. She was admitted to Haslar Hospital and had it pinned under local anaesthetic, due to her breathing problems. Her recovery was not as fast as other patients and after about four weeks was transferred to Gosport War Memorial Hospital for rehabilitation.

Initially Mrs Code A was very happy at Gosport War Memorial Hospital, she was mobile although could not walk far and did have some pain in her hip, was eating, drinking and making progress. There was then a change in Mrs Code A She would stay in bed, had a catheter fitted, was still suffering pain from her hip and would avoid doing her physio. When the nursing staff were challenged they replied "Because she doesn't want to get up", she then didn't eat or drink much and again when the staff were asked about this replied "They don't make them eat if they don't want to" and "They are at the time of their life that they can do as they please".

- Mrs Code A had a tube put into her stomach for pain killers, she was full up and bored and said that she "had had enough". Although this didn't concern her family as she was always saying things like that.

Some days she was slumped and depressed, others cheerful and chatty. At this time the family's expectation was that she would leave hospital by Christmas.

On Saturday 20th November 1999 Mrs Code A was happy, bright and alert. She didn't complain of being in pain nor did she appear to be suffering any pain.

On Sunday 21st November 1999 she was lying on her side, drowsy and not with it.

On Monday 22nd November 1999 Mrs Code A was unconscious and when her hand was held did not wake up or stir. At 5.30pm (1730) that day Mrs Code A died.

The family were of the opinion that the circumstances of Mrs Code A was not right and that she died very suddenly.

Mrs Code A was buried at Anns Hill Cemetery.

Sequence of Mrs Code A medical history.

Code A a Code A year-old lady in 1999 was admitted as an emergency on 15th August 1998 to Haslar Hospital.

She had a number of chronic conditions including a partial Thyroidectomy and Hypertension. In 1990 she was admitted with acute on chronic episode of obstructive airways disease. In 1991 an episode of abdominal pain and vomiting that was thought possible was pancreatitis. During this admission she received 6 doses on Omnopon each of 20 mgs with no ill effect. (Omnopon is Papaveretum, 15.4mg is the equivalent of 10mg of Morphine). In 1995 she attends the geriatric day hospital under the care of a consultant geriatrician with a number of problems, including headaches, slow atrial fibrillation, left ventricular failure and mitral regurgitation confirmed by an echo cardiogram. She has an episode of diplopia and is noted to have marked bruising.

She is thought to be depressed and is referred to a Dr Code A a psycho-geriatrician, who does not think she is significantly depressed but although she scores 10/10 on the mental test score, he does suspect possible early dementia. At that time she is on Frusemide, Thyroxine, Aspirin, regular Co-Proxamol and inhalers.

In December 1998 she is admitted severely ill to Haslar Hospital with chronic airways disease and left ventricular failure. She is in severe respiratory failure with a measured partial pressure of carbon dioxide (pCO2) of 12.6. However, she does recover and on this admission is declined Social Services intervention. In February 1999 she is reviewed in outpatients for episodic breathlessness. A chest x-ray in December 1998 confirms that she had heart failure.

On 15th August 199 she is admitted with a fractured proximal right femur and has a dynamic hip screw performed on 16th August. She seems to make a relatively uneventful recovery medically, although the occupational health notes on 20th August show that she is needing two to do most things and comments that she is not overly motivated. On 27th August her right leg is noted to be swollen and is started on Erythromycin. On 1st September it is still swollen.

In the meantime she has been referred to the geriatric team and is seen on 24th August. Dr Code A documents that she had a fractured neck of femur, that she has had acute on chronic confusion since the operation and that she had an episode of diarrhoea. He also writes in the Haslar notes after saying that he will transfer her to Gosport, "will get home?"

She is transferred on 3rd September 1999 to Gosport and the letter from Haslar states that she is using a Zimmer frame with help, has an indwelling catheter and is doubly incontinent. It also documents that she has had previous asthma, heart failure and is allergic to Penicillin. It states that at times she is very confused.

The notes on transfer to Dryad Ward (Dr Code A record she had a fractured neck of femur and a past medical history of hypothyroidism, asthma and cardiac failure. Needs help with ADL. She is incontinent and transfers for two with a Barthel of 3-4. The plan is to get to know her, gentle rehabilitation and she may need a nursing home. The record asks the nurses to make her comfortable and states "I am happy for the nursing staff to confirm death".

On 6th September she is seen by a different doctor after she had been noted to have a left-sided facial droop which has resolved. An examination is recorded in the notes and it also notes that she has pain tenderness in her right wrist. ("snuffbox"). She is started on Aspirin for her atrial fibrillation and x-rays are arranged. The x-ray showed no bony injury. At this stage her Barthel is 2 (very heavily dependent) with a Waterlow score of 35 identifying that she at very high risk of pressure sores.

She is then reviewed regularly on the ward with comment most weeks. In summary they document her very poor appetite, agitation and variable confusion with a lack of significant improvement in mobility. She remains catheterised and has faecal incontinence. Blood tests taken during this time, including a full blood count, liver function test and thyroid function test are all unremarkable, her weight on 22nd October is 45.3 kgs.

The lack of progress in rehabilitation and continued dependency, continues until the 1st November 1999 when an episode of vomiting is noted. On 11th November, her Barthel is still very dependent at 6.

On 15th November she is noted to be less well, it is thought possible that she has a chest infection and is having nausea. An examination is undertaken and recorded in the notes but no firm diagnosis is recorded. But there appears to have been some sort of change in her status. However, on the 18th November there is marked deterioration in her general condition. This is also noted in the nursing cardex, which states she is quite distressed and breathless. There is no medical examination recorded, however, it was decided to start oral opiates in a small dose and to "make comfortable". Dr Code A who saw her on this day records that she will speak to the Code A and again states that she was happy for nursing staff to certify death. She does suggest that there might have been a further stroke, but no examination is recorded.

On 19th November, nursing cardex reports her as poorly but stable.

On 22nd November a further decline is noted and that she is comfortable, an examination is undertaken and recorded and notes that she is breathless, chest is clear and she has uncontrolled atrial fibrillation. The decision to continue the Diamorphine is recorded, she dies 17.20 on 22nd November, and death is verified by Staff Nurse Code A and Staff Nurse Code A.

There are three main drug charts in the notes for her stay in Gosport. The first is from the 3rd September to 6th October. This records regular Thyroxine, Iron Lactulose, Senna, Atrovent Becloforte, Paracetamol, Aspirin, Fluoxetine and nebulizers.

On the as required part there is Co-dydramol, Prochlorperazine, Oramorph 10mgs in 5 mls, 2.5 – 5 mls prn (never given) also Diamorphine, Hyoscine, Midazolam, all of which are never given and Thioridazine which she receives on a regular basis together with Zopiclone at night.

The next drug chart goes from 7th October – 17th November. Regular medication includes Thyroxine, Fluoxetine, Aspirin, Paracetamol, Senna, Lactulose, Thioridazine and Temazepam. She receives 3 days of antibiotics from 1st November – 3rd November.

On the as required part Oramorphine, 10mgs in 5mls 2.5 -5mls orally four hourly prn is written up and one dose is given on 11th November. Metoclopromide and Gaviscon Loperamide are also written up.

The final drug chart goes from the 18th November up unto her death. On the regular side Oramorphine 10 mgs in 5mls is written up and 2.5mls (i.e.5mgs) is given 6 hourly on 18th and 19th November and on the morning of 20th November. Thyroxine, Fluoxetine continue to be given regularly up until 21st November.

Diamorphine 20 – 80 mgs subcutaneously in 24 hours, together with Hyoscine, Midazolam and Cyclizine are all written up on the as required part of the drug chart on 18th November. Diamorphine 20 mgs in 24 hours with 50 mgs of Cyclizine is given in an infusion pump. The first one starting on 20th November and the second on 21st November.

Dr Code A

The doctor on a day to day basis for the treatment and care of Code A was a Clinical Assistant. As such her role in caring for patients is governed by Standards of Practice and Care as outlined by the General Medical Council. The medical care provided by Dr Code A to Mrs Code A during her transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council, Good Medical Practice, October 1995, (pages 2–3)

The medical records were examined by two independent experts.

Dr Code A reports :-

Code A a Code A year old lady with a number of serious chronic diseases suffers a fall and fractured neck of femur in August 1999. She is admitted to the Haslar Hospital and making little rehabilitation progress, with a very poor prognosis she is transferred to the Gosport War Memorial Hospital.

There is some weakness in the documentation of her condition in particular on her admission to the Gosport War Memorial Hospital and on the 18th November when her definitive final clinical deterioration is documented. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patient's and any drugs or other treatment prescribed". The lack of clinical examination both on admission and more important Mrs Code A s care deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above I am satisfied that Mrs Code A 's death was of natural causes and that her overall clinical management in Gosport was just adequate.

Dr Code A 's report is awaiting completion although he has reviewed Mrs Code A 's medical notes and reports :-

- In summary, pain did not appear to be a major problem for Mrs Code A at the time of her transfer to Dryad Ward. Any pain present appeared satisfactorily controlled with p.r.n. doses of co-dydramol 2 tablets, twice a day at most. During Mrs Code A 's time on Dryad Ward, she appears to have experienced a number of pains. Apart from the pain in the right wrist, no medical assessment is documented and their underlying cause is unclear. Nevertheless, they were generally treated with paracetamol only. Thus, in my opinion, from a pain point of view, there was no justification for the prescription of diamorphine, hyoscine and midazolam to be given in a syringe driver on the day that she was transferred to Dryad Ward and when the drug chart was rewritten on the 18th November 1999. However, she did not receive any diamorphine until 20th November 1999. One obvious conclusion, that should be explored further, is that the use of these drugs, in these doses, was part of a 'standard' approach, that had little, if any, immediate consideration or relevance to an individual patient. The reasoning behind such an approach should be identified.
- In my opinion, from a pain point of view, there was no justification for the prescription of the regular oral morphine on the 18th November 1999 and the indication for its use needs to be determined. If it was for anxiety, as the nursing notes suggest, this in my opinion is not an appropriate use of morphine. However, opioids are indicated for the relief of symptoms other than pain, e.g. cough and breathlessness, and Mrs Code A did have breathlessness. In my experience, morphine is widely used to relieve breathlessness (generally occurring at rest) in patients with cancer. It is used less in non-cancer conditions causing breathlessness, although this practice may be increasing. Nevertheless, it is generally used for symptomatic relief of breathlessness that persists despite the optimal treatment of the underlying cause. In this regard, there is a lack of documentation in the medical notes that an assessment was made of Mrs Code A 's medical condition around the times that breathlessness seemed a particular problem, e.g. 17th and 19th November 1999. If a thorough medical assessment of Mrs Code A 's breathlessness on the 17th November 1999 had considered it to be due to heart failure, then appropriate management of her heart failure could be seen as a more appropriate response to her episodes of breathlessness and anxiety rather than the use of morphine per se. On the 19th November 1999, a stat dose of frusemide 40mg was given IM at 15.45h because of breathlessness. In my experience, it is generally the case that a patient who is considered to be a degree of heart failure sufficient to warrant parenteral frusemide, also warrants a medical review. Given this occurred at 15.45h, I would have considered it appropriate for Dr Code A /the doctor on call to have assessed Mrs Code A as soon as was possible the same day, and not to have left until the following morning. Even so, there was no medical notes entry for 20th November 1999, although regular oral frusemide 40mg once a day was presc\\ribed. I am not a cardiologist however, and the opinion of one could be sought if considered necessary regarding the above.

- The use of a syringe driver with an anti-emetic was reasonable, given that Mrs Code A was experiencing nausea and vomiting, and this is an indication for its use. The appropriateness of the use of diamorphine depends on the indication for the oral morphine.
- However, the above issues aside, Mrs Code A's decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of diamorphine, the physical findings on the day of Mrs Code A's death would suggest that the dose she was receiving was unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.

Interview of Dr Code A

Dr Code A has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified a registered medical practitioner in 1972. In addition to her GP duties she took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 25th August 2005 Dr Code A, in company with her solicitor, Mr Code A, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Code A at the Gosport War Memorial hospital.. The interviewing officers were DC Code A Code A and DC Code A.

The interview commenced at 0900 and lasted for 33 minutes. During this interview Dr Code A read a prepared statement, later produced as JB/PS/8.

This statement dealt with the specific issues surrounding the care and treatment of Code A Code A

The expert response to Dr Code A's statement is awaiting completion

Version 2 of complete report 1st November 2005 – Code A

SUMMARY OF CONCLUSIONS

Code A a Code A year old lady with a number of serious chronic diseases suffers a fall and fractured neck of femur in August 1999. She is admitted to the Haslar Hospital and making little rehabilitation progress, with a very poor prognosis she is transferred to the Gosport War Memorial Hospital.

There is some weakness in the documentation of her condition in particular on her admission to the Gosport War Memorial Hospital and on the 18th November when her definitive final clinical deterioration is documented. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patient's and any drugs or other treatment prescribed". The lack of clinical examination both on admission and more important Mrs Code A care deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above I am satisfied that Mrs Code A s death was of natural causes and that her overall clinical management in Gosport was just adequate.

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

Version 2 of complete report 1st November 2005 – Code A

Name	Professor Code A
Address	Code A
Telephone	Code A **E-mail:** Code A
DOB	Code A
Place	Code A
GMC	Full registration. No: Code A
Defence Union	Medical Defence Union. No: Code A

EDUCATION

Code A

DEGREES AND QUALIFICATIONS

Code A

SPECIALIST SOCIETIES

British Geriatrics Society

British Society of Gastroenterology

British Association of Medical Managers

Version 2 of complete report 1st November 2005 – Code A

PRESENT POST

Code A

PREVIOUS POSTS

Code A

PUBLICATIONS

Code A

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Code A

BOOK

Code A

RECENT SIGNIFICANT PRESENTATIONS

Secondary care as part of the whole system. Laing & Buisson conference on intermediate care. April 2001

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

The Geriatricians view of the NSF. BGS Autumn Meeting 2001

Version 2 of complete report 1st November 2005 – Code A

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

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

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

Revalidation - the State of Play. A Survival Guide for Physicians. Mainz July 2002

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

Developing Consultant Careers. Workshop: BAMM Medical Directors Meeting. Nov 2002

Lang and Buisson. Update on Intermediate Care Dec 2002

Intermediate Care Update: London National Elderly Care Conference. June 2003.

Appraisal- an update. GMC symposium on revalidation. Brighton. June 2003.

Innovations in emergency care for older people. HSJ Conference. London July 2003.

Emergency Care & Older People: separate elderly teams? RCP London March 2004

Professional Performance & New Consultants. London Deanery Conference April 2004

Mentoring as part of induction for new consultants. Mentoring in Medicine Conference. Nottingham. April 2004

The Future of Chronic Care- Where, How and Who? CEO & MD conference. RCP London. June 2004

Mentoring as part of consultant induction. Surviving to Thriving. New Consultant Conference, London June 2004

360 Degree Appraisal. Chairman National Conference. Nottingham June 2004

Maintaining Professional Performance. BAMM Annual Summer School. June 2004

Chronic Disease management. BGS Council Study Day. Basingstoke. July 2004

MMC post FP2. BGS Study Day. Basingstoke. July 2004

Designing care for older peoples. Emergency services conference. London July 2004.

The Modern Geriatric Day Hospital. Multidisciplinary Day. South East Kent hospitals. Sept 2004

Version 2 of complete report 1st November 2005 – Code A

Geriatricians and Acute General Medicine. BGS Autumn Meeting . Harrogate Oct 2004

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Code A (BJC/21)

[2] Operation Rochester Briefing Document Criminal Investigation Summary.

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

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

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

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

5.1. Code A a Code A year-old lady in 1999 was admitted as an emergency on 15th August 1998 to Haslar Hospital (H32).

5.2. She had a number of chronic conditions including a partial Thyroidectomy and Hypertension. In 1990 (H198) she was admitted with acute on chronic episode of obstructive airways disease. In 1991 (H205) an episode of abdominal pain and vomiting that was thought possible was pancreatitis. During this admission she received 6 doses on Omnopon each of 20 mgs with no ill effect (H363). (Omnopon is Papaveretum, 15.4mg is the equivalent of 10mg of Morphine). In 1995 she attends the geriatric day hospital under the care of a consultant geriatrician with a number of problems, including headaches (13), slow atrial fibrillation (33), left ventricular failure and mitral regurgitation (37) confirmed by an echo cardiogram (79). She has an episode of diplopia (39) and is noted to have marked bruising

(65).

5.3. She is thought to be depressed and is referred to a Dr Code A a psycho-geriatrician, who does not think she is significantly depressed but although she scores 10/10 on the mental test score, he does suspect possible early dementia. At that time she is on Frusemide, Thyroxine, Aspirin, regular Co-Proxamol and inhalers.

5.4. In December 1998 she is admitted severely ill to Haslar Hospital with chronic airways disease and left ventricular failure (H40). She is in severe respiratory failure with a measured partial pressure of carbon dioxide (pCO_2) of 12.6 (H49). However, she does recover and on this admission is declined Social Services intervention. In February 1999 (H31) she is reviewed in outpatients for episodic breathlessness. A chest x-ray in December 1998 (H8) confirms that she had heart failure.

5.5. On 15th August 199 she is admitted with a fractured proximal right femur (H32) and has a dynamic hip screw performed on 16th August (H32). She seems to make a relatively uneventful recovery medically, although the occupational health notes on 20th August show that she is needing two to do most things and comments that she is not overly motivated (H64). On 27th August her right leg is noted to be swollen and is started on Erythromycin (H84/85). On 1st September it is still swollen (H86).

5.6. In the meantime she has been referred to the geriatric team and is seen on 24th August (11). Dr Code A documents that she had a fractured neck of femur, that she has had acute on chronic confusion since the operation and that she had an episode of diarrhoea. He also writes in the Haslar notes after saying that he will transfer her to Gosport, "will get home?" (H83).

5.7. She is transferred on 3rd September 1999 to Gosport and the letter from Haslar (9,10) states that she is using a Zimmer frame with help, has an indwelling catheter and is doubly incontinent. It also documents that she has had previous asthma, heart failure and is allergic to Penicillin. It states that at times she is very confused.

5.8. The notes on transfer to Dryaed Ward 966) (Dr Code A) record she had a fractured neck of femur and a past medical history of

hypothyroidism, asthma and cardiac failure. Needs help with ADL. She is incontinent and transfers for two with a Barthel of 3-4. The plan is to get to know her, gentle rehabilitation and she may need a nursing home. The record asks the nurses to make her comfortable and states "I am happy for the nursing staff to confirm death".

5.9. On 6th September (67) she is seen by a different doctor after she had been noted to have a left-sided facial droop which has resolved. An examination is recorded in the notes and it also notes that she has pain tenderness in her right wrist. ("snuffbox"). She is started on Aspirin for her atrial fibrillation and x-rays are arranged. The x-ray showed no bony injury (127). At this stage 9195) her Barthel is 2 (very heavily dependent) with a Waterlow score of 35 (191) identifying that she at very high risk of pressure sores.

5.10. She is then reviewed regularly on the ward with comment most weeks (67-69). In summary they document her very poor appetite, agitation and variable confusion with a lack of significant improvement in mobility. She remains catheterised and has faecal incontinence. Blood tests taken during this time, including a full blood count, liver function testand thyroid function test are all unremarkable (101,111,99), her weight on 22nd October is 45.3 kgs (226).

5.11. The lack of progress in rehabilitation and continued dependency, continues until the 1st November 1999 (69) when an episode of vomiting is noted. On 11th November, her Barthel is still very dependent at 6 (193).

5.12. On 15th November (69) she is noted to be less well, it is thought possible that she has a chest infection and is having nausea. An examination is undertaken and recorded in the notes but no firm diagnosis is recorded. But there appears to have been some sort of change in her status. However, on the 18th November (70) there is marked deterioration in her general condition. This is also noted in the nursing cardex (239), which states she is quite distressed and breathless. There is no medical examination recorded, however, it was decided to start oral opiates in a small dose and to"make comfortable". Dr Code A who saw her on this day records that she will speak to the Code A and again states that she was happy for nursing staff to certify death. She does suggest that there might have been a further stroke, but no examination is recorded.

5.13. On 19th November, nursing cardex reports her as poorly but stable. (239)
On 22nd November a further decline is noted and that she is comfortable, an examination is undertaken and recorded and notes that she is breathless, chest is clear and she has uncontrolled atrial fibrillation. The decision to continue the Diamorphine is recorded, she dies 17.20 on Code A and death is verified by Staff Nurse Code A and Staff Nurse Code A (70).

5.14. There are three main drug charts in the notes for her stay in Gosport. The first is from the 3rd September to 6th October (154-166). This records regular Thyroxine, Iron Lactulose, Senna, Atrovent Becloforte, Paracetamol, Aspirin, Fluoxetine and nebulizers.

On the as required part there is Co-dydramol, Prochlorperazine, Oramorph 10mgs in 5 mls, 2.5 – 5 mls prn (never given) also Diamorphine, Hyoscine, Midazolam, all of which are never given and Thioridazine which she receives on a regular basis together with Zopiclone at night.

5.15. The next drug chart goes from 7th October – 17th November. Regular medication includes Thyroxine, Fluoxetine, Aspirin, Paracetamol, Senna, Lactulose, Thioridazine and Temazepam. She receives 3 days of antibiotics from 1st November – 3rd November.

On the as required part Oramorphine, 10mgs in 5mls 2.5 -5mls orally four hourly prn is written up and one dose is given on 11th November. Metoclopromide and Gaviscon Loperamide are also written up.

5.16. The final drug chart goes from the 18th November up unto her death. On the regular side Oramorphine 10 mgs in 5mls is written up and 2.5mls (i.e.5mgs) is given 6 hourly on 18th and 19th November and on the morning of 20th November (186). Thyroxine, Fluoxetine continue to be given regularly up until 21st November.

Diamorphine 20 – 80 mgs subcutaneously in 24 hours, together with Hyoscine, Midazolam and Cyclizine are all written up on the as required part of the drug chart on 18th November. Diamorphine 20 mgs in 24 hours with 50 mgs of Cyclizine is given in an infusion pump. The first one starting on 20th November and the second on 21st November.

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

6.2. Mrs Code A had a number of chronic diseases prior to her terminal admission following a fractured neck of femur. She had severe lung disease documented to going back to at least 1990, and in my view was extremely lucky to survive the admission in December 1998 at the age of Code A years. She also had documented heart failure, atrial fibrillation and heart cardiac valvular disease going back to at least 1995. It seems likely that she had cerebral vascular disease following the episode of diplopia in 1995 and the confusion that was subsequently documented is probably evidence of mild to moderate multiple infarct disease.

6.3. As is all too common, a very frail elderly lady has a fall and she suffered a fractured neck of femur. She is admitted to the Haslar Hospital for operative repair. There is always a very significant mortality and morbidity after fractured neck of femurs in old people, particularly in those who have had previous cardiac and other chronic diseases.

6.4. In the post operative period in Haslar, she remains doubly incontinent of both urine and faeces and has considerable confusion, especially at night. She makes very little rehabilitation progress. All of these are very poor prognostic signs at the age of 91.

6.5. She is subsequently assessed by the geriatric team and appropriately transferred to Gosport Hospital. The comment in the notes in Haslar, "will get home?" (H83) suggest that a consultant view was that even at this early stage, significant improvement was very unlikely. I would agree with that assessment.

6.6. When she is transferred to the Gosport War Memorial Hospital she is seen by Dr Code A who fails to record a clinical examination apart from some short statements about her past medical history and her functional history. However, Mrs Code A appears to have been in a relatively stable clinical condition and no harm

seems to befall her as a result of this failure to examine her.

6.7. However, she is examined three days later by a different doctor when she had been noted to have a left sided facial droop and it seems quite likely that she had a further small stroke at this time as part of her multiple infarct disease.

6.8. Essentially she makes no improvement in rehabilitation during her two months in Gosport War Memorial. She remains extremely dependent, eating very little and reliant on very considerable nursing input. There is ongoing discussion about the possibility of a long term nursing home placement.

6.9. On 15th November she is noted to be quite unwell, the diagnosis was not entirely clear and I wonder whether something was actually starting on 1st November when there was an episode of vomiting. The patient is examined and that examination is recorded in the notes. However, by 18th November, she has very rapidly deteriorated and Dr Code A makes a record in the notes that because of her deterioration in general condition, oral opiates should be started in a small dose. Based on the nursing assessment of her distress and breathlessness, this was an appropriate response to someone who has an extremely poor prognosis, multiple chronic illnesses and is making no significant progress after 3 months in hospital. A symptomatic response to this lady's problems are a reasonable clinical decision.

6.10. She receives 5 mgs 6 hourly of Oramorphine on the 18th and 19th December, which I believe to be an appropriate dosage and therapeutic regime. No improvement is made and she starts on Diamorphine pump at 20 mgs on 20th November. It would appear that the decision to start this was a nursing one as no specific medical note is made on that day, however I believe this to have been a reasonable decision for a patient who is dying.

6.11. Diamorphine is specifically prescribed for pain and is commonly used for pain cardiac disease . However, it is also widely used for the distress and agitation that may be associated with terminal illness. Diamorphine can be mixed with Cyclizine (to prevent vomiting) in the same syringe driver. Diamorphine subcutaneously after Oramorphine is usually given a maximum ratio of 1 to 2 (for example up to 10 mgs of Diamorphine for 20 mgs of Oramorphine). On this occasion Code A had been receiving 20 mgs of Oramorphine a day on 18th and 19th where an absolute minimum dose of Diamorphine would have been 10 mgs in the syringe driver over the first 24 hours. However the

increased to 20 mgs over 24 hours after 2 days of 20 mgs of Oramorphine would be within the range of acceptable clinical practice.

6.12. Seen on the 22nd, she is now very ill with a rapid pulse, a rapid respiratory rate with a clear sounding chest. This suggests to me that the agonal event may well have been a pulmonary embolus. However, this would not be surprising after a long period of poor mobilisation, following a fractured neck of femur.

6.13. A remaining concern regarding the clinical management is the anticipatory prescribing of strong opioid analgesia on both the first and second drug charts written between 3rd September and 17th November. Except where this would be useful as part on normal clinical management (for example after a heart attack), there appears to be no clinical justification for this prescribing pattern. However, although this may represent poor clinical practice, no harm came to Mrs Code A as a result of it.

7. OPINION

7.1. Code A a Code A year old lady with a number of serious chronic diseases suffers a fall and fractured neck of femur in August 1999. She is admitted to the Haslar Hospital and making little rehabilitation progress and with a very poor prognosis, she is transferred to the Gosport War Memorial Hospital.

7.2. There is some weakness in the documentation of her condition in particular on her admission to the Gosport War Memorial Hospital and on the 18th November when her definitive final clinical deterioration is documented. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patient's and any drugs or other treatment prescribed". The lack of clinical examination both on admission and more important Mrs Code A care deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above I am satisfied that Mrs Code A s death was of natural causes and that her overall clinical management in Gosport

was just adequate.

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: _____

Dr Code A 22nd December 2005

DRAFT OVERVIEW

OF

Code A (BJC/21 and JR/12)

PREPARED BY: Dr Code A MB ChB FRCP DM
Reader in Palliative Medicine and Medical Oncology

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. INSTRUCTIONS

To examine and provide a preliminary overview of the case of Code A

2. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Code A (BJC/21 and JR/12).

[2] Full set of medical records of Code A on CD-ROM (BJC/21).

[3] Hampshire Constabulary summary of care of Code A.

3. COMMENTS

Note: These comments are based on a preliminary read through the case notes of Code A *They are made without prejudice and a more detailed review may produce a report with differing comments and conclusions.*

For brevity and in keeping with the purpose of this overview I have restricted my comments under the following sub-headings.

Was pain clearly documented as a problem and assessed?

On the 15th August 1999, Mrs Code A fell and fractured her right hip (neck of femur) and was admitted to the Royal Hospital Haslar. The fracture was treated surgically with a dynamic hip screw on the 16th August 1999. For postoperative analgesia, Mrs Code A required occasional doses of 'weak' opioid analgesics as required (p.r.n.); initially she took no more than two doses of tramadol 100mg (which may have worsened her confusion) and subsequently co-dydramol (2 tablets; each tablet contains paracetamol 500mg and dihydrocodeine 10mg) per day. Pain did not appear to be a problem when Mrs Code A was reviewed by Code A on the 24th August 1999, nor in the transfer

letter written on the day of her transfer to Dryad Ward on the 3rd September 1999, at which time she was mobilising with a zimmer frame and the help of one other person. There was no mention of pain as a problem in the medical or nursing notes on her transfer to Dryad Ward. On an assessment sheet, which although undated appears as to have been filled in at the time of her transfer, the section on pain is completed to suggest that pain was present but controlled (page 243 of 346).

On the 6th September 1999, the medical notes record that Mrs Code A had pain and tenderness in the right 'snuff box' (wrist). This could have been injured when she fell, and an X-ray was carried out to exclude a fracture. I presume it was because of this wrist pain, that paracetamol was commenced regularly (1G four times a day) and continued until 23rd October 1999, after which the administration became erratic. There was no further mention of any pain in the medical notes. In the nursing care plan, other mentions of pain were:

- 22nd October 1999 - indigestion, given Gaviscon (an antacid)
- 25th October 1999 - pain in the right leg, given paracetamol
- 16th November 1999 - 'discomfort', site not specified, given paracetamol
- 17th November 1999 - pain in neck (followed by unintelligible word ?arm; page 204/346), given paracetamol
- 19th November 1999 - breathless and pain in shoulder, given frusemide (a diuretic) but no additional analgesia. Was receiving regular morphine at this point.

Apart from the pain in the right wrist, no medical assessment is documented and the underlying cause of these other pains is unclear. Nevertheless, they were generally treated with paracetamol only.

Was the management of the pain appropriate?

On her transfer to Dryad Ward on the 3rd September 1999, Mrs Code A was prescribed 2 co-dydramol tablets p.r.n., as at Royal Hospital Haslar. In my opinion, this was appropriate.

She was also prescribed oral morphine (Oramorph) 5–10mg every 4h p.r.n. It is unclear from the medical notes why this was considered necessary, particularly as Mrs Code A had only been requiring occasional doses of co-dydramol. Some practitioners do use small doses of morphine rather than dihydrocodeine, and although a dose of 5–10mg is in keeping with the BNF recommendations, given Mrs Code A s advanced age, a dose of morphine 2.5mg p.r.n. may well have sufficed. It would also have equated more closely to her dose of co-dydramol; morphine is 10 times more potent as dihydrocodeine and hence two tablets of co-dydramol (20mg dihydrocodeine) is equivalent to 2mg morphine.

On the day of her transfer, Mrs Code A was also prescribed diamorphine 20–200mg SC/24h, hyoscine (hydrobromide) 200–800microgram SC/24h and midazolam 20–80mg SC/24h by syringe driver. There is nothing documented that supports the prescription of these drugs; at the time of her transfer there was no suggestion that Mrs Code A had symptoms that required these drugs in these doses. Further, the medical plan for Mrs Code A was for gentle rehabilitation. However, Mrs Code A did not receive any diamorphine by syringe driver until 20th November 1999.

The subsequent prescription and administration of opioids does not appear to have been primarily for pain, and the exact reason for their use should be clarified. On the 17th November 1999 the nursing summary notes record that Mrs Code A was not very well in the evening and was becoming quite distressed and breathless at times and that morphine 5mg was given to relieve

her distress with good effect. In my opinion, opioids are not indicated as a non-specific treatment of 'distress.' If Mrs Code A was distressed because of her breathlessness, it would have been most appropriate to have first assessed and treated any underlying cause, when possible and appropriate. There are many reasons why someone may become breathless, many of which are relevant given Mrs Code A s past medical history, e.g. chest infection, asthma/chronic obstructive airways disease, atrial fibrillation and heart failure. The latter may be particularly relevant as Mrs Code A s only heart failure treatment she had been receiving (captopril) was discontinued at Haslar, possibly because of low blood pressure peri-operatively.

On the 18th November 1999, she was seen by Dr Code A, and the medical notes conclude that Mrs Code A may have had a further CVA (cerebrovascular accident; a stroke), although the medical history/physical findings that led to this conclusion are not documented. There was no documentation of breathlessness or distress, and no documentation that a physical examination had taken place. Oral morphine was commenced regularly (5mg every four hours and 10mg at night). The nursing summary note seems to indicate that the morphine was commenced because Mrs Code A was feeling anxious. In my opinion, this is not an appropriate use of morphine.

The drug chart was rewritten on the 18th November 1999, and again included prescriptions for diamorphine (now in a range of 20–80mg SC/24h), hyoscine (hydrobromide) 200–800microgram SC/24h and midazolam 20–80mg SC/24h by syringe driver. On the afternoon of the 20th November 1999, a syringe driver was commenced containing diamorphine 20mg and cyclizine (an anti-emetic) 50mg SC over 24h. This was continued on the 21st November 1999 and Mrs Code A died at 17.20h. Mrs Code A had been experiencing nausea and

vomiting and this is an indication for the use of a syringe driver containing an anti-emetic. The cyclizine was prescribed as a range (50–200mg/24h) but I note Mrs Code A received a stat dose of 50mg at 13.15h on 20th November 1999. The dose in the syringe driver (50mg/24h) was smaller than that generally given (150mg/24h). In order to comment on the appropriateness of the use of the diamorphine, clarification is required on the indication for the oral morphine.

Were excessive doses of morphine/diamorphine/midazolam administered?

In my opinion, on the day of her transfer, the prescription of diamorphine 20–200mg SC/24h and midazolam 20–80mg SC/24h by syringe driver appears unnecessary and inappropriate. However, Mrs Code A did not receive any diamorphine by syringe driver until 20th November 1999.

On the 18th November 1999, Mrs Code A was seen by Dr Code A and commenced on oral morphine 5mg every 4h and 10mg at night. The reason for this should be clarified. It is not unusual for a double dose to be given at 22.00h, to try and avoid the need for a 02.00h dose. This starting dose is in keeping with the BNF (i.e. 30mg/24h). However, given Mrs Code A s advanced age, a smaller dose may well have sufficed and would have been more appropriate in my opinion (i.e. 15mg/24h). Mrs Code A received this dose of oral morphine for 48h, between the 18–20th November 1999.

The drug chart was rewritten on the 18th November 1999 and again included prescriptions for diamorphine 20–80mg SC over 24h, hyoscine and midazolam. Mrs Code A commenced a syringe driver containing 20mg of diamorphine on the 20th November at 17.00h. To calculate an appropriate dose of SC diamorphine, the daily oral morphine dose is divided by 2 or more generally 3. Given that Mrs Code A had been receiving 30mg/24h of oral morphine, her SC

diamorphine dose should thus have been 10–15mg/24h rather than the 20mg/24h she received. Although these figures do not differ greatly, they may be important in an elderly patient and it should be ascertained how Dr Code A calculated or determined that the dose of diamorphine 20mg/24h was appropriate for Mrs Code A.

Was the death of the patient anticipated?

Mrs Code A was a frail Code A year old with significant medical problems, namely heart failure, atrial fibrillation and a probable cerebrovascular accident (CVA) who had fell and fractured her right hip. She was confused at times. Following transfer to Dryad ward Mrs Code A was slow to mobilise. She possibly sustained a further small stroke causing the left side of her face to droop and her to lean to the left when standing. Her mobility failed to improve significantly. On the 27th September 1999, she was noted to be 'generally less well' and on the 11th October 1999, 'very dependent and delightfully (usually) confused' and the aim then became nursing home placement. On the 15th November 1999, she was noted to be frailer, less well and to have a chest infection. She also had occasional bouts of nausea. On the 18th November 1999, a further deterioration in Mrs Code A general condition was noted and it was considered that she may have had a further CVA. She was commenced on oral opioids for a reason that remains to be clarified. Mrs Code A subsequently declined further and was commenced on a syringe driver on the 20th November 1999 and died on the Code A 1999 at 17.20h. Earlier on that day, Mrs Code A was reviewed by Dr Code A who noted her to be able to give short verbal responses, to have a respiratory rate of 24 breaths/min and her chest clear at (unintelligible word; page 70/346).

Thus, Mrs Code A s physical decline had been documented over several weeks. Part of her deterioration appeared to have been the symptom of breathlessness. It is unclear from the medical notes, what the underlying cause of this was, although it may have been multifactorial; Mrs Code A had asthma/chronic obstructive airways disease, heart failure and a chest infection. The use of frusemide IM and subsequently orally does suggest that heart failure was considered to be a contributing factor. Contrary to this would be the finding of a clear chest on the 15th and the 22nd November 1999; in heart failure generally crackles, caused by excess fluid, are audible in the chest.

The reason for the prescription of the oral morphine and subsequently the diamorphine remains to be clarified. However, the fact that Mrs Code A was capable of responding and had a respiratory rate of 24 breaths/min suggests that the dose of diamorphine she was receiving was not excessive to the point of rendering her unresponsive or depressing her respiration.

4. CONCLUSION

In summary, pain did not appear to be a major problem for Mrs Code A at the time of her transfer to Dryad Ward. Any pain present appeared satisfactorily controlled with p.r.n. doses of co-dydramol 2 tablets, twice a day at most. During Mrs Code A s time on Dryad Ward, she appears to have experienced a number of pains. Apart from the pain in the right wrist, no medical assessment is documented and their underlying cause is unclear. Nevertheless, they were generally treated with paracetamol only. Thus, in my opinion, from a pain point of view, there was no justification for the prescription of diamorphine, hyoscine and midazolam to be given in a syringe driver on the day that she was transferred to Dryad Ward and when the drug chart was rewritten on the 18th

November 1999. However, she did not receive any diamorphine until 20th November 1999. One obvious conclusion, that should be explored further, is that the use of these drugs, in these doses, was part of a 'standard' approach, that had little, if any, immediate consideration or relevance to an individual patient. The reasoning behind such an approach should be identified.

In my opinion, from a pain point of view, there was no justification for the prescription of the regular oral morphine on the 18th November 1999 and the indication for its use needs to be determined. If it was for anxiety, as the nursing notes suggest, this in my opinion is not an appropriate use of morphine. However, opioids are indicated for the relief of symptoms other than pain, e.g. cough and breathlessness, and Mrs Code A did have breathlessness. In my experience, morphine is widely used to relieve breathlessness (generally occurring at rest) in patients with cancer. It is used less in non-cancer conditions causing breathlessness, although this practice may be increasing. Nevertheless, it is generally used for symptomatic relief of breathlessness that persists despite the optimal treatment of the underlying cause. In this regard, there is a lack of documentation in the medical notes that an assessment was made of Mrs Code A's medical condition around the times that breathlessness seemed a particular problem, e.g. 17th and 19th November 1999. If a thorough medical assessment of Mrs Code A's breathlessness on the 17th November 1999 had considered it to be due to heart failure, then appropriate management of her heart failure could be seen as a more appropriate response to her episodes of breathlessness and anxiety rather than the use of morphine per se. On the 19th November 1999, a stat dose of frusemide 40mg was given IM at 15.45h because of breathlessness. In my experience, it is generally the case that a patient who is considered to be a degree of heart failure sufficient to

warrant parenteral frusemide, also warrants a medical review. Given this occurred at 15.45h, I would have considered it appropriate for Dr Code A /the doctor on call to have assessed Mrs Code A as soon as was possible the same day, and not to have left until the following morning. Even so, there was no medical notes entry for 20th November 1999, although regular oral frusemide 40mg once a day was prescribed. I am not a cardiologist however, and the opinion of one could be sought if considered necessary regarding the above.

The use of a syringe driver with an anti-emetic was reasonable, given that Mrs Code A was experiencing nausea and vomiting, and this is an indication for its use. The appropriateness of the use of diamorphine depends on the indication for the oral morphine.

However, the above issues aside, Mrs Code A s decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of diamorphine, the physical findings on the day of Mrs Code A s death would suggest that the dose she was receiving was unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.

Form MG15(T)

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RECORD OF INTERVIEW

Enter type: ROT
I
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: Code A

Place of interview: NETLEY SUPPORT HEADQUARTERS

Date of interview: 25/08/2005

Time commenced: 0900 Time concluded: 0933

Duration of interview: 33 MINUTES (→) Tape reference nos. CSY/JAB/9

Interviewer(s): DC Code A / DC Code A

Other persons present: MR Code A, SOLICITOR

Police Exhibit No: CSY/JAB/9A	Number of Pages: 26
Signature of interviewer producing exhibit	

Person speaking	Text
DC Code A	This interview is being tape recorded. I am DC Code A Code A. My colleague is …
DC Code A	DC Code A.
DC Code A	… I'm interviewing Doctor Code A. Doctor will you please give your full name and your date of birth?
Code A	Code A

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DC Code A — Thank you. Also present is Mr Code A who is Doctor Code A's solicitor. Can you please introduce yourself with your full name?

Code A — Gladly my name is Code A and I confirm I am Doctor Code A's solicitor.

DC Code A — Thank you. This interview is being conducted in an office within the Fraud Squad at Netley Support Headquarters in Hampshire. The time is nine o'clock, 0900 hours and the date is the 25th of August 2005. At the conclusion of the interview I'll give you a notice explaining what will happen to the tapes. I must remind you doctor that you're still entitled to free legal advice. Mr Code A is here as your legal advisor. Have you had enough time to consult with Mr Code A in private or would you like further time?

Code A — Fine thank you.

DC Code A — If at any time you wish to stop the interview and take legal advice then just say so and we'll stop the interview and that can be done. I'd also like to point out that you have attended voluntarily, you're not under arrest and you've come here of your own free will. So if at any time that you wish to leave you're free to do so. I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court. Anything you do say maybe given in evidence. Do you understand that caution?

Code A — I do.

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DC Code A — I usually ask you to explain it for my own peace of mind but end up explaining it myself, which I will do. I'll split it into the three normal parts, the first part is you haven't got to speak to us which you know. The last part is it can be given in evidence, it's being tape recorded. It's the middle bit, if you do not mention when questioned something which you later rely on in court. If you're asked questions and you do not mention something now and later should this go to court and give an answer then the court may and it is a may, take an inference. It's a very brief synopsis of it. On this occasion the room is not remotely monitored otherwise there would be a little red light on the machine. As before it'll be me speaking to you the majority of the time but DC Code A will almost certainly be taking some notes during the interview. Mr Code A the last time we met, hope I get it right this time, was Thursday 14th of July.

Code A — You're right.

DC Code A — Thank you and we handed you by way of advanced disclosure for this interview copies of the medical notes of Code A and a brief synopsis of her care, is that right?

Code A — Code A?

DC Code A — Code A. My fault.

DC Code A — No it's alright we've got Code A with us, Code A Code A sorry had to get something wrong in there.

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Code A — It's not a problem.

DC Code A — Right are you happy with the disclosure we've given you anyway?

Code A — I'm happy that you've given me, ...

DC Code A — Can you confirm ...

Code A — ... I can confirm that you've given me the medical records in relation to Code A as I am saying they are, yeah.

DC Code A — ... yeah. Right this investigation is being conducted by the Hampshire Constabulary and it started in September 2002 and by now it's already been running nearly three years and still going to continue to run for a little bit more yet. It's an investigation into allegations of the unlawful killing of a number of patients at the Gosport War Memorial Hospital between 1990 and 2000. Now no decision has been made as to whether an offence or any offence has been committed but it's important to be aware that the offence range being investigated runs from potential murder right the way down to assault. Part of the ongoing enquiries is to interview witnesses who were involved in the care and treatment of the patients during that period. You were a clinical assistant, doctor, at the Gosport War Memorial Hospital at the time of these deaths so your knowledge of the working of the hospital, the care and the treatment of the patients is very central to our enquiry. The interview

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today will concentrate on the care and treatment of Code A Code A, who was admitted to Gosport War Memorial Hospital. Perhaps doctor in your own words you could tell me what you recollect of Mrs Code A 's care and treatment that she received whilst at the Gosport War Memorial Hospital. Now the normal set up here is that you've got a prepared statement is that what's going to happen?

Code A That's precisely correct.

DC Code A Okay. I'll ask you to read it in a second doctor. Can I just confirm that it's your statement and you made it?

Code A My statement and I made it.

DC Code A Lovely, well if you'd like to read the statement doctor.

Code A 'I am Dr Code A 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.

I understand you are concerned to interview me in relation to a patient at the Gosport War Memorial Hospital, Mrs Code A . Unfortunately at this remove of time I have no recollection at all of Mrs Code A As you are aware, I provided you with a statement on the 4th 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 Gosport War Memorial. I adopt that statement now in relation to general issues insofar as they relate to Mrs Code A

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 War Memorial Hospital 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 Mrs Code A.

Mrs Code A was Code A years of age and lived alone in warden controlled accommodation. It appears that she was independent although had problems with mobility. She was supported by her extended family.

Her past medical history included emphysema (chronic obstructive pulmonary disease), hypothyroidism, ischaemic heart disease and atrial fibrillation. In 1995 she was seen

by Consultant Geriatrician Dr Code A at the Queen Alexandra Hospital who found that Mrs Code A 's main problems at that stage were hypertension, slow atrial fibrillation, mitral regurgitation and possible pulmonary congestion. A chest x-ray in February 1995 revealed that her heart was enlarged. ECG confirmed very slow atrial fibrillation with some lateral ischaemia.

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On the 15th August 1999 Mrs Code A was admitted once more to the Royal Hospital Haslar following a fall. She was diagnosed as having a closed fracture of the proximal femur and at operation the following day a dynamic hip screw was inserted. The anaesthetist

conducting anaesthesia for the procedure assessed her in advance of the procedure as being ASA IV, being a high anaesthetic risk, commenting that she had very poor respiratory and cardio-vascular system reserve.

Mrs Code A 's post operative recovery appears to have been relatively uncomplicated. On the 23rd August Dr Code A was asked to see her with a view to considering rehabilitation. In fact, it was Consultant Geriatrician, Dr Code A, who then saw her on the 23rd August. In her subsequent letter of the 24th August to Consultant Orthopaedic Surgeon Mr Code A, Dr Code A observed that she had a past medical history of hypothyroidism, asthma and cardiac failure. At the time of the assessment she had an acute on chronic confusional state. Dr Code A noted that Mrs Code A had previously lived alone in a warden controlled flat with family to help out. Apparently she was normally a bit confused but managed to get out to the shops. Her confusion had increased after the operation, particularly at night. She was now often quite confused and needed to be orientated in time and place. Dr Code A noted a previous medical history of myxoedema, asthma and cardiac failure. She had been suffering from diarrhoea and had had a fever the previous day but she was beginning to mobilise and take a few steps with one nurse using a Zimmer frame. Dr Code A said she would be happy to take Mrs Code A to the Gosport War Memorial Hospital. In her note of her assessment the previous day, Dr Code A has also recorded:- "? will get home?", from which it would seem that whilst Dr Code A felt that even if Mrs Code A did recover, she was not anticipating

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I admitted Mrs Code A to Dryad Ward at the GWMH on 3rd September in Mrs Code A 's records in this regard reads as follows:-

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PMH hypothyroidism
Asthma
Cardiac failure
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Plan Get to know
Gentle rehab
? nursing home
please make comfortable
I am happy for nursing staff to confirm death'.

As it is clear from my note, I assessed Mrs Code A 's Barthel score as 3-4, though two days later a nursing assessment has it recorded as 2. It was apparent though

that Mrs Code A was significantly dependent at that time. In accordance with my usual practice, I recorded that I was happy for nursing staff to confirm death. As I have previously indicated, this was simply to ensure that nursing staff were aware that it was not necessary for a doctor to be called out of hours if the patient were to die and a doctor was not available at the hospital at the time. From my assessment, I hoped that rehabilitation might indeed prove possible but at the same time, recognising that Mrs Code A had had the trauma of a fracture, followed by operation and then a move to another hospital, and in circumstances in which she had a number of medical problems, there was the clear possibility for deterioration in her condition.

I prescribed medication for Mrs Code A in the form of Co-dydramol and Oramorph for pain relief, the Oramorph at a dose of 2.5 to 5mls in a 10mg 5mls solution 4 hourly. Prochloperazine as an anti-emetic, and Zopiclone to help her sleep, all to be available as required. I also prescribed Thyroxine 100mcgs once a day for hypothyroidism, Ferrous Sulphate 200mgs 3 times a day for iron deficiency anaemia, Lactulose 15mls twice a day and 2 senna tablets at night both for constipation, and Atrovent and Becloforte inhalers for her chronic obstructive pulmonary disease.

In addition, I also prescribed Diamorphine 20-200mgs, Hyoscine 200-800mcgs and Midazolam 20-80mgs to be available via syringe driver if necessary. In doing so, I did not consider that it was necessary for these medications including Diamorphine to be administered at that point and

would not have approved the administration if I had been asked to do so. Rather, I was concerned that if there were to be a deterioration, such medication could then be available as necessary. If I was not immediately available in the hospital, I would nonetheless be consulted by the nursing staff before it was commenced.

The nursing entry the same day – 3rd September recorded that Mrs Code A could become confused at times and needed orientating in terms of time and space. She was noted to mobilise with the help of one nurse and using a Zimmer frame and had an in-dwelling catheter and could be incontinent of faeces.

I anticipate that I would then have seen Mrs Code A to review her condition day by day, each week day. Unfortunately, I was not able to make notes in my routine assessments of her, I anticipate due to the sheer pressure of work at the time and in circumstances in which the Consultant was in any event making a regular weekly note following ward round assessment. I would have endeavoured to make a note if Mrs Code A's condition changed significantly.

By 1999 the Healthcare Trust had appointed a Clinical Director, Dr Code A and one of his responsibilities was for Dryad Ward. In consequence, unless he was unavailable, Dr Code A would carry out a weekly ward round. Dr Code A had effectively taken over responsibility for Dryad Ward from Dr Code A who, having returned from maternity leave, did not then carry out

clinical care work at Gosport War Memorial Hospital as best I can recall it.

Unfortunately, although Dr Code A's weekly attendance for a ward round on Dryad Ward was welcome, Dr Code A, in addition to agreeing to a transfer of patients for other hospitals, would also agree to take admissions from home. Patients admitted from home had not had the same degree of thorough investigation and stabilisation prior to admission, and this increased the workload still further.

In any event on the 6th September Mrs Code A was seen by a locum Consultant Dr Code A who recorded that she was noticed to have left sided facial droop, but was now better. There was apparently no visual disturbance, no facial weakness nor arm weakness and both plantars were down. He considered that Mrs Code A was in atrial fibrillation and had a small pressure sore. She was said to be 'in retention', by which I anticipate he meant that she was retaining urine. He noted pain and tenderness in the right anatomical snuff box – on her wrist/hand. Dr Code A prescribed Aspirin for the atrial fibrillation, asked for an x-ray of the right hand, clearly suspecting a scaphoid fracture and indicated that she should mobilise.

The nursing record on the 6th September confirms that she was seen by Dr Code A complaining and complained of a painful right thumb, with Dr Code A suspecting a Scaphoid fracture, although it appears the x-ray was reported as normal.

From Dr Code A's note it appears that there was a suspicion that Mrs Code A might have had a cerebro-vascular accident or thrombotic stroke, particularly in the presence of atrial fibrillation, but in fact none of the hard neurological signs were present which would have demonstrated the diagnosis.

In addition to the Aspirin Dr Code A also prescribed Fluoxetine, which was commenced the following day. The prescription for Fluoxetine was actually written out by me and no doubt I would have done this on Dr Code A's request. This would have been provided for depression.

It appears that the same day I also prescribed Paracetamol Ellixir 1gm 4 times a day to be available to Mrs Code A to relieve pain.

Mrs Code A was seen again the following week, on the 13th September by Dr Code A in the course of what would have been his weekly ward round. He noted that she was leaning to the left while standing, had a poor appetite, was confused but witty. He felt that she had a poor inhaler technique and that she should try nebulisers. He therefore changed the prescription for inhalers to nebulisers, specifically Ipritropin and Budesonide nebulisers.

I prescribed Daktacort cream the same day for what I anticipate was a fungal infection on the skin.

Mrs Code A was reviewed again by Dr Code A the following week on his ward round on 20th September. His

note on this occasion indicated she was managing nebulisers but had a very poor appetite. There was variable confusion, and she was able to mobilise one to two steps with the help of two people. Dr Code A asked that routine blood tests should be undertaken and there is a corresponding entry in the nursing records to that effect.

Three days later on the 23rd September Mrs Code A was apparently found on the floor next to her bed, with no apparent injuries. Cot sides were put in place.

Mrs Code A was seen once more by Dr Code A on his weekly ward round on the 27th September and on this occasion he noted that her appetite had slightly improved, as had her mood and he recorded that the Fluoxetine should continue. However, he noted that she was generally less well although there were no obvious physical signs.

On the 1st October Mrs Code A was apparently found on the floor twice in the course of the night, and I think in consequence of that I then prescribed Thioridazine on 1st October, to relieve agitation.

Dr Code A reviewed Mrs Code A again on the 4th October, noting that she had much better motivation. She needed the help of one person and occasionally two for most activities. He recorded that she needed Thioridazine for occasional agitation and still needed encouragement to eat and drink.

It appears that restlessness and agitation at night was a feature of Mrs Code A 's condition, it being noted that she required sedation to help her sleep.

It seems the Thioridazine was effective, subsequent entries in the night nursing record following 1st October recording that Thioridazine was generally given with good effect.

On 7th October Sister Code A recorded that Mrs Code A was generally unwell, complaining of acute pain in the top of her head and the side of her face and was feeling nauseated.

I wrote up a further drug chart for Mrs Code A the same day, prescribing Thyroxine, Lactulose, Senna tablets, Fluoxetine Elixir, Aspirin, Paracetamol, Thioridazine and Temazepam, the last being available to assist with sleeping if the Thioridazine was unsuccessful in relieving Mrs Code A 's restlessness at night. The Diamorphine, Hyoscine and Midazolam continued to be available, in the event of deterioration.

The nursing records indicate that on 8th October Mrs Code A continued to feel nauseous at times with a small amount of diet being taken. Accordingly, I prescribed Gaviscon to be available as required, although the drug chart appears to indicate that it was not necessary to administer Gaviscon until 23rd October. I also wrote up Oramorph to be available, as indeed it had been previously, at 2.5 to 5mls in a 10mg/5mls solution 4 hourly.

Dr Code A saw Mrs Code A again on his ward round on the 11th October, recording that she was still very depressed, was dehydrating visibly and was confused. He said that she needed a nursing home placement, apparently of the view that if she could be rehabilitated, she would be unable to live at home.

It appears that the same day I asked that Metoclopramide be prescribed, Sister Code A noting this on the prescription chart as being a verbal request by me, which I then subsequently endorsed with my signature. I anticipate that Mrs Code A had experienced nausea or vomiting and I would have been concerned that medication should be available for her if there was any recurrence.

On his next weekly ward round, on 18th October, Dr Code A noted that Mrs Code A had unformed faeces and he instructed that lactulose should be withheld for the time being. He again noted that she was to be referred for nursing home care. The prescription chart shows that on the same day, and I anticipate in view of the finding noted by Dr Code A I prescribed Loperamide.

On 22nd October it was noted on the nursing care plan that Mrs Code A had a poor appetite and might be prone to becoming malnourished. The aim was to ensure that she had adequate nutritional intake.

Dr Code A saw Mrs Code A once more, on 25th October when he recorded that she could walk with a frame and with significant persuasion. She needed one to two people

to assist her in transferring and dressing. She remained catheterised.

On 27th October Sister Code A recorded on the drug chart that my partner, Dr Code A, had signed out a prescription for Magnesium Hydroxide, 20mls twice a day, apparently on a verbal request from me. I anticipate that I would have been concerned about the possibility of constipation as I think Lactulose had been discontinued about 2 weeks earlier.

On 1st November Dr Code A then recorded that Mrs Code A had had an episode of vomiting that day but seemed well when he saw her. He recorded that she still had soft mushy stools and that the Magnesium Hydroxide should be reduced to 10mls twice a day.

Accordingly, I wrote a prescription to that effect, in substitution for the one I had written on 27th October.

I also prescribed an antibiotic Cefaclor, the same day, 1st November, though this does not appear to have been administered and I am unable now to say why.

There is no entry in the clinical records by Dr Code A for 8th November, and I cannot now say if he would have seen Mrs Code A on this occasion. I anticipate that her condition was essentially unchanged at this time.

It appears that on 11th November I wrote up a further 'as required' prescription for Diamorphine, Hyoscine,

Midazolam and Cyclizine at the previously stated dose ranges, to be available by syringe driver. Again, it was not my expectation that it was immediately necessary to administer that medication but I would have been concerned as previously, that Mrs Code A 's condition might deteriorate and the medication should be available if necessary. Clearly Dr Code A would have reviewed the prescription chart when conducting his weekly ward rounds and would have been aware of the fact that I had consistently written up these drugs to be available if necessary. At no time did Dr Code A indicate any concern that these drugs had been written up to be available on this basis and within these dose ranges, either in relation to Mrs Code A or indeed for any other patient for whom I considered it necessary to prescribe such medication.

As I have indicated above, I believe that I would have reviewed Mrs Code A day by day each weekday, though there may of course have been days when I was unable to attend at the hospital. However, I was abroad on leave from 12th November until 16th November and would not have seen Mrs Code A again until my return.

In my absence, Dr Code A saw Mrs Code A again on 15th November when he recorded that she was less well, had a chest infection and was frailer. He noted occasional bouts of nausea. On examination she had no raised temperature, her pulse rate was 84 beats per minute and regular. She had loud heart sounds with the third sound radiating into the axilla and neck. There was no oedema,

and Dr Code A felt that her treatment should continue save for a change to Thioridazine – to be available as required.

Unfortunately, it appears that Mrs Code A continued to deteriorate. A nursing entry on the 17th November records that she was not very well that evening, becoming quite distressed and breathless at times. In view of this, it was felt appropriate to administer 5mgs of Oramorph at 10pm (2200) in order to relieve distress, and the nursing record indicates this had good effect.

The following day, 18th November Mrs Code A was noted to be still unwell, feeling quite anxious and the nurses have recorded that after discussion with me it was felt that Oramorph at 5mgs to be given on a regular basis – 4 hourly would be of benefit. 5mgs was then given at 1030am, 2.35pm (1435) and 6.30pm (1830) that day.

I also made a specific entry in Mrs Code A's notes on 18th November, recording as follows:-

'18-11-99 Further deterioration in general condition
Start oral opiates in a small does
Please make comfortable
I will speak to Code A
I am happy for nursing staff to confirm death
? further C.V.A.?'

Clearly in view of my note I was concerned that Mrs Code A might have had another cerebro-vascular

accident, perhaps accounting for the further deterioration in her condition. My note confirms that I agreed with the nursing staff that a small amount of Oramorph should be available in order to make Mrs Code A comfortable. I believe that I was concerned now that Mrs Code A was deteriorating and that she might well now die. I would have been anxious in those circumstances to speak with Mrs Code A 's Code A to warn her that this might be the case. I wrote up a further prescription chart the same day for Thyroxine, Fluoxetine Elixir, Magnesium Hydroxide and Oramorph. In addition to the 2.5mls of Oramorph 4 times a day, I also recorded that a further 5mls should be available at night and accordingly a further 5mls appears to have been given at 10pm (2200).

In addition I also wrote up a further 'as required' prescription on the 18th November for the Diamorphine, Hyoscine, Midazolam and Cyclizine at the previously stated doses.

The following day, 19th November the nurses recorded that Mrs Code A was poorly but stable in the morning. She then complained of shortness of breath in the afternoon. I think I was informed of this by the nursing staff and in consequence of that asked that Frusemide should be given – 40mgs intra-muscularly in order to reduce what I probably felt was pulmonary oedema. I think I was concerned that Mrs Code A was likely to be developing congestive cardiac failure. In those circumstances the administration of Oramorph would also

have assisted in relieving her shortness of breath and indeed the anxiety and distress produced from this.

The nursing record indicates that 5mls of Oramorph was administered prior to Mrs Code A settling and that she then slept for long periods. It appears therefore that she had a peaceful night, and that the Oramorph might well have been successful in relieving the distress of her condition.

Unfortunately, the following day – 20th November some deterioration was noted by the nursing staff and Mrs Code A 's granddaughter was advised to visit her that morning. Mrs Code A apparently vomited and Cyclizine was given, apparently with good effect.

In view of Mrs Code A 's continuing deterioration, I felt that it was appropriate to change from repeated administrations of Oramorph to the administration of Diamorphine via the syringe driver. On the 18th November Mrs Code A had received 25mgs of Oramorph and a further 30mgs the following day. Diamorphine was commenced at 20mgs representing a relatively moderate increase from the level of opiates from the Oramorph previously provided. 50mgs of Cyclizine was also administered via the syringe driver, that having previously been given intra-muscularly with good effect.

Mrs Code A was then said to have had a comfortable night and the syringe driver was apparently satisfactory.

The nursing record indicates that on the afternoon of the 21st November Mrs Code A's condition remained poorly and that all care continued.

Dr Code A then reviewed Mrs Code A once more on his weekly ward round on 22nd November. His note indicates that there had been a further deterioration. He recorded that Mrs Code A was comfortable, opening her eyes to speech and with short verbal responses. Her pulse was uncontrolled with atrial fibrillation and her respiratory rate was 24 breaths per minute. Her chest was clear at that time. He indicated that the Frusemide should be stopped, but specifically recorded that the Diamorphine should continue.

Clearly from this note it is apparent that Dr Code A felt able to modify medication which I had prescribed, specifically stopping the Frusemide. I anticipate that he would have felt by this stage that Mrs Code A was dying and that the Frusemide administered orally would not be of any significant benefit. Clearly, however, he was content that the Diamorphine which I had instituted should be continued.

Dr Code A's note that Mrs Code A's pulse was uncontrolled and that there was atrial fibrillation would suggest to me that Mrs Code A was experiencing heart failure and was dying.

I anticipate that I would have seen Mrs Code A the same day and the nursing staff would also have attended to

see her, though neither the nursing staff nor I had the opportunity to make a note in addition to Dr Code A's record. Sadly it appears that Mrs Code A died peacefully at about 5.20pm (1720) on the afternoon of Code A Code A.

The Diamorphine and indeed the Oramorph which preceded it, was prescribed by me and in my view administered solely with the intention of relieving the shortness of breath Mrs Code A was experiencing from what I believed to be her cardiac failure and the anxiety and distress which Mrs Code A was suffering in consequence. At no time was the medication provided with the intention of hastening Mrs Code A's demise'.

DC Code A — Thank you very much. I think, certainly at paragraph 12 was it ...

Code A — Yes can I also draw a couple of points to Dr Code A's attention ...

DC Code A — ... yes.

Code A — ... help? First off at paragraph ten in fact I think there might be a couple of words missing, 'I admitted Mrs Code A to Dryad Ward at the Gosport War Memorial Hospital on 3rd of September' and I think it should perhaps say 'and my note' after the word September. Does that make sense?

RESTRICTED

DC Code A Yeah. sorry as you add these in Doctor can I just get you to ...

Code A Initial them?

DC Code A ... initial them, yeah it will save doing them later.

Code A And there's the mistake with the Ferrous Sulphate dosage it's 200.

Code A You said 200.

DC Code A Yeah.

Code A That's it.

DC Code A So is it 200 or is it 20?

Code A 200.

DC Code A It is 200.

Code A And just to be clear at paragraph 18, four lines up from the bottom there where it says 'tenderness in the right ...' and you added the word anatomical ...

Code A Anatomical snuff box, sounds as if she was carrying tobacco on her person otherwise.

Code A ... I think those are the only additions which are of significance, yes.

RESTRICTED

DC Code A Can I ask, I normally ask you Doctor if your'e happy with that statement to sign it at the end.

Code A It's also for Lactulose is fifteen mils not milligrams.

Code A Oh and that's paragraph twelve?

Code A It's only in paragraph twelve, yes. So you'd like signed ...

DC Code A And handed to DC Code A

Code A Lovely.

DC Code A I think for the purpose of the tape I'll give this prepared statement an identification reference of JB/PS/8, thank you. I intend to call a stop to the interview at the moment. It's just where we (inaudible) the time in order that we can consider the information that you've provided in this statement. I may well wish to put a number of questions to you later about, this statement but would you be prepared to answer any questions if I did?

Code A No.

DC Code A No.

Code A Can I say that Doctor Code A is answering that on the basis of advice that I've tended to her previously and I won't rehearse them all over again the reasons for that but

RESTRICTED

the same reasons that I've articulated previously apply and I know you understand.

DC Code A That's not a problem at all. Is there anything that you wish to clarify? Anything you wish to add?

Code A No thank you.

DC Code A Got a notice here explains the tape recording procedure and what will happen to the tapes. The time is 0933 hours and I'm turning the recorder off.

Copy JB/PS/8

STATEMENT OF DR Code A

RE: Code A

1. I am Dr Code A 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, Mrs Code A. Unfortunately, at this remove of time I have no recollection at all of Mrs Code A As you are aware, I provided you with a statement on the 4th 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 Mrs Code A

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 Mrs Code A

4. Mrs Code A was Code A years of age and lived alone in warden controlled accommodation. It appears that she was independent although had problems with mobility. She was supported by her extended family.

5. Her past medical history included emphysema (chronic obstructive pulmonary disease), hypothyroidism, ischaemic heart disease, and atrial fibrillation. In 1995 she was seen by Consultant Geriatrician Dr Code A Code A at the Queen Alexandra Hospital who found that Mrs Code A s main problems at that stage were hypertension, slow atrial fibrillation, mitral regurgitation and possible pulmonary congestion. A chest x-ray in February 1995 revealed that her heart was enlarged. ECG confirmed very slow atrial fibrillation with some lateral ischaemia.

6. In December 1998 Mrs Code A was admitted to the Royal Hospital, Haslar suffering with breathlessness for 2 days. When seen by the Clinicians at the hospital she was apparently unresponsive and was felt to be having an acute respiratory arrest. The overall impression was apparently of an acute type 2 respiratory failure with some underlying left ventricular failure. A chest x-ray carried out at that time confirmed the enlargement of the heart and it was felt the features were consistent with heart failure. Following discharge Mrs Code A was reviewed again at the Royal Hospital Haslar in February 1999, and at that time, although she had had occasional attacks of breathlessness for which she had been taking Salbutamol and Atrovent, it was felt that

there was no evidence of left ventricular failure, although she had a loud murmur of mitral regurgitation.

7. On the 15th August 1999 Mrs Code A was admitted once more to the Royal Hospital Haslar following a fall. She was diagnosed as having a closed fracture of the proximal femur, and at operation the following day a dynamic hip screw was inserted. The Anaesthetist conducting anaesthesia for the procedure assessed her in advance of the procedure as being ASA IV, being a high anaesthetic risk, commenting that she had very poor respiratory and cardio-vascular system reserve.

8. Mrs Code A's post-operative recovery appears to have been relatively uncomplicated. On the 23rd August Dr Code A was asked to see her with a view to considering rehabilitation. In fact, it was Consultant Geriatrician, Dr Code A, who then saw her on the 23rd August. In her subsequent letter of the 24th August to Consultant Orthopaedic Surgeon Mr Code A Dr Code A observed that she had a past medical history of hypothyroidism, asthma and cardiac failure. At the time of the assessment she had an acute on chronic confusional state. Dr Code A noted that Mrs Code A had previously lived alone in a warden controlled flat with family to help out. Apparently she was normally a bit confused but managed to get out to the shops. Her confusion had increased after the operation, particularly at night. She was now often quite confused and needed to be orientated in time and place. Dr Code A noted a previous medical history of myxoedema, asthma and cardiac failure. She had been suffering from diarrhoea and had had a fever the previous day, but she was beginning to mobilise and take a few steps with one nurse using a Zimmer frame. Dr Code A said she would be happy to take Mrs Code A to the GWMH. In her note of her assessment the previous day, Dr Code A has also recorded: - "? will get

home?", from which it would seem that whilst Dr Code A felt that even if Mrs Code A did recover, she was not anticipating complete rehabilitation and mobilisation to her previous state, and that she might have to go into residential care.

9. In any event Mrs Code A was then transferred to the GWMH on the 3rd September 1999. The referral letter from the Royal Hospital Haslar confirmed the previous history of left ventricular failure, hypertension, asthma and hypothyroidism. The medication she was then taking was also itemised.

10. I admitted Mrs Code A to Dryad Ward at the GWMH on 3rd September and my note in Mrs Code A's records in this regard reads as follows:- Code A

"3-9-99 Transfer to Dryad Ward continuing care
HPC # no femur ® 16-8-99
PMH hypothyroidism
asthma
cardiac failure
Barthel needs help c ADL
incontinent
transfers with 2 Barthel 3-4
Plan Get to know
Gentle rehab
? nursing home
please make comfortable
I am happy for nursing staff to confirm death"

11. As is clear from my note, I assessed Mrs Code A's Barthel score as 3-4, though two days later a nursing assessment has recorded it as 2. It was apparent though that Mrs Code A was significantly dependent at that time. In accordance with my usual practice, I recorded that I was happy for nursing staff to confirm death. As I have previously indicated, this was simply to ensure that nursing staff were aware that

it was not necessary for a doctor to be called out of hours if the patient were to die and a doctor was not available at the hospital at the time. From my assessment, I hoped that rehabilitation might indeed prove possible, but at the same time, recognising that Mrs Code A had had the trauma of a fracture, followed by operation, and then a move to another hospital, and in circumstances in which she had a number of medical problems, there was the clear possibility for deterioration in her condition.

12. I prescribed medication for Mrs Code A in the form of Co-dydramol and Oramorph for pain relief, the Oramorph at a dose of 2.5 to 5mls in a 10mg 5mls solution 4 hourly, Prochloperazine as an anti-emetic, and Zopiclone to help her sleep, all to be available as required. I also prescribed Thyroxine 100mcgs once a day for hypothyroidism, Ferrous Sulphate 200mgs 3 times a day for iron deficiency anaemia, Lactulose 15mls twice a day and 2 senna tablets at night both for constipation, and Atrovent and Becloforte inhalers for her chronic obstructive pulmonary disease.

13. In addition, I also prescribed Diamorphine 20-200mgs, Hyoscine 200-800mcgs, and Midazolam 20-80mgs to be available via syringe driver if necessary. In doing so, I did not consider that it was necessary for these medications including Diamorphine to be administered at that point, and would not have approved the administration if I had been asked to do so. Rather, I was concerned that if there were to be a deterioration, such medication could then be available if necessary. If I was not immediately available in the hospital, I would nonetheless be consulted by the nursing staff before it was commenced.

14. The nursing entry the same day - 3rd September recorded that Mrs Code A could become confused at times and needed orientating in terms of time and space. She was noted to mobilise with the help of one nurse and using a Zimmer frame, and had an in-dwelling catheter and could be incontinent of faeces.

15. I anticipate that I would then have seen Mrs Code A to review her condition day by day, each week day. Unfortunately, I was not able to make notes in my routine assessments of her, I anticipate due to the sheer pressure of work at the time and in circumstances in which the Consultant was in any event making a regular weekly note following ward round assessment. I would have endeavoured to make a note if Mrs Code A 's condition changed significantly.

16. By 1999 the Healthcare Trust had appointed a Clinical Director, Dr Code A Code A and one of his responsibilities was for Dryad Ward. In consequence, unless he was unavailable, Dr Code A would carry out a weekly ward round. Dr Code A had effectively taken over responsibility for Dryad Ward from Dr Code A who, having returned from maternity leave, did not then carry out clinical care work at GWMH as best I can recall it.

17. Unfortunately, although Dr Code A s weekly attendance for a ward round on Dryad Ward was welcome, Dr Code A in addition to agreeing to a transfer of patients for other hospitals, would also agree to take admissions from home. Patients admitted from home had not had the same degree of thorough investigation and stabilisation prior to admission, and this increased the workload still further.

18. In any event on the 6th September Mrs Code A was seen by a locum Consultant Dr Code A who recorded that she was noticed to have left sided facial droop, but was now better. There was apparently no visual disturbance, no facial weakness nor arm weakness and both plantars were down. He considered that Mrs Code A was in atrial fibrillation and had a small pressure sore. She was said to be 'in retention', by which I anticipate he meant that she was retaining urine. He noted pain and tenderness in the right anatomical snuff box - on Code A wrist/hand. Dr Code A prescribed Aspirin for the atrial fibrillation, asked for an x-ray of the right hand, clearly suspecting a scaphoid fracture, and indicated that she should mobilise.

19. The nursing record on the 6th September confirms that she was seen by Dr Code A complaining, and complained of a painful right thumb, with Dr Code A suspecting a Scaphoid fracture, though it appears the x-ray was reported as normal.

20. From Dr Code A's note it appears that there was a suspicion that Mrs Code A might have had a cerebro-vascular accident or thrombotic stroke, particularly in the presence of atrial fibrillation, but in fact none of the hard neurological signs were present which would have demonstrated the diagnosis.

21. In addition to the Aspirin Dr Code A also prescribed Fluoxetine, which was commenced the following day. The prescription for Fluoxetine was actually written out by me, and no doubt I would have done this on Dr Code A's request. This would have been provided for depression.

22. It appears that the same day I also prescribed Paracetamol Ellixir 1gm 4 times a day to be available to Mrs Code A to relieve pain.

23. Mrs Code A was seen again the following week, on the 13th September by Dr Code A in the course of what would have been his weekly ward round. He noted that she was leaning to the left while standing, had a poor appetite, was confused but witty. He felt that she had a poor inhaler technique and that she should try nebulisers. He therefore changed the prescription for inhalers to nebulisers, specifically Ipritropin and Budesonide nebulisers.

24. I prescribed Daktacort cream the same day for what I anticipate was a fungal infection on the skin.

25. Mrs Code A was reviewed again by Dr Code A the following week on his ward round, on 20th September. His note on this occasion indicated that she was managing nebulisers but had a very poor appetite. There was variable confusion, and she was able to mobilise one to two steps with the help of two people. Dr Code A asked that routine blood tests should be undertaken, and there is a corresponding entry in the nursing records to that effect.

26. Three days later on the 23rd September Mrs Code A was apparently found on the floor next to her bed, with no apparent injuries. Cot sides were put in place.

27. Mrs Code A was seen once more by Dr Code A on his weekly ward round on the 27th September, and on this occasion he noted that her appetite had slightly improved, as had her mood, and he recorded that the Fluoxetine should continue. However, he noted that she was generally less well although there were no obvious physical signs.

28. On the 1st October Mrs Code A was apparently found on the floor twice in the course of the night, and I think in consequence of that I then prescribed Thioridazine on 1st October, to relieve agitation.

29. Dr Code A reviewed Mrs Code A again on the 4th October, noting that she had much better motivation. She needed the help of one person and occasionally two for most activities. He recorded that she needed Thioridazine for occasional agitation and still needed encouragement to eat and drink.

30. It appears that restlessness and agitation at night was a feature of Mrs Code A's condition, it being noted that she required sedation to help her sleep.

31. It seems the Thioridazine was effective, subsequent entries in the night nursing record following 1st October recording that Thioridazine was given generally with good effect.

32. On 7th October Sister Code A recorded that Mrs Code A was generally unwell, complaining of acute pain in the top of her head and the side of her face, and was feeling nauseated.

33. I wrote up a further drug chart for Mrs Code A the same day, prescribing Thyroxine, Lactulose, Senna tablets, Fluoxetine Elixir, Aspirin, Paracetamol, Thioridazine and Temazepam, the latter being available to assist with sleeping if the Thioridazine was unsuccessful in relieving Mrs Code A's restlessness at night. The Diamorphine, Hyoscine and Midazolam continued to be available, in the event of deterioration.

34. The nursing records indicate that on 8th October Mrs Code A continued to feel nauseous at times with a small amount of diet being taken. Accordingly, I prescribed Gaviscon to be available as required, although the drug chart appears to indicate that it was not necessary to administer Gaviscon until 23rd October. I also wrote up Oramorph to be available, as indeed it had been previously, at 2.5 to 5mls in a 10mg/5mls solution 4 hourly.

35. Dr Code A saw Mrs Code A again on his ward round on the 11th October, recording that she was still very depressed, was dehydrating visibly and was confused. He said that she needed a nursing home placement, apparently of the view that if she could be rehabilitated, she would be unable to live at home.

36. It appears that the same day I asked that Metoclopramide be prescribed, Sister Code A noting this on the prescription chart as being a verbal request by me, which I then subsequently endorsed with my signature. I anticipate that Mrs Code A had experienced nausea or vomiting, and I would have been concerned that medication should be available for her if there was any recurrence.

37. On his next weekly ward round, on 18th October, Dr Code A noted that Mrs Code A had unformed faeces and he instructed that lactulose should be withheld for the time being. He again noted that she was to be referred for nursing home care. The prescription chart shows that on the same day, and I anticipate in view of the finding noted by Dr Code A, I prescribed Loperamide.

38. On 22nd October it was noted on the nursing care plan that Mrs Code A had a poor appetite and might be prone to becoming malnourished. The aim was to ensure that she had adequate nutritional intake.

39. Dr Code A saw Mrs Code A once more, on 25th October when he recorded that she could walk with a frame and with significant persuasion. She needed one to two people to assist her in transferring and dressing. She remained catheterised.

40. On 27th October Sister Code A recorded on the drug chart that my partner Dr Code A had signed out a prescription for Magnesium Hydroxide, 20mls twice a day, apparently on a verbal request from me. I anticipate that I would have been concerned about the possibility of constipation as I think Lactulose had been discontinued about 2 weeks earlier.

41. On 1st November Dr Code A then recorded that Mrs Code A had had an episode of vomiting that day but seemed well when he saw her. He recoded that she still had soft mushy stools, and that the Magnesium Hydroxide should be reduced to 10mls twice a day.

42. Accordingly, I wrote a prescription to that effect, in substitution for the one I had written on 27th October.

43. I also prescribed an antibiotic Cefaclor, the same day, 1st November, though this does not appear to have been administered, and I am unable now say why.

44. There is no entry in the clinical records by Dr Code A for 8th November, and I cannot now say if he would have seen Mrs Code A on this

occasion. I anticipate that her condition was essentially unchanged at this time.

45. It appears that on 11th November I wrote up a further 'as required' prescription for Diamorphine, Hyoscine, Midazolam and Cyclizine at the previously stated dose ranges, to be available by syringe driver. Again, it was not my expectation that it was immediately necessary to administer that medication, but I would have been concerned as previously, that Mrs Code A's condition might deteriorate and the medication should be available if necessary. Clearly Dr Code A would have reviewed the prescription chart when conducting his weekly ward rounds, and would have been aware of the fact that I had consistently written up these drugs to be available if necessary. At no time did Dr Code A indicate any concern that these drugs had been written up to be available on this basis and within these dose ranges, either in relation to Mrs Code A or indeed for any other patient for whom I considered it necessary to prescribe such medication.

46. As I have indicated above, I believe that I would have reviewed Mrs Code A day by day each weekday, though there may of course have been days when I was unable to attend at the hospital. However, I was abroad on leave from 12th November until 16th November, and would not have seen Mrs Code A again until my return.

47. I my absence, Dr Code A saw Mrs Code A again on 15th November when he recorded that she was less well, had a chest infection and was frailer. He noted occasional bouts of nausea. On examination she had no raised temperature, her pulse rate was 84bpm and regular. She had loud heart sounds with the third sound radiating into the axilla and neck. There

was no oedema, and Dr Code A felt that her treatment should continue save for a change to Thioridazine - to be available as required.

48. Unfortunately, it appears that Mrs Code A continued to deteriorate. A nursing entry on the 17th November records that she was not very well that evening, becoming quite distressed and breathless at times. In view of this, it was felt appropriate to administer 5mgs of Oramorph at 10pm in order to relieve distress, and the nursing record indicates this had good effect.

49. The following day, 18th November Mrs Code A was noted to be still unwell, feeling quite anxious and the nurses have recorded that after discussion with me it was felt that Oramorph at 5mgs to be given on a regular basis - 4 hourly would be of benefit. 5mgs was then given at 10.30am, 2.35pm and 6.30pm that day.

50. I also made a specific entry in Mrs Code A s notes on 18th November, recording as follows:-

> "18-11-99 Further deterioration in general condition
> Start oral opiates in a small dose
> please make comfortable
> I will speak to Code A
> I am happy for nursing staff to confirm death
> ? further C.V.A. ?"

51. Clearly in view of my note I was concerned that Mrs Code A might have had another cerebro-vascular accident, perhaps accounting for the further deterioration in her condition. My note confirms that I agreed with the nursing staff that a small amount of Oramorph should be available in order to make Mrs Code A comfortable. I believe that I was concerned now that Mrs Code A was deteriorating and that she

might well now die. I would have been anxious in those circumstances to speak with Mrs Code A 's Code A to warn her that this might be the case. I wrote up a further prescription chart the same day for Thyroxine, Fluoxetine Elixir, Magnesium Hydroxide and Oramorph. In addition to the 2.5mls of Oramorph 4 times a day, I also recorded that a further 5mls should be available at night, and accordingly a further 5mls appears to have been given at 10pm.

52. In addition I also wrote up a further 'as required' prescription on the 18th November for the Diamorphine, Hyoscine, Midazolam and Cyclizine at the previous stated doses.

53. The following day, 19th November the nurses recorded that Mrs Code A was poorly but stable in the morning. She then complained of shortness of breath in the afternoon. I think I was informed of this by the nursing staff and in consequence of that asked that Frusemide should be given - 40mgs intra-muscularly in order to reduce what I probably felt was pulmonary oedema. I think I was concerned that Mrs Code A was likely to be developing congestive cardiac failure. In those circumstances the administration of Oramorph would also have assisted in relieving her shortness of breath, and indeed the anxiety and distress produced from this.

54. The nursing record indicates that 5mls of Oramorph was administered prior to Mrs Code A settling, and that she then slept for long periods. It appears therefore that she had a peaceful night, and the Oramorph might well have been successful in relieving the distress of her condition.

60. Clearly from this note it is apparent that Dr Code A felt able to modify medication which I had prescribed, specifically stopping the Frusemide. I anticipate that he would have felt by this stage that Mrs Code A was dying, and the Frusemide administered orally would not be of any significant benefit. Clearly, however, he was content that the Diamorphine which I had instituted should be continued.

61. Dr Code A's note that Mrs Code A's pulse was uncontrolled and that there was atrial fibrillation would suggest to me that Mrs Code A was experiencing heart failure and was dying.

62. I anticipate that I would have seen Mrs Code A the same day, and the nursing staff would also have attended to see her, though neither the nursing staff nor I had the opportunity to make a note in addition to Dr Code A's record. Sadly it appears that Mrs Code A died peacefully at about 5.20pm on the afternoon of 22nd November.

63. The Diamorphine, and indeed the Oramorph which preceded it, was prescribed by me and in my view administered solely with the intention of relieving the shortness of breath Mrs Code A was experiencing from what I believed to be her cardiac failure, and the anxiety and distress which Mrs Code A was suffering in consequence. At no time was the medication provided with the intention of hastening Mrs Code A's demise.

Signed and handed to Code A

25-2-03

Code A