FFW/104/01

HAMPSHIRE CONSTABULARY

OPERATION ROCHESTER

QUEEN ALEXANDRA MEMORIAL HOSPITAL

HELENA SERVICE

Volume 1

Main file

Confidential information
Case summary
Expert witness reports
Suspect interviews

31

GMC AND BARTON INDEX OF FILES RECEIVED FROM HAMPSHIRE POLICE ON 18 JANUARY 2007.

1. Index of all evidence obtained
2. Generic Case File
3. Generic Case File (exhibits)
4. Generic Case File (exhibits)
5. Generic Case File (further exhibits)
6. Generic Case File further evidence re: Devine, Cunningham and Lake
7. Generic Case File further evidence - interviews with Dr Reid
8. Devine Volume 1
9. Devine Volume 2
10. Devine Additional Evidence
11. Devine Hospital Medical Records
12. Spurgin Volume 1
13. Spurgin Volume 2
14. Spurgin - further evidence
15. Spurgin - further evidence
16. Spurgin Hospital Medical Records
17. Spurgin Hospital Medical Records
18. Cunningham Volume 1
19. Cunningham Volume 2
20. Cunningham Hospital Medical Records
21. Cunningham Hospital Medical Records
22. Packman Volume 1
23. Packman Volume 2
24. Packman - further evidence
25. Packman police interviews with Dr Reid
26. Packman Hospital Medical Records
27. Lake Volume 1

28. Lake Volume 2
29. Lake Hospital Medical Records
30. Lake Hospital Medical Records
31. Service Volume 1
32. Service Volume 2
33. Service Hospital Medical Records
34. Service Hospital Medical Records
35. Gregory Volume 1
36. Gregory Volume 2
37. Gregory Hospital Medical Records
38. Gregory Hospital Medical Records
39. Wilson Volume 1
40. Wilson Volume 2
41. Wilson Hospital Medical Records
42. Wilson Hospital Medical Records
43. Lavender Volume 1
44. Lavender Volume 2
45. Lavender Hospital Medical Records
46. Lavender Hospital Medical Records
47. Lavender Hospital Medical Records
48. Pittock Volume 1
49. Pittock Volume 2
50. Pittock Hospital Medical Records
51. Further evidence re: Wilson, Lavender & Pittock
52. GP Records for Spurgin, Pittock, Service, and packman
53. GP Records for Devine, Cunningham and Lavender
54. Copy Extracts from Patient Admission Records
55. Extracts from controlled drugs record book dated 26 June 1995 - 24 May 1996

56. Richards (Eversheds) file: 1 of 2
57. Richards (Eversheds) file: 2 of 2
58. Richards: Medical Records
59. Richards: Further Medical Records
60. Richards: Further Medical Records
61. Richards (Police) - Witness Statements file
62. Richards (Police) - Transcripts of Interviews file
63. Page (Experts' Reports and Medical Records)
64. Wilkie (Eversheds) file: Experts' Reports and Medical Records
65. Clinical Team Assessments for Page, Cunningham, Wilkie, Wilson and Richards.
66. Clinical Team Assessments for Devine, Gregory, Lavender, Packman, Spurgin, Lake and Pittock

Operation ROCHESTER.

Key points July 2006.

Helena SERVICE born Code A

Code A was 99years of age when she died at Gosport War Memorial Hospital on the 5th June 1997 two days after her admission.

Born in Watford, Helena married in 1929 and moved to the Stubbington area of Hampshire upon her husband's retirement.

Following her husbands death shortly after his retirement Mrs SERVICE lived alone (she had no children) until 1993 when she moved to a nursing home.

She had suffered gastric ulcers in 1981 a stroke in 1984 and fractured ribs following a fall in 1989. During the 80's and 90's she is recorded as suffering increasing heart problems and gout for which she was admitted to hospital both in January 1995 and January 1996.

During 1997 Mrs SERVICE became very unwell at the nursing home suffering back pain, a bed sore and a chest infection and was admitted to the Queen Alexandra Hospital, COSHAM on the 17th May 1997 confused, disorientated and most likely suffering a chest infection precipitating worsening of cardiac failure. She was very deaf, and because of this it was impossible to take a history from Mrs SERVICE herself, this was provided by way of a GP referral letter.

Initially Mrs SERVICE was appropriately assessed and managed by hospital staff resulting in an improvement in her condition, she was more alert and her heart rate improved as did her renal function. However she was suffering left ventricular failure, a failure of the left side of the heart to pump properly, causing a build up of pressure in the veins in the lungs and fluid on the lungs.

Nursing notes between the 21st May 1987 and 2nd June 1997 indicate that Mrs SERVICE was 'breathless on exertion' and variously describe her as demanding and confused,

On the 26th May 1997 it is likely that Mrs SERVICE suffered a stroke, as a result she became more dependant and was unable to return to her nursing home.

On the 28th May 1997 Mrs SERVICE was referred to geriatricians for 'continuing care'.

On 29th May Consultant Geriatrician Dr ASHBAL examined Mrs SERVICE reporting her longstanding cardiac failure breathlessness and deafness. He reported improvement that 'clinically she was better but in a degree of heart failure'.

Entries in medical notes for 30th May and 2nd June 1997 report that she was well and her condition unchanged. The nursing notes comment that she was 'not confused but quite agitated at times' Mrs SERVICE is recorded as being 'very demanding and shouting constantly overnight' on 2nd June 1997.

On 3rd June 1997 she was seen by consultant Dr MILLER who noted her to be 'well' and due for transfer to Dryad Ward at Gosport War Memorial hospital that day.

The nursing transfer letter summarised that Mrs SERVICE had been admitted with atrial fibrillation, confusion a chest infection and was very deaf.

She had received intravenous fluids and antibiotics, oxygen therapy and digoxin. Treatment was listed as thioridazine 25mg at night, lisinopril 2.5mg twice a day, bumetamide 1 mg once a day, aspirin 75mg once a day. Allopurinol 100mg at night, and digoxin 125 microgram once a day.

Dr Jane BARTON conducted the admission assessment of Mrs SERVICE on the 3rd of June 1997. She described her as no longer able to mobilise, ie 'off her legs' and was confused. Dr BARTON recorded that she was a non – insulin dependent diabetic and that she had upper respiratory tract infection and congestive cardiac failure. Under examination Mrs SERVICE was 'breathless and plethoric' this meaning that she was of purple/blue colour to the extremities indicating cyanosis consequent on the heart failure. Dr BARTON listened to her heart concluding that it was struggling to cope and that she was clearly in heart failure was very unwell and was probably dying.

Dr BARTON reports that Mrs SERVICE had deteriorated upon transfer and prescribed opiate analgesia.

On assessment at Dryad Ward Mrs SERVICE was prescribed diamorphine hyoscine and midazolam and administered in increasing doses over the first two days.

Midazolam was commenced at 20mg subcutaneously over the first 24 hours upon the basis that she was failing to settle during her first night at the hospital.

The following day the 4th June 1997 she was administered double the amount of midazolam and additionally 20 mg diamorphine per 24ours via syringe driver, Dr BARTON considering that it would have the effect of relieving pulmonary oedema and the significant anxiety and distress produced from that sensation.

The Hyoscine was to be available to dry the chest secretions.

The terminal prognosis was not consistent however with the results of blood tests carried out the same day (according to consultant palliative care expert Dr WILCOCK)

A Bartel assessment carried out on the 3rd June revealed a 'zero score' meaning that Mrs SERVICE was totally dependent.

Mrs SERVICE continued to deteriorate and passed away at 3.45am on the morning of the 5th June 1997. Her cause of death was recorded by Dr BARTON as congestive cardiac failure.

Clinical Team assessment.

Mrs SERVICE was very old, and had many medical problems including diabetes, heart failure, confusion and sore skin.

She was 'agitated' in the Queen Alexandra hospital but they accepted it and used thioridazine orally. Upon transfer to Gosport War Memorial Hospital, she was placed on sedation via a syringe driver at night. She became less well the next day and diamorphine was added to the driver (she had not required analgesia other than paracetomal at the Q.A.H). Mrs SERVICE died the following day.

Medication could have contributed towards her death, the need for such medication was not clear.

Account Dr Jane BARTON from interview with police 27th October 2005.

Within a prepared statement Dr BARTON commented that by 1997 there had been a significant increase in dependency, increase in bed occupancy and consequent decrease in the ability to make notes of each and every assessment and review of a patient these difficulties applying at the time of her care of Mrs SERVICE.

Dr BARTON reported Mrs SERVICE'S medical history in particular her heart problems and her GP Dr REES recording on 12th May 1997 that she had been diagnosed as being in heart failure.

Dr BARTOIN summarised Mrs SERVICE'S treatment at the Queen Alexandra hospital following her admission and that a senior registrar confirmed left ventricular failure and that her condition was not suitable for resuscitation.

Dr ASHBAL noted on 29th May that he was to transfer her to Gosport war memorial hospital. That it was not done immediately was probably an indication that there was high bed occupancy at the time, confirmed in notes of 2nd June indicating that a bed was still awaited.

On transfer on 3rd June 1997 Dr BARTON carried out an assessment Mrs SERVICE was clearly in heart failure and very unwell and probably dying. She had probably reached 'multi-system' failure. Care would have been more appropriate at Queen Alexandra hospital but a transfer by ambulance would not have been in her best interests.

Dr BARTON prescribed medication including diamorphine, hyoscine and midazolam.

A barthel score of zero on 3rd June indicated total dependency.

Mrs SERVICE was administered the opiates but continued to deteriorate and her nephew was contacted to inform him of her poorly condition.

She was suffering terminal heart failure and was distressed and agitated as a consequence.

The diamorphine and midazolam were prescribed and administered solely with the intention of relieving Mrs SERVICES agitation and distress with the diamorphine having the additional affect of treating the pulmonary oedema from her heart failure.

At no time was any medication provided with the intention of hastening her death.

<u>Expert Witness Dr Andrew WILCOCK (Palliative medicine and medical oncology) comments:-</u>

Mrs SERVICE was a 99year old woman who was admitted to the Queen Alexandra Hospital on the 17th May 1997 confused and disorientated most likely as a result of a chest infection, and a fast irregular pulse precipitating a worsening of her cardiac failure.

She was appropriately assessed investigated and managed and her condition improved relatively quickly, she was more alert, her heart rate was controlled and her renal function improved. She remained confused at times and noisy at night.

On 26th May it is likely she suffered a stroke affecting the left side of her body.

She was seen by Dr Code A who agreed to take her to Gosport War memorial hospital for assessment with regards to continuing care.

On the day of her transfer she was described as 'well' by Consultant Physician Dr Code A.

Her behaviour remained challenging particularly at night however apart from the regular use of thioridazine as a night time sedative Mrs SERVICE's behaviour was managed by the nursing staff using non-drug means.

On Dryad Ward there was an inadequate assessment of Mrs SERVICE's current symptoms and cardiovascular status. Her medication continued mostly unchanged other than the thioridazine.

She was prescribed diamorphine, midazolam and hyoscine with inadequate justification for the dosage.

Dr BARTON reports that in her view Mrs SERVICE was terminally ill with heart failure, however blood tests were taken from her on the same day and these would not be indicated in patients who were imminently dying and the fact that they were carried out suggests that doubt existed.

The blood test confirmed renal impairment and low potassium possibly due to her medication and/or inadequate fluid intake. These could have contributed towards a worsening condition and were potentially reversible with appropriate treatment.

If it were that Mrs SERVICE was not actively dying as the notes on her transfer to Dryad Ward suggest then the failure to re-hydrate her together with the use of midazolam and diamorphine could have contributed more than minimally negligibly or trivially to her death.

If it were considered that Mrs SERVICE were actively dying then it would have been reasonable not to have re-hydrated her and the use of midazolam and diamorphine could have been justified.

However, in the opinion of Dr WILCOCK the starting dose of diamorphine was likely to be excessive to her requirements and access to smaller doses would have been a more appropriate way of initially dealing with her symptoms.

Given that elderly frail patients of significant morbidity can deteriorate with little or sometimes no warning it could be argued that it is difficult to distinguish with complete confidence which of the above scenarios was the most likely for Mrs SERVICE.

The opinion of a cardiologist should be sought on Mrs Service's likely prognosis, scope for optimising her heart failure therapy and the role of opioids in chronic heart failure in 1997.

Expert Witness Dr Code A Consultant Cardiologist:-

Dr Code A reported that Mrs Code A at the time of her death had a long medical history with evidence of heart disease by 1989 and heart failure by 1995. The average survival of patients with this sort of heart failure is 2 years

hence her terminal decline in 1997 was not unexpected. Once the decision had been made that she was not for resuscitation as it was in the Queen Alexandra hospital in May 1997, then the palliative care with increasing doses of diamorphine and midazolam was appropriate. These drugs were administered in accordance with cardiological practice in 1997.

Mrs SERVICE remained unwell despite corrective treatment (at Queen Alexandra hospital). Opiates, notably diamorphine are standard drugs for the alleviation of shortness of breath and distress associated with pulmonary oedema and are particularly helpful at night. The administration of diamorphine has been standard practice for cardiologists for decades.

Mrs SERVICES prognosis was hopeless. The administration of diamorphine together with midazolam was reasonable given the circumstances as described by Dr BARTON.

Expert Witness Dr David BLACK (Geriatrics) comments:-

Mr SERVICE was admitted to Queen Alexandra Hospital on 17th May 1997 at the age of 99 at the request of her GP to hospital with confusion, disorientation and progressive failure for the rest home to be able to cope with.

She had been progressively failing in the residential care home, unlikely that this was dramatic change in function but the end point of slow deterioration of her multiple illnesses including her progressive heart disease, her cerebro – vascular disease and the physiological frailty of an age of 99 years.

She was diagnosed to have a combination of dehydration and left ventricular failure and recorded as having long standing congestive cardiac failure.

On the basis of her nursing notes she makes very little improvement in her confusion or her breathlessness and indeed things take a turn for the worse when she probably has a new stroke on 26th May, she remains totally dependent after this.

She is seen by a locum consultant geriatrician Dr Code A on the 29th May his assessment is that she will not return to her residential nursing home and that he is transferring her to Gosport with a view to considering continuing care. By this he probably means an assessment as to whether this lady is dying or perhaps to simply remain in an NHS continuing care bed until she does die.

By the 2nd June Mrs SERVICE is deteriorating, she is very demanding overnight shouting continuously suggesting that she is acutely delirious and so breathless that she has to sit up all night on the 2nd June.

I believe that this lady is now physically deteriorating but it is impossible to tell if this is progression of heart failure, a pulmonary embolus, or chest infection

on top of her other problems. I have little doubt that she was entering a terminal phase of her illness.

Mrs SERVICE was transferred to Gosport War Memorial Hospital on 3rd June where she is noted to have a buttock bedsore. The recorded medical assessment is brief but does include an examination which although notes that she had tachycardia and is very breathless, fails to give an overall impression of her status and whether this is acute, chronic or acute on chronic and fails to record her pulse and blood pressure.

A thorough objective assessment of this lady's clinical status is not possible from the notes made on admission and would appear to be below an acceptable standard of good medical practice.

The cause of death in the view of the expert was 'multi-factorial'. The dose of 20mg of diamorphine combined with the 40mg dose of midazolam was higher than necessary in this very elderly and frail lady's terminal care and the medication may have slightly shortened life although this opinion did not reach the standard of proof of beyond all reasonable doubt. The expert would have expected a difference (of survival) of at most no more than a few hours or days had a lower dose been used.

Evidence of other key witnesses.

Alexander TUFFEY (Nephew of deceased) General family and medical background as relates to Mrs SERVICE, speaks of her developing a bad cough in 1997 leaving her frail and weak.

Elsie TUFFEY Details family history. Although unwell at the age of 99 the family expected her to recover.

Florence TUFFEY Visited Mrs SERVICE four times at Queen Alexandra Hospital. She seemed to be recovering, was chatty and cheerful. Also visited at Gosport War Memorial Hospital, she was very 'dopey' and did not realise that Mrs TUFFEY was there, surprised at her death.

Delia KEENE (Personal friend of deceased) Close detail of her recent medical history and increasing dizzy spells precipitating her admission to 'willow cottage' rest home. Admitted to Q.A.H following a cough and seemed to be improving. Transferred to GWMH visited on 4th June 1997, seemed to be unconscious.

Jean KENNEDY (home help and friend) Post 1991 describes Mrs SERVICE as very sound in mind but of frail body. Describes Mrs SERVICE as alert bright and witty at Q.A.H and was shocked at her condition at G.W.M.H. She was told by a nurse that 'she had to be given something to make the journey more comfortable'.

Code A Proprietor Willow Cottage Guest house) describes her medication and care plan for 1997. Mrs SERVICE was diagnosed by Dr REESE as being in heart failure on 12th May 1997 her next of kin were informed.

Code A (Co-proprietor) information as above. Describes how Mrs SERVICE became increasingly frail over the years. In May 1997 she was diagnosed with heart failure, became breathless and poorly.

Code A (General practitioner) Details medical history and the fact that Mrs SERVICE had suffered heart problems since 1984. Dr REES details considerable visits during the 1990's. On 12th May her drowsiness had increased she had ankle swelling and her chest infection appeared to have exacerbated her heart failure symptoms. She was very unwell and in her judgement was dying.

Code A (Consultant general medicine) Conducted ward round at Q.A.H on 18th May 1997. Noted Mrs SERVICE temperature normal but she was mildly dehydrated. Her clear chest sounds suggested an improvement in the function of her heart. X-rays showed classic indications of left heart failure. Subsequent examinations showed improvements in heart and breathing functions but attempts to mobilise her proved difficult. On 28th May 1997 her referred her to the elderly care medical team at G.W.M.H asking for continuation of the measures for continuing care. His final assessment of 3rd June 1997 was that she was well.

Code A (Further statement) Describes medication and rational for prescription.

Code A (Consultant Cardiologist) In 1997 a senior house officer at Q.A.H. His role to see new admissions. Jointly examined Mrs SERVICE with Dr Code A. Her ECG and X-ray showed heart failure, not reversible. Noted condition improving by 21st May 1997, and wrote referral letter on 28th May for considering continuing care.

Code A (Nurse Q.A.H) Explains nursing note entries between 17th and 30th May 1997.

Code A (Nurse Q.A.H) Explains her nursing note entries in particular a nursing transfer note to G.W.M.H.

Code A (Consultant Physician) specifically assessed Mrs SERVICE whilst at Q.A.H for continuing care and wrote transfer letter.

Code A (Nurse Dryad Ward G.W.M.H) The admitting nurse at G.W.M.H on 3rd June 1997.. describes as a pleasant lady normal diet but needed assistance with meals, faecally incontinent, buttocks red and sore and skin broken, skin quite dry superficial grazes on spine and skin on lower arms discoloured.

Sharon RAY (Senior staff night nurse G.W.M.H) Explains nursing entries overnight 3rd June 1997 including that she had failed to settle and was very restless and agitated, as a consequence 20mgs of Midazolam administered at 0200hrs over 24hrs via syringe driver.

Sharon RING (Staff nurse Dryad Ward G.W.M.H) Wrote patient summary on 4th June 1997 'condition appears to have deteriorated overnight, remains restless. Seen by Dr BARTON. Driver re-charged with diamorphine 20mgs midazolam 40mgs in 50 millimols hourly. Rang Mr TUFFEY (nephew) to inform him of poorly condition. Nurse RING confirms that she administered the midazolam and diamorphine.

Freda SHAW (Nurse G.W.M.H) Catheterised Mrs SERVICE on 4th June 1997 and explains associated nursing notes.

Irene DORRINGTON (Nurse G.W.M.H) at 0440hrs on 5th June 1997 wrote on the nursing notes that Mrs SERVICE had died peacefully at 0345hrs.

Code A (Social worker) re referral summary.

Code A (House physician Q.A.H) spoke to referring GP on 17th May 1997.. and conducted initial examination of Mrs Code A .explains detailed notes made between 17th and 23rd May 1997.

Code A (Senior registrar) completed admissions entry on 17th May 1997. ECG and X-ray indicated findings of heart failure. Dr MEEKING instructed that Mrs SERVICE should be resuscitated if her heart was to stop beating given that the probability of success was remote due to her age, history and heart disease.

Code A (Locum house officer Q.A.H) examined Mrs SERVICE on 26/27th May 1997.. suffered a small stroke.

Detective Constables Code A . Interviewed Dr BARTON on 27th October 2005 and received from her a prepared statement ID ref: JB/PS/10.

D.M.WILLIAMS
Detective Superintendent Code A
19th 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 Jane BARTON 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 Jane BARTON.

Two allegations (SPURGIN and PACKMAN) were pursued in respect of a consultant Dr Richard REID.

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

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 BARTON.

The General Medical Council also heard evidence during Interim Order Committee Hearings to determine whether the registration of Dr BARTON 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 BARTON 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 Gladys RICHARDS aged 91 years.

Mrs. Richards 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. Richards two of her daughters, Mrs. MACKENZIE and Mrs. LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs. MACKENZIE 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. MACKENZIE 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. MACKENZIE 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 Gladys RICHARDS on Monday 17th April 2000.

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

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys RICHARDS in a manner as to cause her death."

- "Mr. Philip James BEED, Ms. Margaret COUCHMAN and Ms. Christine JOICE were also knowingly responsible for the administration of these drugs."

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

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

Treasury Counsel took the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs. RICHARDS 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 LIVESLEY 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 RICHARDS 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 Gladys RICHARDS 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 FORD and MUNDY who were each provided with copies of the medical records of the four cases in addition to the medical records of Gladys RICHARDS.

The reports from Professor FORD and Professor MUNDY 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 RICHARDS 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 FORD and Professor MUNDY 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 Liam DONALDSON commissioned Professor Richard BAKER 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 BAKER. Immediately following the meeting nurse Anita TUBBRITT (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 BARTON in respect of prescription and administration of Diamorphine.

Nurse TUBRITT'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 Richard BAKER 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, Matthew LOHN 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 David BLACK 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:-

- Clifford HOUGHTON.
- Thomas JARMAN.
- Edwin CARTER.
- Norma WINDSOR

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 Andrew WILCOCK (Palliative care) and Dr David BLACK (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 Reid and Dr Barton 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 BLACK and WILCOCK.

A common denominator in respect of the ten cases was that the attending clinical assistant was Dr Jane BARTON 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 BARTON 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 BARTON in respect of care delivered to individual patients. Dr BARTON 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 BARTON exercised her right of silence refusing to answer any questions.

Consultant Dr Richard REID was interviewed in respect of 2 cases (PACKMAN and SPURGIN) following concerns raised by expert witnesses. Dr REID 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. Elsie DEVINE 88yrs. Admitted to GWMH 21st October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died 21st November 1999, 32 days after admission cause of death recorded as Bronchopnuemonia and Glomerulonephritis.

2. Elsie LAVENDER 83yrs. 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 6th March 1996, 14 days after admission cause of death recorded as Cerebrovascular accident.

3. Sheila GREGORY 91yrs. Admitted to GWMH 3rd September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died 22nd November 1999, 81 days after admission cause of death Bronchopnuemonia.

4. Robert WILSON. 74 yrs. Admitted to GWMH 14th October 1998 with fractured left humerus and alcoholic hepatitis. Died 18th October 1998 4 days after admission cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Enid SPURGIN 92 yrs. Admitted to GWMH 26th March 1999 with a fractured neck of the femur. Died 13th April 1999 18 days after admission cause of death recorded as cerebrovascular accident.

6. Ruby LAKE 84 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 21st August 1998 3 days after admission cause of death recorded as bronchopneumonia.

7. Leslie PITTOCK 82 yrs. Admitted to GWMH 5th January 1996 with Parkinsons disease he was physically and mentally frail immobile suffering depression. Died 24th January 1996 15 days after admission cause of death recorded as bronchopneumonia.

8. Helena SERVICE 99 yrs. Admitted to GWMH 3rd June 1997 with many medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died 5th June 1997 2 days after admission cause of death recorded as congestive cardiac failure.

9. Geoffrey PACKMAN 66yrs. Admitted to GWMH 23rd August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died 3rd September 1999 13 days after admission cause of death recorded as myocardial infarction.

10. Arthur CUNNINGHAM 79 yrs. Admitted to GWMH 21st September 1998 with Parkinson's disease and dementia. Died 26th September 1998 5 days after admission cause of death recorded as bronchopneumonia.

Dr David WILCOCK 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:-*

  Enid Spurgin – orthopaedic surgeon, microbiologist
  Geoffrey Packman – general physician, gastroenterologist
  Helena Service – general physician, cardiologist
  Elsie Lavender – haematologist
  Sheila Gregory – psychogeriatrician
  Leslie Pittock – general physician/palliative care physician
  Arthur Cunningham – palliative care physician.

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

There was however little consensus between the two principal experts Drs BLACK and WILCOCK 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.

David WILLIAMS.
Detective Superintendent Code A
Senior Investigating Officer.
16th January 2007.

Police officer witness statements
Transcript suspect interviews

CASE OF HELENA SERVICE

Background/family observations

Helena SERVICE was born on Code A in Watford. She worked in an auctioneers until she married in 1929. They didn't have any children and when her husband retired they moved to Stubbington to live. Her husband died shortly afterwards and Mrs SERVICE lived alone. Apart from being deaf she had no past medical history of any significance until 1990 when she suffered a stroke and lost some use in her left hand.

In 1993 her GP recommended that Mrs SERVICE needed additional care and she moved into Willow Cottage Nursing Home. She enjoyed the home, was mentally alert and active and would do the Daily Telegraph crossword each day.

In 1997 she became very ill and was admitted to the Queen Alexandra Hospital via her GP. During her stay at QA Mrs SERVICE did not appear ill and was bright, alert and witty. As she didn't need a medical bed at the QA and the nursing home could not provide the sort of care that Mrs SERVICE required she was transferred to Gosport War Memorial Hospital.

When Mrs SERVICE was visited the following day at Gosport War Memorial Hospital she was found lying on her back with her mouth wide open and didn't respond when her hand was squeezed. When questioned about her condition a nurse said "A lady of this age, we have to give her something to make the journey more comfortable for her for the journey".

Mrs SERVICE never woke up and she died on the 5th June 1997. Her death was unexpected and she had never complained of being in any pain although she was frail. She was subsequently cremated.

Her death certificate stating that she died of Congestive Cardiac Failure.

Medical history of Helena SEVICE

Events at Queen Alexander Hospital, May 17th–June 3rd 1997

Mrs Helena Service, a 99 year old woman who lived in a rest home, was admitted to Queen Alexander Hospital on the 17th May 1997 at 14.00h. A junior doctor (House Officer) clerked Mrs Service and noted that she was very deaf, confused, disorientated and unable to carry out a mini-mental test. Because it was impossible to obtain a history from Mrs Service, this was taken from the General Practitioner's referral letter. This noted that she had recently developed a urinary tract infection, initially responding to antibiotics but was now short of breath, confused, disorientated and that the rest home were unable to cope. A past history of gout, non-insulin dependent diabetes mellitus (NIDDM) and congestive cardiac failure (CCF) was also noted.

Review of the recent rest home (Willow Cottage) notes revealed that Mrs Service had been prescribed thioridazine at night to help her to sleep on the 21st April 1997; paracetamol on the 1st May 1997 for pain in her back due to osteoporosis; antibiotics on the 6th May 1997 for a chest infection and stronger pain killers for her back pain (no details given); her lisinopril dose was increased on 12th May 1997 because of heart failure; she was noted to be very restless on the 14th May 1997 and had developed a bed sore; on the 17th May 1997 she was described as poorly and admitted to hospital.

In 1981 she underwent a cholecystectomy and gasterectomy for gastric ulcers, in October 1984 suffered a cerebrovascular accident (a 'stroke') affecting especially her left hand and wrist. She recovered well but residual weakness remained; her heart failure was longstanding - a chest x-ray in 1984 revealed that her heart was enlarged; in 1988 had polymyalgia rheumatica, treated with steroids that precipitated her diabetes mellitus; in August 1989 she fell and fractured her ribs, a chest X-ray again revealing signs of heart failure; in 1990 had a cataract removed; in 1992 was admitted with a chest infection, diarrhoea and vomiting and found to be in atrial fibrillation, later that year she had a further stroke with good improvement); in January 1995 heart failure was a problem, she was peripherally cyanosed and short of breath on exertion, had an elevated jugular venous pressure, a heart murmur of mitral regurgitation and oedema to her thighs. She was admitted to commence an ACE inhibitor treatment for heart failure (going home on lisinopril 5mg at night), her digoxin was also discontinued; in January 1996 she was admitted for gout affecting her wrist. History was unavailable on admission because her hearing aid wasn't working and she was profoundly deaf. Her urea was 17.6mmol/L (normal 3–7.6mmol/L), creatinine 167micromol/L (45–90micromol/L) and uric acid 0.45mmol/L (0.13–0.36mmol/L) (page 177 of 401) and she was treated with IV antibiotics and fluids. Her Barthel score was 3 on admission and 6 on discharge, she was slightly breathless on exertion, occasionally woke at night and was prescribed temazepam 10mg p.r.n..

Mrs Service's current medication consisted of lisinopril 2.5mg twice a day, bumetanide 1mg once a day (both for heart failure), aspirin 75mg once a day (to thin the blood), allopurinol 100mg once a day (for gout) and thioridazine 25mg at night as required 'p.r.n.' (an antipsychotic sedative). During the examination Mrs Service vomited. She was alert but disorientated, confused and dehydrated (+++). Other main findings were an irregular pulse (due to atrial fibrillation), crackles in her chest (suggestive of either excess fluid or infection) and mild swelling of her ankles. She was unable to cooperate with a neurological examination. The initial impression was that Mrs Service was deaf with increasing confusion possibly due to a urinary tract ± chest infection. She also had atrial fibrillation.

A number of investigations were carried out including blood tests, blood, urine and sputum cultures (to look for infection), blood gases, chest and abdominal x-rays and an electrocardiogram (ECG). These tests confirmed that Mrs Service was dehydrated (sodium of 149mmol/L (normal range 135–146mmol/L), urea of 14.4mmol/L (normal range 3–7.6mmol/L) and creatinine 151micromol/L (normal range 45–90micromol/L); had a low level of oxygen in her blood stream (PaO_2 6.7kPa, normal 11.3–12.6kPa; oxygen saturation 88.5%, normal 95–98%); had patchy shadowing on her chest x-ray, was constipated and confirmed to be in uncontrolled atrial fibrillation at a rate of 135 beats per minute. Her full blood count was normal.

The initial treatment plan consisted of intravenous fluid and encouraging oral fluid intake, intravenous antibiotics (cefuroxime), oxygen and digoxin to slow the rate of the atrial fibrillation. Mrs Service's oxygen saturation was to be monitored, her general observations recorded every 4h and blood sugars checked twice a day.

Her other medication was continued unchanged. Mrs Service took thioridazine 25mg on the 24th, 25th, 26th, 27th, 28th, 30th, 31st of May and the 1st and 2nd June, generally between 22–23.00h. She was also prescribed paracetamol 1g p.r.n. but received only one dose at 08.25h on the 25th May.

That evening she was reviewed by a more experienced doctor (senior registrar) who considered that the chest x-ray and crackles were suggestive of left ventricular failure. This is a failure of the left side of the heart to pump properly, causing a build up of pressure in the veins in the lungs which in turn allows fluid to collect on the lungs (pulmonary oedema). The senior doctor did not think Mrs Service appropriate for more intensive therapies nor cardiopulmonary resuscitation and agreed with the treatment plan outlined above. The nursing care plan noted that Mrs Service was very confused and this continued into the night. The nursing notes record that she was breathless. Subsequent entries on the 21st–23rd, 25–26th, 28th May–2nd June note that Mrs Service was breathless on exertion but do not record that she was breathless at rest.

On the 18th February 1997, Mrs Service was reviewed by the consultant, Dr Miller, and it was noted that she was more alert, her pulse rate had slowed to 80 beats per minute, blood pressure 125/80 and her chest was clear. The nursing care plan recorded that Mrs Service seemed less confused, with confusion only apparent when 'patient was unable to hear what is being said to her.' The night entry recorded 'remains confused, slept for periods'.

On the 19th May she was noted to be 'very deaf! But much better, sitting in a chair and talking ++'. Blood tests revealed an improvement in her hydration state; sodium 146mmol/L, urea 7.9mmol/L and creatinine 114micromol/L. Full blood count revealed a slightly elevated white blood count 11.2×10^9/L (neutrophils 8.2×10^9/L). The plan was to discontinue the intravenous fluids when oral intake adequate and change to oral antibiotics and to repeat her blood tests. The nursing notes record that she remained 'confused at times but at times very lucid' and at night 'remains confused'.

On the 20th May 1997 she was noted to be sleeping in the chair with some shortness of breath at rest. She remained apyrexial with a blood pressure of 120/80 and pulse rate of 88. Examination revealed her to be in atrial fibrillation and slightly dry. Nursing notes recorded 'sleepy and confused after an active night; slept most of the afternoon despite numerous attempts to remain awake by staff; drowsy early evening and slept most of the night'.

Full blood count on the 21st May 1997 revealed a persistently raised white blood cell count 13.3×10^9/L (neutrophils 10.1×10^9/L). Nursing notes recorded 'asleep much of morning but lucid when awake; some confusion pm. Drowsy night time, remains confused, slept for short periods only'.

On the 22nd May she was noted to be apyrexial, to have a pulse rate of 80, blood pressure 120/80 and a few crackles at the bases of her lungs. The plan was to push more fluids, continue antibiotics until tomorrow and aim for home. The nursing notes recorded 'lucid and very demanding this am. Bowels open++; night time remains confused' .

On the 23rd May 1997 she was apyrexial, comfortable at rest with a blood pressure of 120/70 and pulse of 88. Thyroid function tests were normal. The plan was to continue intravenous fluids until oral intake improved, to check her digoxin level (1.8mmol/L, normal 0.9–2.6mmol/L and plan for home the following week. The IV cannula was pulled out, but as she was drinking well the IV fluids were not resumed. Nursing notes recorded 'no change. Night time: remains noisy at times'.

On the 24th May 1997 the nursing notes recorded 'remains confused at times'.

On the 25th May 1997, her biochemistry revealed continued improvement; sodium, potassium, urea were normal and creatinine 111micromol/L (normal 45–90micromol/L). Nursing notes report that she was confused at times and noisy at night .

On the 26th May 1997 she was seen by the on-call doctor at the nurses request who noticed that Mrs Service was not weight bearing and her left hand was weak. Mrs Service herself was unaware of any problem with her left hand. On examination she appeared to be using her left arm less and although more floppy was able to move it. The strength of the muscles were reduced and the reflexes were increased in the left arm and it was considered that she may have had a cerebrovascular accident (a 'stroke') or a transient ischemic attack (a 'stroke' that resolves quickly and completely). The nursing notes reported that she remained confused at times. There were problems with the hearing aid and the battery was changed and the ear piece cleaned that improved Mrs Service's ability to hear. That night the nursing notes recorded 'when hearing aid is in place understands the question and answers appropriately. Quiet most of the night, only asking a couple of times to be sat up'.

When reviewed on the 27th May it was noted that her left arm was weak and she was referred to Social Services. To return to the rest home, Mrs Service needed to be able to transfer with only one nurse, but she required the help of two. Nursing notes record no problems with confusion in the day or overnight.

On the 28th May 1997 it was noted that her Barthel score was 4 and she was referred to the geriatricians for continuing care, the referral note recording that Mrs Service had presented with left ventricular failure that had improved and that her 'Humphrey' hearing aid was needed to speak to her. The nursing notes reported that she was 'very demanding...wanting to get in/out of bed. Confusion due to hearing problems. Less confused overnight'.

On the 29th May 1997 she was seen by a locum consultant geriatrician, Dr Code A The letter summarising his review of Mrs Service reads 'thank you very much for asking me to see this delightful lady, whom I saw on the ward today. She has longstanding cardiac failure and was admitted again because of breathlessness and general deterioration. She was found to be in heart failure. She is deaf and uses a deaf aid. Although clinically she is better, she is still in a degree of heart failure. She is normally in a rest home, but I doubt whether they can manage her. I will put her on the list for Gosport War Memorial Hospital for assessment, with a view to considering continuing care'. The nursing notes recorded 'remains very demanding today. At night: no change, remains quite noisy at times'.

Entries in the medical notes for the 30th May and 2nd June 1997 noted that she was well and her condition unchanged. Over this time the nursing notes record 'not confused but is quite agitated at times. At night less confused (30th May); less confused, noisy at times; slept well, less noisy (31st May); no signs of confusion but very demanding at times during the day and night (1st June); no signs of confusion. Very demanding overnight, shouted out constantly' (2nd June).

On the 3rd June 1997 she was seen by Dr Code A noted to be well and due to transfer to Gosport that day. The nursing transfer letter from F1 ward to Dryad Ward summarised that Mrs Service had been admitted with atrial fibrillation and confusion, a chest infection and had received IV fluids, IV antibiotics, oxygen therapy and digoxin; that she was very deaf (wears hearing aid in right ear, known as Humphrey (this was now working well, required all care with eating and drinking and took two people to transfer. Treatment was listed as thioridazine 25mg at night, lisinopril 2.5mg twice a day, bumetamide 1mg once a day, aspirin 75mg once a day, allopurinol 100mg at night and digoxin 125microgram once a day. The medical discharge summary from F1 noted that Mrs Service had been admitted because of shortness of breath and confusion, treated with intravenous fluids, cefuroxime, oxygen and digitalisation for pulmonary oedema secondary to left ventricular failure and dehydration. It listed the medication as lisinopril, bumetamide, aspirin, allopurinol and digoxin but not the thioridazine

Events at Gosport War Memorial Hospital, 3rd–5th June 1997

3rd June 1997

The medical notes entry reads 'Transferred to Dryad Ward, recent admission 17th May 1997, confused, off legs, URTI (upper respiratory tract infection), NIDDM, CCF (congestive cardiac failure), gout, came from a rest home. On examination slightly breathless plethoric lady, heart sounds 1 and 2 + gallop, bases clear, ankles √√ (possibly indicates no swelling (oedema)), needs palliative care if necessary. I am happy for nursing staff to confirm death'.

The nursing summary notes recorded 'admitted today from F1 ward QA. Helena is a very pleasant lady. She has a normal diet but needs assistance at meal times. She has faecal incontinence. Her buttocks are very red and sore and the skin is broken. Her skin is quite dry. She has 2 superficial grazes on her spine. Skin on lower arms is discoloured. Helena uses a Humphrey hearing aid which has a microphone. She is able to respond to questions. Helena is a non-insulin dependent diabetic, has congestive cardiac failure, suffers from confusion, has upper respiratory infection also gout. Helena has had bowels open and passed urine since admission. First swabs of MRSA screening sent (which were negative). Helena has not eaten supper this evening but has had a drink of water. Her Barthel score was 0.

The medication chart reveals she continued her bumetamide, lisinopril, allopurinol, digoxin and aspirin as before. However, Mrs Service was not written up for thioridazine 25mg p.r.n. that she had been taking most nights. She was also prescribed diamorphine 20–100mg SC/24h, hyoscine 200–800microgram SC/24h and midazolam 20–80mg SC/24h all p.r.n.. On the once only and pre-medication drugs section diamorphine 5–10mg IM was also prescribed, but not apparently given.

The nursing summary entry for the night of 3rd June 1997 records 'Spenco mattress in situ, nursed on alternate sides overnight. Zinc and castor oil to sore sacrum. Not passed urine. Oral fluids encouraged and taken fairly well. Tongue dry and coated – mouth care given.

4th June 1997

The nursing notes at 02.00h record 'failed to settle – very restless and agitated, midazolam 20mg given by a syringe driver (started at 02.15h) over 24 hours with some success'.

Nursing summary entry reads 'condition appears to have deteriorated overnight – remains restless. Seen by Dr Barton. Driver recharged with diamorphine 20mg, midazolam 40mg at 09.20h...Rang nephew to inform him of poorly. There was no medical notes entry but a blood test was undertaken. This revealed that Mrs Service was dehydrated with sodium 156mmol/L (normal range 135–146mmol/L), urea 13.2mmol/L (3–7.6mmol/L) and creatinine 126micromol/L (45–90micromol/L). There were low values of potassium 2.7mmol/L (3.5–5mmol/L), albumin 29g/L (37–50g/L) and calcium 1.97mmol/L (2.25–2.70mmol/L).

5th June 1997

Nursing summary entry at 04.00h reads 'condition continued to deteriorate and died very peacefully at 03.45h. Nephew informed.

On Mrs Service's death certificate the cause of death was given as 1a (disease or condition directly leading to death) congestive cardiac failure with an approximate interval between onset and death given as two days.

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Helena SERVICE was a Clinical Assistant Dr Jane BARTON. The medical care provided by Dr BARTON to Mrs SERVICE following 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, General Medical Council, October 1995, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination.
- in providing care you must 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
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs
- in providing care you must be willing to consult colleagues.

The medical records were examined by two independent experts. Dr Code A in his review of Dr BARTON's care reported specifically:-

Mrs Service's hospital notes go back for 16 years prior to her death. They document that she has heart disease with an irregular heartbeat (atrial fibrillation) in 1981 and heart enlargement in 1984 (229). She also has two previous strokes documented in both 1984 and 1992. The natural history of heart disease is in general for progressive decline over time, with a very poor prognosis once serious heart failure has developed, as documented on this lady in 1995.

She is also profoundly deaf which leads to communication difficulties and makes a patient more likely to get acute confusion. She suffers from Diabetes Mellitus, which is unmasked when she receives steroid treatment for polymyalgia rheumatica, she is also thought to have had an episode of gout and has been dehydrated with impaired kidney function on at least two occasions.

Despite her noted physical frailty she eventually makes a good recovery from a stroke in 1984. By 1995 she has moved into a residential home. We do not know what precipitated this, however in 1995 her Barthel is documented at only 10/20 meaning that she required considerable help with her routine activities of daily living.

In 1996 she is admitted with gout, and is found to be profoundly dependent on admission with a Barthel of 3/20, which improves to 6/20 on discharge. Very poor mobility is noted and she has a Waterlow score which is a risk score for pressure sores (12) of 30 putting her into a very high-risk category. There is no doubt that this lady would normally be

cared for in a nursing home, with this level of dependency, or even in NHS continuing care if she had not already been living in a residential home that was committed to her care.

By the time she is admitted on 17th May 1997 she has been progressively failing in the residential home. It seems unlikely that this was a dramatic change in function, but the end point of a slow deterioration of her multiple illnesses, including her progressive heart disease, her cerebro-vascular disease and of course the physiological frailty of an age of 99 years,

When admitted to hospital she was found to be both dehydrated and in again heart failure. This is often a combination suggesting poor prognosis. She has acute confusion (delirium) and this does not resolve, although it does fluctuate, during all her time in the Queen Alexander Hospital. Investigations on admission found she is dehydrated with a raised creatinine of 151 but she is also markedly hypoxic (low oxygen in the blood) with a PO2 of 6.7 kPa (normal range 12.7+0.7) with a PCO 5.6 kPa (normal range 5.3+0.3) She is now very unwell, and highly dependent with a Barthel at best 4/10 (162). On the basis of the nursing notes she makes very little improvement in her confusion or her breathlessness and indeed things take a turn for the worse when she probably has a new stroke on 26th May (116) (303). She remains totally dependent after this.

She is seen by a locum consultant geriatrician, Dr [Code A] on 29th May. His assessment is that she will not return to her residential home and that he is transferring her to Gosport "with a view to considering continuing care". By this he probably means an assessment as to whether this lady is dying or will improve enough to be discharged into a nursing home, or perhaps to simply remain in an NHS continuing care bed until she does die. However, this is not spelt out in the letter or the notes.

The medical notes make very little further comment on her clinical condition at the Queen Alexander Hospital, however, the nursing notes on the 2nd June comment she is very demanding overnight, shouting out continuously, suggesting that she is acutely delirious again and that she is so breathless that she has to sit up all night on the night of the 2nd June. I believe this lady is now physically deteriorating, but it is impossible to tell if this is progression of heart failure, a pulmonary embolus, or chest infection on top of her other problems. I have little doubt that she was entering a terminal phase of her illness.

On the 3rd June she is transferred to Gosport War Memorial hospital where she is noted to have a buttock bedsore. The recorded medical assessment is brief but does include an examination, which although it notes that she has a tachycardia and is very breathless, fails to give an overall impression of her status and whether this is acute, chronic or acute on chronic, and fails to record her pulse and blood pressure. A thorough objective assessment of this lady's clinical status is not possible from the notes that are made on admission, and would appear to be below an acceptable standard of good medical practice.

It seems likely though that the doctor recognises that this lady was seriously ill as the only comment under the examination is "needs palliative care if necessary". There is no record in the notes of this being discussed at this stage with the nurses or the family.

. The drug chart is written up with all the usual medication from Queen Alexander Hospital and this is given on both the 3rd and 4th June.

Diamorphine with Midazolam and Hyoscine are written up PRN on admission. The Midazolam is usually used for terminal restlessness and is widely used subcutaneously in doses from 5 – 80 mgs per 24 hours for this purpose. 20 mgs is within current guidance but at the top end for elderly patients. Elderly patients usually need a dose of between 5 – 20 mgs per 24 hours.

Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. It can be difficult to predict exactly the starting dose of Diamorphine to give in a syringe driver but many would give between 5 – 15 mgs of Diamorphine in the first 24 hours, in this case the 20 mgs is at the upper limit.

Mrs Service becomes extremely restless and agitated on the night of 4th June (probably similar to the previous night at the Queen Alexander hospital). Midazolam is now started via a syringe driver at 20 mgs. The restlessness is probably being caused by her severe breathlessness and heart disease and Diamorphine at this stage might well have been the drug of choice, but it is difficult to criticise the use of Midazolam.

She continues to deteriorate over night and the Midazolam is now replaced with Diamorphine 20 mgs a day and Midazolam 40 mgs. She then deteriorates further and dies 15 hours later.

There is no evidence in the notes that any other medical assessment was done prior to the starting of the Diamorphine and Midazolam in the syringe driver, nor is there any evidence at all that at any time after her admission to Gosport was further advice obtained from the consultant who was presumably responsible for this patient's care. It is not clear from the notes if the locum consultant (Dr Code A) was responsible for the patient's care once they had transferred to Gosport Hospital and it would have been good medical practice for the doctor at Gosport to have sought further advice from their consultant when a patient was transferred, apparently so seriously ill, and immediate palliative care was being considered.

It is also possible to criticise the care at Queen Alexander. All to often when a patient is not obviously going home and a bed elsewhere has been found, the pressure is to move the patient at the first opportunity, even when it may not be in their best interest. It seems likely to me that her condition was deteriorating in the Queen Alexander Hospital and the stress of an ambulance transfer would not have helped this lady's care.

The cause of death in Mrs Service was multifactorial. In my view the dose of 20mg Diamorphine combined with the 40mg dose of Midazolam was higher than necessary in this very elderly and frail lady's terminal care and the medication may have slightly shortened life, although this opinion does not reach the standard of proof of "beyond reasonable doubt". However, I would have expected a difference of, at most, no more than a few hours to days, if a lower dose of either or both of the drugs had been used instead.

Dr Andrew WILCOCK reports:-

Mrs Helena Service was a 99 year old woman who was admitted to the Queen Alexandra Hospital on the 17th May 1997, confused and disorientated most likely as a result of a chest

infection ± a fast irregular pulse (atrial fibrillation) precipitating a worsening of her cardiac failure. Mrs Service was appropriately assessed, investigated and managed and her condition improved relatively quickly; she was more alert, her heart rate was controlled and her renal function improved. She remained confused at times and noisy at night. On the 26th May it is likely that Mrs Service had a further cerebrovascular accident (a stroke) affecting the left side of her body, particularly the left arm and hand and she became more dependent on the nursing staff to transfer her. As a result, she was unable to return to the rest home and she was referred to the geriatricians. Mrs Service was seen by Dr [Code A] who agreed to take her to Gosport War Memorial Hospital for assessment with regards to continuing care. Mrs Service's behaviour remained challenging at times, particularly at night. However, apart from the regular use of thioridazine as a night time sedative, Mrs Service's behaviour was managed by the nursing staff using non-drug means. On the day of her transfer to Dryad Ward, Mrs Service was seen by consultant physician Dr [Code A] and was noted to be 'well'. There are no concerns regarding the care proffered to Mrs Service at the Queen Alexander Hospital.

On Dryad Ward, there was an inadequate assessment of Mrs Service's current symptoms and cardiovascular status. Mrs Service's medication was mostly continued unchanged except the thioridazine was omitted. She was prescribed diamorphine 20–100mg SC/24h, hyoscine (hydrobriomide) 200–800microgram/24h and midazolam 20–80mg SC/24h all p.r.n. (as required). Diamorphine 5–10mg IM was prescribed as a stat dose, but not apparently given. There is inadequate justification documented in the notes for the prescription of these drugs in these doses. Midazolam 20mg SC/24h was commenced on the first night Mrs Service spent on Dryad Ward because she 'failed to settle'. Mrs Service was however, elderly, very deaf, confused/prone to confusion, had been moved to unfamiliar surroundings with unfamiliar staff and her usual night sedative had been omitted. Thus, there were many reasons why Mrs Service could have been restless on her first night on Dryad Ward. The following day, there was no documented assessment of Mrs Service's condition, but the midazolam was increased to 40mg SC/24h and diamorphine 20mg SC/24h added to the syringe driver. The increase in midazolam appeared to be in response to Mrs Service's persistent restlessness. There is no justification in the notes as to why the diamorphine was considered necessary but in her statement Dr Barton reports that in her view Mrs Service was terminally ill with heart failure'. However, blood tests were taken from Mrs Service on the same day and these would not be indicated in patients who were imminently dying and the fact that they were carried out suggests that doubt existed.

The blood test result confirmed that Mrs Service had renal impairment and a low potassium, possibly due to her medication and/or an inadequate fluid intake. These could have contributed to worsening confusion and were potentially reversible with appropriate treatment. There is no documentation relating to these results and why it was not considered appropriate to act on them.

If it were that Mrs Service was not actively dying, as the notes on her transfer to Dryad Ward suggest, then the failure to rehydrate her, together with the use of midazolam and diamorphine could have contributed more than minimally, negligibly or trivially to her death. If it were considered that Mrs Service was actively dying, then it would have been reasonable not to have rehydrated her and the use of diamorphine and midazolam could be justified. However, in my opinion, the starting dose of diamorphine was likely to be excessive to her requirements and access to smaller doses of diamorphine (and midazolam) p.r.n. would have been a more appropriate way of initially addressing Mrs Service's symptoms, identifying her dose requirements and justifying the need for regular dosing and subsequent dose titration. Given that elderly, frail patients with significant medical morbidity can deteriorate with little or sometimes no warning, it could be argued that it is

difficult to distinguish with complete confidence which of the above scenarios was most likely for Mrs Service.

He further states specifically;-

i) There was insufficient assessment and documentation of Mrs Service's symptoms and physical (particularly cardiac) state on her transfer to Dryad Ward on the 3rd June 1997.

ii) On the day of her transfer, Mrs Service was prescribed a stat dose of IM diamorphine and diamorphine and midazolam by syringe driver p.r.n. in dose ranges that would be excessive to her needs.

iii) The use of midazolam in a syringe driver, appears an excessive response to Mrs Service's 'failure to settle' on her first night in a new environment.

iv) There was insufficient assessment and documentation of Mr Service's clinical condition when she was restless on the 4th June 1997.

v) Mrs Service received a starting dose of diamorphine that was likely to be excessive for her needs.

Interview of Dr Jane BARTON.

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified as 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 27th October 2005 Dr BARTON in company with her solicitor Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Helena SERVICE at the Gosport War Memorial Hospital. The interviewing officers were DC Code A and DC Code A.

The interview commenced at 0911hrs and lasted for 23 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/10. This statement dealt with the specific issues surrounding the care and treatment of Helena SERVICE.

DRAFT REPORT

regarding

HELENA SERVICE (BJC/72 and JR/16)

PREPARED BY: Dr Andrew Wilcock MB ChB FRCP DM
Reader in Palliative Medicine and Medical Oncology

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

Mrs Helena Service was a 99 year old woman who was admitted to the Queen Alexandra Hospital on the 17th May 1997, confused and disorientated most likely as a result of a chest infection ± a fast irregular pulse (atrial fibrillation) precipitating a worsening of her cardiac failure. Mrs Service was appropriately assessed, investigated and managed and her condition improved relatively quickly; she was more alert, her heart rate was controlled and her renal function improved. She remained confused at times and noisy at night. On the 26th May it is likely that Mrs Service had a further cerebrovascular accident (a stroke) affecting the left side of her body, particularly the left arm and hand and she became more dependent on the nursing staff to transfer her. As a result, she was unable to return to the rest home and she was referred to the geriatricians. Mrs Service was seen by Dr Code A who agreed to take her to Gosport War Memorial Hospital for assessment with regards to continuing care. Mrs Service's behaviour remained challenging at times, particularly at night. However, apart from the regular use of thioridazine as a night time sedative, Mrs Service's behaviour was managed by the nursing staff using non-drug means. On the day of her transfer to Dryad Ward, Mrs Service was seen by consultant physician Dr Code A and was noted to be 'well'. There are no concerns regarding the care proffered to Mrs Service at the Queen Alexander Hospital.

On Dryad Ward, there was an inadequate assessment of Mrs Service's current symptoms and cardiovascular status. Mrs Service's medication was mostly continued unchanged except the thioridazine was omitted. She

was prescribed diamorphine 20–100mg SC/24h, hyoscine (hydrobriomide) 200–800microgram/24h and midazolam 20–80mg SC/24h all p.r.n. (as required). Diamorphine 5–10mg IM was prescribed as a stat dose, but not apparently given. There is inadequate justification documented in the notes for the prescription of these drugs in these doses. Midazolam 20mg SC/24h was commenced on the first night Mrs Service spent on Dryad Ward because she 'failed to settle'. Mrs Service was however, elderly, very deaf, confused/prone to confusion, had been moved to unfamiliar surroundings with unfamiliar staff and her usual night sedative had been omitted. Thus, there were many reasons why Mrs Service could have been restless on her first night on Dryad Ward. The following day, there was no documented assessment of Mrs Service's condition, but the midazolam was increased to 40mg SC/24h and diamorphine 20mg SC/24h added to the syringe driver. The increase in midazolam appeared to be in response to Mrs Service's persistent restlessness. There is no justification in the notes as to why the diamorphine was considered necessary but in her statement Dr Barton reports that in her view Mrs Service was terminally ill with heart failure'. However, blood tests were taken from Mrs Service on the same day and these would not be indicated in patients who were imminently dying and the fact that they were carried out suggests that doubt existed.

The blood test result confirmed that Mrs Service had renal impairment and a low potassium, possibly due to her medication and/or an inadequate fluid intake. These could have contributed to worsening confusion and were potentially reversible with appropriate treatment. There is no

documentation relating to these results and why it was not considered appropriate to act on them.

If it were that Mrs Service was not actively dying, as the notes on her transfer to Dryad Ward suggest, then the failure to rehydrate her, together with the use of midazolam and diamorphine could have contributed more than minimally, negligibly or trivially to her death. If it were considered that Mrs Service was actively dying, then it would have been reasonable not to have rehydrated her and the use of diamorphine and midazolam could be justified. However, in my opinion, the starting dose of diamorphine was likely to be excessive to her requirements and access to smaller doses of diamorphine (and midazolam) p.r.n. would have been a more appropriate way of initially addressing Mrs Service's symptoms, identifying her dose requirements and justifying the need for regular dosing and subsequent dose titration. Given that elderly, frail patients with significant medical morbidity can deteriorate with little or sometimes no warning, it could be argued that it is difficult to distinguish with complete confidence which of the above scenarios was most likely for Mrs Service.

2. 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 suboptimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

3. ISSUES

3.1 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?

3.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

4. BRIEF CURRICULUM VITAE

Dr Andrew Wilcock MB ChB, FRCP, DM, Reader in Palliative Medicine and Medical Oncology, University of Nottingham and Honorary Consultant Physician, Nottingham University Hospitals NHS Trust.

Trained in general medicine, including experience in health care of the elderly (acute medicine and rehabilitation) prior to specialising in Palliative Medicine, working in Specialist Palliative Care Units in Nottingham and Oxford. Appointed to present post as Senior Lecturer in 1995. Promoted to Reader in 2001. Carries out research in pain, breathlessness and exercise capacity. Regularly lectures on national and international courses. Palliative care prescribing advisor to the British National Formulary (2002-). Expert reviewer for Prodigy national palliative care guidelines for general practitioners. Joint author of the international Palliative Care Formulary that has sold over 90,000 copies, and the 3rd edition of Symptom Management in Advanced Cancer, with Dr Code A Previously Chair of the Mid-Trent Cancer Services Network Palliative Care Group, Nottingham

Cancer Centre Palliative Care Group, inaugural Secretary for the Science Committee of the Association for Palliative Medicine of Great Britain and Ireland and member of the National Institute for Clinical Excellence Lung Cancer Guidelines Development Group.

Operates the international Palliative Medicine mailbase mailing list and co-owns and edits www.palliativedrugs.com that publishes the Palliative Care Formulary on the internet. With 21,000 members it is the largest Palliative Care resource of its kind. Provisional Member of the Expert Witness Institute.

5. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Helena Service, including the medical certificate of cause of death.

[2] Full set of medical records of Helena Service on CD-ROM. Note. The page numbering on the CD-ROM does not correspond to the page numbering on the paper set, .e.g. page 155 of 380 on CD-ROM = page 164 of 401 in paper notes.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

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

[5] Hampshire Constabulary Summary of Care of Helena Service.

[6] Palliative Care Handbook Guidelines on Clinical Management, Third

Edition, Salisbury Palliative Care Services (1995); also referred to as the 'Wessex Protocols.'

[7] Portsmouth Health Care NHS Trust Policies:

i) Control of Administration of Medicines by Nursing Staff Policy (January 1997).

ii) Prescription Writing Policy (July 2000).

iii) Policy for Assessment and Management of Pain (May 2001).

iv) Compendium of Drug Therapy Guidelines, Adult Patients (1998).

v) Draft Protocol for Prescription Administration of Diamorphine by Subcutaneous Infusion, Medical Director (December 1999).

vi) Medicines Audit carried out by the Trust referred to as Document 54 on page 52 in the Chi Report (reference 6).

[8] General Medical Council, Good Medical Practice (October 1995).

[9] British National Formulary (BNF). Section on Prescribing in Terminal Care (March 1997).

[10] British National Formulary (BNF). Section on Prescribing in the Elderly (March 1997).

[11] Statement of Dr Jane Barton as provided to me by Hampshire Constabulary (undated).

[12] Statement of Dr Jane Barton RE: Helena Service, 27th October 2005.

[13] Draft Report regarding Statement of Dr Jane Barton RE: Helena Service (BJC/72), Dr A Wilcock, 2nd February 2006.

[14] Draft overview of Helena Service (BJC/72), Dr A Wilcock, 12th November 2005.

[15] Report regarding Helena Service, Dr Code A February 2006.

6. CHRONOLOGY/CASE ABSTRACT

Events at Queen Alexander Hospital, May 17th–June 3rd 1997

Mrs Helena Service, a 99 year old woman who lived in a rest home, was admitted to Queen Alexander Hospital on the 17th May 1997 at 14.00h. A junior doctor (House Officer) clerked Mrs Service and noted that she was very deaf, confused, disorientated and unable to carry out a mini-mental test. Because it was impossible to obtain a history from Mrs Service, this was taken from the General Practitioner's referral letter. This noted that she had recently developed a urinary tract infection, initially responding to antibiotics but was now short of breath, confused, disorientated and that the rest home were unable to cope (pages 51 and 155 of 401). A past history of gout, non-insulin dependent diabetes mellitus (NIDDM) and congestive cardiac failure (CCF) was also noted.

Review of the recent rest home (Willow Cottage) notes revealed that Mrs Service had been prescribed thioridazine at night to help her to sleep on the 21st April 1997; paracetamol on the 1st May 1997 for pain in her back due to osteoporosis; antibiotics on the 6th May 1997 for a chest infection and stronger pain killers for her back pain (no details given); her lisinopril dose was increased on 12th May 1997 because of heart failure; she was noted to be very restless on the 14th May 1997 and had developed a bed sore; on the 17th May 1997 she was described as poorly and admitted to hospital (pages 282 and 283 of 401).

Review of the notes also reveals that: in 1981 she underwent a cholecystectomy (page 374 of 401) and gasterectomy for gastric ulcers (page 233, 243, 244 and 252 of 401); in October 1984 suffered a cerebrovascular accident (a 'stroke') affecting especially her left hand and wrist. She recovered well but residual weakness remained (pages 222 and 225 of 401); her heart failure was longstanding - a chest x-ray in 1984 revealed that her heart was enlarged (pages 86, 87, 229 of 401); in 1988 had polymyalgia rheumatica, treated with steroids that precipitated her diabetes mellitus (pages 79 and 341 of 401); in August 1989 she fell and fractured her ribs, a chest X-ray again revealing signs of heart failure (page 35 of 105); in 1990 had a cataract removed (page 329 of 401); in 1992 was admitted with a chest infection, diarrhoea and vomiting and found to be in atrial fibrillation, later that year she had a further stroke with good improvement (page 70 of 401); in January 1995 heart failure was a problem, she was peripherally cyanosed and short of breath on exertion, had an elevated jugular venous pressure, a heart murmur of mitral regurgitation and oedema to her thighs. She was admitted to commence an ACE inhibitor treatment for heart failure (going home on lisinopril 5mg at night), her digoxin was also discontinued (pages 58, 59, 68, 69, 144, 146 and 325 of 401); in January 1996 she was admitted for gout affecting her wrist. History was unavailable on admission because her hearing aid wasn't working and she was profoundly deaf. Her urea was 17.6mmol/L (normal 3–7.6mmol/L), creatinine 167micromol/L (45–90micromol/L) and uric acid 0.45mmol/L (0.13–0.36mmol/L) (page 177 of 401) and she was treated with IV antibiotics and fluids. Her Barthel score was 3 on admission

and 6 on discharge, she was slightly breathless on exertion, occasionally woke at night and was prescribed temazepam 10mg p.r.n. (pages 11, 13 and 260 of 401).

Mrs Service's current medication consisted of lisinopril 2.5mg twice a day, bumetanide 1mg once a day (both for heart failure), aspirin 75mg once a day (to thin the blood), allopurinol 100mg once a day (for gout) and thioridazine 25mg at night as required 'p.r.n.' (an antipsychotic sedative) (pages 52 and 155 of 401). During the examination Mrs Service vomited. She was alert but disorientated, confused and dehydrated (+++). Other main findings were an irregular pulse (due to atrial fibrillation), crackles in her chest (suggestive of either excess fluid or infection) and mild swelling of her ankles. She was unable to cooperate with a neurological examination. The initial impression was that Mrs Service was deaf with increasing confusion possibly due to a urinary tract ± chest infection. She also had atrial fibrillation (page 156 of 401).

A number of investigations were carried out including blood tests, blood, urine and sputum cultures (to look for infection), blood gases, chest and abdominal x-rays and an electrocardiogram (ECG) (page 157 of 401). These tests confirmed that Mrs Service was dehydrated (sodium of 149mmol/L (normal range 135–146mmol/L), urea of 14.4mmol/L (normal range 3–7.6mmol/L) and creatinine 151micromol/L (normal range 45–90micromol/L) (pages 157 and 172 of 401)); had a low level of oxygen in her blood stream (PaO_2 6.7kPa, normal 11.3–12.6kPa; oxygen saturation 88.5%, normal 95–98%) (page 173 of 401); had patchy shadowing on her

chest x-ray, was constipated and confirmed to be in uncontrolled atrial fibrillation at a rate of 135 beats per minute (pages 157, 175 of 401). Her full blood count was normal (page 192 of 401).

The initial treatment plan consisted of intravenous fluid and encouraging oral fluid intake, intravenous antibiotics (cefuroxime), oxygen and digoxin to slow the rate of the atrial fibrillation (page 270 of 401). Mrs Service's oxygen saturation was to be monitored, her general observations recorded every 4h and blood sugars checked twice a day (page 157 of 401).

Her other medication was continued unchanged. (pages 270, 273 of 401). Mrs Service took thioridazine 25mg on the 24th, 25th, 26th, 27th, 28th, 30th, 31st of May and the 1st and 2nd June, generally between 22–23.00h (page 273 of 401). She was also prescribed paracetamol 1g p.r.n. but received only once dose at 08.25h on the 25th May (page 273 of 401).

That evening she was reviewed by a more experienced doctor (senior registrar) who considered that the chest x-ray and crackles were suggestive of left ventricular failure. This is a failure of the left side of the heart to pump properly, causing a build up of pressure in the veins in the lungs which in turn allows fluid to collect on the lungs (pulmonary oedema). The senior doctor did not think Mrs Service appropriate for more intensive therapies nor cardiopulmonary resuscitation and agreed with the treatment plan outlined above (page 158 of 401). The nursing care plan noted that Mrs Service was very confused and this continued into the night (page 295 of 401). The nursing notes record that she was breathless (page 297 of 401). Subsequent entries on the 21st–23rd, 25–26th, 28th May–2nd June note

that Mrs Service was breathless on exertion but do not record that she was breathless at rest (page 297 and 298 of 401).

On the 18th February 1997, Mrs Service was reviewed by the consultant, Dr Code A and it was noted that she was more alert, her pulse rate had slowed to 80 beats per minute, blood pressure 125/80 and her chest was clear (page 158 of 401). The nursing care plan recorded that Mrs Service seemed less confused, with confusion only apparent when 'patient was unable to hear what is being said to her.' The night entry recorded 'remains confused, slept for periods' (page 295 of 401).

On the 19th May she was noted to be 'very deaf! But much better, sitting in a chair and talking++'. Blood tests revealed an improvement in her hydration state; sodium 146mmol/L, urea 7.9mmol/L and creatinine 114micromol/L (page 159 of 401). Full blood count revealed a slightly elevated white blood count $11.2x10^9$/L (neutrophils $8.2x10^9$/L) (page 189 of 401). The plan was to discontinue the intravenous fluids when oral intake adequate and change to oral antibiotics and to repeat her blood tests (pages 158 and 272 of 401). The nursing notes record that she remained 'confused at times but at times very lucid' and at night 'remains confused' (page 295 of 401).

On the 20th May 1997 she was noted to be sleeping in the chair with some shortness of breath at rest. She remained apyrexial with a blood pressure of 120/80 and pulse rate of 88. Examination revealed her to be in atrial fibrillation and slightly dry. Nursing notes recorded 'sleepy and confused after an active night; slept most of the afternoon despite

numerous attempts to remain awake by staff; drowsy early evening and slept most of the night' (page 295 of 401).

Full blood count on the 21st May 1997 revealed a persistently raised white blood cell count $13.3x10^9$/L (neutrophils $10.1x10^9$/L) (page 193 of 401). Nursing notes recorded 'asleep much of morning but lucid when awake; some confusion pm. Drowsy night time, remains confused, slept for short periods only' (page 295 of 401).

On the 22nd May she was noted to be apyrexial, to have a pulse rate of 80, blood pressure 120/80 and a few crackles at the bases of her lungs. The plan was to push more fluids, continue antibiotics until tomorrow and aim for home (pages 159 and 160 of 401). The nursing notes recorded 'lucid and very demanding this am. Bowels open++; night time remains confused' (page 295 of 401).

On the 23rd May 1997 she was apyrexial, comfortable at rest with a blood pressure of 120/70 and pulse of 88. Thyroid function tests were normal (page 170 of 401). The plan was to continue intravenous fluids until oral intake improved, to check her digoxin level (1.8mmol/L, normal 0.9–2.6mmol/L; page 167 of 401) and plan for home the following week (page 160 of 401). The IV cannula was pulled out, but as she was drinking well the IV fluids were not resumed (page 302 of 401). Nursing notes recorded 'no change. Night time: remains noisy at times' (page 295 of 401).

On the 24th May 1997 the nursing notes recorded 'remains confused at times' (page 295 of 401).

On the 25th May 1997, her biochemistry revealed continued improvement; sodium, potassium, urea were normal and creatinine 111micromol/L

(normal 45–90micromol/L)(page 166 of 401). Nursing notes report that she was confused at times and noisy at night (page 295 of 401).

On the 26th May 1997 she was seen by the on-call doctor at the nurses request who noticed that Mrs Service was not weight bearing and her left hand was weak. Mrs Service herself was unaware of any problem with her left hand. On examination she appeared to be using her left arm less and although more floppy was able to move it. The strength of the muscles were reduced and the reflexes were increased in the left arm and it was considered that she may have had a cerebrovascular accident (a 'stroke') or a transient ischemic attack (a 'stroke' that resolves quickly and completely) (pages 160 and 161 of 401). The nursing notes reported that she remained confused at times. There were problems with the hearing aid and the battery was changed and the ear piece cleaned that improved Mrs Service's ability to hear (page 299 of 401). That night the nursing notes recorded 'when hearing aid is in place understands the question and answers appropriately. Quiet most of the night, only asking a couple of times to be sat up' (page 296 of 401).

When reviewed on the 27th May it was noted that her left arm was weak and she was referred to Social Services (page 161 of 401). To return to the rest home, Mrs Service needed to be able to transfer with only one nurse, but she required the help of two (pages 266 and 267 of 401). Nursing notes record no problems with confusion in the day or overnight (page 296 of 401).

On the 28th May 1997 it was noted that her Barthel score was 4 and she was referred to the geriatricians for continuing care, the referral note

recording that Mrs Service had presented with left ventricular failure that had improved and that her 'Humphrey' hearing aid was needed to speak to her (page 162 of 401). The nursing notes reported that she was 'very demanding...wanting to get in/out of bed. Confusion due to hearing problems. Less confused overnight' (page 296 of 401).

On the 29th May 1997 she was seen by a locum consultant geriatrician, Dr Code A (page 162 of 401). The letter summarising his review of Mrs Service reads 'thank you very much for asking me to see this delightful lady, whom I saw on the ward today. She has longstanding cardiac failure and was admitted again because of breathlessness and general deterioration. She was found to be in heart failure. She is deaf and uses a deaf aid. Although clinically she is better, she is still in a degree of heart failure. She is normally in a rest home, but I doubt whether they can manage her. I will put her on the list for Gosport War Memorial Hospital for assessment, with a view to considering continuing care' (page 39 of 401). The nursing notes recorded 'remains very demanding today. At night: no change, remains quite noisy at times' (page 296 of 401).

Entries in the medical notes for the 30th May and 2nd June 1997 noted that she was well and her condition unchanged. Over this time the nursing notes record 'not confused but is quite agitated at times. At night less confused (30th May); less confused, noisy at times; slept well, less noisy (31st May); no signs of confusion but very demanding at times during the day and night (1st June); no signs of confusion. Very demanding overnight, shouted out constantly' (2nd June) (page 296 of 401).

On the 3rd June 1997 she was seen by Dr Code A noted to be well and due to transfer to Gosport that day (page 163 of 401). The nursing transfer letter from F1 ward to Dryad Ward summarised that Mrs Service had been admitted with atrial fibrillation and confusion, a chest infection and had received IV fluids, IV antibiotics, oxygen therapy and digoxin; that she was very deaf (wears hearing aid in right ear, known as Humphrey (this was now working well, page 300 of 401)), required all care with eating and drinking and took two people to transfer (page 303 of 401). Treatment was listed as thioridazine 25mg at night, lisinopril 2.5mg twice a day, bumetamide 1mg once a day, aspirin 75mg once a day, allopurinol 100mg at night and digoxin 125microgram once a day (page 263 of 401). The medical discharge summary from F1 noted that Mrs Service had been admitted because of shortness of breath and confusion, treated with intravenous fluids, cefuroxime, oxygen and digitalisation for pulmonary oedema secondary to left ventricular failure and dehydration. It listed the medication as lisinopril, bumetamide, aspirin, allopurinol and digoxin but not the thioridazine (page 50 of 401).

Events at Gosport War Memorial Hospital, 3rd–5th June 1997

3rd June 1997

The medical notes entry reads 'Transferred to Dryad Ward, recent admission 17th May 1997, confused, off legs, URTI (upper respiratory tract infection), NIDDM, CCF (congestive cardiac failure), gout, came from a rest home. On examination slightly breathless plethoric lady, heart sounds 1 and 2 + gallop, bases clear, ankles √√ (meaning not clarified by Dr Barton,

but possibly indicates no swelling (oedema)), needs palliative care if necessary. I am happy for nursing staff to confirm death' (page 164 of 401). The nursing summary notes recorded 'admitted today from F1 ward QA. Helena is a very pleasant lady. She has a normal diet but needs assistance at meal times. She has faecal incontinence. Her buttocks are very red and sore and the skin is broken. Her skin is quite dry. She has 2 superficial grazes on her spine. Skin on lower arms is discoloured. Helena uses a Humphrey hearing aid which has a microphone. She is able to respond to questions. Helena is a non-insulin dependent diabetic, has congestive cardiac failure, suffers from confusion, has upper respiratory infection also gout. Helena has had bowels open and passed urine since admission. First swabs of MRSA screening sent (which were negative, page 165 of 401). Helena has not eaten supper this evening but has had a drink of water (page 22 of 401). Her Barthel score was 0 (page 24 of 401).

The medication chart reveals she continued her bumetamide, lisinopril, allopurinol, digoxin and aspirin as before. However, Mrs Service was not written up for thioridazine 25mg p.r.n. that she had been taking most nights (page 38 of 401). She was also prescribed diamorphine 20–100mg SC/24h, hyoscine 200–800microgram SC/24h and midazolam 20–80mg SC/24h all p.r.n. (page 37 of 401). On the once only and pre-medication drugs section diamorphine 5–10mg IM was also prescribed, but not apparently given (page 37 of 401).

The nursing summary entry for the night of 3rd June 1997 records 'Spenco mattress in situ, nursed on alternate sides overnight. Zinc and castor oil to

sore sacrum. Not passed urine. Oral fluids encouraged and taken fairly well (page 36 of 401). Tongue dry and coated – mouth care given.

4th June 1997

The nursing notes at 02.00h record 'failed to settle – very restless and agitated, midazolam 20mg given by a syringe driver (started at 02.15h) over 24 hours with some success' (pages 22, 23, 36 and 37 of 401).

Nursing summary entry reads 'condition appears to have deteriorated overnight – remains restless. Seen by Dr Barton. Driver recharged with diamorphine 20mg, midazolam 40mg at 09.20h...Rang nephew to inform him of poorly condition' (pages 23 and 37 of 401). There was no medical notes entry but a blood test was undertaken. This revealed that Mrs Service was dehydrated with sodium 156mmol/L (normal range 135–146mmol/L), urea 13.2mmol/L (3–7.6mmol/L) and creatinine 126micromol/L (45–90micromol/L). There were low values of potassium 2.7mmol/L (3.5–5mmol/L), albumin 29g/L (37–50g/L) and calcium 1.97mmol/L (2.25–2.70mmol/L) (pages 47 and 48 of 401).

5th June 1997

Nursing summary entry at 04.00h reads 'condition continued to deteriorate and died very peacefully at 03.45h. Nephew informed (pages 23 and 36 of 401).

On Mrs Service's death certificate the cause of death was given as 1a (disease or condition directly leading to death) congestive cardiac failure with an approximate interval between onset and death given as two days.

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Syringe drivers, diamorphine, midazolam and hyoscine hydrobromide

A syringe driver is a small portable battery-driven pump used to deliver medication subcutaneously (SC) via a syringe, over 24h. Indications for its use include swallowing difficulties or a comatose patient. In the United Kingdom, it is commonly used in patients with cancer in their terminal phase in order to continue to deliver analgesic medication. Other medication required for the control other symptoms, e.g. delirium, nausea and vomiting can also be added to the pump.

Diamorphine is a strong opioid that is ultimately converted to morphine in the body. In the United Kingdom, it is used in preference to morphine in syringe drivers as it is more soluble, allowing large doses to be given in very small volumes. It is indicated for the relief of pain, breathlessness and cough. The initial daily dose of diamorphine is usually determined by dividing the daily dose of oral morphine by 3 (BNF 33, March 1997). Others sometimes suggest dividing by 2 or 3 depending on circumstance (Wessex protocol). Hence, 60mg of morphine taken orally a day could equate to a daily dose of 20 or 30mg of diamorphine SC. It is usual to prescribe additional doses for use 'as required' in case symptoms such as pain breakthrough. The dose is usually 1/6th of the 24h dose. Hence for someone receiving 30mg of diamorphine in a syringe driver over 24h, a

breakthrough dose would be 5mg. One would expect it to have a 2–4h duration of effect, but the dose is often prescribed to be given hourly as required. As the active metabolites of morphine are excreted by the kidneys, caution is required in patients with impaired kidney function.

Midazolam is a benzodiazepine, a diazepam like drug. It is commonly used in syringe drivers as a sedative in patients with terminal agitation. Sedation can be defined as the production of a restful state of mind. Drugs that sedate will have a calming effect, relieving anxiety and tension. Although drowsiness is a common effect of sedative drugs, a patient can be sedated without being drowsy. Most practitioners caring for patients with cancer in their terminal phase would generally aim to find a dose that improves the patients' symptoms rather than to render them unresponsive. In some patients however, symptoms will only be relieved with doses that make the patient unresponsive. A typical starting dose for an adult is 30mg a day. A smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The BNF (BNF 33, March 1997) recommends 20–100mg SC over 24h. The Wessex protocol suggests a range with the lowest dose of 5mg a day. The regular dose would then be titrated every 24h if the sedative effect is inadequate. This is generally in the region of a 33–50% increase in total dose, but would be guided by the severity of the patients symptoms and the need for additional 'as required' doses. These are generally equivalent to 1/6th of the regular dose, e.g. for midazolam 30mg in a syringe driver over 24h, the 'as required' dose would be 5mg given as a stat SC injection. The duration of effect is generally no more than 4h, and it may need to be given more frequently. As an active metabolite of

midazolam is excreted by the kidneys, caution is required in patients with impaired kidney function.

Hyoscine hydrobromide is an antimuscarinic drug most commonly given to reduce excessive saliva or retained secretions ('death rattle'). It also has anti-emetic, antispasmodic (smooth muscle colic) and sedative properties. Repeated administration can lead to cummulation and this can occasionally result paradoxically in an agitated delirium, highlighted in both in the BNF and the Wessex protocol (page 41). It is usually given in a dose of 600–2400microgram SC over 24h (BNF 33, March 1997) or 400–600microgram as a stat SC dose. The Wessex protocol gives a dose range of 400–1200microgram over 24h.

The titration of the dose of analgesic or sedative medication is guided by the patients symptom control needs. The number and total dose of p.r.n. doses needed over a 24h period are calculated and this guides the increase necessary in the regular dose of the drugs in the syringe driver in a way that is proportional to the patients needs. The ideal outcome is the relief of the symptoms all of the time with no need for additional p.r.n. doses. In practice, this can be difficult to achieve and the relief of the symptoms for the majority of the time along with the use of 1–2 'as required' doses over a 24h period is generally seen as acceptable.

ii) The principle of double effect

The principle of double effect states that:

'If measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable provided the doctor's intention is to relieve the distress and not kill the patient.'

This is a universal principle without which the practice of medicine would be impossible, given that every kind of treatment has an inherent risk. Many discussions on the principle of double effect have however, involved the use of morphine in the terminally ill. This gives a false impression that the use of morphine in this circumstance is a high risk strategy. When correctly used (i.e. in a dose *appropriate* to a patient's need) morphine does not appear to shorten life or hasten the dying process in patients with cancer. Although a greater risk is acceptable in more extreme circumstances, it is obvious that effective measures which carry less risk to life will normally be used. Thus, in an extreme situation, although it may occasionally be necessary (and acceptable) to render a patient unconscious, it remains unacceptable (and unnecessary) to cause death deliberately. As a universal principle, it is also obvious that the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care.

8. OPINION

Events at Queen Alexander Hospital, May 17th–June 3rd 1997

Mrs Helena Service was a 99 year old woman who lived in a rest home. It is unclear from the recent rest home notes whether she was normally confused. However, communication was hampered by her profound deafness. Prior to her admission she had received antibiotics on the 6th

May for a chest infection and her lisinopril dose increased on 12th May because of worsening heart failure. She was noted to be very restless on the 14th May and subsequently admitted on the 17th May. At this point she was confused, disorientated and unable to provide a history. Examination revealed her to be dehydrated and to have a fast irregular pulse due to uncontrolled atrial fibrillation. There were crackles in her chest and mild swelling of her ankles suggestive of cardiac failure. It is likely that the chest infection ± the atrial fibrillation had precipitated a worsening of her cardiac failure. This caused fluid to collect on her lungs (pulmonary oedema) which interfered with her ability to get enough oxygen into the blood stream (hypoxaemia). Hypoxaemia ± an infection would be sufficient to cause confusion in an elderly patient. She developed renal impairment as a result of dehydration ± heart failure. However, with intravenous fluids, antibiotics, oxygen and digoxin (to slow the rate of the atrial fibrillation), Mrs Service's condition improved relatively quickly; she was more alert, her heart rate was controlled and her renal function improved. She remained confused at times and noisy at night. On the 26th May it is likely that she had a further cerebrovascular accident (a stroke) affecting the left side of her body, particularly the left arm and hand (she had had at least two previous strokes affecting this side). This led Mrs Service to require two nurses to transfer her, when previously only one was required. As a result, she was unable to return to the rest home and she was referred to the geriatricians for consideration of continuing care. On the 26th May after her hearing aid battery was changed and the earpiece cleaned, this appeared to improve Mrs Service's ability to hear and her confusion. She was reviewed by Dr

Code A who noted that she was better, but still in a degree of heart failure and agreed to take her to Gosport War Memorial Hospital for assessment with a view to considering continuing care. This term has different meanings in different places and the context in which it is being used in relation to Mrs Service should be clarified. Mrs Service's behaviour remained challenging at times, particularly at night; sometimes she was 'quite agitated', 'very demanding' or 'shouting out constantly'. However, on the day of her transfer, 3rd June 1997, she was seen by consultant physician Dr Code A and was noted to be 'well'. The nursing transfer letter and medical discharge summary gave a concise summary of her admission, noting that she required help with eating and drinking and listed all her relevant medication. Her medical discharge summary however, did not list the thioridazine 25mg p.r.n. at night that she had in effect been taking regularly.

Mrs Service appeared to have experienced an exacerbation of her long-standing cardiac failure due to a chest infection ± uncontrolled atrial fibrillation. She was appropriately assessed, investigated and managed, leading to a resolution of her confusion, dehydration and improvement in her heart failure. However, she remained agitated and demanding at times. Apart from the regular use of thioridazine at night for the 24th May–3rd June, Mrs Service's behaviour must have been managed by the nursing staff using non-drug means. I have no concerns regarding the care proffered to Mrs Service at the Queen Alexander Hospital.

Events at Gosport War Memorial Hospital, 3rd–5th June 1997.

Infrequent entries in the medical notes during Mrs Service's stay on Dryad Ward make it difficult to closely follow her progress over the last two days of her life. There is only one medical note entry prior to the confirmation of death taking up half a page. In summary and in approximate chronological order, Mrs Service was admitted to Dryad Ward. Dr Code A had transferred Mrs Service with the aim of assessing her for continuing care needs. There was no stated aim on the transfer note other than 'needs palliative care if necessary'. The term palliative care is used variably and the meaning here should be clarified. A brief history summarised the details on the transfer note. There was no structure to the history with regards Mrs Service's current symptoms (e.g. was pain or breathlessness a problem for her? The nursing notes recorded that she was able to respond to questions). There was a brief examination but no record of heart rate, blood pressure or jugular venous pulse, all relevant for a patient with heart failure. Heart sounds were noted and revealed a gallop rhythm that occurs in heart failure. However, her lungs were clear and ankles do not appear to have been swollen.

Mrs Service's medication was continued mostly unchanged except the thioridazine, which she had been using both at the rest home and on F1 ward, was omitted. She was prescribed diamorphine 20–100mg SC/24h, hyoscine (hydrobriomide) 200–800microgram/24h and midazolam 20–80mg SC/24h all p.r.n. (as required). On the once only and pre-medication drugs section of the drug chart, diamorphine 5–10mg IM was prescribed, but not apparently given. There is no justification documented in the notes for the

prescription of the stat dose of diamorphine p.r.n., although in her statement Dr Barton reports it was because she was concerned that '[Mrs Service] was in congestive cardiac failure'. Opioids are used for breathlessness caused by heart failure, as highlighted by Dr Code A However, on the day of transfer to Dryad Ward Mrs Service was reported as 'well' by Dr Code A Thus, although Mrs Service may well have been in a degree of heart failure (e.g. heart sounds revealed a gallop, but chest clear), this did not appear to be as severe as on her admission to F1 ward (e.g. crackles heard in chest, pulmonary oedema on chest x-ray) and it is of note that it was not considered necessary at that stage to prescribe or administer opioids to Mrs Service. Similarly, in my opinion, there was no clear indication for the prescription of diamorphine, hyoscine or midazolam by syringe driver on the day of her transfer.

The midazolam was prescribed in a dose range of 20–80mg SC/24h, p.r.n. and 20mg SC/24h was commenced on the first night that Mrs Service spent on Dryad Ward at 02.00h because she 'failed to settle – very restless and agitated.' Mrs Service was however, elderly, very deaf, confused/prone to confusion and had been moved to unfamiliar surroundings with unfamiliar staff. Further, she was not prescribed/given her thioridazine 25mg at night on Dryad Ward that she had been receiving as a night sedative. Thus, there were many reasons why Mrs Service could have been restless on her first night on Dryad Ward. It is of note that Mrs Service appears to have been admitted to the Queen Alexander Hospital in a more confused state than she was at the time of her transfer to Dryad Ward. Nevertheless, during her almost three weeks stay on F1, despite the fact she was

documented as being demanding and noisy at times during the night, she appears to have been managed satisfactorily by the nursing staff, without the need to use parenteral antipyschotics or sedatives, just her night time dose of oral thioridazine. Further, the notes also comment that confusion only seemed apparent when Mrs Service was unable to hear what was being said to her.

Subsequently, the midazolam was increased to 40mg SC/24h and diamorphine 20mg SC/24h added to the syringe driver. The increase in midazolam appeared to be in response to Mrs Service's persistent restlessness. There is no explanation in the notes as to why the diamorphine was considered necessary but in her statement Dr Barton reports that in her view Mrs Service was terminally ill with heart failure.....and it was appropriate to administer the diamorphine and midazolam in the hope of reducing the pulmonary oedema brought on by heart failure.' Opioids are used for breathlessness caused by heart failure, as highlighted by Dr Code A Midazolam is used for terminal breathlessness for its anxiolytic/sedative effects. However, as noted before, on her transfer, Mrs Services cardiac failure was unlikely to have been as severe as on her admission to F1 ward, there was no assessment of Mrs Service on the 4th June 1997 that documented that she was distressed by breathlessness, had a sudden worsening of her pulmonary oedema, nor were more usual approaches to relieve acute pulmonary oedema utilised (e.g. oxygen, diuretics, nitrates, etc.). Further, blood tests were taken from Mrs Service on the 4th June 1997. Blood tests would not be indicated in

patients who were obviously dying and the fact that they were carried out suggests that doubt existed.

It is difficult to follow fully the logic of Dr Barton's statement. She states that, on her transfer, in her view, Mrs Service was 'clearly in heart failure', 'unwell and likely to die shortly' yet 'considered Mrs Service would have been more appropriate for care at the Queen Alexandra Hospital'. This suggests that Dr Barton considered that Mrs Service could have benefited from care available at Queen Alexandra Hospital that was not available on Dryad Ward. No attempts however, were made to transfer Mrs Service back to Queen Alexandra Hospital, to seek advice from Dr Code A or the medical team at Queen Alexandra Hospital and no changes were made to Mrs Service's heart failure medication other than the prescription of p.r.n. opioids as a one-off stat dose or by syringe driver. The results of the blood tests could not have influenced Dr Barton's initial management of Mrs Service, as these were not undertaken until the 4th June, the day after her admission.

The blood test result confirmed that Mrs Service had renal impairment and a low potassium, possibly due to her medication (the diuretics ± the lisinopril; the dose had been increased at the residential home just prior to her admission) and/or an inadequate fluid intake (her tongue was dry and coated that suggests she was dehydrated). Dehydration and low potassium could have directly or, indirectly via digoxin toxicity, contributed to worsening confusion, all of which are potentially reversible with appropriate treatment. These results were available on the 4th June 1997, but there are

no comments in the notes regarding them or why it was considered inappropriate to act upon them.

If it were that Mrs Service was not actively dying, as the notes on her transfer to Dryad Ward suggest, then the failure to rehydrate her, together with the use of midazolam and diamorphine could have contributed more than minimally, negligibly or trivially to her death. If it was considered that Mrs Service was actively dying, then it would have been reasonable not to have rehydrated her and the use of diamorphine and midazolam could be justified, albeit that the dose of diamorphine was likely to be excessive for her needs. Given that elderly, frail patients with significant medical morbidity can deteriorate with little or sometimes no warning, it could be argued that it is difficult to distinguish with complete confidence which of the above scenarios was most likely for Mrs Service.

On Mrs Service's death certificate the cause of death was given as congestive cardiac failure with an approximate interval between onset and death given as two days. This is incorrect; she had had documented cardiac failure for several years.

In conclusion, Mrs Service was elderly, severely hard of hearing, confused/prone to confusion, spending her first night in a new environment, with new staff and her usual night sedation was not given. The commencement of a syringe driver containing midazolam in a dose sufficient to sedate an elderly patient, could be interpreted as an over reaction to what is a well recognised and understandable response of a confused patient to new surroundings. Subsequently, the addition of diamorphine in a dose of 20mg SC/24h is without documented justification

in the medical and nursing notes. Mrs Service had long-standing cardiac failure and was becoming increasingly frail with a progressive decline in her Barthel score over several admissions. Nevertheless, at the time of her transfer from F1 ward she was reported as 'well', and at the time of the prescription of diamorphine, midazolam and hyoscine by syringe driver it was not apparent that she was imminently dying. This is also suggested by the fact blood tests were carried out the day after her transfer. In these circumstances, it could be argued that the lack of appropriate medical care, together with the use of midazolam and diamorphine could have contributed more than minimally, negligibly or trivially to her death. However, elderly, frail patients with significant medical morbidity can deteriorate with little or sometimes no warning and Mrs Service could have naturally entered her terminal stage. In these circumstances, the lack of medical intervention could be seen as appropriate and the use of midazolam and diamorphine reasonable. Even so, in my opinion, the starting dose of diamorphine was likely to be excessive to her requirements and access to smaller doses of diamorphine (and midazolam) p.r.n. would have been a more appropriate way of initially addressing Mrs Service's symptoms, identifying her dose requirements and justifying the need for regular dosing and subsequent dose titration.

Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day?

The medical provided by Dr Barton to Mrs Service following 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 (General Medical Practice, General Medical Council, July 1995, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination
- in providing care you must keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs.

Specifically:

i) There was insufficient assessment and documentation of Mrs Service's symptoms and physical (particularly cardiac) state on her transfer to Dryad Ward on the 3rd June 1997.

ii) On the day of her transfer, Mrs Service was prescribed a stat dose of IM diamorphine and diamorphine and midazolam by syringe driver p.r.n. in dose ranges that would be excessive to her needs.

iii) The use of midazolam in a syringe driver, appears an excessive response to Mrs Service's 'failure to settle' on her first night in a new environment.

iv) There was insufficient assessment and documentation of Mr Service's clinical condition when she was restless on the 4th June 1997.

v) Mrs Service received a starting dose of diamorphine that was likely to be excessive for her needs.

If the care is found to be suboptimal what treatment should normally have been proffered in this case?

Issue i (lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate and contemporaneous patient records).

Mrs Service's admission to Dryad Ward was accompanied by the minimum of medical notes. A medical assessment usually consists of information obtain from the patient ± others, the existing medical records (the history), and the findings of a relevant physical examination documented in a structured fashion. Although the history can be restricted to the most salient points, it is unusual to omit relevant sections, e.g. current symptoms, drug history, etc. When a new medical team takes over the day-to-day care of a patient with serious medical problems, a physical examination is warranted to inform the ongoing management of those medical problems and to also provide a base line for future comparison. This allows monitoring of changes for the better or worse. A clear assessment and documentation of medical care is also particularly useful for on-call doctors who may have to see a patient, whom they have never met, for a problem serious enough to require immediate attention.

Dr Barton considered Mrs Service to be 'clearly in heart failure' and very unwell. Despite this, there was a lack of a documented assessment of the symptoms of heart failure, e.g. breathlessness at night or at rest, that would support the use of opioids for symptom relief; there was a lack of a documented physical examination of relevance for someone in heart failure,

e.g. pulse rate, jugular venous pulse, blood pressure, that would provide evidence that Mrs Service's condition had deteriorated compared to when on F1 ward.

Issue ii (in providing care you must prescribe only the treatment, drugs or appliances that serve patients needs).

On the day of her transfer, Mrs Service was prescribed a stat dose of IM diamorphine 5–10mg IM (but not apparently given) and diamorphine 20–100mg SC/24h, hyoscine 200–800microgram SC/24h and midazolam 20–80mg SC/24h all p.r.n. by syringe driver. The wide dose range of diamorphine 20–100mg/24h is not justified at all in the notes and likely to be excessive for a 99 year old patient with renal failure and no recent exposure to weak or strong opioids. Doses of opioids excessive to a patients needs are associated with an increase risk of drowsiness, delirium, nausea and vomiting and respiratory depression.

I note that Dr Code A considers the prescription of the diamorphine as a stat dose 'entirely appropriate' and in the syringe driver 'reasonable'. I would disagree with Dr Code A that the stat dose of diamorphine 5–10mg IM was entirely appropriate, as although, as he points out, it reflects the dose range given in the BNF, the BNF also suggests that the 10mg dose is for 'heavier, well muscled patients'. Given Mrs Service's advanced age, renal impairment and lack of exposure to other weak or strong opioid analgesics, even the 5mg dose could be excessive and, in my opinion, a stat dose of diamorphine 2.5mg IM would have been more prudent. With regards the prescription of the diamorphine in the syringe driver p.r.n., it would aid

understanding if Dr Code A could outline in more detail how a typical cardiologist utilises opioids in heart failure with regard to any existing guidelines, preferred route of administration, starting dose and schedule (regular or p.r.n.), rate of titration, how the magnitude of the dose change is determined, doses typically required and any special considerations necessary for a 99 year old patient. My limited understanding, from a palliative care colleague with an interest in heart failure who has published in this area and works within the cardiology clinic, is that opioids are indicated for breathlessness at night, at rest or on minimum exertion that persists despite other heart failure treatments. They are given initially orally, in small doses, e.g. codeine 30–60mg four times a day or morphine 1.25–5mg every four hours, and titrated accordingly. Even without taking Mrs Service's age and renal impairment into account, this experience supports a dose of 2.5mg diamorphine IM or less as an appropriate stat dose (equivalent to morphine 5–7.5mg PO) and diamorphine 10mg/24h SC as an appropriate starting dose if the oral route was unavailable (equivalent to morphine 20–30mg/24h PO).

I disagree with Dr Code A that Dr Barton's practice is in keeping with recommendations in the BNF based on the quote 'diamorphine can be given by subcutaneous infusion in a strength of up to 250mg/ml' as this arises in the mixing and compatibility section and relates specifically to the solubility of diamorphine and not as a practice recommendation.

The prescription of a syringe driver containing diamorphine, midazolam and hyoscine hydrobromide p.r.n. with such a wide dose range is not usual in my experience. This is because of the inherent risk that would arise from a

lack of clear prescribing instructions on why, when and by how much the dose can be altered within this range and by whom. For these reasons, prescribing a drug as a range, particularly a wide range, is generally discouraged. Doctors, based upon an assessment of the clinical condition and needs of the patient usually decide on and prescribe any change in medication. It is not usual in my experience for such decisions to be left for nurses to make alone. If there were concerns that a patient may experience, for example, episodes of pain, anxiety or agitation, it would be much more usual, and indeed seen as good practice, to prescribe appropriate doses of morphine/diamorphine or diazepam/midazolam respectively, which could be given p.r.n. PO or SC. This allows a patient to receive what they need, when they need it, and guides the doctor in deciding if a regular dose is required, the appropriate starting dose and subsequent dose titration.

Issue iii (in providing care you must prescribe only the treatment, drugs or appliances that serve patients needs).

The use of midazolam in a syringe driver appears an excessive response to Mrs Service's 'failure to settle' on her first night in a new environment. She was hard of hearing, confused/prone to confusion and agitated intermittently. In my opinion, all reasonable non-drug approaches should have been utilised and, if a drug approach was considered necessary, the administration of her usual dose of thioridazine would have been most appropriate. Subsequent nights may have improved as Mrs Service got used to her surroundings and got to know the staff and vice versa. If it were

considered that this episode was somehow different to Mrs Service's other disturbed nights, i.e. an acute delirium, then she should have been appropriately medically assessed and managed. In these circumstances, if a parenteral medication was considered necessary, then haloperidol, an antipsychotic initially in a small dose, repeated as required, is usually considered an appropriate choice. Some practitioners supplement haloperidol with midazolam, when greater levels of sedation are desirable. In my opinion, given Mrs Service's situation, this would have been most appropriately given as a small dose, e.g. midazolam 2.5–5mg p.r.n. The effect of this p.r.n. dose could have been assessed, the possible cause(s) of the agitation assessed subsequently by the medical team, the temporary or persistent state of her agitation subsequently assessed (e.g. it can be variable; typically worse at night than in the day) and hence the need to continue with only p.r.n., or to commence regular sedation established and a reasonable dose schedule justified.

The reliance on a prescription of a wide dose range of midazolam by syringe driver without clear instructions, ultimately exposed Mrs Service to the risk of receiving a continuous dose of midazolam that was not discussed with the doctor on-call beforehand; not fully justified in the medical or nursing notes (it did not appear to be for symptoms of heart failure, e,g, breathlessness, as Dr Barton envisaged) and was in stark contrast to how Mrs Service's disturbed nights on F1 ward were managed.

Issue iv (lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate and contemporaneous patient records).

There was insufficient assessment and documentation of Mr Service's clinical condition when she was restless on the 4th June 1997. There was no documented assessment of the cause(s) of Mrs Service's agitation nor cardiac state that would help justify the need for diamorphine and midazolam by syringe driver. Generally, when a patient's clinical condition changes for the worse, a thorough medical assessment should be carried out to ascertain the possible cause(s) in order to identify if they are reversible with appropriate treatment. The assessment will consist of the history, examination and appropriate investigation. Even basic observations have not been recorded including, for example, temperature, pulse rate/rhythm, blood pressure and auscultation of heart and breath sounds. This would help to identify a potentially reversible complication and Dr Barton should be asked to state on what basis she satisfied herself that Mrs Service was in a terminal decline and not unwell as a result of a potentially reversible complication. Similarly, it should be clarified why if it was considered that Mrs Service was dying, blood tests were carried out and, conversely, why the results of the blood tests were not acted upon.

Issue v (in providing care you must prescribe only the treatment, drugs or appliances that serve patients needs).

Mrs Service was commenced on diamorphine 20mg/24h SC (equivalent to morphine 40–60mg/24h PO). From the above comments, even without taking Mrs Service's age and renal impairment into account, diamorphine 10mg/24h SC would, in my opinion, have been a more prudent starting dose if the oral route was unavailable (equivalent to morphine 20–30mg/24h

PO). Doses of opioids excessive to a patients needs are associated with an increase risk of drowsiness, delirium, nausea and vomiting and respiratory depression.

If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

Dr Barton had a duty to provide a good standard of practice and care that would include good palliative and terminal care. In this regard Dr Barton fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, October 1995, pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient and providing treatment that likely to be excessive to the patients needs.

The stat dose of diamorphine 5–10mg IM p.r.n. for Mrs Service's heart failure, although never administered, was unjustified (no assessment of how bothered/distressed she was by breathlessness) and likely to be excessive for her needs. The use of midazolam 20mg/SC for 'failure to settle' appears an excessive response to an elderly patient's first night in new surroundings, particularly when they are confused/prone to confusion and agitation. This dose of midazolam is likely to sedate a 99 year old and hamper a subsequent assessment of the possible cause(s) in order to identify if there were temporary or not. The initial dose of diamorphine 20mg/24h SC was also likely to be excessive to her needs. A dose of diamorphine excessive to Mrs Service's needs would be associated with an

increased risk of drowsiness, confusion, agitation, nausea and vomiting and respiratory depression.

In patients with cancer, the use of diamorphine and other sedative medications (e.g. midazolam) when appropriate for the patient's needs, do not appear to hasten the dying process. This has not been examined in patients dying from other illnesses to my knowledge, but one would have no reason to suppose it would be any different. The key issue is whether the use and the dose of diamorphine and other sedatives were *appropriate* to the patient's needs. Although the principle of double effect could be invoked here (see technical issues), it remains that a doctor has a duty to employ effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose opioid that was *appropriate* and not excessive for a patients needs.

Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate and contemporaneous patient records, had been attempting to allow Mrs Service a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge, illustrated, for example, by the reliance on large dose range of diamorphine and midazolam by a syringe driver rather than a smaller, more appropriate, fixed dose along with the provision of p.r.n. doses that would allow Mrs Service's needs to guide the dose titration. Dr Barton could also be seen as a doctor who breached the duty of care she owed to Mrs Service by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded

the safety of Mrs Service by unnecessarily exposing her to doses of midazolam and diamorphine that were difficult to justify and likely to be excessive to her needs at the time they were commenced.

However, Mrs Service had significant medical problems. Although her cardiac failure appeared to be better controlled by the time of her transfer from F1 ward, she was becoming progressively frailer, increasingly dependent on others and her blood tests had deteriorated again. In this regard, it would not have been that unusual if Mrs Service had naturally entered a terminal decline. As such it is difficult to say with any certainty that the dose of midazolam or diamorphine she received would have contributed more than minimally, negligibly or trivially to her death.

9. LITERATURE/REFERENCES

British National Formulary 33 (March 1997):

- Prescribing in terminal care, pages 12–15
- Prescribing for the elderly, pages 16–17

Good Medical Practice, General Medical Council October 1995, pages 2–3

Palliative Care Handbook, Guidelines on Clinical Management, Third Edition 'Wessex Protocol' Salisbury Palliative Care Services May 1995.

10. 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.

11. 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: _____

Report on the Care and Death of
Helena Service
5th June 1997
Draft: 6th November 2004

This report has been provided by Dr David A Black, MA MB BChir (Cantab) FRCP, Consultant Physician at Queen Mary's Sidcup NHS trust. This report is in two parts, a factual summary of time line including important investigations and in the second part an opinion on the events that occurred. The numbers in brackets refer to the pages of evidence to support the statements.

1. Timeline

1.1. Mrs Service's hospital notes start in 1991 when she is investigated for difficulty in swallowing (102) this was initially thought to be a cancer (101). She is noted to be in atrial fibrillation (99) and eventually has a major abdominal operation (a partial gastrectomy) (99), which finds that she has benign gastric ulcer disease (no cancer). She has no complications following surgery.

1.2. In 1994 she is admitted with a stroke causing a left sided hemiplegia (weakness), she remains in atrial fibrillation has high blood pressure (94) and spends 4 weeks in hospital (86-87). Her heart is documented to be enlarged at that time (229). A home visit (92) shows that she is slow but independent, but her "memory is poor" (90).

1.3. 1987 progression of her profound deafness due to otosclerosis is documented (81).

1.4. In 1988 she presents with a high blood sugar (diabetes mellitus) unmarsked because she was started on steroid tablets for a presumed diagnosis of polymyalgia rheumatica. She has a week of inpatient care (79). Her mental test score is documented at 9/10 (79).

1.5. In 1992 she is admitted having been found on the floor with a new stroke and new left sided weakness (70). She is thought to be confused but her mental test score is again documented at 9/10. Albumin is 31; haemoglobin is 10.9 (70).

1.6. In January 1995 she has now moved into a residential home. A visit to the home finds that she is in congestive cardiac failure with mitral regurgitation and it is thought she is likely to need hospital admission (68 – 69). She is subsequently admitted to hospital for a week and is noted to be in quite severe congestive cardiac failure on admission (58-59)

1.7. After admission needs a week in hospital where her medication is altered and she returns to her residential care (56 – 57). She now has significant documented dependency with a Barthel of 10/20 (326).

1.8. In January 1996 she is admitted with a diagnosis of gout and dehydration. Her Barthel is 3/20 on admission and 6/10 on discharge (11). Her Waterlow score is 30 on 27th January (12) giving her a very high risk of pressure sores. Very poor mobility is documented (13) despite this, she returns to her residential care home (54).

1.9. The notes from her residential home show that she is declining in health in May 1997, for example, her bedsores have started bleeding in the residential care home notes (283).

1.10. On the 17th May 1997 at the age of 99 she is admitted at the request of her GP to hospital with confusion, disorientation and progressive failure for the rest home to be able to cope. (51 – 52). She is now on Melleril (Thioridazine) a major tranquilliser often used for people who are confused and disorientated. She is thought to be dehydrated (156). Admission creatinine is raised 151 (157). She is found to be markedly hypoxic (PO2 of 6.7, PCO2 of 5.6 (157) and is diagnosed to have a combination of "dehydration and left ventricular failure" (158).

1.11. She is thought to make some progress. However on the 20th May she is sleeping in a chair. Her creatinine has fallen with, rehydration, to 114 (159).

1.12. On 26th May she is noted to have a possible new left sided weakness due to a new stroke (160). The nursing notes 26th May (296) she "remains confused". They also note (303) that after 26th May she remains totally dependent "transfers with two". Social Services assessment on 27th May (276) records a maximum Barthel of 4.

1.13. On 28th May she is referred to the geriatric team, her Barthel remains 4 (162). Dr [Code A] sees her on 29th May and records that she has had long standing congestive cardiac failure, is deaf and he is clear that she will not return to a level of function that will allow her to return to the residential home. He says that he will arrange transfer to the Gosport Memorial Hospital "with a view to considering continuing care" (39).

1.14. The medical notes at the Queen Alexander record no obvious change in function but the nursing notes for the 2nd June (296) note that she was "very demanding overnight , shouting out continuously". This suggests that she was acutely confused. Also on the 2nd June she remained continuously breathless and

needed to be "nursed upright all night" (298)

1.15. On 3rd June she is transferred to the Gosport War Memorial Hospital. The transfer note (164) states that she is confused, "off legs", has diabetes and heart failure. There is an examination recorded, which states that she is breathless and lethargic, there is a "gallop rhythm" with normal first and second heart sounds, chest was clear. Written underneath the examination record, the notes state "needs palliative care as necessary" and "happy for nursing staff to confirm death".

Barthel of 0/20 on admission to Gosport is documented. (24).

There were no further medical notes apart from a nursing note confirming that she had died peacefully at 3.45 am 5th June 1997.

1.16. The nursing cardex on admission to Gosport (22) documented "very pleasant lady" and a buttock bedsore.

1.17. At 02.00 on 4th June she was noted to be very restless and agitated and Midazolam 20 mgs over 24 hours is started by syringe driver.

1.18. On 4th June it is documented that she has deteriorated overnight and the syringe driver is replaced by Diamorphine 20 mgs and Midazolam 40 mgs. She continues to deteriorate and dies at 03.45 on 5th June (22).

1.19. Drug Chart Analysis:

1996 Drug Chart shows nothing unusual and the only drugs on the "as required" side are Temazepam and Metaclopamide (260). When she is admitted to the Queen Alexander Hospital (269-273) she is on Zestril, Bumetanide, Aspirin and Digoxin for her heart disease and atrial fibrillation, Allopurinol for her gout. On the "as required" side, Thioridazine (which is then given it each night as a sedative), and Paracetamol.

1.20. In 1997 on admission to Gosport: Bumetanide, Lisinopril, Lanoxin, Aspirin are all continued with Allopurinol and all these drugs are given to her on both 3rd and 4th June. (38). On the "as required" side Diamorphine 20 – 60 mgs subcutaneously in 24 hours is written up, also Hyoscine 200 – 400 micrograms and Midazolam 20 – 40 milligrams (37) all in 24 hours. Midazolam is started at 2.15 am on 4th June (37) 20 mgs for 24 hours and is then replaced with 20 mgs Diamorphine with 40 Midazolam at 9.20 am on 4th June.

A single dose of Diamorphine 5 – 10 mgs i/m is also signed for on the once only section of the drug chart, (37). It is not dated or timed and it is not clear if this was even given.

2. Expert Opinion:

2.1. This section will consider if there are any actions so serious they might amount to gross negligence or any unlawful acts or deliberate unlawful killing in the care of Mrs Helena Service. Also if the actions or omissions by the medical team, nursing staff or attendant GP's contributed to the demise of Mrs Service, in particular, whether beyond reasonable doubt, actions or admissions more than minimally, negligently or trivially contributed to death.

2.2. In particular, I will discuss a) whether Mrs Service had become terminally ill and if so whether symptomatic treatment was appropriate and b) whether the treatment provided was then appropriate.

Mrs Service's hospital notes go back for 16 years prior to her death. They document that she has heart disease with an irregular heartbeat (atrial fibrillation) in 1981 and heart enlargement in 1984 (229). She also has two previous strokes documented in both 1984 and 1992. (86 and 70). The natural history of heart disease is in general for progressive decline over time, with a very poor prognosis once serious heart failure has developed, as documented on this lady in 1995 (58-59).

2.3. She is also profoundly deaf which leads to communication difficulties and makes a patient more likely to get acute confusion. She suffers from Diabetes Mellitus, which is unmasked when she receives steroid treatment for polymyalgia rheumatica, she is also thought to have had an episode of gout and has been dehydrated with impaired kidney function on at least two occasions.

2.4. Despite her noted physical frailty she eventually makes a good recovery from a stroke in 1984, (92). By 1995 she has moved into a residential home. We do not know what precipitated this, however in 1995 her Barthel is documented at only 10/20 (326) meaning that she required considerable help with her routine activities of daily living.

2.5. In 1996 she is admitted with gout, and is found to be profoundly dependent on admission with a Barthel of 3/20 (11), which improves to 6/20 on discharge. Very poor mobility is noted and she has a Waterlow score which is a risk score for pressure sores (12) of 30 putting her into a very high-risk category. There is no doubt that this lady would normally be cared for in a nursing home, with this level of dependency, or even in NHS continuing care if she had not already been living in a residential home that was committed to

her care.

2.6. By the time she is admitted on 17th May 1997 she has been progressively failing in the residential home (283). It seems unlikely that this was a dramatic change in function, but the end point of a slow deterioration of her multiple illnesses, including her progressive heart disease, her cerebro-vascular disease and of course the physiological frailty of an age of 99 years,

2.7. When admitted to hospital she was found to be both dehydrated and in again heart failure. This is often a combination suggesting poor prognosis. She has acute confusion (delirium) and this does not resolve, although it does fluctuate, during all her time in the Queen Alexander Hospital. Investigations on admission found she is dehydrated with a raised creatinine of 151 (157) but she is also markedly hypoxic (low oxygen in the blood) with a PO2 of 6.7 kPa (normal range 12.7+0.7) with a PCO 5.6 kPa (normal range 5.3+0.3) She is now very unwell, and highly dependent with a Barthel at best 4/10 (162). On the basis of the nursing notes she makes very little improvement in her confusion or her breathlessness and indeed things take a turn for the worse when she probably has a new stroke on 26th May (116) (303). She remains totally dependent after this.

2.8. She is seen by a locum consultant geriatrician, Dr Code A on 29th May. His assessment is that she will not return to her residential home and that he is transferring her to Gosport "with a view to considering continuing care". By this he probably means an assessment as to whether this lady is dying or will improve enough to be discharged into a nursing home, or perhaps to simply remain in an NHS continuing care bed until she does die. However, this is not spelt out in the letter or the notes.

2.9. The medical notes make very little further comment on her clinical condition at the Queen Alexander Hospital, however, the nursing notes on the 2nd June comment she is very demanding overnight, shouting out continuously, suggesting that she is acutely delirious again and that she is so breathless that she has to sit up all night on the night of the 2nd June. I believe this lady is now physically deteriorating, but it is impossible to tell if this is progression of heart failure, a pulmonary embolus, or chest infection on top of her other problems. I have little doubt that she was entering a terminal phase of her illness.

2.10. On the 3rd June she is transferred to Gosport War Memorial hospital where she is noted to have a buttock bedsore (22). The recorded medical assessment is brief but does include an examination, which although it notes that she has a tachycardia and is very breathless, fails to give an overall impression of her status and whether this is acute, chronic or acute on chronic, and

fails to record her pulse and blood pressure. A thorough objective assessment of this lady's clinical status is not possible from the notes that are made on admission, and would appear to be below an acceptable standard of good medical practice.

2.11. It seems likely though that the doctor recognises that this lady was seriously ill as the only comment under the examination is "needs palliative care if necessary". There is no record in the notes of this being discussed at this stage with the nurses or the family.

2.12. The drug chart is written up with all the usual medication from Queen Alexander Hospital and this is given on both the 3rd and 4th June.

2.13. Diamorphine with Midazolam and Hyoscine are written up PRN on admission. The Midazolam is usually used for terminal restlessness and is widely used subcutaneously in doses from 5 – 80 mgs per 24 hours for this purpose. 20 mgs is within current guidance but at the top end for elderly patients. Elderly patients usually need a dose of between 5 – 20 mgs per 24 hours.

2.14. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. It can be difficult to predict exactly the starting dose of Diamorphine to give in a syringe driver but many would give between 5 – 15 mgs of Diamorphine in the first 24 hours, in this case the 20 mgs is at the upper limit.

2.15. Mrs Service becomes extremely restless and agitated on the night of 4th June (probably similar to the previous night at the Queen Alexander hospital). Midazolam is now started via a syringe driver at 20 mgs. The restlessness is probably being caused by her severe breathlessness and heart disease and Diamorphine at this stage might well have been the drug of choice, but it is difficult to criticise the use of Midazolam.

2.16. She continues to deteriorate over night and the Midazolam is now replaced with Diamorphine 20 mgs a day and Midazolam 40 mgs. She then deteriorates further and dies 15 hours later.

2.17. There is no evidence in the notes that any other medical assessment was done prior to the starting of the Diamorphine and Midazolam in the syringe driver, nor is there any evidence at all that at any time after her admission to Gosport was further advice obtained from the consultant who was presumably responsible for this patient's care. It is not clear from the notes if the locum consultant (Dr Code A) was responsible for the patient's care once they had transferred to Gosport Hospital and it would have been good medical practice for the doctor at Gosport to have sought further advice from their consultant when a patient was transferred, apparently so seriously ill, and immediate palliative care was being

considered.

2.18. It is also possible to criticise the care at Queen Alexander. All to often when a patient is not obviously going home and a bed elsewhere has been found, the pressure is to move the patient at the first opportunity, even when it may not be in their best interest. It seems likely to me that her condition was deteriorating in the Queen Alexander Hospital and the stress of an ambulance transfer would not have helped this lady's care.

2.19. The cause of death in Mrs Service was multifactorial. In my view the dose of 20mg Diamorphine combined with the 40mg dose of Midazolam was higher than necessary in this very elderly and frail lady's terminal care and the medication may have slightly shortened life, although this opinion does not reach the standard of proof of "beyond reasonable doubt". However, I would have expected a difference of, at most, no more than a few hours to days, if a lower dose of either or both of the drugs had been used instead.

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the witness statements in the case of Helena Service. In particular, if they raise issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This report is based on the following document:

2.1 Witness statements to the hospital care and death of Helena Service provided to me by the Hampshire Constabulary (June 2006). In total 19 statements.

2.2 Report regarding Helena Service (BJC/72) Dr D Black 6th November 2004.

3. COMMENTS

3.1 Comments on Witness Statement (2.1)

3.1.1 I have read all the statements and would note that in paragraph 1.14 of my report, I state that Mrs Service was "continuously breathless". The nursing notes actually state "dyspnoeic on exertion" (298). However I interpret that as "continuously breathless" as Mrs Service was immobile (Barthel 0-4) and needed to be "nursed upright all night"

4. CONCLUSION

4.1 Having read all the documents above provided by Hampshire Constabulary, I would wish to above change to be noted. This does not change the overall conclusion of my expert report.

Dr Code A

March 2006

DRAFT REPORT

Regarding

MRS HELENA SERVICE
(Code A – 05.06.1997)

PREPARED BY: Dr Code A

AT THE REQUEST OF: Hampshire Constabulary

1.0 Summary of Conclusions

1.1 Mrs Service was aged 99 years at the time of her death and had a long medical history with evidence of heart disease by 1989, and heart failure by 1995. The average survival of patients with this sort of heart failure is 2 years and hence Mrs Service's terminal decline in 1997 was not unexpected. Once the decision had been made that she was not for resuscitation, as it was in the Queen Alexandra Hospital in May 1997, then palliative care with increasing doses of Diamorphine and Midazolam was appropriate. These drugs were administered in accordance with cardiological practice in 1997.

2.0 Instructions

2.1 This report has been prepared on the instructions of Dave Grocott, Detective Inspector, Operation Rochester, that is an investigation by the Hampshire Police Major Crime Investigation Team in to the deaths of a number of elderly patients at Gosport War Memorial Hospital (GWMH).

2.2 The questions posed by D I Grocott are as follows:

3.0 Issues

3.1 The essential issue in this case is whether the death of Mrs Service was accelerated by the treatment that she received at GWMH, and in particular the administration of Diamorphine subcutaneously by a syringe driver.

4.0 Brief Curriculum Vitae

4.1 I am Dr. Code A Code A

Code A

Code A My experience includes all aspects of clinical cardiology, cardiac pacing and coronary intervention, teaching, research, management, legal work, etc. I have published over 100 papers/chapters, most recently on the subject of heart disease and ability to work. I serve/have served on many National and European committees including the Department of Transport's Honorary Medical Advisory Panel on Driving and Diseases of the Cardiovascular System, in recognition of which I was appointed OBE in 2001.

5.0 Documentation

5.1 This report has been prepared from copies of the medical records **(BJC/72)** including those from the RNH Haslar relating to her admissions in 1989 and 1992, and those from Queen Alexandra Hospital, St Mary's Hospital, Willow Cottage Residential Care Home, and GWMH. The last are crucial to this investigation and have been identified for me by DI Dave Grocott. The handwriting also is not always easy to read. However, page 164 of 401 dated the 3rd June 1997, entitled "transfer to Dryad Ward" refers to Dr Jane Barton's notes. Pages 37 and 38 of 401 can be more reliably identified because page 37 has at the top "Hospital – GWM, Ward – Dryad". The nursing records cannot be attributed to GWMH since the heading reads "Portsmouth Healthcare NHS Trust". I am however reliably informed that pages 22 and 23 dated the 5th June 1997 relate to GWMH. In addition to the foregoing documentation, I have also seen the statement of Dr Jane Barton dated ? 27th October 2005 which helpfully describes the standard of care available in GWMH in 1997.

6.0 Summary of Medical History

6.1 Mrs Service had a long medical history including a partial gastrectomy and cholecystectomy in 1981, and left cataract surgery in the same year. She suffered a stroke (left hemiparesis) necessitating admission to hospital between the 29th October and the 27th November 1984; in 1988 she suffered polymyalgia rheumatica and following treatment with Prednisolone developed diabetes mellitus which was considered to be iatrogenic; on the 15th August 1989 she suffered a fall with multiple rib fractures on the left side, for the first time her heart was mentioned – she had developed an abnormal rhythm (atrial fibrillation) and her heart was noted to be enlarged on the chest X-Ray; on the 13th November 1992 she was again admitted to hospital with a chest infection; she was again admitted on the 29th December 1992 with a left sided weakness and kept in hospital until the 8th January 1993.

6.2 On the 13th January 1995 Dr Althea Lord describes her domiciliary visit and her findings of shortness of breath and heart failure. Mrs Service was therefore admitted to hospital for more intensive medical treatment which appeared to be successful.

6.3 By January 1996 Mrs Service had developed gout with painful swollen wrists. By that stage she was described as being profoundly deaf; by May 1997 Mrs Service had deteriorated physically with a recurrence of her heart failure, urinary infection, chest infection and a physical state that was such that the senior registrar felt that in the event of a cardiac arrest Mrs Service should not be resuscitated. She improved to some degree but was not sufficiently independent to go back to Willow Cottage. She was therefore transferred to Dryad ward GWMH.

6.4 On admission to GWMH Mrs Service was seen by Dr Jane Barton. Her clinical note (page 164 of 401) and typed version (paragraph 20 of her statement) indicate that Mrs Service was not expected to live long. This was phrased as "needs palliative care if necessary. I am happy for nursing staff to confirm death".

6.5 The nursing records from the 3rd June 1997 describe her condition and at 02:00 state "failed to settle – very restless and agitated. Midazolam 20mg given via syringe driver over 24 hours. On the 4th June 1997 the entry reads "condition appears to have deteriorated overnight – remains restless. Seen by Dr Barton. Driver exchange with Diamorphine 20mg Midazolam 40mg at 09:20 at a rate of 50mls per hour. Rang Mr Tipping (nephew) to inform him of poorly condition", and on the 5th June 1997 "04:00 hours condition continued to deteriorate and died very peacefully at 03:45 hours. Nephew informed".

6.6 The prescription charts (pages 37 and 38 of 401) relate to the 3rd June 1997 and include Diamorphine 5 – 10mg IM under once only prescription and Diamorphine 20 – 100mg SC over 24 hours. This was administered starting on the 4th June 1997 at 09:20 hours as in the nursing records. Midazolam 20mg was also prescribed and given as was Bumetamide, Lisinopril, Allopurinol, Lanoxin, Aspirin, and Midazolam, but not the Hyoscine. This is in accordance with the Witness Statement of Dr Barton.

6.7 There is no record of a post mortem examination nor of any toxicology analysis. I have not seen a copy of the death certificate.

7.0 (1) Was Mrs Service's treatment for her congestive cardiac failure appropriate for 1997?

Yes.

(2) Given that despite her existing anti-failure therapy she remained breathless, and heart sounds revealed a gallop, what would have been considered reasonable treatment options (taking into account her age, circumstances, biochemistry etc.) in 1997.

Palliative Care

(3) Would uploads have a role for the relief of breathlessness due to chronic heart failure in 1997?

Yes.

(4) I opioids did have a role for the relief of breathlessness due to chronic heart failure in 1997, in what circumstances would they be used, in what dose and by what route?

When the decision had been taken curative treatment was no longer possible and by any parenteral route for example 2.5mg IM or IV, and 20mg SC initially. But tolerance would have developed and bigger doses would have been required.

(5) What is your opinion of Mrs Service's likely prognosis from her heart failure point of view?

Her heart failure was terminal i.e., a few days.

(6) What is your view on the prescription of Diamorphine 5 – 10mg IM prn for congestive cardiac failure?

Appropriate.

(7) What is your view on the prescription for Diamorphine 20 – 100mg SC/24h together with Midazolam 20 – 80mg SC/24h by syringe driver prn, in case she *'deteriorated and developed pulmonary oedema'*?

Appropriate.

(8) What is your view on the subsequent administration of Diamorphine 20mg SC/24h and Midazolam 40mg/24h in order to 'reduce the pulmonary oedema and the distress and agitation from the drowning sensation of the pulmonary oedema'?

Appropriate and desirable.

8.0 Opinion

8.1 Mrs Service suffered from heart failure which was well advanced in 1997 and terminal by June of that year. She was receiving appropriate treatment to correct this including the diuretic Bumetamide to alleviate the congestion, Lisinopril which is one of the angiotensin converting enzyme inhibitor drugs which has been shown both to improve survival and alleviate symptoms in heart failure, and also Digoxin (Lanoxin) which improves the strength of cardiac contraction and slows the heart rate in atrial fibrillation such that symptoms are improved.

Her other drugs including Allopurinol to counter the gouty tendency, and Aspirin to reduce blood stickiness and prevent vascular complications.

8.2 Mrs Service remained unwell despite the corrective treatment outlined above. Opiates, notably Diamorphine, are standard drugs for the alleviation of shortness of breath and distress associated with pulmonary oedema, and are particularly helpful at night. The administration of Diamorphine has been standard practice for myself and other cardiologists for many decades and remains so. Intramuscular and subcutaneous administration is usual.

8.3 Mrs Service's prognosis was hopeless. The administration of Diamorphine 5 – 10mg IM would have been entirely appropriate and the prescription for Diamorphine 20 – 100mg SC/24 hours together with Midazolam is reasonable given the circumstances of the practice described by Dr Barton in her statement. There would have been a clear, if unwritten, understanding that the nurses should start with the smaller dose, namely 20mg which, given the erratic absorption of subcutaneous drugs, would amount to less than a milligram per hour. All opiates induce tolerance and with the passage of time the dose has to be increased. Hence the nurses would have been able to implement this without further reference to Dr Barton. This practice is in keeping with the recommendations in the British National Formulary (Volume 48 September 2004 page 225) which reads as follows: "chronic pain, by mouth, or by subcutaneous or intramuscular injection, 5 – 10mg regularly every four hours"; and in the section entitled "Prescribing in Palliative Care".... "Diamorphine can be given by subcutaneous infusion in a strength of up to 250mg per ml".

9.0 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 is 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.

11. 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: Code A Date: 5.4.06

Form MG15(T)

RESTRICTED

RECORD OF INTERVIEW

Enter type: FUL
L TRANSCRIPT
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: NETLEY SUPPORT HEADQUARTERS

Date of interview: 27/10/2005

Time commenced: 0911 Time concluded: 0934

Duration of interview: 23 MINUTES (→) Tape reference nos. CSY/JAB/11

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

Other persons present: MR BARKER, SOLICITOR

Police Exhibit No: CSY/JAB/11A Number of Pages: 18

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 Jane BARTON. Doctor will you please give your full name and your date of birth?
Code A	Jane Ann BARTON, 19/10/48.
DC Code A	Thank you. Also present is Mr BARKER, who is Doctor BARTON's solicitor. Can you please introduce yourself

RESTRICTED

with your full name?

BARKER — Gladly I confirm that I am Ian BARKER and I am Doctor BARTON's solicitor.

DC Code A — This interview is being conducted in an office at the Police Support Headquarters at Netley in Hampshire. The time is 0911 hours and the date is the 27th of October 2005. At the conclusion of the interview I will 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 BARKER is here as your legal advisor. Have you had enough time to consult with Mr BARKER in private or would you like further time?

BARTON — Fine thank you.

DC Code A — If at any time you wish to stop the interview and take legal advice just say and the interview will be stopped in order that you can do this. 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?

BARTON — I do.

DC Code A — I'll break it down again as I always do anyway. The

caution can be broken into three sections. The first is it's your right in law to say, not to say anything when you're being questioned by us okay. The second part is the slightly more confusing part, if this matter should go to court it may harm your defence if you wish to rely on something as part of your defence, if you've had the opportunity to mention it now in other words if you say something now or you don't say something now and should this go to court and later on you do want to give a reason for something the court may be less likely to believe it and finally the third part again is quite simple, it's being taped and this interview could be, if necessary, played in court o r the transcript read. Do you understand that?

BARTON — Thank you.

DC Code A — On this occasion again the room here is not equipped with monitoring facilities so nobody can listen to this interview. As before it will be me speaking to you the majority of the time and Code A will be taking notes during the interview. Mr BARKER the last time we met was Thursday the 15th of September?

BARKER — I believe you're right.

DC Code A — We handed you by way of advance disclosure for this interview, copies of the medical notes of Helena SERVICE?

BARKER — You did indeed yes.

DC Code A — And a brief synopsis of her care?

BARKER — That's correct.

DC Code A — Okay. Right this investigation is being conducted by the Hampshire Constabulary and started in September 2002 it's been running over three years. 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. 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 enquiry is to interview witnesses who were involved in the care and treatment of the patients during that period. You were a clinical assistant 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 today will concentrate on the care and treatment of Helena SERVICE. Mrs SERVICE was a 99 year old woman who was admitted to Gosport War Memorial Hospital from the Queen Alexandra Hospital in June 1997. Mrs SERVICE subsequently died on the 5th June 1997. Perhaps Doctor in your own words you can tell me what you recollect of Mrs SERVICE and the care and treatment that she received whilst at the Gosport War Memorial Hospital. Now I see that you've got a prepared statement. So it's the usual questions I have to ask you. Is this your statement?

RESTRICTED

BARTON It is.

DC Code A And it's you who prepared it?

BARTON I have.

DC Code A Okay then in that case would you like to read it out doctor?

BARTON I am Dr Jane BARTON of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital.

I understand you are concerned to interview me in relation to a patient at the Gosport War Memorial Hospital, Mrs Helena SERVICE. Unfortunately, at this remove of time I have no recollection at all of Mrs SERVICE. 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 Hospital. I adopt that statement now in relation to general issues insofar as they relate to Mrs SERVICE.

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 Gosport War Memorial Hospital in 1998. I confirm that these comments are indeed a fair and accurate summary of the position then.

The demands on my time were probably only marginally less in 1997 than the position which then pertained in 1998 and beyond. Certainly by 1997 there had been a significant increase in dependency, increase in bed occupancy, and consequent decrease in the ability to make notes of each and every assessment and review of a patient. These difficulties clearly applied to both myself and my nursing staff at the time of our care of Mrs SERVICE. Similarly I had by this stage felt obliged to adopt the policy of pro-active prescribing to which I have made reference in my previous statement to you, given the constraints and demands on time.

From Mrs SERVICE's medical records it is apparent that in 1981 she had a partial gastrectomy and cholecystectomy for what appeared initially to be a malignant stomach ulcer, but on histology this turned out to be benign. An x-ray report in October 1984 revealed that her heart was enlarged, and she was admitted in December of that year to

St. Mary's Hospital with a right sided cerebro-vascular accident and left sided hemiparesis in consequence. Following extensive physiotherapy she made a very good recovery and was discharged home.

In August 1987 she was admitted to hospital having sustained rib fractures after a fall at home. She was noted to be in controlled atrial fibrillation, but at that time there were no signs of cardiac failure. Chest x-ray again confirmed enlargement of the heart.

In December 1992 Mrs SERVICE was admitted to the Queen Alexandra Hospital having suffered another cerebro-vascular accident. She had a left hemiparesis, but again appears to have made a good improvement and was discharged.

Following a request by her General Practitioner, Mrs SERVICE was then seen by Dr Althea LORD by way of a domiciliary visit on the 9th January 1995. The letter from her GP in this record shows that Mrs SERVICE had been increasingly short of breath over the preceding two weeks in spite of an increase in diuretic medication she was receiving, and also had pitting oedema to her knee. Her GP suspected that she might need an ACE inhibitor. The pro forma domiciliary visit record for Dr LORD appears to indicate the GP's view that Mrs SERVICE was in heart failure.

Dr LORD then carried out a domiciliary assessment on the 10th January, writing to her GP on the 13th January 1995.

Dr LORD observed that Mrs SERVICE's pulse was irregular, that she had a pan systolic murmur at the apex that radiated towards the axilla, and she agreed that Mrs SERVICE had congestive cardiac failure due to mitral regurgitation and possible atrial fibrillation. Dr LORD felt that her diuretics should be increased in the first instance to 80mgs of Frusemide daily. She did not feel that ACE inhibitors should be started immediately as there was a need to ensure that renal function was normal first, Dr LORD had apparently made arrangements for monitoring that with the proprietor of the Rest Home at which Mrs SERVICE was resident.

Subsequently, renal function was established to be normal. Mrs SERVICE apparently remained breathless on exertion and her mobility was said to be quite limited. In her report to Mrs SERVICE's GP, Dr LORD stated on the 17th January 1995, that she was arranging for her to be admitted to the Queen Alexandra Hospital for an ACE inhibitor to be commenced. On examination in hospital, Mrs SERVICE was said to be peripherally cyanosed and syspnoeic on minimal exertion. Atrial fibrillation, a Jugular venous pressure which elevated to her ears, and a mitral regurgitant murmur that radiated to the axilla were also noted. She was given a trial of an ACE inhibitor, being started on Lisinopril in addition to 80mgs of Frusimide daily, and was subsequently discharged on the 25th January 1995.

Mrs SERVICE was admitted to hospital again the following year. She was complaining of pain in the wrist,

and was thought to have been hitting her wrists persistently against the wall. A diagnosis of gout was made.

Unfortunately, in May 1997 Mrs SERVICE deteriorated, and the Residential Home became unable to cope with her needs. A care plan for the 12th May 1997 recorded that her GP, Dr Code A had visited and that she had diagnosed as being in heart failure. At that stage Mrs SERVICE was described as "very poorly". Admission was arranged to the Queen Alexandra Hospital. In her referral letter, Dr Code A indicated that Mrs SERVICE had recently developed a urinary tract infection, which had responded initially to antibiotics, but Mrs SERVICE had now become increasingly short of breath, confused and disorientated.

On admission to the Queen Alexandra Hospital Mrs SERVICE was found to have atrial fibrillation, and a possibility of chest infection/bronchial pneumonia was also raised. It was felt there was evidence of left ventricular failure. An ECG was performed which showed Q waves inferiorally, consistent with ischaemia, and a chest x-ray showed patchy consolidation consistent with the pneumonia. Mrs SERVICE was treated aggressively with antibiotics and fluids, and her atrial fibrillation was controlled with Digoxin. The Senior Registrar reviewed Mrs SERVICE following admission confirming the impression of left ventricular failure, and noted that she was not for "555", meaning that her condition was such that she was not suitable for resuscitation.

Mrs SERVICE's condition improved a little over the following days. It seems the nursing staff contacted the Rest Home on the 22nd May 1997 and were informed that she needed to be able to transfer with the assistance of one person in order to return to the home. Referral to the Social Services would therefore have been necessary in case a nursing home was required.

Mrs SERVICE's antibiotics were completed on the 23rd May 1997 and the intravenous fluids were to be discontinued. The following day she then developed a floppy left hand and became unaware of the hand with reduced tone, giving the impression of a cerebro-vascular accident or a transient ischaemic accident.

It appears then that the Rest Home declined to take Mrs SERVICE back as she was unable to weight bear and had a left sided weakness. A referral was then made to Social Services on the 27th May 1997 by the Senior Registrar on the ward round. At this point Mrs SERVICE's Barthel was 4, and Social Services apparently indicated that she had to be referred to Elderly Services as she was too dependent for them to place. In consequence of this it appears that Mrs SERVICE was then referred back to the Geriatricians.

Consequent on that referral, Mrs SERVICE was seen by Dr Code A Locum Geriatrician, on the 29th May 1997. Dr Code A noted that there had been a further episode of left ventricular failure, and she was still "congested", by which I anticipate he meant she was still in congestive cardiac failure, although he noted that she was better. His entry in

the notes for 29th May indicates that he was to transfer Mrs SERVICE to the Gosport War Memorial Hospital.

Mrs SERVICE then remained at the Queen Alexandra Hospital waiting for a bed to become available at the Gosport War Memorial Hospital. The fact that immediate transfer was not possible is probably an indication that there was very high bed occupancy at Gosport War Memorial Hospital at that time. An entry for a ward round on the 2nd June 1997 indicates that a bed was still awaited, and Mrs SERVICE was said to be "well". The nursing records, however, suggest a rather different picture of Mrs SERVICE being dysnoeic on exertion, a condition which had persisted throughout her stay at the hospital. The night staff on 2nd June recorded that there were no signs of confusion, but Mrs SERVICE was said to be very demanding over night, shouting out constantly.

Mrs SERVICE was then transferred to Gosport War Memorial Hospital the following day, 3rd June. She was recorded as being 99 years old, with atrial fibrillation and confusion. Medication on transfer consisted of Melleril, 25mgs at night, Lisinopril 2.5mg twice daily, Bumetanide, 1mg once a day, Aspirin 75mgs once a day, Allopurinol 100mgs at night, and Digoxin 125mcg once a day.

My expectation is that Mrs SERVICE would have been transferred from the ward at the Queen Alexandra Hospital to the Transfer Lounge, waiting there until it was possible to bring her to Gosport. This would understandably have been a stressful experience for an elderly lady suffering

from heart failure. In any event, on arrival, I carried out an assessment, and my record in her notes reads as follows:-

"3-6-97 Transfer to Dryad Ward
Recent admission 17-5-97
Confusion
Off legs
Upper Respiratory Tract Infection
Non Insulin Dependent Diabetes Melitus
Congestive Cardiac Failure
Gout
came from a Rest Home
On examination slightly breathless plethoric lady
Heart Sounds I and II + gallop
Bases clear
Ankles okay
Needs palliative care if necessary
I am happy for nursing staff to confirm death"

As my note indicates, Mrs SERVICE was now no longer able to mobilise - hence the reference "off legs", and she was confused. I recorded the fact that she was a non-insulin dependent diabetic and that she had had an upper respiratory tract infection. I also recorded that she was in congestive cardiac failure. My note indicates that I undertook examination, recording that she was breathless and plethoric, by which I meant that she had purple/blue colouring of the extremities, indicating cyanosis, consequent on the heart failure. I listened to her heart

sounds. I was able to hear a 'gallop' - a third heart sound, indicating that the heart was struggling to cope, and that she was clearly in heart failure.

In my view, Mrs SERVICE was very unwell. I believed she was probably dying and might well indeed die shortly. She had probably reached the stage of multi system failure. Blood tests results revealed a high sodium level probably brought about by dehydration due to powerful diuretics, which were vital in treating her heart failure. She had low potassium, and high urea and creatinine levels. At the time of my assessment, I considered Mrs SERVICE would have been more appropriate for care at the Queen Alexandra Hospital, but a return transfer in an ambulance was probably not in her best interests. She had probably deteriorated consequent upon the transfer to the Gosport War Memorial Hospital, and would have further deteriorated through a transfer back to the Queen Alexandra Hospital. No doubt her bed there would have been allocated to another patient and she might well have had to wait on a trolley whilst another bed was found. In all the circumstances, we had to do the best we could to care for her.

Having assessed Mrs SERVICE I then wrote up appropriate medication on her drugs chart. Concerned that she was in congestive cardiac failure I recorded a PRN prescription for 5 to 10mgs of Diamorphine to be administered intramuscularly. I prescribed Bumetanide 1mg once a day as a diuretic, Lisinopril 2.5mgs twice a day for her heart failure, being the ACE inhibitor. Allopurinol

100mgs daily for her gout, Lanoxin 125mcgs daily for the atrial fibrillation, and 75mgs daily of Aspirin to help prevent a further cerebro-vascular accident.

In addition to that medication, I also prepared a prescription for Diamorphine 20 - 100mgs subcutaneously over 24 hours, Hyoscine 200 - 800mcgs subcutaneously over 24 hours, and Midazalam 20 - 80mgs subcutaneously over the same period. If Mrs SERVICE's condition deteriorated and she developed pulmonary oedema consequent on the cardiac failure, the Diamorphine would assist in relieving the pulmonary oedema. Pulmonary oedema can cause a sensation of drowning which would be profoundly distressing for a dying patient in such circumstances. The Diamorphine and Midazolam would have the effect of relieving the significant distress and anxiety produced from that sensation, with the Hyoscine being available to dry chest secretions.

A Barthel assessment carried out on the 3rd June revealed a zero score, indicating that Mrs SERVICE was now totally dependent. The nursing records noted her admission and it was recorded that her buttocks were very red and sore with broken skin. A pressure relieving "Spenco" mattress was made available.

The nursing records go on to indicate that over night Mrs SERVICE failed to settle and was very restless and agitated. Quite appropriately, 20mgs of Midazalam was given via syringe driver in accordance with my prescription. Whilst ordinarily I believe the nursing staff

would contact me when making use of such an anticipatory prescription this would ordinarily be in the event of provision of Diamorphine. In circumstances in which Midazalam only was given and at this time, I anticipate the nursing staff properly administered the Midazalam without further reference to me.

Sadly, it was felt the following morning that Mrs SERVICE's condition had deteriorated overnight. She remained restless. The nursing notes record that she was seen by me the following morning and the syringe driver was re-charged this time with 20mgs of Diamorphine, and 40mgs of Midazalam. Mrs SERVICE's nephew was contacted to inform him of her poorly condition.

Unfortunately, I have not made an entry of my assessment of Mrs SERVICE on this occasion, for reasons I have indicated previously - that I would simply have had no opportunity to do so through the need to attend to all my various patients. I anticipate that the agitation and restlessness observed overnight had been due to continuing cardiac failure, and this deterioration was further apparent when I reviewed Mrs SERVICE on the morning of 4th June. Given that she was in my view now terminally ill with heart failure, and distressed and agitated in consequence of that condition, it was in my view entirely appropriate to administer the Diamorphine and Midazalam in the hope of reducing the pulmonary oedema brought on by the heart failure, and the distress and agitation from the drowning sensation of the pulmonary oedema.

Sadly, Mrs SERVICE continued to deteriorate and she was recorded as having passed away at 3.45am (0345) on the morning of 5th June 1997.

The Diamorphine and Midazalam were prescribed and in my view administered solely with the intention of relieving Mrs SERVICE's agitation and distress, with the Diamorphine having the additional beneficial effect of treating the pulmonary oedema from her heart failure. At no time was any medication provided with the intention of hastening her death.

DC Code A — Right thank you. I think possibly there's a few amendments.

BARKER — Yes I've noted them and would it help if I suggested them to Doctor BARTON she can. Paragraph two, line two (inaudible) at the end. Paragraph eight, line four it's preceding not proceeding. Doctor BARTON the third line up there you also said pitting oedema to her knee. I don't know whether it should be to or of

BARTON — To.

BARKER — ... so that needs to be changed as well. Paragraph twelve, it's the fourth line up from the bottom there, the last word is Mrs. Paragraph seventeen, second line up from the bottom, 'I anticipate he meant'. Paragraph nineteen Digoxin is micro grams mcgs.

DC Code A — It's Digoxin.

BARTON Yeah.

BARKER And paragraph twenty three ...

BARTON Same again.

BARKER ... it's the same with the Lanoxin and paragraph thirty, third line up it's beneficial effect not affect.

BARTON B minus for my typing.

DC YATES Lovely, right if, if you're happy with that now then doctor if I can ask you to sign it at the back and date it and just having handed it to me, DC Code A and if you didn't do it already ...

BARTON Initial the ...

DC Code A ... initial your amendments.

BARTON Yeah.

DC Code A You have?

BARTON Yeah, mm.

DC Code A If you can countersign the back.

BARKER I can sign it off yeah.

DC Code A — Thank you. Right for the purpose of the tape then we'll give this prepared statement identification reference of JB/PS/10. We'll call a stop to this interview now for a moment just in order that we can go and consider your statement and the information that you've put in it. We may well wish to put a number of questions to you about this statement and other factors surrounding the care and treatment of Helena SERVICE. Would you be prepared to answer those questions if we were to ask them?

BARTON — No.

DC Code A — Okay.

BARKER — Could I make it clear that that answer is given on the basis of the advice previously tended to Doctor BARTON and for the reasons previously explained?

DC Code A — Yeah. Is there anything that you wish to clarify at the moment?

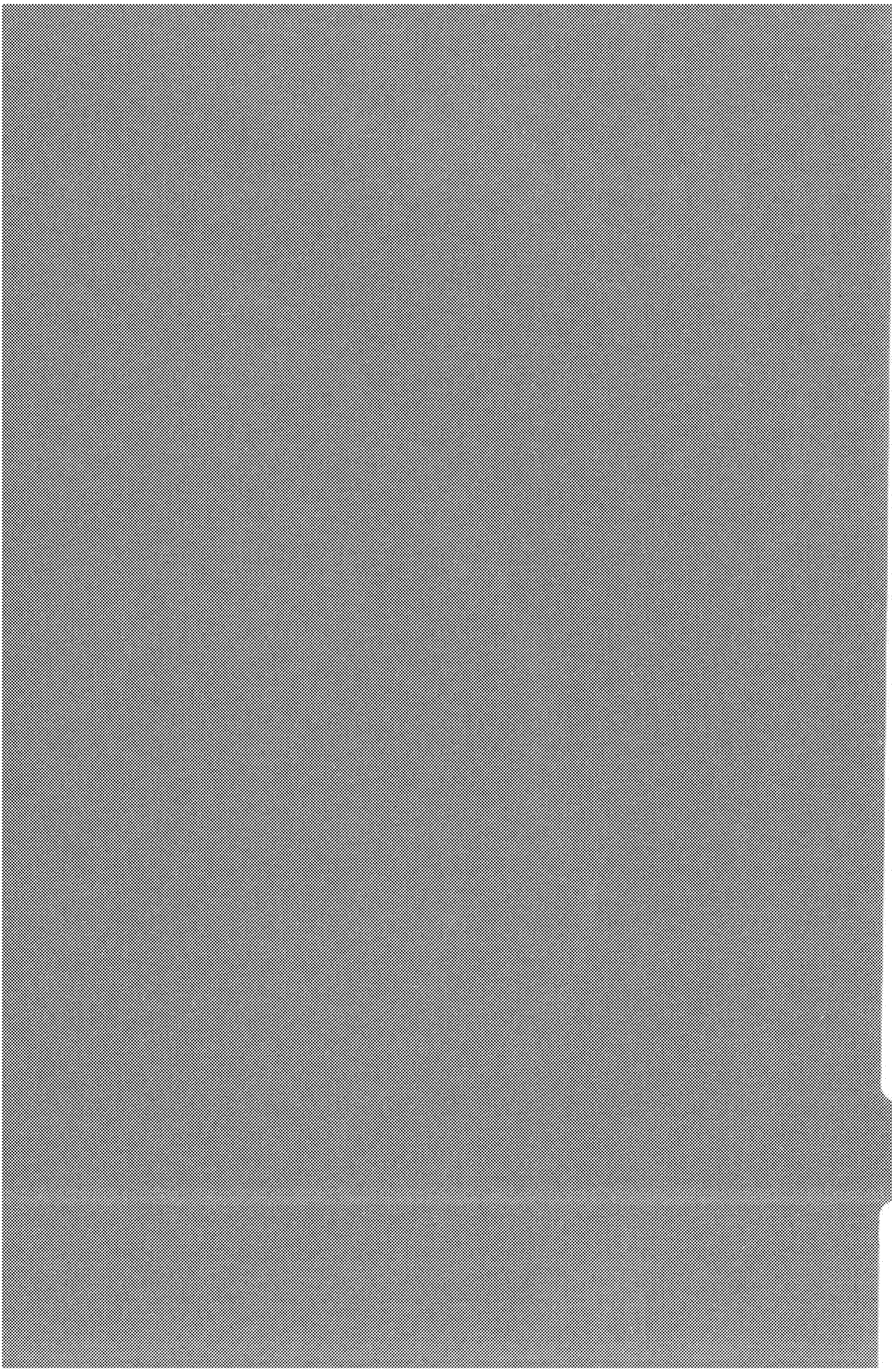
BARTON — No.

DC Code A — Is there anything you wish to add?

BARTON — No thank you.

DC Code A — Right. We'll give you a notice explaining what happens to the tapes and the tape recording procedure. The time is 0934 hours and we'll turn the recorder off.

RESTRICTED



copy

STATEMENT OF DR JANE BARTON

RE: HELENA SERVICE

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mrs Helen Service. Unfortunately, at this remove of time I have no recollection at all of Mrs Service. 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 Service.

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.

4. The demands on my time were probably only marginally less in 1997 than the position which then pertained in 1998 and beyond. Certainly by 1997 there had been a significant increase in dependency, increase in bed occupancy, and consequent decrease in the ability to make notes of each and every assessment and review of a patient. These difficulties clearly applied to both myself and my nursing staff at the time of our care of Mrs Service. Similarly I had by this stage felt obliged to adopt the policy of pro-active prescribing to which I have made reference in my previous statement to you, given the constraints and demands on time.

5. From Mrs Service's medical records it is apparent that in 1981 she had a partial gastrectomy and cholecystectomy for what appeared initially to be a malignant stomach ulcer, but on histology this turned out to be benign. An x-ray report in October 1984 revealed that her heart was enlarged, and she was admitted in December of that year to St Mary's Hospital with a right sided cerebro-vascular accident and left sided hemiparesis in consequence. Following extensive physiotherapy she made a very good recovery and was discharged home.

6. In August 1987 she was admitted to hospital having sustained rib fractures after a fall at home. She was noted to be in controlled atrial fibrillation, but at that time there were no signs of cardiac failure. Chest x-ray again confirmed enlargement of the heart.

7. In December 1992 Mrs Service was admitted to the Queen Alexandra Hospital having suffered another cerebro-vascular accident. She had a

left hemiparesis, but again appears to have made a good improvement and was discharged.

8. Following a request by her General Practitioner, Mrs Service was then seen by Dr Althea Lord by way of a domiciliary visit on the 9th January 1995. The letter from her GP in this regard shows that Mrs Service had been increasingly short of breath over the preceeding two weeks in spite of an increase in diuretic medication she was receiving, and also had pitting oedema to her knee. Her GP suspected that she might need an ACE inhibitor. The pro forma domiciliary visit record for Dr Lord appears to indicate the GP's view that Mrs Service was in heart failure.

9. Dr Lord then carried out a domiciliary assessment on the 10th January, writing to her GP on the 13th January 1995. Dr Lord observed that Mrs Service's pulse was irregular, that she had a pan systolic murmur at the apex that radiated towards the axilla, and she agreed that Mrs Service had congestive cardiac failure due to mitral regurgitation and possible atrial fibrillation. Dr Lord felt that her diuretics should be increased in the first instance to 80mgs of Frusemide daily. She did not feel that ACE inhibitors should be started immediately as there was a need to ensure that renal function was normal first, Dr Lord had apparently made arrangements for monitoring that with the proprietor of the Rest Home at which Mrs Service was resident.

10. Subsequently, renal function was established to be normal. Mrs Service apparently remained breathless on exertion and her mobility was said to be quite limited. In her report to Mrs Service's GP, Dr Lord stated on the 17th January 1995 that she was arranging for her to be admitted to the Queen Alexandra Hospital for an ACE inhibitor to be commenced. On examination in hospital, Mrs Service was said to be peripherally cyanosed

and dyspnoeic on minimal exertion. Atrial fibrillation, a JVP which elevated to her ears, and a mitral regurgitant murmur that radiated to the axilla were also noted. She was given a trial of an ACE inhibitor,being started on Lisinopril in additional to 80mgs of Frusimide daily, and was subsequently discharged on the 25th January 1995.

11. Mrs Service was admitted to hospital again the following year. She was complaining of pain in the wrist, and was thought to have been hitting her wrists against the wall persistently. A diagnosis of gout was made.

12. Unfortunately, in May 1997 Mrs Service deteriorated, and the Residential Home became unable to cope with her needs. A care plan for the 12th May 1997 recorded that her GP, Dr Code A had visited and that she had diagnosed as being in heart failure. At that stage Mrs Service was described as "very poorly". Admission was arranged to the Queen Alexandra Hospital. In her referral letter, Dr Code A indicated that Mrs Service had recently developed a urinary tract infection, which had responded initially to antibiotics, but Mrs Service had now become increasingly short of breath, confused and disorientated.

13. On admission to the Queen Alexandra Hospital Mrs Service was found to have atrial fibrillation, and a possibility of chest infection/bronchial pneumonia was also raised. It was felt there was evidence of left ventricular failure. An ECG was performed which showed Q waves inferiorally, consistent with ischaemia, and a chest x-ray showed patchy consolidation consistent with the pneumonia. Mrs Service was treated aggressively with antibiotics and fluids, and her atrial fibrillation was controlled with Digoxin. The Senior Registrar reviewed Mrs Service following admission confirming the impression of left ventricular failure,

and noted that she was not for "555", meaning that her condition was such that she was not suitable for resuscitation.

14. Mrs Service's condition improved a little over the following days. It seems the nursing staff contacted the Rest Home on the 22nd May 1997 and were informed that she needed to be able to transfer with the assistance of one person in order to return to the home. Referral to the Social Services would therefore have been necessary in case a nursing home was required.

15. Mrs Service's antibiotics were completed on the 23rd May 1997 and the intravenous fluids were to be discontinued. The following day she then developed a floppy left hand and became unaware of the hand with reduced tone, giving the impression of a cerebro-vascular accident or a transient ischaemic accident.

16. It appears then that the Rest Home declined to take Mrs Service back as she was unable to weight bear and had a left sided weakness. A referral was then made to Social Services on the 27th May 1997 by the Senior Registrar on the ward round. At this point Mrs Service's Barthel was 4, and Social Services apparently indicated that she had to be referred to Elderly Services as she was too dependent for them to place. In consequence of this it appears that Mrs Service was then referred back to the Geriatricians.

17. Consequent on that referral, Mrs Service was seen by Dr Code A, Locum Geriatrician, on the 29th May 1997. Dr Code A noted that there had been a further episode of left ventricular failure, and she was still "congested", by which I anticipate she meant she was still in congestive cardiac failure, though he noted that she was better. His entry in the

notes for the 29th May indicates that he was to transfer Mrs Service to the Gosport War Memorial Hospital.

18. Mrs Service then remained at the Queen Alexandra Hospital waiting for a bed to become available at the GWMH. The fact that immediate transfer was not possible is probably an indication that there was very high bed occupancy at GWMH at the time. An entry for a ward round on the 2nd June 1997 indicates that a bed was still awaited, and Mrs Service was said to be "well". The nursing records, however, suggest a rather different picture of Mrs Service being dysnoeic on exertion, a condition which had persisted throughout her stay at the hospital. The night staff on 2nd June recorded that there were no signs of confusion, but Mrs Service was said to be very demanding over night, shouting out constantly.

19. Mrs Service was then transferred to GWMH the following day, 3rd June. She was recorded as being 99 years old, with atrial fibrillation and confusion. Medication on transfer consisted of Melleril, 25mgs nocte, Lisinopril 2.5mg BD, Bumetanide, 1mg once a day, Asprin 75mgs once a day, Allopurinol 100mgs nocte, and Digoxin 125~~mgs~~ mcgs once a day.

20. My expectation is that Mrs Service would have been transferred from the ward at the Queen Alexandra Hospital to the Transfer Lounge, waiting there until it was possible to bring her to Gosport. This would understandably have been a stressful experience for an elderly lady suffering with heart failure. In any event, on arrival, I carried out an assessment, and my record in her notes reads as follows:-

"3-6-97 Transfer to Dryad Ward
Recent admission 17-5-97
Confusion

Off legs
URTI
NIDDM
CCF
Gout
came from a Rest Home
O/E slightly breathless plethoric lady
HS I and II + gallop
Bases clear
ankles ✓✓
needs palliative care if necessary
I am happy for nursing staff to confirm death"

21. As my note indicates, Mrs Service was now no longer able to mobilise - hence the reference "off legs", and she was confused. I recorded the fact that she was a non-insulin dependent diabetic and that she had had an upper respiratory tract infection. I also recorded that she was in congestive cardiac failure. My note indicates that I undertook examination, recording that she was breathless and plethoric, by which I meant that she had purple/blue colouring of the extremities, indicating cyanosis, consequent on the heart failure. I listened to her heart sounds. I was able to hear a 'gallop' - a third heart sound, indicating that the heart was struggling to cope, and that she was clearly in heart failure.

22. In my view, Mrs Service was very unwell. I believed she was probably dying and indeed might well die shortly. She had probably reached the stage of multi system failure. Blood test results revealed a high sodium level probably brought about dehydration due to powerful diuretics, which were vital in treating her heart failure. She had low potassium, and high urea and creatinine levels. At the time of my assessment, I considered Mrs Service would have been more appropriate for care at the Queen Alexandra Hospital, but a return transfer in an ambulance

was very probably not in her best interests. She had probably deteriorated consequent upon the transfer to the GWMH, and would have further deteriorated through a transfer back to the Queen Alexandra Hospital. No doubt her bed there would have been allocated to another patient and she might well have had to wait on a trolley whilst another bed was found. In all the circumstances, we had to do the best we could to care for her.

23. Having assessed Mrs Service I then wrote up appropriate medication on her drugs chart. Concerned that she was in congestive cardiac failure I recorded a PRN prescription for 5 to 10mgs of Diamorphine to be administered intramuscularly. I prescribed Bumetanide 1mg once a day as a diuretic, Lisinopril 2.5mgs twice a day for her heart failure, being the ACE inhibitor, Allopurinol 100mgs daily for her gout, Lanoxin 125~~mgs~~ mcgs daily for the atrial fibrillation, and 75mgs daily of Aspirin to help prevent a further cerebro-vascular accident.

24. In addition to that medication, I also prepared a prescription for Diamorphine 20 - 100mgs subcutaneously over 24 hours, Hyoscine 200 - 800mcgs subcutaneously over 24 hours, and Midazalam 20 - 80mgs subcutaneously over the same period. If Mrs Service's condition deteriorated and she developed pulmonary oedema consequent on the cardiac failure, the Diamorphine would assist in relieving the pulmonary oedema. Pulmonary oedema can cause a sensation of drowning which would be profoundly distressing for a dying patient in such circumstances. The Diamorphine and Midazolam would have the effect of relieving the significant distress and anxiety produced from that sensation, with the Hyoscine being available to dry chest secretions.

25. A Barthel assessment carried out on the 3rd June revealed a zero score, indicating that Mrs Service was now totally dependent. The nursing records noted her admission and it was recorded that her buttocks were very red and sore with broken skin. A pressure relieving "Spenco" mattress was made available.

26. The nursing records go on to indicate that over night Mrs Service failed to settle and was very restless and agitated. Quite appropriately, 20mgs of Midazalam was given via syringe driver in accordance with my prescription. Whilst ordinarily I believe the nursing staff would contact me when making use of such an anticipatory prescription this would ordinarily be in the event of provision of Diamorphine. In circumstances in which Midazalam only was given and at this time, I anticipate the nursing staff properly administered the Midazalam without further reference to me.

27. Sadly, it was felt the following morning that Mrs Service's condition had deteriorated overnight. She remained restless. The nursing notes record that she was seen by me the following morning and the syringe driver was re-charged this time with 20mgs of Diamorphine, and 40mgs of Midazalam. Mrs Service's nephew was contacted to inform him of her poorly condition.

28. Unfortunately, I have not made an entry of my assessment of Mrs Service on this occasion, for reasons I have indicated previously - that I would simply have had no opportunity to do so through the need to attend to all my various patients. I anticipate that the agitation and restlessness observed overnight had been due to continuing cardiac failure, and that this deterioration was further apparent when I reviewed Mrs Service on the morning of 4th June. Given that she was in

my view now terminally ill with heart failure, and distressed and agitated in consequence of that condition, it was in my view entirely appropriate to administer the Diamorphine and Midazalam in the hope of reducing the pulmonary oedema brought on by the heart failure, and the distress and agitation from the drowning sensation of the pulmonary oedema.

29. Sadly, Mrs Service continued to deteriorate and she was recorded as having passed away at 3.45am on the morning of 5th June 1997.

30. The Diamorphine and Midazalam were prescribed and in my view administered solely with the intention of relieving Mrs Service's agitation and distress, with the Diamorphine having the additional beneficial affect of treating the pulmonary oedema from her heart failure. At no time was any medication provided with the intention of hastening her death.