FFW/157/04

HAMPSHIRE CONSTABULARY

OPERATION ROCHESTER

GOSPORT WAR MEMORIAL HOSPITAL

GEOFFREY PACKMAN

Volume 1

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Operation ROCHESTER.

Key points June 2006.

Geoffrey PACKMAN born Code A

Geoffrey PACKMAN was born in Derbyshire. He married his wife Betty in 1956 and they adopted two children Mark and Victoria.

Mr PACKMAN and family moved to Emsworth Hampshire in 1969 whilst working in London in the insurance business.

Following a knee injury and decreasing mobility Mr PACKMAN began to put on weight, as a consequence he suffered gross morbid obesity for many years thereafter.

By 1983 he had become a taxi driver and was weighing 17/18stone, he retired in 1989 aged 57yrs.

He continued to put on weight causing his legs to weep fluid. By 1998 Mr PACKMAN was virtually housebound being visited by a health visitor 3 times a week to change leg dressings. He was suffering leg ulcers and severe cellulitis.

In April 1999 Mr PACKMANS GP noted his weight at 146kg, in excess of 23stone.

On 6th August 1999 Mr PACKMAN suffered a fall at his home address and was unable to mobilise himself. He was admitted to the Queen Alexandra Hospital COSHAM with leg ulcers, marked cellulitis in the groin and left lower limb, at this point he was 68 years of age.

Mr PACKMAN was assessed as being totally dependent with abnormal liver function and impaired renal function. He was treated by way of intravenous antibiotics, variously between 6th and 23rd August 1999 penicillin, flucloxacillin and an anticoagulant clexane.

Mr PACKMAN was reviewed by the specialist registrar the following day the 7th August 1999 who noted that he should not be resuscitated in the event of

arrest the same assessment also being made on 11th 13th and 20th August whilst at Queen Alexandra hospital.

On 8th August he was noted to have 'grade 3 sores' on the sacrum suggesting full thickness skin loss involving damage of subcutaneous tissue.

By the 9th August 1999 Mr PACKMAN seemed to be making some progress with his cellulitis settling. On 11th August 1999 there was reported a deterioration of his heel ulcers with a large necrotic ulcer on his left heel.

On the 13th August 1999 a possible melaena (black bowel motion) was noted, it was not clear whether Mr PACKMAN had a gastro intestinal bleed at that time.

By 17th August Mr PACKMAN is recorded as having deep and malodorous sacral sores.

Mr PACKMAN was transferred to Dryad Ward, Gosport War memorial hospital on 23rd August 1999 for recuperation and rehabilitation.

The clinical examination by Dr RAVINDRANE on admission shows Mr PACKMAN as stable but very dependent and high risk with a declining ability to look after himself over the previous 8 days and little prospect of active rehabilitation.

The transfer for continuing care to Gosport War memorial according to Dr RAVINDRANE did not mean that his condition had improved, but that it had stabilised.

Dr RAVINDRANE recorded that Mr PACKMANS problems were obesity, arthritis to the knees, immobility, suffering pressure sores and constipation. He had a good mental test score and was not in pain. His respiratory system was normal. His legs were slightly oedematous, chronic skin changes were noted. He noted the presence of a meleama on 13th August 1999 also noting the patient's stable heamoglobin.

Dr RAVINDRANE asked for his blood to be re-checked and his condition to be reviewed later in the week.

Medication was prescribed, Doxazosin 4mgs daily for hypertension, Frusemide 80mgs a day a diuretic for Mt PACKMANS oedema, Clexane 40mgs a day for DVT prophylaxis and atrial fibrillation, Parecetomal 1gm 4 times a day for pain relief, Magnesium Hydroxide 10mls twice daily for constipation, Gaviscon for indigestion and cream for pressure sores.

On 24th August it is noted that Mr PACKMAN was suffering complex pressure sores on both buttocks and the sacrum, and that pain needed to be controlled (at odds with admission report of 23rd August).

Dr BARTON prescribed Temazapam for Mr PACKMAN on an as required basis at the dose range of 10 – 20mgs. 10 mgs were administered to Mr PACCKMAN that night the nursing record indicating that he had slept for long periods.

On 25th August Mr PACKMAN was passing blood rectally and also vomiting, he had seven to eight loose bowel actions throughout the afternoon and evening and fresh blood was observed. As a consequence locum GP Dr BEASLEY took the decision to withhold Mr PACKMAN'S administration of enoxaparin, a drug designed to interfere with the clotting ability of blood.

The following day the locum consultant geriatrician Dr RAVI was contacted he agreed the discontinuation of enoxaparin and asked that his haemaglobin be checked on 26th and 27th August.

During the morning of 26th August Mr PACKMAN is recorded as having had a fairly good morning with no further vomiting. By lunchtime he was feeling unwell and had a poor colour.

About 1800hrs on 26th August Mr PACKMAN complained of indigestion like pain in his throat and vomiting. A verbal order was taken from Dr BARTON for a start dose of 10mg diamorphine, an anti-emetic was also given.

About 1900hrs on 26th August 1999 Mr PACKMAN was reviewed by Dr BARTON who recorded that he was clammy and unwell and might be suffering myocardial infarction. He was treated with diamorphine and oramorphine overnight. It is recorded as an alternative that he might be suffering a gastro-intestinal bleed although this was unlikely due to the absence of haematemesis. Dr BARTON concluded that Mr PACKMAN was not well enough to be transferred to an acute unit and that he should be kept comfortable adding that she was 'happy for nursing staff to confirm death'.

A blood count was taken recording marked reduction in haemagloblin, these results are said to be significant (by Dr BLACK) but not commented on at any stage within nursing or clinical notes.

The drug chart for 26th August indicated that Mr PACKMAN could be administered 10mgs diamorphine (verbal message 1800hrs) this is signed by Dr BARTON 2 days later.

40mgs of diamorphine and was administered to Mr PACKMAN on the 28th 29th and 30th August.

20mgs of midazolam were administered on 28th and 29th August and this dose was increased to 40mgs on 30th August.

Oramorph is written up at 20mgs per night and administered on 26th, 27th, 28th and 29th August.

On 27th August there was some improvement noted but discomfort with dressings.

On 28th August Mr PACKMAN is recorded as being poorly with no appetite. Opiates are prescribed to continue over the weekend.

By 29th August Mr PACKMAN was sleeping for long periods.

By 30th August 1999 he remained in a very poor clinical condition but was eating small amounts. Mr PACKMAN complained of left sided abdominal pain and a syringe driver was commenced at 1445hrs containing 40mgs diamorphine and 20mg midazolam.

On 31st August Mr PACKMAN is recorded as passing a large amount of blood rectally.

On 1st September 1999 Mr PACKMAN was reviewed by consultant Dr REID who noted that he was continuing to pass a melaena stool (blood leaking from upper gastro-intestinal tract). There were pressure sores across the buttocks and posterior aspects of both thighs and Mr PACKMAN was significantly confused. Dr REID recorded that Mr PACKMAN should be for TLC only and that his wife was aware of the poor prognosis. Nursing notes indicate that the syringe driver drugs should be increased given that the previous doses were not controlling his symptoms, 60mgs of diamorphine is administered that day.

On the 2nd September diamorphine was increased to 90mgs and midazolam to 80mg. Hydrobromide was prescribed but not administered.

An entry in the night time nursing reports describes Mr PACKMAN as having a peaceful night.

Mr PACKMAN died at 1350hrs on 3rd September 1999 the cause of death being given as 'myocardial infarction with an approximate interval between onset and death of five days.'

<u>Account Dr Jane BARTON from interview with police 17th November 2005.</u>

Within a prepared statement Dr BARTON detailed the patient history prior to his admission at Gosport War memorial hospital on 23rd August 1999.

Dr BARTON anticipates that she reviewed Mr PACKMAN the following day the 24th August 1999 although she did not have an opportunity to make any entry in his medical records. The prescription chart indicates that she prescribed Temazepam on an as required basis within a dose range of 10-20mgs.

Dr BARTON commented that Mr PACKMAN was seen by Dr BEASLEY on 25th August 1999 and Dr RAVI on the morning of 26th August.

The nursing notes of 26th August indicate that he deteriorated about lunchtime and Dr BARTON was called to see him.

She made an entry on the medical records on 26th August 1999 which indicated that she was concerned that Mr PACKMAN might have suffered a Myocardial infarction and accordingly she decided to immediately administer opiates in the form of diamorphine for consequent pain and distress at a dose of 10mg intramuscularly, recorded on the drug chart as a verbal instruction. In addition Dr BARTON would have been conscious of the large pressure sores on the patient's sacrum and thighs which would have caused significant pain and discomfort.

Dr BARTON additionally recorded that Mr PACKMAN had a gastro intestinal bleed.

Dr BARTON assessed that Mr PACKMAN was very ill and that transfer to an acute unit was quite inappropriate being very likely to have a further deleterious effect on his health.

A blood count taken on the 26th August showed that the patient's heamoglobin had dropped substantially from 2 days earlier.

At 1900hrs on 26th August Dr BARTON again attended the patient prescribing Oramorph 10-20mgs 4 times a day with 20mgs at night, Diamorphine 40-200 mgs subcutaneously over 24hrs together with Midazolam 20-80mgs via the same route on an anticipatory basis concerned that further medication might be required in due course to relieve Mr PACKMANS pain and distress.

Dr BARTON reviewed Mr PACKMAN the following morning and again on 28th August when she made a note in the records reading 'remains poorly but comfortable, please continue opiates over the weekend'.

By 30th August Dr BARTON considered Mr PACKMAN terminally ill and would have been concerned to ensure that he did nor suffer pain and distress as he was dying. Increases in opiates would have been commenced in accordance with Dr BARTON'S instructions.

Dr BARTON anticipates that she would have seen Mr PACKAM during the mornings of 31st August and 1st September 1999 although not having the opportunity to make notes in his records.

Mr PACKMAN was reviewed by consultant geriatrician Dr REID on 1st September who wrote on the notes that he should receive TL, Dr BARTON felt that this was an indication that Dr REID had also considered Mr PACKMAN to be terminally ill.

Sister HAMLIN recorded alter that the syringe driver was renewed at 1915hrs with 60 mgs of Diamorphine and 60 mgs of Midazolam subcutaneously as previous doses were not controlling his symptoms. Dr BARTON anticipates

that she was contacted to authorise this moderate increase in order to alleviate pain and distress.

That night Mr PACKMAN was noted to be incontinent with black tarry faeces but otherwise had a peaceful night.

Dr BARTON believes she reviewed Mr PACKMAN the following day the 2nd September 1999 and that she and the nursing staff increased the medication Diamorphine 90mgs and Midazolam 80mgs to ensure that Mr PACKMAN did not suffer pain and distress as he died.

Mr PACKMAN died the following day. Dr BARTON believed the cause of death to be myocardial infarction. At no time was any medication provided with the intention of hastening Mr PACKMAN'S demise.

Dr BARTON was further interviewed under caution by police on 6th April 2006 making no comment to questions asked.

Clinical team member assessment (Geriatrician.)

Geoffrey PACKMAN. 67 years died 3rd September 1999 thirteen days after transfer to Gosport War Memorial hospital.

'I have more concerns with this case than the other members of the team. This man was treated for a myocardial infarction but died of a gastrointestinal bleed. I have been told that this was considered as the diagnosis in Queen Alexandra Hospital and the decision was made not to treat it. I have not found this and I believe they did not take this seriously in GWMH and treated him with opiates. I consider the cause of death to be natural (although potentially treatable) and the medical care terrible.

Quality assurance comment.

Mr PACKMAN was admitted to Gosport War Memorial Hospital in July 1999 with an irritating rash on his side and groin. It appears from the medical notes that he had an episode of black stools prior to being discharged from Portsmouth Hospitals NHS trust.

Following admission to Gosport War memorial Hospital on 23rd August 1999 Mr PACKMAN was noted as remaining very poorly with no appetite. It was noted in Mr PACKMANS nursing records that he was passing fresh blood per rectum on 25th August 1999.

On 26th August 1999 he complained of feeling unwell with indigestion pain in his throat together with nausea and vomiting.

At this point he was commenced on opiate medication. No active measures were taken to resuscitate Mr PACKMAN and following rapidly increasing doses of Diamorphine he died on 3rd September 1999.

There is a variation in the view taken of this case by the experts reviewing the notes. Concern is expressed by the geriatrician that although the death was natural the gastrointestinal bleed was potentially treatable.

An expert report from a gastrointestinal surgeon/physician is to be sought.

Expert Gastroentorologist Dr Jonathon MARSHALL comments:-

Mr PACKMAN did not experience a significant life threatening gastrointestinal bleed while an in patient at Portsmouth Hospital. He developed a mild anaemia of chronic disease secondary to his underlying medical problems during that part of his admission. His medical state was stable and there was no medical reasons to delay transfer to a 'step down' care facility from an acute hospital.

Mr PACKMAN is likely to have suffered a significant gastrointestinal bleed while an out patient at Gosport War Memorial Hospital (approx 3 days after transfer) Medical assessment at that time was limited and was managed with escalating doses of opiate analgesia before he died on 3rd September 1999.

His main problems recorded throughout his stay were obesity, leg oedema, cellulites, poor mobility, arthritis and pressure sores. His mental state was very good and he had no pain. Overall he doesn't look ill and it was mainly a nursing problem.

During the admission period at the previous hospital the only analgesia he received was paracetamol.

Transfer for endoscopic surgery should have been considered in Mr PACKMANS case when the possibility of a G/I bleed was first seriously considered when he deteriorated (26.8.1999) allowing accurate diagnosis of the site and cause of bleeding. Endoscopy can only occur after resuscitative measures have been taken such as intravenous fluids, oxygen etc. It also allows further procedures to try and stop the bleeding and is 'bread and butter' emergency gastroenterology available in any endoscopic unit.

The critical determinant would be how fit Mr PACKMAN was after resuscitative measures.

Mr PACKMAN would represent a high risk for surgery, it would be difficult to justify the potential mortality of elective surgery in a morbidly obese patient. However each situation is judged on its own merits. A failure of endoscopic surgery to stop bleeding is an indication for emergency surgery. In these situations it has to be put to the patient and family that death during or soon after surgery is a high probability but it is essential to proceed with this high risk option as the only possible way to save life.

Expert witness Dr Andrew WILCOCK (Palliative medicine and medical oncology) comments:-

Mr Packman was a 67 year old man with obesity impairing his mobility, swelling of his legs and leg ulcers admitted to the Queen Alexander Hospital because of cellulitis (infection of the skin) affecting his left leg and groin. He also had pressure sores over his buttocks and thighs. He improved with treatment with antibiotics. He passed loose black stools, suggestive of melaena (blood in the stool) on a couple of occasions, but his haemoglobin was stable, excluding a significant gastrointestinal bleed. He was transferred to Dryad Ward for rehabilitation.

During his admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal; there was a lack of clear, accurate and contemporaneous patient records, inadequate assessment of Mr Packman's condition; a lack of consultation with colleagues and the use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs.

Mr Packman became acutely unwell on the 26th August 1999. A blood test revealed a large drop in his haemoglobin which made a significant gastrointestinal bleed likely. This is a serious and life-threatening medical emergency which requires urgent and appropriate medical care. The commonest underlying cause, a peptic ulcer, can however, be cured. Mr Packman should have been transferred without delay to the acute hospital. However, Mr Packman was not transferred; the blood test result was not obtained or acted upon and he went on to receive doses of diamorphine and midazolam which were not obviously justified and likely to have been excessive to his needs.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mr Packman by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Packman by failing to adequately assess his condition and taking suitable and prompt action when he became unwell with a gastrointestinal bleed. He was not appropriately assessed, resuscitated with fluids, transferred or discussed with the on-call medical team. The use of regular morphine and subsequent use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs were inappropriate.

It is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Expert Witness Dr David BLACK (Geriatrics) comments:-

Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in

hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

There are a number of weaknesses in the clinical care provided to Mr Packman:-

- Gastro-intestinal haemorrhage is suspected in Portsmouth, but although never disproven he is continued on his anticoagulant.

- Despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.

- On assessment on 25th August 1999 a further bleed does not lead to medical attention.

- On 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.

- A difficult clinical decision is made without appropriate involvement of senior medical opinion.

- Prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor. A higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is the Dr BLACKS opinion that Mr Packman died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

Evidence of other key witnesses:-

Victoria PACKMAN. Daughter of the deceased, describes father as not very tall but very big he drank and ate to excess. Background re employment and describes how father became virtually housebound during the last few years of his life. Describes admission to Queen Alexandra hospital and general improvement in health. Father declined at Gosport War Memorial hospital. The change was dramatic and became progressively worse until death.

Betty PACKMAN. Widow of deceased. Background re deceased who came from a plump family. Medical history in respect of increasing weight and warnings for high blood pressure. Husband did not drink alcohol but huge

amounts of fizzy drinks. His legs were a constant problem would weep fluid and were never dry. It reached the stage that he could not walk properly around the house. The district nurse visited regularly to change leg dressings. Describes how she had left her husband in the bathroom on 5th August 1999 and his subsequent admission to Queen Alexandra hospital.
Describes how husband made a good recovery and was cheerful and transfer to Gosport War Memorial Hospital for recuperation and rehabilitation. Remained cheerful, but after one visit she was told that her husband was going to die. Husband then became progressively worse, it was explained that her husband was on diamorphine but she was not told why.

Elliot BERESFORD Friend of deceased .. Background information re lifestyle of deceased, and concerns regarding the attitude of Dr BARTON.

Dorothy BERESFORD As above.

Mark PACKMAN Son of deceased. Background information and lifestyle.

Ruth Elizabeth TOPPING Daughter in law of deceased. Lifestyle and background.

David LATHAM Brother in Law of deceased. Lifestyle and background.

Margaret SHERWIN Retired local priest. Administered the last rites to Mr PACKMAN. + background information.

Code A General practitioner Havant Health Centre and GP to Mr PACKMAN. Last saw deceased in July 1999 visited surgery and checked blood pressure. Patient suffered, hypertension, obesity, immobility, cellulitis of legs and atrial fibrillation. Referred to a Dermatology Consultant Dr Code A re leg ulcers.

Code A Consultant Urologist. Refers to letter from Dr Code A referring Mr PACKMAN for urology problems. Has no record of any examination.

Code A Consultant Dermaologist. Mentions referral by Dr Code A but comments that Mr PACKMAN in fact examined by Dr CLARKE on 30.6.99.

Code A Specialist Registrar. Comment re admission of Mr PACKAM to Queen Alexandra Hospital on 6th August 1999 and detailed examination.

Code A GP Examined Mr PACKMAN 11th August 1999 regarding the underlying cause of Mr PACKMANS cellulitis.

Code A Doctor. Made entry on medical notes 6th August 1999 'In view of pre-morbid state + multiple medical problems not for CPR in event of arrest' Explains that CPR is a treatment and at that time it was decided that if Mr

PACKMAN had an arrest then the chances of treatment being successful were very slim.

Arumugan RAVINDRANE (2 statements) Consultant Physician in elderly medicine. August 1999 employed as registrar under Dr REID. Examined Mr PACKMAN 23rd August 1999 (on admission to Gosport war memorial hospital) and explains medical notes detailing condition of patient. Describes as a high or very high risk patient. States that Mr PACKMAN died of internal bleeding, cannot say whether it could have been prevented. Had the hospital acted when black stools were noted at Q.A.H and clexane had been stopped then it may have been prevented if done in conjunction with administration of anti-ulcer drugs.
It was too late for this action by 26.8.1999.
In second statement discusses the decision to stop clexane and monitor haemoglobin on 26.8.1999.

Gillian HAMBLIN Senior Sister Dryad Ward. Detailed background re - working practices at Gosport War Memorial Hospital. Explains hers and other entries on medical and nursing notes particularly her report of 26th August 1999. Discussed patients condition with Dr RAVANDRANE and Dr BEASLEY. Wrote up prescriptions for Diamorphine and Midazolam on verbal instructions of Dr BARTON and would have agreed levels with her over the telephone.

Siobhan COLLINS Staff Nurse Dryad Ward. Explains nursing notes and medical terminology. Recorded Mr PACKMANS Barthel scores on 23/8 30/8 and 1/9/1999 indicating his worstening condition. Wrote Nursing care plan on admission. Explains her detailed entries on nursing notes.

Shirley HALLMAN Staff Nurse Dryad Ward. Concerns re patient care general around alternative analgesia. Questioned Nurse HAMBLIN about the issue who commented 'I hope when you die you die in pain' Verified Mr PACKMANS death at 1350hrs on 1st September 1999. Also explains her nursing entries of 23, 26th August 1999 and her administration of Oramorph between 27th and 30th August 1999.

Jeanette FLORIO Staff Nurse Dryad Ward. Describes ward practices and wrote nursing note 2.9.1999 to the effect that Diamorphine and Midazolam levels had been increased to 90mgs and 80mgs respectively. Witnessed these drugs being administered by Shirley HALLMAN on 2.9.1999.

Beverly TURNBULL Staff Nurse Dryad Ward. Background re use of syringe drivers and opiate drugs, and voices her concerns in use for patients not in pain. Explains her nursing entries in respect of care to Mr PACKMAN and on 31st August 1999 that he continued to pass 'black tarry faeces' Administered Oramorph between 27th and 29th August 1999.

Anita TUBRITT Staff Nurse Dryad Ward. Articulates concerns re lack of Opiate drug/syringe driver training. Witnessed various administration of Oramorph to Mr PACKMAN between 26th and 29th August 1999.

Irene DORRINGTON Staff nurse Dryad Ward (retired). Details limited I/V drug and syringe driver training during her 38years nursing. Worked nights only. Administered Oramorph to Mr PACKMAN between 26th and 30th August 1999 and nursing note entries with reference to black faeces and abdominal pain.

Code A Ward Aide Dryad Ward. Witnessed Oramorph administration.

Code A Medical Secretary. Produces medical records Mr PACKAMN from archives.

Code A Produces GP records Mr PACKMAN.

Detective Constables Code A Conduct caution interviews Dr BARTON on 17th November 2005.

D.M.WILLIAMS
Detective Superintendent 7227
27th June 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 7227
Senior Investigating Officer.
16th January 2007.

Police officer witness statements
Transcript suspect interviews

SUMMARY OF EVIDENCE

CASE OF GEOFFREY PACKMAN

Background/Family Observations

Geoffrey PACKMAN was born in Derbyshire on Code A He was known as Mick, he had three sisters and always worked in office jobs. He met his future wife Betty whilst working in local government in Derbyshire and they married in July 1956.

In Code A Mick and Betty adopted their son Mark and in Code A they adopted their daughter Victoria (known as Vicky). At this time Mick was working in insurance in London and in Code A the family moved to Emsworth in Hampshire.

At this time Mick was fit and healthy; he was on the Committee of the Sea Cadets and would attend the annual camp. He would also 'run the line' for his son's football team. Whilst on an annual camp he injured his knee and his mobility decreased. Due to this his legs started to swell and he began to put on weight.

In 1983 Mick had a falling out at work and became a taxi driver for a local company. In order to do so he had a medical and was found to have high blood pressure and weighed 17/18 stone. In 1985 he started his own business with a friend but after a couple of years the business collapsed and Mick retired, he was 57 years old. During his time as a taxi driver he put on a considerable amount of weight.

By 1998 Mick was virtually housebound. He did not drink alcohol but drank fizzy drinks and liked sweets and crisps. He would sit in his chair in the lounge and listen to classical music. He even started up a music club and friends would visit and listen to music with him. He continued to put on weight and his legs would constantly weep fluid, he couldn't walk properly and had to lean on the furniture and walls to get around the house. For the last 2 or 3 years of his life he had a health visitor who came in and changed the dressings on his legs three times a week.

On 6th August 1999 Mick got stuck on the toilet at home. Four people were needed to get him off the toilet and downstairs. He was admitted via the A & E Department at Queen Alexandra Hospital to Ann Ward. He made good progress his legs dried up and he looked the best he had for years. He was happy, chatty, eating and drinking properly and keen to get home. After two to three weeks he was transferred to Dryad Ward at Gosport War Memorial Hospital for recuperation and rehabilitation.

The family visited on a daily basis and initially he was fine. He was eating and drinking properly, never complained of any pain and was in good spirits.

After a couple of days Mrs PACKMAN whilst visiting Mick was taken to one side by a lady doctor who said in a very abrupt manner, "Your husband is going to die and you have to look after yourself now". It wasn't explained to her why or when this would happen.

At about this time Mrs PACKMAN also received a call from the hospital telling her that Mick had had a heart attack. On visiting him he told her that he hadn't had a heart attack just that he had a bout of indigestion that he always suffered from.

Two or three days after this conversation Mick deteriorated and became 'spaced out'. His eyes were glazed, his head would nod and he had to be propped up in bed. When awake he could still talk but had to be fed. He then became unconscious, he was on diamorphine but no one explained why.

On 3rd September 1999 Mr PACKMAN died. The cause of death on the death certificate was given as heart attack.

Medical history of Geoffrey PACKMAN.

Geoffrey Packman was a sixty eight year old gentleman who was admitted as an emergency on the 6th August 1999 to Portsmouth Hospitals NHS Trust following an attendance at A&E.

He had suffered from gross (morbid) obesity for many years, he had also had venous leg ulceration for at least five years, he was hypertensive and had a raised prostatic specific antigen, suggesting prostatic pathology.

Following a fall at home he was completely immobile on the floor and two ambulance crews were needed to bring him to accident and emergency. He was currently receiving District Nursing three times a week for leg ulcer management. He had become increasingly immobile complicated by the fact that his wife who lived with him and provided care was being investigated for [redacted]. The admission clerking showed that he not only had leg ulcers but he had marked cellulitis, was pyrexial and in atrial fibrillation. Cellulitis was both in his groin and the left lower limb. He was totally dependent needing all help with a Barthel of 0. His white cell count was significantly raised at 25.7, his liver function tests were abnormal with an AST of 196 and his renal function was impaired with a urea of 14.9 and a creatinine of 173. These had all been normal earlier in the year. He was treated with intravenous antibiotics in a special bed.

He appeared to make some progress and on 9th August his cellulitis was settling. A Haemolytic Streptococcus sensitive to the penicillin he had been prescribed was identified. On 11th August the nursing cardex stated that there appeared to have been a deterioration of his heel ulcers with a "large necrotic blister on the left heel". His haemoglobin on 12th August was 13.5.

On 13th August white count was improved at 12.4, his U's and E's were normal and the notes recorded a planned transfer to the Gosport War Memorial Hospital on 16th August.

Later on the 13th black bowel motion is noted but the doctor who examines him records a brown stool only. It is not clear whether he has had a gastro intestinal bleed. On 16th August no comment is made on the possible gastrointestinal (G.I) bleed, but on 20th August his

haemoglobin is noted to be 12.9 no further black stools have been reported so he is planned for transfer on 23rd August. Albumin at this stage is now reduced at 29.

On 17th August sacral sores are now noted in the nursing cardex which by the 20th are now recorded as "deep and malodorous".

He is transferred to the Gosport War Memorial Hospital on 23rd August. A reasonable history and examination is undertaken which notes that there was a history of possible melaena, the clinical examination recorded suggests that he is stable. Blood tests are requested for the next day. The drug chart suggests that his weight is 148 kgs but it is not clear if this is an estimate or a measurement. He is very dependent with a Barthel of 6 and a Waterlow score of 18, putting him in high risk. His haemoglobin on 24th is 12. The nursing cardex on the 24th notes the multiple complex pressure sores on both the buttocks and the sacrum (96-100).

On 25th August the nursing cardex reports that he is passing blood rectally and also vomiting.

On 26th August a doctor (Dr Barton) is asked to see him and records that he is clammy and unwell. The notes suggest that he might have had a myocardial infarction and suggests treating him with Diamorphine and Oramorphine overnight. It records that as an alternative there might be a G.I. bleed but this is recorded as unlikely because he has not had haematemesis. It also notes that he is not well enough to transfer to an acute unit and he should be kept comfortable, including "I am happy for the nursing staff to confirm death". His Clexane (an anticoagulant given to prevent pulmonary embolus) is now stopped. The nursing cardex on the same day records further deterioration throughout the day with pain in his throat and records a verbal request for Diamorphine. A full blood count is taken (this fact is not recorded in the notes) but the result is filed in the notes recording a haemoglobin markedly reduced at 7.7. It also states "many attempts were made to phone Gosport War Memorial Hospital but no response from switchboard". These significant results are not commented on at any stage in the nursing or clinical notes.

On 27th August the nursing notes record some improvement in the morning but discomfort in the afternoon especially with dressings. On 28th August both the medical and the nursing records are noted to be very poorly with no appetite. Opiates are to continue over the weekend. 29th August he is sleeping for long periods and on 30th he is still in a very poor clinical condition but eating very small amounts of diet. He is re-catheterised the same day.

On 31st he is recorded as passing a large amount of blood rectally and on the 9th September he is reviewed by a consultant Dr Reid who notes that he is continuing to pass melaena stool, there are pressure sores across the buttocks and posterior aspects of both thighs, he is now significantly confused. Dr Reid records that he should be for TLC only and that his wife is now aware of the poor prognosis. Nursing notes note that the dose of drugs in the syringe driver should be increased; the previous doses were not controlling his symptoms. The nursing notes of the 2nd September record the fact the Diamorphine is again increased on the 2nd to 90mgs and on 3rd September he dies at 13.50 in the afternoon.

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Geoffrey PACKMAN was a Clinical Assistant Dr Jane BARTON. The medical care provided by Dr

BARTON to Mr PACKMAN following his 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 Robert BLACK in his review of Dr BARTON's care reported specifically:-

Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

There are a number of weaknesses in the clinical care provided to Mr Packman:

- gastro-intestinal haemorrhage is suspected in Portsmouth but although never disproven, he is continued on his anticoagulant.

- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.

- on assessment on 25th August a further bleed does not lead to further medical attention.

- on 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.

- a difficult clinical decision is made without appropriate involvement, of senior medical opinion.

- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.

- a higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is my opinion that Mr Packman died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

Dr Andrew WILCOCK reports:-

There was insufficient assessment and documentation of Mr Packman's clinical condition when he became less well on the afternoon of the 26th August 1999.

There was insufficient assessment and documentation of Mr Packman's clinical condition when he became acutely ill on the evening of the 26th August 1999.

Mr Packman was considered to have experienced either a myocardial infarction or a gastrointestinal haemorrhage, yet advice was not sought from other colleagues nor was he transferred to an appropriate place of care.

Mr Packman received regular oral morphine that may have been excessive to his needs and prescribed a syringe driver, as required, with upper dose ranges of diamorphine and midazolam likely to be excessive to his needs.

Over the days that followed, there was a continued lack of an appropriate medical assessment of Mr Packman's condition; the results of blood tests that would have indicated a gastrointestinal bleed were either not obtained or acted upon.

Mr Packman received increasing doses of diamorphine and midazolam that were likely to be excessive to his needs.

Dr BLACK further states

Both Dr Barton and Dr Reid had a duty to provide a good standard of medical practice and care. In this regard, Dr Barton and Dr Reid fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient, providing treatment that could be excessive to the patients' needs and willingness to consult colleagues.

Mr Packman was admitted for rehabilitation and it was not anticipated that he was likely to die. Although Dr Barton considered a myocardial infarction more likely than a gastrointestinal haemorrhage, the latter would have been confirmed as the more likely if the haemoglobin result was obtained that evening or the following day. A gastrointestinal haemorrhage (or a myocardial infarction) is a serious medical emergency and requires appropriate and prompt medical attention. The cause of Mr Packman's gastrointestinal bleed is unknown. However, as the most common cause is a peptic ulcer which can be cured with appropriate treatment, it is possible that Mr Packman's deterioration was due to a potentially reversible cause that could have been managed by transfer to the acute hospital for appropriate resuscitation with intravenous fluids, blood transfusion and further investigation. This view is in keeping with the opinion of a gastroenterologist, Dr Code A report of 1st April 2005).

Dr Barton considered Mr Packman too unwell to move. In this regard it seems odd that a patient becoming acutely unwell at Gosport War Memorial Hospital would be at a disadvantage compared to if they had become acutely unwell at home. I see no reason that a patient could not be transferred by emergency ambulance if this was in their best interests. When possible they should be medically stabilised beforehand, but the lack of ability to do this should not be the reason not to attempt transfer at all. Even if one accepted the view that Mr Packman was too unwell to move, advice should have been sought on his management from the on-call physicians/geriatricians or cardiologists.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mr Packman by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Packman by failing to adequately assess his condition and taking suitable and prompt action. Mr Packman could have had a potentially treatable and reversible medical condition, which presented with a serious complication (i.e. bleeding). He should have been urgently and appropriately assessed and transferred to an acute medical unit. He was not appropriately assessed, resuscitated with fluids, transferred or discussed with the on-call medical team. In my view, there was no obvious reason why it was not appropriate to provide Mr Packman with this usual course of action.

Morphine and diamorphine are safe drugs when used correctly. The key issue is whether the use and the dose of diamorphine and other sedatives are *appropriate* to the patients' needs. Although some might invoke the principle of double effect (see technical issues), it remains that a doctor has a duty to apply 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 of strong opioid that was *appropriate* and not excessive for a patient's needs. The stat doses of diamorphine could be seen as appropriate for the relief of severe pain. However, in my opinion, the ongoing use of regular morphine and subsequent use of diamorphine and midazolam were inappropriate; their use was not obviously justified and the doses were likely to be excessive to Mr Packman's needs. In my opinion, it is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Dr Jonathan Marshall a specialist Gastroenterologist specifically reports that :-

Mr PACKMAN was likely to have experienced a significant GI bleed approximately 3 days after transfer to GWMH. He was assessed as being unwell and was managed with escalating doses of opiate analgesia until he died on 3-9-99.

He further states that transfer for endoscopic therapy should have been considered in Mr PACKMAN's case, although this can only take place after resuscitative measures have been taken such as I/V fluids, oxygen etc. Endoscopic therapy allows accurate diagnosis of the site and cause of bleeding. It also allows further procedures to try and stop the bleeding and is 'bread and butter' emergency gastroenterology available in any endoscopic unit.

The critical determinant would be how fit Mr Packman was after resuscitative measures for the ambulance transfer to endoscopy.

'Do not resuscitate' orders refer specifically to not commencing cardiopulmonary resuscitation if the heart stops. Mr Packman was in this 'DNR' category reasonably (high chance of technical futility) but not in a group in whom no resuscitation is attempted if they simply becomes *unwell.*

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 17th November 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 Geoffrey PACKMAN at the Gosport War Memorial Hospital. The interviewing officers were DC YATES and DC Code A

The interview commenced at 0914hrs and lasted for 27 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/11. This statement dealt with the specific issues surrounding the care and treatment of Geoffrey PACKMAN.

On Thursday 6th April 2006 Dr Barton was interviewed a further nine times throughout the course of the day where a series of questions were put to her in essence challenging her medical management of Mr PACKMAN. Dr BARTON made 'no comment' to any of the questions.

REPORT

regarding

Geoffrey PACKMAN (Ref No. BJC/34)

PREPARED BY: Dr Code A

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

Mr Packman did not experience a significant (life threatening) gastrointestinal (GI) bleed while an in-patient at Portsmouth Hospital. He developed a mild anemia of chronic disease secondary to his underlying medical problems during that part of his admission.

Mr Packman is likely to have suffered a significant GI bleed while an in-patient at GWMH. Medical assessment at that time was limited and he was managed with escalating doses of opiate analgesia before he died on 3-9-99

2. INSTRUCTIONS

I was asked to prepare this report on the instructions of Detective Sergeant Dave GROCOTT of Hampshire Constabulary based at Fareham Police Station, Quay Street, Fareham, Hampshire PO16 0NA.

3. ISSUES

I was asked to consider the following issues.

3.1 Can you review the papers and establish beyond all reasonable doubt whether or not the gastrointestinal bleed was treatable? If it was, at what point should it have been offered?

3.2 What treatment should have been considered in Mr Packman's case?

3.3 Should non-invasive exploration have been considered by doctors whilst Mr Packman was a patient at Haslar Hospital?

3.4 Was Mr Packman morbidly obese? If so was he unfit therefore for surgery?

4. BRIEF CURRICULUM VITAE

Code A

Code A

Code A

Code A

5. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Geoffrey Packman

6. OPINION

Question 1

Can you review the papers and establish beyond all reasonable doubt whether or not the gastrointestinal bleed was treatable? If it was, at what point should it have been offered?

Opinion: Mr Packman did not experience a *significant* (life threatening) gastrointestinal (GI) bleed while an in-patient at Portsmouth hospital between 6-8-99 and transfer to GWMH on, or around 23-8-99. There would therefore be no basis to investigate him during this part of his admission with any invasive or non-invasive procedures. His medical state was stable and there were no medical reasons to delay transfer to a 'step-down' care facility from an acute hospital.

Mr Packman was likely to have experienced a *significant* GI bleed approximately 3 days after transfer to GWMH. He was assessed as being unwell and was managed with escalating doses of opiate analgesia until he died on 3-9-99.

Basis for opinion: Mr Packman was admitted because his GP and district nurse were 'unable to cope at home' despite '3x visits/day' (by district nurse) [p40]. His main problems, recorded throughout his stay, were obesity [p40], leg oedema, cellulitis and poor mobility [p45] At the time of admission his haemoglobin was 15.7 and platelets 237 [p43]. NB: This clinical record page is un-labelled but a lab print out confirming this result is on p213. He was treated with intravenous flucloxacillin and benzyl penicillin for groin and leg cellulitis [p46]. Overall he 'doesn't look ill' and was 'mainly a nursing problem' [p47]

On 13-8-99 there is a comment about 'black stool overnight' [p52]. But, clinical examination at that time showed a soft abdomen, normal bowel sounds and normal brown stool presumably on rectal examination. Although a differential of bleeding or antibiotic related diarrhoea was proposed [p52], the presence of brown (normal) stool on examination is against significant upper or lower GI bleeding.

On 20-8-99 [p53] 'no further black motion' was recorded. No symptoms of peptic ulceration were elicited on questioning ('no nausea, no epigastric pain'). The blood pressure was stable at 140/80. Further proof to support an *absence* of significant GI bleeding is provided by the stable haemoglobin (Hb) written as 12.9. A laboratory report dated the day before (19-8-99) [p215] confirms this result.

Mr Packman's haemoglobin was 15.7 on admission (6-8-99) and as stated above was 12.9 on 19-8-99. This is a decline of 2-3 units. However, this is likely to be a trend towards the 'anemia of chronic disease' rather than a significant bleeding related fall in haemoglobin because:

- The lab report dated 19-8-99 with the Hb of 12.9 also confirms a normal platelet count of 366 [p215]. This *normal* platelet count is *against* significant bleeding as the platelet count *may* rise as a response to bleeding, especially if this has been occurring over a few days.
- A normal urea at 5.4 [p53] is also *against* a bleed as this typically *rises* in the presence of significant upper (stomach or duodenum) GI bleeding.
- Mr Packmans ESR was typically raised-a marker of inflammation-due to his cellulitis/leg ulceration (ESR 31 on 7-8-99 [p213] and ESR 68 on 19-8-99 [p215]). Chronic infection is associated with raised inflammatory markers (ESR) and 'anemia of chronic disease'- as in this case at this time.
- On the same dates [p213, p215] the MCV was 87.8 on both occasions. This is a *normal* 'mid range' result; A *normal* MCV helps distinguish developing borderline anemia of chronic disease (secondary to infection/cellulitis-as in this case) from iron deficiency anemia typically due to bleeding, albeit slowly, where the MCV is below normal ('microcytic anemia' MCV <80)

On 23-8-99 Mr Packman was transferred to GWMH where his problems were listed as obesity, arthritis, immobility and pressure sores. His mental state was 'very good' and he had 'no pain' [p54]. His lack of significant pain is also supported by an undated assessment on p243 ticking the 'No' box in relation to pain. While his pressure sores could be expected to give him a degree of discomfort, during the admission period at the previous hospital from7/8/99 to 23/8/99 the only analgesia he received was paracetamol 1g 6 hourly [p177 and 179]

On 25-8-99 Nursing staff report Mr Packman 'passing fresh blood PR'. A verbal message from Dr Reasley was received to stop Clexane at that time [p62]. Use of Clexane (low molecular weight heparin) was reasonable in view of Mr Packman's immobility to prevent deep vein thrombosis and pulmonary embolism. With signs of bleeding stopping heparin would be initial management. Mr Packman also complained of vomiting and was given metaclopramide 'with good effect' [p62].

Fresh blood PR is *usually* a sign of *lower* bowel GI bleeding. The commonest cause is haemorrhoids. Under normal circumstances a *non-urgent* sigmoidoscopy examination would be

desirable to confirm this and exclude bowel cancer. This could entirely reasonably be performed as an out-patient following hospital discharge. However, in brisk significant *upper* GI bleeding there is no time for the blood to be digested from stomach to rectum and produce the characteristic black and offensive smelling melena. It is therefore observed as 'passing fresh (bright red blood) PR'. This latter possibility is most likely to have occurred in Mr Packman's case because:

- He vomited [p62]-usually associated with upper GI bleeding.
- Was 'unwell' at lunchtime [p62] and Dr Barton was called. Haemorrhoidal bleeding *rarely* makes the patient unwell but significant upper GI bleeding *invariably* does.
- Experienced a further deterioration in the afternoon complaining of 'indigestion'[p62]. A symptom suggestive of upper GI pathology.
- Clearly was more unwell and so Mrs packman was called in [p62]
- A lab report dated the same day as Mr Packman became unwell (26/8/99) showed an Hb of 7.7 [p205] Yet a result from 2 days earlier (24/8/99) showed an Hb of 12.0 [p207] He had therefore lost at least 4 units of blood in that time. Both lab reports are monogrammed by NAB. There is however no documentation in terms of action taken.
- During these 2 dates the platelet count had *fallen* from 309 to 257. The *fall* in platelet count observed as evidence of bleeding superficially *contradicts* previous comments about bleeding being associated with a *rise* in platelet count. However, while in *slow* bleeding there is an opportunity for the bone marrow to try and correct the loss of platelets needed for coagulation by producing more and tending to cause a rise above normal levels, in *uncontrollable* haemorrhage there is no time for the bone marrow to respond. The net result is that platelets are consumed by the body's attempts to arrest haemorrhage faster than they can be produced by the bone marrow and the platelet count falls as a consequence. This may have occurred in Mr Packman's case.

At around this time a verbal order was received to give 10mg diamorphine from Dr Barton [p62]

On the same date (26-8-05) an assessment in the medical notes by 'NAB' states Mr Packman 'clammy and unwell'. A differential of MI (myocardial infarct) or GI bleed was put forward [p55]. It was stated that he was 'not well enough to transfer' and so diamorphine was commenced [p55]. No attempt is apparently made to ascertain why Mr Packman had become so acutely unwell. There are no clinical observations either in terms of direct questioning of the patient or of examination findings being recorded. 'Simple' treatment for an MI would be aspirin by mouth. Diamorphine would be appropriate if the patient was experiencing severe chest pain, and is standard practice, but typically as a single dose. There is no record of Mr Packman complaining of chest pain at this time and we know that in general terms he did not have severe, opiate requiring, pain (see above). No ecg was performed to look at the possibility of an MI further. Poor copy quality ecgs are in the record on p183,185,186,187 and 188; These appear normal and are undated. The top right corner marks them as 'AandE.' It is likely therefore that they were performed in AandE at admission rather than at this time.

The alternative diagnosis considered was 'GI bleed' [p55]. On the evidence available this appears more likely than MI. It was also considered more likely by the assessing doctor as the clinical details stated on the laboratory request form of 26/8/99 were 'bleeding pr.' This report was monogrammed by NAB [p205].

No documentation in terms of attempting to examine for signs of bleeding or to offer any form of resuscitation is available. '*Resuscitation*' means supporting the patient with intravenous fluids, oxygen and other measures to stabilize a clinical situation. On none of the drug charts reviewed are intravenous 'fluids' that might be used in resuscitation prescribed. 'DNR' or '*Do not resuscitate*' orders refer specifically to not commencing cardiopulmonary resuscitation if the heart stops. Mr

packman was in this 'DNR' category reasonably (high chance of technical futility) [p46] but not in a group in whom no resuscitation is attempted if they simply becomes *unwell.*

Question 2 and 3

What treatment should have been considered in Mr Packman's case? Should non-invasive exploration have been considered by doctors whilst Mr Packman was a patient at Haslar Hospital?

Opinion : Transfer for endoscopic therapy should have been considered in Mr Packman's case when the possibility of a GI bleed was first seriously considered when he deteriorated (26-8-99,[p55]). Endoscopy can only occur after resuscitative measures have been taken such as intravenous fluids, oxygen etc. Endoscopic therapy allows accurate diagnosis of the site and cause of bleeding. It also allows further procedures to try and stop the bleeding and is 'bread and butter' emergency gastroenterology available in any endoscopic unit. In the majority of patients the procedure can be performed on an 'early elective basis (ideally the morning after admission [or event])' This British Society of Gastroenterology (BSG) guideline is followed in our unit and will be followed closely by other UK centres as it is from the National Body [see references]

The critical determinant would be how fit Mr Packman was after resuscitative measures for the ambulance transfer to endoscopy.

Question 4

Was Mr Packman morbidly obese? If so was he unfit therefore for surgery?

Mr Packman was obese and it is stated throughout his record. The definition of 'morbidly obese' depends on knowing height and weight to calculate Body Mass Index (BMI). This information is not however available in this record. The balance of evidence is that he was obese and likely to meet the BMI definition of 'morbidly obese' if calculated.

Mr Packman would represent a high risk for surgery. It would be difficult to justify the potential mortality of *elective* surgery in a morbidly obese patient. However each situation is judged on its merits. A failure of endoscopic therapy to stop bleeding is an indication for emergency surgery. In these situations it has to be put to the patient and family that death during or soon after surgery is a high probability but it is essential to proceed with this high-risk option as the only possible way to save life. Rarely, limits are 'pre-set' if the patient is seriously unwell such as 'for endoscopic therapy only' or 'limit to 10 unit transfusion.' These are however technical discussions between endoscopist, surgeon and anaesthetist.

9. LITERATURE/REFERENCES

British Society of Gastroenterology (BSG) Endoscopy Committee: Management of non-variceal upper gastrointestinal haemorrhage: guidelines Published in Gut October 2002 supplement no iv vol 51

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: Code A Date: 26/4/05

RESTRICTED

Statement number: S329J

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: BLACK

Forenames: DAVID ANDREW

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Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

SUMMARY OF CONCLUSIONS

Mr Geoffrey PACKMAN was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

There are a number of weaknesses in the clinical care provided to Mr PACKMAN:

- gastro-intestinal haemorrhage is suspected in Portsmouth, but although never disproven he is continued on his anticoagulant.
- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.
- on assessment on 25th August a further bleed does not lead to medical attention.
- on 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.
- a difficult clinical decision is made without appropriate involvement of senior medical opinion.
- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.
- a higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is my opinion that Mr PACKMAN died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

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

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

2.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions

on the part of individuals or groups.

3. CURRICULUM VITAE

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

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

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

360 Degree Appraisal. Chairman National Conference. Nottingham June 2004

Maintaining Professional Performance. BAMM Annual Summer School. June 2004

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

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

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

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

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

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Geoffrey PACKMAN (BJC/34)

[2] Operation Rochester Briefing Document Criminal Investigation Summary.

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

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

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

5. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence).

5.1 Geoffrey PACKMAN a sixty eight year old gentleman in 1999 was admitted as an emergency on the 6th August 1999 to Portsmouth Hospitals NHS Trust following an attendance at A&E (40,42).

5.2 Mr PACKMAN had suffered from gross (morbid) obesity for many years, he had also had venous leg ulceration for at least five years (44), he was hypertensive and had a raised prostatic specific antigen, suggesting prostatic pathology. (8)

5.3 Following a fall at home he was completely immobile on the floor and two ambulance crews were needed to bring him to accident and emergency (42). He was currently receiving District Nursing three times a week for leg ulcer management(255). He had become increasingly immobile complicated by the fact that his wife who lived with him and provided care was being investigated for Sensitive. The admission clerking showed that he not only had leg ulcers but he had marked cellulitis, was pyrexial and in atrial fibrillation. Cellulitis was both in his groin and the left lower limb (45). He was totally dependent needing all help (143) with a Barthel of 0 (163). His white cell count was significantly raised at 25.7 (48), his liver function tests were abnormal with an AST of 196 and his renal function was impaired with a urea of 14.9 and a creatinine of 173 (47). These had all been normal earlier in the year. He was treated with intravenous antibiotics (45) in a special bed (187).

5.4 He appeared to make some progress and on 9th August his cellulitis was settling (48) . A Haemolytic Streptococcus sensitive to the penicillin he had been prescribed was identified (225). On 11th August the nursing cardex (134) stated that there appeared to have been a deterioration of his heel ulcers with a "large necrotic blister on the left heel". His haemoglobin on 12th August (211) was 13.5.

5.5 On 13th August white count was improved at 12.4 (50,52), his U's and E's were normal and the notes recorded a planned transfer to the Gosport War Memorial Hospital on 16th August.

5.6 Later on the 13th black bowel motion is noted but the doctor who examines him records a

brown stool only. It is not clear whether he has had a gastro intestinal bleed (52). On 16th August no comment is made on the possible gastrointestinal (G.I) bleed , but on 20th August his haemoglobin is noted to be 12.9 (53) no further black stools have been reported so he is planned for transfer on 23rd August. Albumin at this stage is now reduced at 29 (190).

5.7 On 17th August sacral sores are now noted in the nursing cardex (118) which by the 20th are now recorded as "deep and malodorous" (125).

5.8 He is transferred to the Gosport War Memorial Hospital on 23rd August (54). A reasonable history and examination is undertaken which notes that there was a history of possible melaena, the clinical examination recorded suggests that he is stable. Blood tests are requested for the next day. The drug chart (168) suggests that his weight is 148 kgs but it is not clear if this is an estimate or a measurement. He is very dependent with a Barthel of 6 and a Waterlow score of 18, putting him in high risk. His haemoglobin on 24th is 12 (207). The nursing cardex on the 24th notes the multiple complex pressure sores on both the buttocks and the sacrum (96-100).

5.9 On 25th August the nursing cardex reports that he is passing blood rectally and also vomiting (62,82).

5.10 On 26th August a doctor (Dr BARTON) is asked to see him and records that he is clammy and unwell. (55) The notes suggest that he might have had a myocardial infarction and suggests treating him with Diamorphine and Oramorphine overnight. It records that as an alternative there might be a G.I. bleed but this is recorded as unlikely because he has not had haematemesis. It also notes that he is not well enough to transfer to an acute unit and he should be kept comfortable, including "I am happy for the nursing staff to confirm death". His Clexane (an anticoagulant given to prevent pulmonary embolus) is now stopped. The nursing cardex (62) on the same day records further deterioration throughout the day with pain in his throat and records a verbal request for Diamorphine. A full blood count is taken (this fact is not recorded in the notes) but the result is filed in the notes recording a haemoglobin markedly reduced at 7.7 (205). It also states "many attempts were made to phone Gosport War Memorial Hospital but no response from switchboard". These significant results are not commented on at any stage in the nursing or clinical notes.

5.11 On 27th August (63) the nursing notes record some improvement in the morning but discomfort in the afternoon especially with dressings. On 28th August both the medical (55) and the nursing records (63) are noted to be very poorly with no appetite. Opiates are to continue over the weekend. 29th August he is sleeping for long periods (63) and on 30th he is still in a very poor clinical condition but eating very small amounts of diet. He is re-catheterised the same day (55).

5.12 On 31st he is recorded as passing a large amount of blood rectally (83) and on the 9th September (55 and 64) he is reviewed by a consultant Dr REID who notes that he is continuing to pass melaena stool, there are pressure sores across the buttocks and posterior aspects of both thighs, he is now significantly confused. Dr REID records that he should be for TLC only and that his wife is now aware of the poor prognosis. Nursing notes (64) note that the dose of drugs in the syringe driver should be increased; the previous doses were not controlling his symptoms. The nursing notes of the 2nd September (62) record the fact the Diamorphine is again increased on the 2nd to 90mgs and on 3rd September he dies at 13.50 in the afternoon (55, 64).

5.13 Drug Chart review: There are two drug charts. Chart 1 (174-178) confirms his original admission to Portsmouth Hospital Trust in particular the appropriate use of the antibiotics, Penicillin, Flucloxacillin and the prescription of the anticoagulant Clexane. This goes from 6th August - 23rd August.

5.14 The second drug chart (168-172) goes from his admission to the Gosport War Memorial Hospital on 23rd August to his death on the 3rd September. The once only part of this drug chart on 26th August states Diamorphine IM 10 mgs verbal message given 18.00 hours. Then there is two days later on 28th August, Diamorphine IM 10 mgs signed Dr BARTON. This is never given, this may be a retrospective attempt to legitimise the prescription given verbally 2 days before.

5.15 On the 'as required' part of the drug chart only Gaviscon and Temazepam are written up. On the regular side of the drug chart Doxazosin, Frusemide, Clexane (until 25th August) Paracetamol, Magnesium, Metoclopramide and Loperamide are all written up. Though some of these drugs like the Magnesium appear to have been given in a "as required" fashion. Oramorphine though written up regularly is never given. Diamorphine 40 - 200 mgs subcut in 24

hours is prescribed and appears to have been given 40mgs on 28th, 29th and 30th 60 mgs on 1st September and 90mgs on 2nd September. The drug chart is extremely confusing (171) as these prescriptions have not been properly put in the day and date boxes required, and the nursing staff appear to be putting two days of prescribing into a single day box. Midazolam 20 - 80 mgs subcut in 24 hours is written up and Midazolam is given 20 mgs on the 28th and 29th August, 40mgs on 30th August, 60mgs on 1st September and 80mgs on 2nd September.

5.16 However, on the next regular page of the drug chart (172) Diamorphine 10-20mgs 4 hourly is written up and is signed up to Have been given for 4 doses on 27th, 28th and 29th August. I cannot tell from the drug chart whether 10mgs or 20mgs is given. It is also totally unclear whether this was given at the same time as the syringe driver, at least on the 28th and 29th August, or whether the drug chart was completely misunderstood as to how it should be used. This will need to be clarified with Dr BARTON and the nursing staff. My assumption is that Mr PACKMAN only actually received 40 mgs of Diamorphine on the 28th and 29th August and not 80mgs as might be implied. Oramorphine is written up 20mgs at night and given on 26th, 27th, 28th and 29th August. Hyoscine is written up but never given, although it is prescribed as a regular prescription.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Geoffrey PACKMAN. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Geoffrey PACKMAN, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2 Mr PACKMAN had a number of chronic diseases prior to his terminal admission. The most serious was his gross (morbid) obesity which led to severe immobility and non-healing leg ulcers.

6.3 He then develops an infection (cellulitis) of his leg ulcers which has spread to his groin causing his high white count, his pyrexia, then his total immobility requiring appropriate

admission to the Portsmouth Hospitals NHS Trust. On admission he is recognised to be at high risk of pressure sore development and appears to have been put on a special bed.

6.4 He appears to make reasonable progress from the point of view of his cellulitis and is treated with appropriate antibiotics, however is noted to have developed buttock and sacral pressure sores by 17th August which are in a serious condition by 20th August.

6.5 In the meantime, a black stool is noted on 13th August and the question of whether this is melaena (blood leaking from the upper gastro-intestinal tract which turns black when passing through the gastro-intestinal tract) and whether he has a gastric or duodenal ulcer. Normally this would be investigated with an endoscopy. However this would be quite a major procedure on such a dependent gentleman. Although in retrospect it is easy to say that this was the first bleed, it would not have been clear at the time, the lack of further melaena and the fact that haemoglobin does not significantly fall over the next week, suggests that conservative management was appropriate. However, he is not put on any prophylactic anti-ulcer medication and his anticoagulant is continued. In retrospect both of these decisions may have contributed to his subsequent problems.

6.6 He is transferred to the Gosport War Memorial Hospital on 23rd August. The prognosis for a patient with gross obesity, who is catheterised, and who has recent deep and complex pressure sores is terrible. In my experience such patients almost invariably deteriorate despite the best efforts of staff and die in hospital. He is appropriately clerked on admission and indeed appropriate investigations carried out including haemoglobin which is now 12. Although by itself this is a normal haemoglobin his level of haemoglobin has very slowly drifted down and again in retrospect suggests that he was starting to bleed slowly.

6.7 On 25th August the nursing staff note that he is passing blood rectally and he is vomiting, although the medical staff do not appear to have been asked to seem him. However on the 26th August he is seen when he is unwell, very cold and clammy. Dr BARTON suggests the likeliest diagnosis is a myocardial infarction, although appropriately she does think of a gastro-intestinal bleed. No examination is recorded in the notes, nor are some simple and appropriate investigations undertaken (for example an ECG), to try and differentiate these two problems. However a blood count is sent to the laboratory and haemoglobin has now fallen to 7.7. Mr

PACKMAN has had a massive gastro-intestinal bleed, this is now a re-bleed and in itself would be a marker of significant risk of death. Proven re-bleed needing more than 4 units of blood would in a previously fit patient over 65 be an indication for an emergency operation. However as the laboratory cannot inform the hospital of this result, no-one would appear to have brought it to medical or nursing attention.

6.8 Despite this there is an important decision to be made on the 26th August. Whatever the cause, Dr BARTON identifies that the patient is seriously ill and the acute problems whether a G.I. bleed or a myocardial infarction would not be appropriately managed in a community hospital. Dr BARTON makes the decision that the patient is too ill for transfer and should be managed symptomatically only at Gosport. In my view this is a complex and serious decision that should be discussed with the consultant in charge of the case as well as with the patient and their family if possible. I can find no evidence of such a discussion in the notes. It is my view however, that in view of his other problems it is within boundaries of a reasonable clinical decision to provide symptomatic care only at this stage. The chances of surviving any level of treatment, including intensive care unit and surgery were very small indeed.

6.9 Mr PACKMAN deteriorates further in the evening and is prescribed a single dose of Diamorphine as a result of a verbal request. In paragraphs 5.13 - 5.16 I have identified significant failings in the way the drug chart has been used and written up. Controlled drugs are given on at least one occasion based on a verbal request and the prescription apparently written 2 days later. Regular drugs are written up and never given. There may or may not be confusion over the prescribing of Diamorphine on a regular basis particularly on the 28th and 29th August and the drug chart is used in a most irregular fashion over that period of time. I do not believe that the standards of medical prescribing or nursing delivery meet the expectations of regulations on the prescription in the use of controlled drugs.

6.10 From the 26th August Mr PACKMAN is dying and after a single dose of Diamorphine on the 26th August, receives regular Diamorphine and Midazolam until his death. Diamorphine while specifically prescribed for pain is commonly used to manage the stress and restlessness of terminal illness. Diamorphine is compatible with Midazolam and in itself is particularly used to terminal restlessness, and can be mixed in the same syringe driver. It is very difficult to assess the starting dose of Diamorphine. This would be complicated in this case by the massive obesity

which might well effect the absorption of the Diamorphine from subcutaneous injection, together with his serious pressure sores which would be extremely painful on being dressed. He appears to have been started on 40mgs of Diamorphine in 24 hours with 20mgs of Oramorphine (equivalent to another 10mgs of Diamorphine) at night together with 20mgs of Midazolam. In my view this is a higher dose than most clinicians would start with which would be more likely to be 10-20 mgs in the first 24 hours. However I can find no evidence that there was any significant side effects from the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes.

6.11 He is reviewed by a consultant (Dr REID) on 1st September where it has now become absolutely clear that it is a gastro-intestinal haemorrhage which is causing his death on top of his other problems. Dr REID is happy with the management and later in the day the Diamorphine is increased because the previous dose is no longer controlling his symptoms. Further increase of 50% in dosage occurs on 2nd September and he dies the following day.

6.12 In my view, based on the evidence in the notes the doses of Diamorphine used although higher than might have been conventional at the start, were required to control Mr PACKMAN's symptoms and did not contribute in any significant fashion to his death.

6.13 In my view a death certificate should read:

1a Gastro-intestinal haemorrhage

2 Pressure sores and morbid obesity

7. OPINION

7.1 Mr Geoffrey PACKMAN was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

7.2 There are a number of weaknesses in the clinical care provided to Mr PACKMAN:

- gastro-intestinal haemorrhage is suspected in Portsmouth but although never disproven, he is continued on his anticoagulant.
- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.
- on assessment on 25th August a further bleed does not lead to further medical attention.
- on 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.
- a difficult clinical decision is made without appropriate involvement, of senior medical opinion.
- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.
- a higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is my opinion that Mr PACKMAN died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129
6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.

9. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and

complete professional opinion.

Signed: D A BLACK

Signature witnessed by:

RESTRICTED

Statement number: S329S

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: BLACK

Forenames: DAVID ANDREW

Age: 49 Date of Birth: Code A

Address: Code A Postcode: Code A

Occupation: CONSULTANT PHYSICIAN GERIATRIC MEDICINE

Telephone No.: Code A

Statement Date: 17/01/2006

Appearance Code: Height: Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of Dr Jane BARTON re Geoffrey PACKMAN . In particular, it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This report is based on the following document:

2.1 Job Description for Clinical Assistant Post to the Geriatric Division in Gosport as provided to me by the Hampshire Constabulary (February 2005).

2.2 Statement of Dr Jane BARTON re Geoffrey PACKMAN as provided to me by Hampshire Constabulary (January 2006). Appendix 1

2.3 Statement of Dr Jane BARTON as provided to me by Hampshire Constabulary (February 2005). Appendix 2

2.4 Report regarding Geoffrey PACKMAN (BJC/ 34) Professor D BLACK 2005.

3. COMMENTS

3.1 Comments on Job Description (2.1)

3.1.1 This confirms the Clinical Assistant is responsible for a maximum of 46 patients and confirms that all patients are under the care of a named Consultant Physician who would take overall responsibility for their medical management. A Clinical Assistant should take part in the weekly consultant ward rounds.

3.1.2 A specific responsibility is the writing up of the original case notes and ensuring the follow up notes are kept up to date and reviewed regularly.

3.1.3 The post is for five sessions a week i.e. is half what a full time doctor would commit to the post. However, the time to be spent in the unit is not specified as the time is allowed to be "worked flexibly".

3.1.4 There appears to be some confusion between the statements in the job summary, that "patients are slow stream or slow stream for rehabilitation but holiday relief and shared care patients are admitted" and the statement in the previous sentence "to provide 24 hour medical care to the long stay patients in Gosport". The job description appears to be confusing patients for rehabilitation with long stay patients.

3.1.5 There is no comment on the medical cover to be provided when the post holder is unavailable for out of hours or longer period of leave such as holidays. Lack of explicit cover might explain some gaps in the notes.

3.2 Report on the statement of Dr Jane BARTON re Geoffrey PACKMAN (2.2).

3.2.1. Paragraphs 28 and 29 of Dr BARTON's statement clarify some of the drug prescribing difficulties set out in my report. I now agree that Oramorphine 10-20mg 4 hourly is prescribed on the 26 to the 29th of August not Diamorphine . Also it does not appear that s/c Diamorphine was given at the same time as I postulated was possible in paragraph 5.15. However it is still not possible for me to tell from the notes if the nursing staff gave 10mg or 20mg of the Oramorphine thus a total daily dose of 60mg up to 100mg is possible. Thus the statements of 60 mg in paragraphs 30 and 35 of Dr BARTON's report are unproven. I agree that Diamorpnine s/c 40 mg was given from the 30th of August and this was an appropriate dose.

3.2.2 In view of the above paragraph 6.9 should say Oramorphine on a regular basis, not Diamorphine.

3.3.3 Paragraph 6.10 should say "... after single dose of Diamorphine on the 26th he receives regular Oramorphine, then Diamorphine and Midazolam until his death."
The same paragraph should also say : "He appears to have been started on between 60 and (possibly)100mg of Oramorphine in 24 hours, subsequently (on the 30th) converted to 40mg of Diamorphine together with 20 mg of Midazolam. In my view this is a higher dose than most clinicians would start with, which would be 20-40mg of Oramorphine in the first 24 hours. However I can find no evidence that there was any significant side effects from the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes."

3.3.4 Paragraph 7.2 should say Oramorphine not Diamorphine.

3.2.5 These alterations do not effect the overall conclusions in my report.

3.3 Report on the Statement of Dr Jane BARTON as provided to me by the Hampshire Constabulary (2.3):

3.3.1Page 1 paragraph 3: States that she works eight general practice surgery sessions. It is my understanding that most full time General Practitioners work eight or nine sessions. This suggests to me that she is undertaking a full time General Practitioner job and a half time community hospital job. Despite the fact the job description says that the job can be worked flexibly, an opinion should be obtained from an experienced General Practitioner as to whether this workload is actually deliverable within a reasonable working week.

3.3.2 Page 1 paragraph 4: The job description states 46 beds, Dr BARTON states 48 beds. The CHI report says 44 beds (20 on Dryad and 24 on Daedalus) Dr BARTON uses the phrase "continuing care for long stay elderly patients". The job description also referred to slow stream or slow stream rehabilitation as well as holiday relief and shared care patients. There may have been confusion between staff in terms of the objectives of individual patient management.

3.3.3 Page 1 paragraph 5: This statement is incorrect as the post of Clinical Assistant is not a training post but a service post in the NHS. The only medical training grade posts are pre-registration house officers, senior house officers, specialist registrars and GP registrars.

3.3.4 Page 1 paragraph 5: States that she and her partners had decided to allocate come of the sessions to "out of hours aspects of the post". This would appear to be a local arrangement of the contractual responsibilities: it needs to be clarified if this was agreed with the Portsmouth and South East Hampshire Health Authority. This would influence how much time was expected to be provided for the patients and influence the pressure on Dr BARTON to deliver the aspects of care provided.

3.3.5 Page 2 paragraph 3: This does confirm that there were consultants responsible for all the patients under the care of Dr. BARTON. Thus a consultant should always have been available for discussing complex or difficult management decisions. However,(page 3 paragraph 1) , in my view it would be completely unacceptable of the Trust to have left Dr BARTON with continuing medical responsibilities for the inpatients of Gosport Hospital without consultant supervision and regular

ward rounds. This would be a serious failure of responsibility by the Trust in its governance of patients and in particular failings and in my view the Trust would need to take part of the responsibility for any clinical failings.

3.3.6 Page 3 paragraph 3: This again suggests that Dr BARTON was trying to provide her half time responsibilities by fitting the work around her full time responsibilities as a General Practitioner. She suggests 5 patients were admitted each week, implying approximately 250 admissions and discharges a year. With a bed occupancy around 80%ealth Authority, this would suggest an average length of stay of 5 - 6 weeks. However, CHI state the actual figures were somewhat less, 1997/98 were 169 FCE's for Dryad and Daedalus and 197 FCE's in 1998/99. A new patient assessment including history and examination, writing up the notes, drug charts, talking to the nurses, talking to any relatives present and undertaking blood tests if these had to be taken by a doctor rather than any other staff, would take a maximum of 60 minutes.

Page 5 paragraph 2: The patients who were genuinely long stay or continuing care do not need to be reviewed medically every day, nor would a medical record be made daily. Indeed with average length of stay of six or more weeks, it is clear that many patients were genuinely long-stay patients and one would expect them to be medically reviewed no more than once a week and any medical comments to be no more than once a week. However, whenever patients' physical or mental state has changed and they are reviewed by a doctor, it would be normal practice to always make a comment in the notes. Patients who are in rehabilitation and making a good progress, then review and comments in the notes once or twice a week would also be the norm.

It is my view that with less than 200 FCE's and a total of 44 inpatients, then this should be satisfactorily managed by somebody working half time as a Clinical Assistant with regular consultant supervision.

3.3.7 Page 4 paragraph 2: This suggests that Dr BARTON is stating that she takes personal responsibility for most changes in medication, rather than it being a nursing decision.

3.3.8 Page 9 paragraph 2: An individual doctor must take responsibility for their prescribing however I would agree that consultants should also take responsibility for ensuring patients under their care were having appropriate medical management. It does appear that there was a consultant

responsible for all patients in both Dryad and Daedalus Ward.

4. Conclusions

4.1 Having read all the documents provided by Hampshire Constabulary, I would wish to make a few change to my expert report.

4.2 Paragraph 6.9 should say Oramorphine on a regular basis, not Diamorphine

4.3 Paragraph 6.10 should say "... after single dose of Diamorphine on the 26th he receives regular Oramorphine, then Diamorphine and Midazolam until his death." The same paragraph should also say : "He appears to have been started on between 60 and (possibly)100mg of Oramorphine in 24 hours, subsequently (on the 30th) converted to 40mg of Diamorphine together with 20 mg of Midazolam. In my view this is a higher dose than most clinicians would start with, which would be 20-40mg of Oramorphine in the first 24 hours. However I can find no evidence that there was any significant side effects from the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes."

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APPENDIX 1

APPENDIX 2

RESTRICTED

DOCUMENT RECORD PRINT

Statement number: S329S

Signed: D BLACK

Signature witnessed by:

Geoffrey Packman statements 20th June 2006

CONTENTS

1. **INSTRUCTIONS**

To examine and comment upon the witness statements in the case of Geoffrey Packman. 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 Geoffrey Packman provided to me by the Hampshire Constabulary (June 2006). In total 27 statements.

2.2 Report regarding Geoffrey Packman (BJC/34) Dr D Black 30th October 2005.

3. **COMMENTS**

3.1 Comments on Witness Statement (2.1)

3.1.1 I have read all the statements in particular the statements of Nurse Hamblin and Hallman . Based on these and the previous statement of Dr Barton I feel that I need to produce a new version of my expert statement, taking into account some clarification over the drug chart.

4. **CONCLUSION**

4.1 Having read all the documents above provided by Hampshire Constabulary, I would wish to make changes to my expert report, and enclose a new version (20th June 2006).

Geoffrey Packman statements 20th June 2006

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4. CONCLUSION

4.1 Having read all the documents above provided by Hampshire Constabulary, I would wish to make changes to my expert report, and enclose a new version (20th June 2006).

Version 3 of complete report 20th June 2006 – Geoffrey Packman

SUMMARY OF CONCLUSIONS

Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

There are a number of weaknesses in the clinical care provided to Mr Packman:
- gastro-intestinal haemorrhage is suspected in Portsmouth, but although never disproven he is continued on his anticoagulant.
- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.
- on assessment on 25th August a further bleed does not lead to medical attention.
- on 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.
- a difficult clinical decision is made without appropriate involvement of senior medical opinion.
- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.

Despite all of the above it is my opinion that Mr Packman died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

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

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

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

3. CURRICULUM VITAE

Name	Professor David Andrew Black
Address	Code A
Telephone	
DOB	Code A
Place	Windsor, England.
GMC	Full registration. No: Code A
Defence Union	Medical Defence Union. No: Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

5. **CHRONOLOGY/CASE ABSTRACT.** (The numbers in brackets refer to the page of evidence).

5.1. Geoffrey Packman a sixty eight year old gentleman in 1999 was admitted as an emergency on the 6th August 1999 to Portsmouth Hospitals NHS Trust following an attendance at A&E (40,42).

5.2. Mr Packman had suffered from gross (morbid) obesity for many years, he had also had venous leg ulceration for at least five years (44), he was hypertensive and had a raised prostatic specific antigen, suggesting prostatic pathology. (8)

5.3. Following a fall at home he was completely immobile on the floor and two ambulance crews were needed to bring him to accident and emergency (42). He was currently receiving District Nursing three times a week for leg ulcer management(255). He had become increasingly immobile complicated by the fact that his wife who lived with him and provided care was being investigated Sensitive personal data The admission clerking showed that he not only had leg ulcers but he had marked cellulitis, was pyrexial and in atrial fibrillation. Cellulitis was both in his groin and the left lower limb (45). He was totally dependent needing all help (143) with a Barthel of 0 (163). His white cell count was significantly raised at 25.7 (48), his liver function tests were abnormal with an AST of 196 and his renal function was impaired with a urea of 14.9 and a creatinine of 173 (47). These had all been normal earlier in the year. He was treated with intravenous antibiotics (45) in a special bed (187).

5.4. He appeared to make some progress and on 9th August his cellulitis was settling (48) . A Haemolytic Streptococcus sensitive to the penicillin he had been prescribed was identified (225). On 11th August the nursing cardex (134) stated that there appeared to have been a deterioration of his heel ulcers with a "large necrotic blister on the left heel". His haemoglobin on 12th August (211) was 13.5.

5.5. On 13th August white count was improved at 12.4 (50,52), his U's and E's were normal and the notes recorded a planned transfer to the Gosport War Memorial Hospital on 16th August.

5.6. Later on the 13th black bowel motion is noted but the doctor who examines him records a brown stool only. It is not clear whether he has had a gastro intestinal bleed (52). On 16th August no

comment is made on the possible gastrointestinal (G.I) bleed , but on 20th August his haemoglobin is noted to be 12.9 (53) no further black stools have been reported so he is planned for transfer on 23rd August. Albumin at this stage is now reduced at 29 (190).

5.7. On 17th August sacral sores are now noted in the nursing cardex (118) which by the 20th are now recorded as "deep and malodorous" (125).

5.8. He is transferred to the Gosport War Memorial Hospital on 23rd August (54). A reasonable history and examination is undertaken which notes that there was a history of possible melaena, the clinical examination recorded suggests that he is stable. Blood tests are requested for the next day. The drug chart (168) suggests that his weight is 148 kgs but it is not clear if this is an estimate or a measurement. He is very dependent with a Barthel of 6 and a Waterlow score of 18, putting him in high risk. His haemoglobin on 24th is 12 (207). The nursing cardex on the 24th notes the multiple complex pressure sores on both the buttocks and the sacrum (96-100).

5.9. On 25th August the nursing cardex reports that he is passing blood rectally and also vomiting (62,82).

5.10. On 26th August a doctor (Dr Barton) is asked to see him and records that he is clammy and unwell. (55) The notes suggest that he might have had a myocardial infarction and suggests treating him with Diamorphine and Oramorphine overnight. It records that as an alternative there might be a G.I. bleed but this is recorded as unlikely because he has not had haematemesis. It also notes that he is not well enough to transfer to an acute unit and he should be kept comfortable, including "I am happy for the nursing staff to confirm death". His Clexane (an anticoagulant given to prevent pulmonary embolus) is now stopped. The nursing cardex (62) on the same day records further deterioration throughout the day with pain in his throat and records a verbal request for Diamorphine. A full blood count is taken (this fact is not recorded in the notes) but the result is filed in the notes recording a haemoglobin markedly reduced at 7.7 (205). It also states "many attempts were made to phone Gosport War Memorial Hospital but no response from switchboard". These significant results are not commented on at any stage in the nursing or clinical notes.

5.11. On 27th August (63) the nursing notes record some improvement in the morning but discomfort in the afternoon especially with

dressings. On 28th August both the medical (55) and the nursing records (63) are noted to be very poorly with no appetite. Opiates are to continue over the weekend. 29th August he is sleeping for long periods (63) and on 30th he is still in a very poor clinical condition but eating very small amounts of diet. He is re-catheterised the same day (55).

5.12. On 31st he is recorded as passing a large amount of blood rectally (83) and on the 9th September (55 and 64) he is reviewed by a consultant Dr Reid who notes that he is continuing to pass melaena stool, there are pressure sores across the buttocks and posterior aspects of both thighs, he is now significantly confused. Dr Reid records that he should be for TLC only and that his wife is now aware of the poor prognosis. Nursing notes (64) note that the dose of drugs in the syringe driver should be increased; the previous doses were not controlling his symptoms. The nursing notes of the 2nd September (62) record the fact the Diamorphine is again increased on the 2nd to 90mgs and on 3rd September he dies at 13.50 in the afternoon (55, 64).

5.13. Drug Chart review: There are two drug charts. Chart 1 (174-178) confirms his original admission to Portsmouth Hospital Trust in particular the appropriate use of the antibiotics, Penicillin, Flucloxacillin and the prescription of the anticoagulant Clexane. This goes from 6th August – 23rd August.

5.14. The second drug chart (168-172) goes from his admission to the Gosport War Memorial Hospital on 23rd August to his death on the 3rd September. The once only part of this drug chart on 26th August states Diamorphine IM 10 mgs verbal message given 18.00 hours. Then there is two days later on 28th August, Diamorphine IM 10 mgs signed Dr Barton. This is never given, this may be a retrospective attempt to legitimise the prescription given verbally 2 days before.

5.15. On the 'as required' part of the drug chart only Gaviscon and Temazepam are written up. On the regular side of the drug chart Doxazosin, Frusemide, Clexane (until 25th August) Paracetamol, Magnesium, Metoclopramide and Loperamide are all written up. Though some of these drugs like the Magnesium appear to have been given in a "as required" fashion. Oramorphine (171) though written up regularly is never given. Diamorphine 40 – 200 mgs subcut in 24 hours is prescribed on the 26th (171) and appears to have been given as 40mgs on 30th, 31st, 1st changed to 60 mgs on 1st September and 90mgs on 2nd September. The drug chart is extremely confusing (171) as these prescriptions have not been

properly put in the day and date boxes required, and the nursing staff appear to be putting two days of prescribing into a single day box. Midazolam 20 – 80 mgs subcut in 24 hours is written up and Midazolam is probably given 20 mgs on the 30th and 31st August, 40mgs on 1st September, changed to 60mgs on 1st September and given 80mgs on 2nd September.

5.16. On the next regular page of the drug chart (172) Oramorphine 10-20mgs 4 hourly is written up and is signed up to have been given for 4 doses daily on 27th, 28th and 29th August, with two further doses in the morning of the 30th August. I cannot tell from the drug chart whether 10mgs or 20mgs is given. Oramorphine is written up 20mgs at night and given on 26th, 27th, 28th and 29th August. Hyoscine is written up but never given, although it is prescribed as a regular prescription.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1. This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Geoffrey Packman. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Geoffrey Packman, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2. Mr Packman had a number of chronic diseases prior to his terminal admission. The most serious was his gross (morbid) obesity which led to severe immobility and non-healing leg ulcers.

6.3. He then develops an infection (cellulitis) of his leg ulcers which has spread to his groin causing his high white count, his pyrexia, then his total immobility requiring appropriate admission to the Portsmouth Hospitals NHS Trust. On admission he is recognised to be at high risk of pressure sore development and appears to have been put on a special bed.

6.4. He appears to make reasonable progress from the point of view of his cellulitis and is treated with appropriate antibiotics, however is noted to have developed buttock and sacral pressure sores by 17th August which are in a serious condition by 20th August.

6.5. In the meantime, a black stool is noted on 13th August and the question of whether this is melaena (blood leaking from the upper gastro-intestinal tract which turns black when passing through the

gastro-intestinal tract) and whether he has a gastric or duodenal ulcer. Normally this would be investigated with an endoscopy. However this would be quite a major procedure on such a dependent gentleman. Although in retrospect it is easy to say that this was the first bleed, it would not have been clear at the time, the lack of further melaena and the fact that haemoglobin does not significantly fall over the next week, suggests that conservative management was appropriate. However, he is not put on any prophylactic anti-ulcer medication and his anticoagulant is continued. In retrospect both of these decisions may have contributed to his subsequent problems.

6.6. He is transferred to the Gosport War Memorial Hospital on 23rd August. The prognosis for a patient with gross obesity, who is catheterised, and who has recent deep and complex pressure sores is terrible. In my experience such patients almost invariably deteriorate despite the best efforts of staff and die in hospital. He is appropriately clerked on admission and indeed appropriate investigations carried out including haemoglobin which is now 12. Although by itself this is a normal haemoglobin his level of haemoglobin has very slowly drifted down and again in retrospect suggests that he was starting to bleed slowly.

6.7. On 25th August the nursing staff note that he is passing blood rectally and he is vomiting, although the medical staff do not appear to have been asked to seem him. However on the 26th August he is seen when he is unwell, very cold and clammy. Dr Barton suggests the likeliest diagnosis is a myocardial infarction, although appropriately she does think of a gastro-intestinal bleed. No examination is recorded in the notes, nor are some simple and appropriate investigations undertaken (for example an ECG), to try and differentiate these two problems. However a blood count is sent to the laboratory and haemoglobin has now fallen to 7.7. Mr Packman has had a massive gastro-intestinal bleed, this is now a re-bleed and in itself would be a marker of significant risk of death. Proven re-bleed needing more than 4 units of blood would in a previously fit patient over 65 be an indication for an emergency operation. However as the laboratory cannot inform the hospital of this result, no-one would appear to have brought it to medical or nursing attention.

6.8. Despite this there is an important decision to be made on the 26th August. Whatever the cause, Dr Barton identifies that the patient is seriously ill and the acute problems whether a G.I. bleed or a myocardial infarction would not be appropriately managed in a community hospital. Dr Barton makes the decision that the

patient is too ill for transfer and should be managed symptomatically only at Gosport. In my view this is a complex and serious decision that should be discussed with the consultant in charge of the case as well as with the patient and their family if possible. I can find no evidence of such a discussion in the notes. It is my view however, that in view of his other problems it is within boundaries of a reasonable clinical decision to provide symptomatic care only at this stage. The chances of surviving any level of treatment, including intensive care unit and surgery were very small indeed.

6.9. Mr Packman deteriorates further in the evening and is prescribed a single dose of Diamorphine as a result of a verbal request. In paragraphs 5.13 – 5.16 I have identified significant failings in the way the drug chart has been used and written up. Controlled drugs are given on at least one occasion based on a verbal request and the prescription apparently written 2 days later. Regular drugs are written up and never given. The drug chart is used in a most irregular fashion and I do not believe that the standards of medical prescribing or nursing delivery meet the expectations of regulations on the prescription in the use of controlled drugs.

6.10. From the 26th August Mr Packman is dying and after a single dose of Diamorphine on the 26th August, receives regular Oramorphine, then Diamorphine, and Midazolam until his death. Both Oramorphine and Diamorphine while specifically prescribed for pain are commonly used to manage the stress and restlessness of terminal illness. Diamorphine is compatible with Midazolam and in itself is particularly used to terminal restlessness, and can be mixed in the same syringe driver. It is very difficult to assess the starting dose of Oramorphine and he appears to receive 60mg in total on the 26th. Calculating the dose would be complicated in this case due to his the massive obesity which might well effect the oral dose required , together with his serious pressure sores which would be extremely painful on being dressed. He appears subsequently to have been started on 40mgs of Diamorphine in 24 hours with 20mgs of Oramorphine (equivalent to another 10mgs of Diamorphine) at night, together with 20mgs of Midazolam. The dose of s/c Diamorphine is usually given in a ratio of 1:2, so 20mg might have been the equivalent of the day time dose of 40mg of Oramorphine. However I can find no evidence in the notes that there were any significant side effects from the Oramorphine or the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes.

6.11. He is reviewed by a consultant (Dr Reid) on 1st September where it has now become absolutely clear that it is a gastro-intestinal haemorrhage which is causing his death on top of his other problems. Dr Reid is happy with the management and later in the day the Diamorphine is increased because the previous dose is no longer controlling his symptoms. Further increase of 50% in dosage occurs on 2nd September and he dies the following day.

6.12. In my view, based on the evidence in the notes, the doses of Oramorphine and Diamorphine used although higher than might have been conventional at the start, were required to control Mr Packman's symptoms and did not contribute in any significant fashion to his death.

6.13. In my view a death certificate should read:
1a Gastro-intestinal haemorrhage
2 Pressure sores and morbid obesity

7. OPINION

7.1. Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

7.2. There are a number of weaknesses in the clinical care provided to Mr Packman:
- gastro-intestinal haemorrhage is suspected in Portsmouth but although never disproven, he is continued on his anticoagulant.
- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.
- on assessment on 25th August a further bleed does not lead to further medical attention.
- on 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.
- a difficult clinical decision is made without appropriate involvement, of senior medical opinion.
- prescribing management and use of drug charts by both the nursing

and clinical staff, in particular for controlled drugs, is unacceptably poor.

Despite all of the above it is my opinion that Mr Packman died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129
6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.

9. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.

8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature:_____ Date: _____

DRAFT REPORT

regarding

GEOFFREY PACKMAN (BJC/34)

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

Mr Packman was a 67 year old man with obesity impairing his mobility, swelling of his legs and leg ulcers admitted to the Queen Alexander Hospital because of cellulitis (infection of the skin) affecting his left leg and groins. He also had pressure sores over his buttocks and thighs. He improved with treatment with antibiotics. He passed loose black stools, suggestive of melaena (blood in the stool) on a couple of occasions, but his haemoglobin was stable, excluding a significant gastrointestinal bleed. He was transferred to Dryad Ward for rehabilitation.

During his admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal; there was a lack of clear, accurate and contemporaneous patient records, inadequate assessment of Mr Packman's condition; a lack of consultation with colleagues and the use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs.

Mr Packman became acutely unwell on the 26th August 1999. A blood test revealed a large drop in his haemoglobin which made a significant gastrointestinal bleed likely. This is a serious and life-threatening medical emergency which requires urgent and appropriate medical care. The commonest underlying cause, a peptic ulcer, can however, be cured. Mr Packman should have been transferred without delay to the acute hospital. However, Mr Packman was not transferred; the blood test result was not obtained or acted upon and he went on to receive doses of diamorphine and midazolam which were not obviously justified and likely to have been excessive to his needs.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mr Packman by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Packman by failing to adequately assess his condition and taking suitable and prompt action when he became unwell with a gastrointestinal bleed. He was not appropriately assessed, resuscitated with fluids, transferred or discussed with the on-call medical team. The use of regular morphine and subsequent use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs were inappropriate. It is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

2. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his 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 his 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 City Hospital 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 Robert Twycross. 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 20,000 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 Geoffrey Packman, including the medical certificate of cause of death.

[2] Operation Rochester Briefing Document Criminal Investigation Summary.

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

[4] Hampshire Constabulary Summary of Care of Geoffrey Packman.

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

[6] 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).

[7] General Medical Council, Good Medical Practice (July 1998).

[8] British National Formulary (BNF). Section on Prescribing in Terminal Care (March 1999).

[9] British National Formulary (BNF). Section on Prescribing in the Elderly (March 1999).

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

[11] Statement of Dr Jane Barton RE: Geoffrey Packman, 17th November 2005.

[12] Draft Report regarding Statement of Dr Jane Barton RE: Geoffrey Packman (BJC/34), Dr A Wilcock, 26th January 2006.

[13] Draft overview of Geoffrey Packman (BJC/34), Dr A Wilcock, 5th November 2005.

[14] Draft report regarding Geoffrey Packman, Dr Jonathan Marshall, 1st April 2005.

6. CHRONOLOGY/CASE ABSTRACT

Events at Queen Alexander Hospital, 6th–23rd August 1999

Mr Packman, a 67 year old man who lived with his wife and daughter, was admitted on the 6th August 1999 to Queen Alexander Hospital following a fall at home. Due to his obesity he was unable to get up and two ambulance crews were called to assist (page 42 of 283). He was initially seen in Accident and Emergency and then Anne Ward where he was clerked by the Senior House Officer (SHO) who noted his five year history of lower leg oedema (swelling) that had got worse over the past six months; bilateral leg ulcers for one month; increasing erythema (redness) of the groin for three weeks which had become uncomfortable; increasing weakness and difficulty mobilising for one week (page 44 of 283). Mr Packman's past medical history included hypertension (high blood pressure) since 1985 and arthritis (unspecified). He was receiving doxazosin 4mg once a day, felodipine mr 5mg once a day and bendrofluazide 5mg once a day, possibly all for his hypertension, although the latter (a diuretic, 'water tablet') is also given for oedema. Systemic enquiry revealed a poor urinary stream, constipation for one week and no problems with chest pain or shortness of breath. Mr Packman's wife was undergoing tests for possible Sensitive personal data Sensitive personal data He was a non-smoker. District nurses visited three times a week to apply dressings to his legs and normally he was able to mobilise around the house and occasionally outside with the use of a stick (page 44 of 283). On examination he was obese, had an elevated temperature (37.6°C), an irregular heart rate of 80 beats per minute, fine crackles in the mid zones of his chest bilaterally, a soft, non-tender abdomen and erythema of both

groins particularly on the left which leaked clear fluid. Both legs were swollen particularly the left which was also erythematous. There was bruising on his buttocks in the shape of a toilet seat. The SHO summarised Mr Packman's main problems as leg oedema, cellulitis (infection in the subcutaneous tissues of the skin) in the groin and left lower leg, immobility due to his obesity/oedema/infection and atrial fibrillation (irregular heart rhythm) (page 45 of 283). Investigations were undertaken (blood tests, blood cultures, urine analysis, chest x-ray, electrocardiograph (ECG), swabs from his groin and leg ulcers) and treatment commenced with intravenous antibiotics to treat the infection, and his dose of diuretics increased by switching the bendrofluazide to furosemide 80mg once a day (pages 45 and 174a of 283). The results of the investigations were in keeping with cellulitis: a raised white cell count of $25.7x10^9$/L, 90% neutrophils (page 213 of 283); a C-reactive protein (CRP) of 191mg/L, (normal range <5mg/L; page 202 of 283); haemolytic streptococcus, a bacteria known to cause cellulitis, grown from the sores in his groin and buttocks (pages 227 and 229 of 283) and an elevated aspartate aminotransferase at 194IU/L (normal 12–40IU/L; page 202 of 283). There was also renal impairment; urea and creatinine were elevated 14.9mmol/L (normal 3–7.6mmol/L) and 173micromol/L (normal 60–120micromol/L; page 202 of 283) respectively. Other results revealed a marginally low albumin (a protein) at 36g/L (normal range 37–50g/L), a normal haemoglobin (15.7g/dl; page 213 of 283) and negative blood and urine cultures (pages 221 and 231 of 283). An ECG was reported as showing atrial fibrillation, a common arrhythmia which causes the heart to beat irregularly, but at a satisfactory

rate of 85 beats per minute (pages 45 and 185 of 283). Mr Packman was catheterised because of urinary incontinence (page 144 of 283).

Mr Packman was reviewed later the same day by a more senior doctor (a registrar) who listed Mr Packman's problems as cellulitis of the left leg, chronic leg oedema, poor mobility, morbid obesity, hypertension and possible atrial fibrillation. He agreed with the plan to treat the cellulitis with intravenous antibiotics (flucloxacillin and penicillin G) and because of Mr Packman's immobility, obesity and cellulitis, also commenced low molecular weight heparin (enoxaparin (clexane)) to thin the blood and reduce the risk of a deep vein thrombosis in the leg. The registrar also suggested a repeat ECG rhythm strip, which subsequently confirmed atrial fibrillation (pages 48 and 185 of 283; although I am unable to comment given the quality of the copy) and, as the felopdipine and doxazosin may have been exacerbating Mr Packman's oedema, to consider other drugs to treat his hypertension. Mr Packman was deemed not appropriate for cardiopulmonary resuscitation in the event of a cardiorespiratory arrest because of his 'pre-morbid state and multiple medical problems' (page 46 of 283).

The medication chart indicates that during his stay on Anne Ward, Mr Packman received the antibiotic benzylpenicillin 1.2G intravenously four times a day from 6–11th August 1999, after which it was continued as an oral equivalent, penicillin V 500mg four times a day until 18th August 1999 (pages 174a and 177 of 283). Similarly, the antibiotic flucloxacillin 1G was given intravenously four times a day from the 6–9th August 1999, after which it was continued orally as flucloxacillin 500mg four times a day until the 18th August 1999 (pages 174a and 177 of 283). The antihypertensive

doxazosin 4mg once a day was continued unchanged (page 174a of 283) but the felodipine was reduced and subsequently discontinued on the 19th August 1999 (page 174a of 283). The diuretic furosemide 80mg once a day and the heparin enoxaparin 40mg twice a day were continued throughout his stay (pages 174a, 177 and 179 of 283). Paracetamol 1G was given at 20.10h on the 6th August and 07.15h on the 7th August as once only, nurse prescribed doses, probably to reduce his temperature as there was no mention of pain (page 130 of 283); thereafter it was prescribed regularly 1G four times a day and continued throughout his stay, although intermittently doses were declined (pages 174, 174b, 177 and 179 of 283).

Gaviscon, an antacid, generally given for the relief of dyspepsia (indigestion) was prescribed p.r.n. 'as required'; three doses were taken on the 8th and one dose each on the 9–12th and 14th August 1999 (page 174 of 283).

During his stay on Anne Ward, Mr Packman improved. His temperature and cellulitis began to settle and he was switched to oral antibiotics (pages 48 and 49 of 283). Dr Reid reviewed Mr Packman on the 9th August 1999, who recorded more oedema in the left than the right foot and more arthritis in the left than the right knee and hip, although this was mild (page 48 of 283). Mr Packman's weight was recorded as 148.6kg on 12th August 1999 (page 121 of 283). On the 13th August 1999, blood test results had improved; white blood cell count and CRP had fallen and his renal function returned to normal (pages 196, 200, 211 of 283). Following discussion with Mrs Packman, because of Mr Packman's immobility, pressure sores and social

circumstances, the plan was to transfer him to Dryad Ward for rehabilitation (pages 50, 108, 121, 122 of 283).

According to his observation chart, some time on the evening of the 11th August, Mr Packman's blood pressure was measured as he was 'feeling dizzy'; it was 'normal' for him at 170/90 but his pulse was not recorded and I can find no other mention of this episode (page 159 of 283). An entry on the comments sheet on the 11th August 1999 at 13.45h reports loose black stools (suggestive of melaena, which is blood in the stool, see technical issues; page 133 of 283). Mr Packman opened his bowels several times between the 11–13th August, with no mention of melaena (pages 134 and 135 of 283). An entry made by Dr Tandy on the 13th August 1999 noted 'black stools overnight - nil today, says bowels looser than usual. No pain. Abdomen soft. Bowel sounds normal. PR (digital examination of the rectum) normal brown stool. Chase haemoglobin to rule out bleed. ?Antibiotic related diarrhoea. Stool chart' (pages 52, 53 of 283). Mr Packman's haemoglobin was checked and was essentially stable; 13.5g/dL (12th August) 12.9g/dL (19th August), 12.9g/dL (20th August), (pages 209, 211, 215 of 283).

Blood tests carried out on the 14th August 1999, revealed normal thyroid function tests, that the aspartate aminotransferase had returned to normal (40IU/L), but that his albumin had fallen to 29g/L (normal 37–50g/L; pages 196 and 198 of 283).

On the 15th August Mr Packman was incontinent of loose faeces (page 136 of 283). An entry dated 16th August 1999 noted that Mr Packman had pressure sores over his buttocks, sacrum and thighs that required daily

dressings and that he was faecally incontinent (page 51 of 283). An entry dated 18th August 1999 reported that he was stable, and that his wounds looked better, and the antibiotics were discontinued on the 19th August (page 51 of 283). A communication sheet entry on the 19th August 1999 at 06.00h noted that Mr Packman twice passed small amounts of black tarry stools (pages 119 and 137 of 283). A later entry the same day reported bowels open small amount with no mention of melaena (page 138 of 283). An entry dated 20th August 1999 notes no further black motions, no nausea, epigastric pain or tenderness (page 53 of 283). Blood test results on the 20th August revealed a stable haemoglobin at 12.9g/dL and an improved albumin at 34g/L (pages 192 and 209 of 283).

Mr Packman's Barthel score had improved from 0 to 6 representing improvements in continence of bowels, ability to undertake his own grooming (washing face, cleaning teeth etc.) feeding himself independently and being able to transfer with major help from having been unable to transfer (page 163 of 283). Nevertheless, he remained in bed, using a monkey bar to raise himself off the bed and otherwise being moved with a hoist (page 148 of 283). The sores in his groin had improved (page 149 and 150 of 283) but the sacral pressure sore persisted, with dressings needing frequent changing due either to being sodden with exudate or soiled with faeces (page 150 of 283).

Events at Dryad Ward, 23rd August 1999 until 3rd September 1999.

23rd August 1999

An entry was made in the medical notes on 23rd August 1999, which I assume was done on Dryad ward, although this should be clarified (page 54 of 283). The clerking doctor noted that Mr Packman's ongoing problems were obesity, arthritis in his knees, immobility, pressure sores and constipation. They noted that Mr Packman was 'on a high protein diet, ? melaena 13th August 1999, haemoglobin stable' but was better in himself, with a good mental test score and no pain. There was little to find on examination bar his obesity, swollen legs and pressure sores (page 54 of 283).

The nursing summary notes recorded that Mr Packman had been 'transferred from Anne Ward following an episode of immobility and sacral sores. Catheterised. On profile bed, hoist only. Able to feed himself. Mrs Packman is awaiting a decision Sensitive personal at Queen Alexander Hospital tomorrow' (page 62 of 283). Several nursing care plans were produced: 'Requires full assistance to settle at night' (page 78 of 283); 'Due to immobility...prone to constipation' (page 82 of 283); 'Urinary catheter' (page 84 of 283); 'Pressure sore areas' (page 96 of 283).

The drug chart reveals he was continued on regular doxazosin 4mg once a day, furosemide 80mg once a day, enoxaparin 40mg twice a day, paracetamol 1G four times a day; commenced on magnesium hydroxide 10ml twice a day (a laxative), subsequently taken intermittently; two doses on the 24th, one dose on the 25th, two doses on the 28th, 29th and one

dose on the 30th (page 170 of 283) and p.r.n. 'as required' gaviscon (undated but most probably on the 23rd August)(pages 168, 170 of 283).

24th August 1999

A handling profile noted in the section for pain 'needs to be controlled' (page 90 of 283). This is at odds with the medical notes entry for the 23rd August 1999 that states 'no pain' (page 54 of 283). Pain is not mentioned anywhere else. His bowels were well open (no melaena specified) and swabs taken from his pressure sores for microbiology (pages 82 and 97 of 283).

Blood test results revealed a haemoglobin of 12g/dL and a white cell count of $12.2x10^9$/L (Page 207 of 283); a marginally raised urea 8.9mmol/L (normal 3.0–7.6mmol/L) and a reduced albumin 31g/L (normal 37–50g/L). Both forms were signed with the initials 'JAB' (pages 190 and 207 of 283). Note: the biochemistry results form given as page 190, differs in my two files, one having a more complete set of results for the 24th August 1999. Temazepam 10–20mg was prescribed p.r.n. and he took 10mg at 22.10h (page 168 of 283).

25th August 1999

Mr Packman was noted to have 'bowels open medium, formed, leaking some fluid' and later 'several loose bowel actions throughout the afternoon and evening - 7–8. Some fresh blood present, ? due to medication - same stopped. For review later' (pages 82 and 83 of 283). The nursing summary notes recorded that Mr Packman had been passing fresh blood PR ? due to

the enoxaparin (clexane). A verbal order from Dr Beasley was to withhold the 18.00h dose and review with Dr Barton in the morning. Mr Packman was also vomiting and metoclopramide 10mg IM was given at 17.55h (page 171 of 283).

Mr Packman took temazepam 20mg at 22.05h and loperamide 4mg (for diarrhoea) as a one off dose at a time I can not decipher (page 168 of 283). He was also prescribed loperamide 2mg four times a day regularly on the daily review prescriptions section, and appeared to have received this at 06.00h, 12.00h and 18.00h on 25th August 1999.

26th August 1999

The nursing summary notes recorded 'fairly good morning, no further vomiting - Dr Ravi contacted re enoxaparin (clexane). Advised to discontinue and repeat haemoglobin today and tomorrow. Not for resuscitation. Unwell at lunchtime, colour poor, complaining of feeling unwell. Seen by Dr Barton this afternoon - await result of haemoglobin. Further deterioration – complaining of ? indigestion – pain in throat, not radiating – vomited again this evening. Verbal order from Dr Barton diamorphine 10mg stat - same given at 18.00h. Metoclopramide 10mg given IM. Mrs Packman informed will visit this evening (page 62 of 283).

The medical notes record 'called to see, pale, clammy, unwell. Suggest ? myocardial infarction (MI). Treat stat diamorphine and oramorph overnight. Alternative possibility gastrointestinal (GI) bleed but no haematemesis. Not well enough to transfer to acute unit. Keep comfortable. I am happy for nursing staff to confirm death (page 55 of 283). The entry in the nursing

summary notes at 19.00h recorded 'Dr Barton here. For oramorph four hourly. Wife seen by Dr Barton, explained Mr Packman's condition and medication used' (page 62 of 283).

The drug chart showed that he received diamorphine 10mg at 18.00h prescribed as a verbal order in the once only section (page 168 of 283). The prescription was repeated below this one, but it does not appear to have been given. (page 168 of 283) Oral morphine solution (Oramorph) was commenced regularly 10–20mg every four hours with 20mg at night which Mr Packman continued until 10.00h on the 30th August 1999 (page 172 of 283). Regular oral morphine solution 10mg every 4 hours was also prescribed in the daily review prescription, which appears to be an error and unnecessary duplication; none appears to have been prescribed from this section however (page 171 of 283). Diamorphine 40–200mg and midazolam 20–80mg SC/24h were also prescribed on the 26th August 1999 (page 171 of 283).

A full blood count revealed a significant fall in Mr Packman's haemoglobin to 7.7g/dL. A comment on the form reads 'many attempts were made to phone these results, no answer from Gosport War Memorial Hospital switchboard'. The results are signed with the initials JAB (page 205 of 283).

27th August 1999

The nursing summary entry noted 'some marked improvement since yesterday. Seen by Dr Barton this am - to continue with oramorph four hourly - same given tolerated well. Some discomfort this afternoon – especially when dressings being done. Wife has visited this afternoon and

is aware that condition could deteriorate again. Still remains poorly' (page 63 of 283).

Mr Packman's pressure sore dressings were renewed to all areas 'some improvement since Wednesday especially to the areas on the left buttock. Area on right buttock remains offensive and some exudates (page 97 of 283). Mr Packman night was recorded as 'oramorph given as prescribed. Comfortable night, not complaining of any chest pain' (page 79 of 283).

28th August 1999

Medical notes entry noted 'Remains poorly but comfortable so please continue opiates over weekend' (page 55 of 283). Nursing summary noted 'Remains very poorly – no appetite has refused all food. Wife visited – very distressed as she Sensitive personal this coming week' (page 63 of 283). The entry for the night noted 'Oramorph given as prescribed. Condition remains poorly and variable. Drinking well. Dressings remain intact' (page 63 of 283). An entry in the nursing care plan for 'requires full assistance to settle at night' noted 'Oramorph given as prescribed, condition variable, drinking well, appears hydrated. Slept long periods' (page 79 of 283).

29th August 1999

Nursing summary entry for night, noted 'Slept for long periods. Oramorph given as prescribed (page 63 of 283). The nursing care plan for 'requires full assistance to settle at night' noted 'Quite sleepy. Medication given as prescribed. Is complaining of left sided abdominal pain ?bowel or ?' (page 79 of 283).

30th August 1999

The nursing summary notes recorded 'This morning complaining of left abdominal pain', then 'Condition remains poor. Syringe driver commenced at 14.45h with diamorphine 40mg, midazolam 20mg. No further complaints of abdominal pain – very small amount of diet taken – managing mainly puddings. Recatherised this afternoon, draining (see also pages 55 and 85 of 283). When possible encourage fluids. Dressings also renewed' (page 63 of 283).

The drug chart confirms a syringe driver containing 40mg of diamorphine and 20mg of midazolam was commenced at 14.45h (page 171 of 283). However, the midazolam 20mg appears dated the 26th August 1999 (page 171 of 283).

His pressure sores were redressed. The small pressure sore on his left buttock was much cleaner; an area of slough was removed from the pressure sore on the lower right buttock exposing a large crater one inch deep which was redressed (page 98 of 283).

An entry in the nursing care plan for 'requires full assistance to settle at night' noted 'appeared to have a peaceful and comfortable night. No faecal incontinence until mane (morning) and then it was a large amount of black soft faeces' (page 79 of 283).

31st August 1999

Nursing summary noted 'Appeared to have a comfortable and peaceful night. This morning has passed a large amount of black faeces. The nursing summary for the night noted 'Comfortable night continues to pass

tarry black faeces' (page 63 of 283). This was repeated in the nursing care plan for 'Due to immobility...prone to constipation' (page 83 of 283).

Mr Packman's pressure sores on his left buttock were reported to be producing a copious amount of exudate (page 98 of 283).

An entry in the nursing care plan for 'requires full assistance to settle at night' noted 'Peaceful night. Incontinent of black tarry faeces+++ (a lot), nil taken by mouth, remains hot' (page 79 of 283).

1st September 1999

A medical notes entry made by Dr Reid notes 'Rather drowsy, but comfortable, passing melaena stools, abdomen huge, but quite soft, pressure sores over buttock and over the posterior aspect of both thighs. Remains confused. For T.L.C. (tender loving care) – stop furosemide and doxazosin. Wife aware of poor prognosis' (page 55 of 283).

The diamorphine dose in the syringe driver was increased to 60mg/24h at 19.15h (page 171 of 283). The dose of midazolam was also increased to 40mg/24h at 15.45h and 60mg/24h at 19.15h (page 171 of 283).

Nursing summary entry notes 'Dr Reid here. To continue', then 'Syringe driver renewed at 19.15h with diamorphine 60mg and midazolam 60mg as previous dose not controlling symptoms. Dressings renewed this afternoon. Mrs Packman had visited this afternoon and is aware of poor condition. Mrs Packman being Sensitive personal data [redacted]. Please contact her son in the event of Mick's death. No night calls please' (page 64 of 283). The nursing summary nocte (night) entry reported 'Incontinent of black tarry faeces on settling. Peaceful night all care given. Syringe driver

satisfactory. Syringe driver reprimed' (page 64 of 283). The black stools were also recorded in the nursing care plan for 'Due to immobility...prone to constipation' (pages 82 and 83 of 283).

The nursing care plan relating to Mr Packman's pressure sores noted that they were contaminated with faeces and so redressed (page 98 of 283) and slough removed from the large pressure sore on his left buttock (page 100 of 283).

2nd September 1999

The nursing summary entry noted 'diamorphine increased to 90mg, midazolam 80mg (page 64 of 283). The drug chart notes this was at 18.40h (page 171 of 283). Hysocine (hydrobromide) was prescribed in a dose range of 800microgram–2g (an incorrect upper dose range) although never given (page 172 of 283).

An entry in the nursing care plan for 'Due to immobility...prone to constipation' noted 'some slight faecal soiling' (page 83 of 283) and the care plan related to his catheter noted 'some drainage but debris present' (page 85 of 283). An entry in the nursing care plan for 'requires full assistance to settle at night' noted 'Incontinent of black tarry faeces on settling. Nursed on side. Peaceful night. Strong radial pulse, open eyes when spoken to' (page 81 of 283).

3rd September 1999

A medical and nursing notes entries were made confirming death at 13.50h (pages 55 and 64 of 283). The cause of death was given as '1a Myocardial

infarction', with an approximate interval between onset and death of five 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 37, March 1999). 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 37, March 1999) 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 37, March 1999) 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 'as required' 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 'as required' 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.

iii) Melaena.

Melaena refers to black 'tarry' faeces that are associated with gastro-intestinal haemorrhage. The black colour is caused by oxidation of the iron in haemoglobin during its passage through the ileum and colon. Bleeding originating from the lower gastrointestinal tract is generally associated with the passage of bright red blood. Only blood that originates from a high

source such as the small intestine, or bleeding from a lower source that occurs slowly enough to allow for oxidation, is associated with melaena. Thus, melaena is most often associated with haemorrhage in the stomach or duodenum and the most common cause of melaena is a peptic ulcer. If the source of bleeding is suspected to be in the upper gastrointestinal tract, an endoscopy is usually performed to diagnose the cause.

IV) Not for resuscitation

The medical notes record that Mr Packman was 'not for resuscitation' and Dr Barton refers to this in her statement. In my experience and opinion, the meaning of 'not for resuscitation' is quite specific. A medical judgement has been made that in the event of a patient's heart or breathing stopping *unexpectedly* (a cardiorespiratory arrest), there is little or no chance of cardiopulmonary resuscitation being successful (i.e. it would be medically futile) and thus should not be attempted. The decision not to resuscitate will be influenced by the presence of progressive life-threatening illness or other significant medical problems. This status does not however, mean that the patient is automatically excluded from receiving appropriate treatment for other medical problems that may arise. Thus, for example, patients with far advanced cancer, who may be admitted seriously unwell with an infection, given that cardiopulmonary resuscitation is likely to be futile, a 'not for resuscitation' decision is generally made. This does not however, prevent them from receiving appropriate treatment for their infection, even with intravenous antibiotics or fluids if necessary, when this is appropriate to their overall situation.

8. OPINION

Events at Queen Alexander Hospital, 6th–23rd August 1999

Mr Packman was a 67 year old man with obesity which limited his mobility and contributed to a several year history of swelling of his legs which in turn predisposed him to leg ulcers. Following three weeks of increasing redness of the groins he became less well with increasing weakness, leading to a fall which precipitated his admission to the Queen Alexander Hospital on the 6th August 1999. The main reason for his deterioration was cellulitis of the left leg ± groins. There were also pressure sores over his buttocks and thighs and he was noted to have atrial fibrillation (an irregular heart rhythm). He received appropriate treatment with intravenous then oral antibiotics and an increased dose in his diuretics and subsequently he and his blood test results improved. At 13.45h on the 11th August 1999 it was noted that he passed loose black stools, suggestive of melaena, blood in the stool. Sometime in the evening of 11th August 1999, Mr Packman complained of feeling dizzy and his blood pressure was checked and was normal for him at 170/90. It would be usual practice for the nursing staff to report melaena to the medical staff and it is a little surprising to find the first mention of melaena in the medical notes was two days later on the 13th August 1999 in an entry made by Dr Tandy. However, she undertook an appropriate assessment of Mr Packman including a digital rectal examination which revealed normal brown stool on the glove; his full blood count was checked and was found to be essentially stable. This would exclude a significant bleed. Although it is reported that Mr Packman had no abdominal pain, it is of note that he intermittently took Gaviscon, a treatment for indigestion,

between the 8–14th of August 1999. Mr Packman again passed small amounts of black tarry stools on the 19th August 1999; there was no nausea, epigastric pain or abdominal tenderness and his haemoglobin remained stable.

Although Mr Packman's Barthel score improved, he remained in bed requiring a hoist to be moved. His pressure sores persisted and he was transferred to Dryad Ward on the 23rd August 1999 for rehabilitation. In my opinion there are no issues relating to the standard of care or treatment proffered to Mr Packman during his admission to Anne ward and I note that Dr Marshall has no concerns regarding the management of his melaena.

Events at Dryad Ward, 23rd August 1999 until 3rd September 1999.

Infrequent entries in the medical notes during Mr Packman's stay on Dryad Ward make it difficult to closely follow his progress over the last twelve days of his life. There are five entries prior to the confirmation of death, taking up just over one and a half pages in length. In summary in approximate chronological order, Mr Packman was admitted to Dryad Ward for rehabilitation, his ongoing problems were noted to be obesity, arthritis in the knees, immobility, pressure sores and constipation. The episode of possible melaena on the 13th August 1999 was clearly noted and that his haemoglobin was stable. It was also reported that Mr Packman was better in himself with a good mental test score and no pain. The drug chart reveals he was continued on the same drugs as he received on Anne Ward bar the introduction of regular magnesium hydroxide (a laxative). On the 24th August 1999, a nursing handling profile noted in the section for pain

that it 'needed to be controlled'. This is at odds with the medical notes entry above and pain is not mentioned anywhere else. On the 25th August 1999, Mr Packman experienced seven to eight loose bowel actions throughout the afternoon and evening and fresh blood was observed. He also vomited and required an intramuscular anti-emetic. Dr Beasley, the general practitioner on-call for Dryad Ward that evening was contacted by the nursing staff whose decision was to withhold the 18.00h dose of enoxaparin and for Mr Packman to be reviewed by Dr Barton in the morning. Enoxaparin is designed to interfere with the clotting ability of the blood and thus would exacerbate any bleeding problems and it was reasonable to stop it. However, I can find no record that Mr Packman's heart rate or blood pressure were measured by the nursing staff or requested by Dr Beasley, which would help to inform the medical decision made. For example, a rapid heart rate ± a low blood pressure would potentially indicate a significant bleed and an immediate medical review in my opinion would have been indicated.

On the 26th August 1999, Mr Packman was reported to have had a fairly good morning with no further vomiting. Dr Ravi (who Dr Barton identifies as a locum consultant geriatrician) was contacted regarding the enoxaparin. He agreed with its discontinuation and asked that Mr Packman's haemoglobin be checked on the 26th and 27th August 1999. The nursing notes record that Mr Packman complained of feeling unwell at lunchtime and had a poor colour and that he was seen by Dr Barton and the plan was for to await the result of his haemoglobin. There was no entry in the medical notes regarding Dr Barton's assessment and no record that even

the basic observations of heart rate and blood pressure were taken. At approximately 18.00h on the 26th August 1999, Mr Packman complained of indigestion-like pain in his throat and vomiting. A verbal order was taken from Dr Barton for a stat dose of diamorphine 10mg and anti-emetic was also given. Dr Barton reviewed Mr Packman at 19.00h, noting that he was pale, clammy and unwell, but no basic observations (e.g. temperature, heart rate, blood pressure) or results of a medical examination (e.g. heart sounds, chest, abdomen) were recorded. Dr Barton considered that Mr Packman had had a myocardial infarction, but this was based on the history alone with no supporting evidence from an electrocardiograph (ECG). Dr Barton's plan was to treat Mr Packman with the stat dose of diamorphine and then regular oral morphine solution overnight, 10mg every four hours with 20mg at night. In my experience, it is usual to give patients who have had a myocardial infarction diamorphine as required, 'p.r.n.', but I have never seen oral morphine solution given regularly.

Dr Barton reported Mr Packman to be 'not be well enough' to transfer to the acute unit. I do not understand this comment. If Mr Packman was at home when he became this unwell, he would have been admitted to a hospital with appropriate facilities by emergency ambulance. Hence, a transfer via an emergency ambulance could have been arranged for Mr Packman. The fact that Mr Packman was not for resuscitation would not in my opinion have excluded him from receiving the most appropriate treatment and if his needs could not be met at Dryad Ward then emergency transfer to the acute hospital setting should have been undertaken. Instead Dr Barton recorded 'keep comfortable' and that she was 'happy for nursing staff to

confirm death'. In addition to the diamorphine and the oral morphine solution, Dr Barton also prescribed diamorphine 40–200mg and midazolam 20–80mg SC over 24h p.r.n.

Dr Barton also considered the alternative possibility of a gastrointestinal bleed but appeared to rule this out on the basis that there was no haematemesis. My understanding is that the absence of haematemesis does not rule out the possibility of a gastrointestinal bleed and in my opinion, a gastrointestinal bleed was much more likely given Mr Packman's pain, indigestion, melaena and falling haemoglobin. All of this information was/could have been available to Dr Barton on the evening of the 26th August 1999. In particular, the fall in haemoglobin from 12g/dl on the 24th August 1999 to 7.7g/dl on the 26th August 1999 was revealed by the blood test undertaken, analysed and reported on the 26th August 1999. A note on the report states that the lab gave up attempting to notify the ward, as it was unable to get through to Gosport War Memorial Hospital switchbaord. Nevertheless, given that Dr Barton's plan from earlier that day was to await the results of the haemoglobin and that Dr Barton considered that a gastrointestinal bleed was at least a possibility, I would have thought it reasonable for her to have made attempts to obtain the results via the on-call service.

On the 27th August 1999 there was an 'marked improvement' in Mr Packman's condition and he was seen by Dr Barton but no entry was made relating to this assessment, and as far as I can ascertain, the results of the blood test taken on the 26th August were either not obtained or acted upon, a further blood test as per Dr Ravi's plan not taken, Mr Packman's changing

condition not discussed with Dr Ravi or another consultant and he was not transferred to the acute hospital. Instead the plan was to continue with the regular morphine even though he was no longer complaining of the pain in his throat. The same can be said for the 28th August 1999.

On the 30th August 1999 (probably a Bank holiday) Mr Packman complained of left sided abdominal pain. A syringe driver was commenced at 14.45h containing diamorphine 40mg and midazolam 20mg/24h. This was a new pain, yet there is no indication that Mr Packman was either discussed with or was assessed by the on-call doctor prior to the commencement of the syringe driver. Thus it is unclear if a syringe driver containing diamorphine and midazolam was indicated or appropriate.

On the 31st August 1999 Mr Packman passed a large amount of melaena and the diagnosis of a gastrointestinal bleed should not have been in doubt. There is no evidence to suggest that his basic observations were taken or that he was assessed by a doctor. On the 1st September 1999, Mr Packman was noted by Dr Reid to be passing melaena stools, comfortable but drowsy and confused. This could have been due to Mr Packman's progressive anaemia and/or the dose of diamorphine may have been excessive for his needs. Dr Reid indicated that Mr Packman was for TLC (tender loving care). At 15.45h the dose of midazolam was increased to 40mg/24h without apparent reason. Subsequently, the diamorphine was increased to 60mg/24h and the midazolam increased to 60mg/24h at 19.15h as 'previous dose not controlling symptoms'. However, there is no explanation of what these symptoms were and if the increase was discussed with the on-call doctor.

On the 2nd September 1999, the diamorphine was increased to 90mg/24h and the midazolam to 80mg/24h without explanation. Hyoscine hydrobromide was also prescribed with an up limit of 2g. This is incorrect by a factor of 1000 as the upper limit should be 2mg. However, hyoscine hydrobromide was never given. An entry in the nursing care plan for the night time reports peaceful night, strong radial pulse, open eyes when spoken to.

Mr Packman was confirmed dead at 13.50h on the 3rd September 1999. The cause of death was given as myocardial infarction with an approximate interval between onset and death of five days. In my opinion, the circumstances of Mr Packman's deterioration and death were more in keeping with a gastrointestinal haemorrhage rather than a myocardial infarction, particularly given the fall in haemoglobin and melaena stool.

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 care provided by Dr Barton and Dr Reid to Mr Packman following his 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 1998, 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 and, if 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
- in providing care you must be willing to consult colleagues.

Specifically:

i) There was insufficient assessment and documentation of Mr Packman's clinical condition when he became less well on the afternoon of the 26th August 1999.

ii) There was insufficient assessment and documentation of Mr Packman's clinical condition when he became acutely ill on the evening of the 26th August 1999.

iii) Mr Packman was considered to have experienced either a myocardial infarction or a gastrointestinal haemorrhage, yet advice was not sought from other colleagues nor was he transferred to an appropriate place of care.

iv) Mr Packman received regular oral morphine that may have been excessive to his needs and prescribed a syringe driver, as required, with upper dose ranges of diamorphine and midazolam likely to be excessive to his needs.

v) Over the days that followed, there was a continued lack of an appropriate medical assessment of Mr Packman's condition; the results of blood tests that would have indicated a gastrointestinal bleed were either not obtained or acted upon.

vi) Mr Packman received increasing doses of diamorphine and midazolam that were likely to be excessive to his 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).

Mr Packman was reported to be feeling unwell with a poor colour (generally indicates pallor) at lunchtime on the 26th August 1999. The nursing notes record that he was seen by Dr Barton but there is no entry in the medical notes relating to this. It is unclear what assessment was made of Mr Packman and even whether the most basic of observations were undertaken (e.g. temperature, heart rate and blood pressure). The nursing notes record only that the plan was to await the result of the haemoglobin level checked that day. When a patients' clinical condition changes for the worse, a thorough medical assessment should be carried out to ascertain the possible cause(s) and to identify if they are reversible with appropriate treatment. The assessment would consist of the history, examination and appropriate investigation.

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

Dr Barton was contacted about Mr Packman when he developed his indigestion-like pain at 18.00h on the 26th August 1999 and requested that diamorphine 10mg be given by intramuscular injection. This stat dose was

appropriate given that a delay was anticipated in her getting to the hospital and the dose appropriate given Mr Packman's pain (it was considered to be a myocardial infarction), size and age. It is unclear how long it took Dr Barton to get to the hospital, but it was recorded that she was there at 19.00h.

When a patients' clinical condition changes for the worse, a thorough medical assessment should be carried out to ascertain the possible cause(s) and to identify if they are reversible with appropriate treatment. The assessment would consist of the history, examination and appropriate investigation. Dr Barton's entry in the medical notes recorded Mr Packman's appearance as pale, clammy and unwell. This suggests he was 'shocked'; a situation where a low cardiac output leads to a low blood pressure. However, basic observations such as his temperature, heart rate and blood pressure are not recorded nor is there a documented physical examination. These should have been undertaken, particularly as Dr Barton considered that Mr Packman had a serious underlying cause of being unwell, either a myocardial infarction or a gastrointestinal bleed.

There appears to have been no attempt to confirm the diagnosis of myocardial infarction; I understand there was limited access to an ECG machine out of hours at Dryad, but no attempts appear to have been made to obtain one subsequently or blood tests taken for cardiac enzymes.

Given that Dr Barton considered that a gastrointestinal bleed was a possibility, it would have been reasonable for her to have made attempts to obtain the result of the haemoglobin checked that day from the on-call pathology service. This would have revealed the fall in the haemoglobin to

7.7g/dl and made a diagnosis of gastrointestinal haemorrhage the more likely possibility.

Issue iii (providing treatment that serves the patients needs; willing to consult colleagues).

Gastrointestinal haemorrhage is a medical emergency and Mr Packman should have been thoroughly assessed and cared for in a clinical environment set up to respond to such an emergency (similarly, if he was having a myocardial infarction). I am led to believe that Dryad Ward was (understandably) limited in its ability to respond to such medical emergencies. For example, they lacked the ability to provide intravenous fluids, antibiotics or blood transfusions. Hence, I understand that the policy was to transfer patients who became acutely medically unwell to the acute hospital setting when this was appropriate. I see no reason for this not to have been appropriate for Mr Packman; he had been transferred to Dryad Ward for rehabilitation, had no known underlying life-threatening illness, death was not anticipated and a 'not for resuscitation' status should not have excluded him from receiving appropriate treatment for medical problems that arose. Whilst the cause of Mr Packman's gastrointestinal bleed is unknown, one of the commonest causes is a peptic ulcer which can be cured with appropriate treatment. Thus, Mr Packman may have had a potentially treatable and reversible medical condition, which presented with a serious complication (gastrointestinal bleeding) that should have been managed as a medical emergency. This would have included:

- obtaining intravenous access

- taking blood for a full blood count, clotting and cross-matching for blood transfusion
- correction of fluid losses and restoration of blood pressure
- caring for him in an clinical environment that can respond to such an emergency.

It is my understanding that Dryad Ward was not able to provide Mr Packman with such care and thus, in my opinion, he should have been transferred to the acute hospital setting. Whilst I appreciate it is not ideal to transfer medically unstable patients from one hospital to another, given the lack of even basic resuscitative measures at Gosport War Memorial Hospital, there was, in effect, little alternative and in this context, I do not understand Dr Barton's comment that Mr Packman was not well enough to transfer to an acute hospital. The lack of ability to medically stabilise a patient can not be a reason not to attempt a transfer at all, otherwise, logically, ill patients would not be able to be taken from home to hospital. Instead, patients who become unwell at home, are taken to hospital by an emergency ambulance, and in my opinion, transfer by emergency ambulance could have been arranged for Mr Packman. Even if one adopted the view of Dr Barton that he was too unwell to transfer, then there were subsequent opportunities to transfer him. For example, he was reported as showing 'some marked improvement since yesterday' on the 27th August 1999 and he lived for another eight days. Further, despite Dr Barton's assessment that Mr Packman was so unwell that he could not be transferred, there is nothing documented to suggest that she sought advice

regarding appropriate management of Mr Packman from the on-call physicians/geriatricians or the cardiologists.

Issue iv (prescribe only the treatment, drugs, or appliances that serve patients' needs).

If Mr Packman was distressed by severe pain related to a peptic ulcer (or myocardial infarction) then the prescription of morphine parenterally was reasonable. Although generally 5mg would be given, 10mg can be used in heavier patients. The repeated use of this dose, p.r.n. for the relief of severe pain, would also be reasonable. In her statement, Dr Barton concludes (point 24) that the diamorphine was additionally justified on the basis that Mr Packman had a large pressure on his sacrum and thighs which would have been causing him significant pain and discomfort. In my opinion, this is not a robust conclusion; there was no mention of Mr Packman being in pain due to his pressure sores at the Queen Alexander Hospital (where his only analgesic was paracetamol), in the medical clerking on his transfer to Dryad Ward or in the nursing care plan relating to his pressure sores. One nursing summary entry a day later on the 27th August 1999, records 'some discomfort this afternoon - especially when dressings being done.' The significance of this is unclear; a discomfort is generally used to describe a mild pain, the site of the discomfort is unspecified and there is no mention of discomfort or pain on changing his dressings that day in the nursing care plan relating to his pressure sores.

In my experience, I have never seen oral morphine solution subsequently prescribed regularly for patients considered likely to have had either a

myocardial infarction or a gastrointestinal haemorrhage and the use of regular oral morphine solution was, in my opinion, inappropriate. The oral morphine solution was prescribed as a range 10–20mg four times a day and 20mg at night; one of the problems of prescribing drugs as a range is that it can be difficult to know what dose patients actually received, when the bigger or smaller dose should be given and who should decide this. Thus, it is unclear from the prescription chart and nursing summary notes what dose of morphine Mr Packman actually received during the daytime.

Similarly, the prescription of diamorphine and midazolam in a syringe driver p.r.n., on the 26th August 1999, in my opinion, was not justified; the dose range of diamorphine 40–200mg and midazolam 20–80mg/24h would have exposed Mr Packman to doses likely to have been excessive for his needs. A dose of an opioid which is excessive to a patient's needs is associated with an increased risk of drowsiness, delirium, nausea and vomiting and respiratory depression.

It is unusual that drugs to be given by syringe driver are prescribed p.r.n. particularly in a wide dose range. This is because of the inherent risks 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. Dr Barton in her statement notes that the prescription for the diamorphine and midazolam were on an anticipatory basis in case they were required in due course and that it was not her intention that they

be administered at that time (point 29). However, there are no instructions on the prescription chart that would provide a safeguard in this respect.

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, diazepam/midazolam and other drugs that could be given intermittently p.r.n. orally 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, or, if already taking a regular dose, how it should be titrated.

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

Over the days that followed, there was a continued lack of an appropriate medical assessment of Mr Packman's condition; no attempts were made to obtain an ECG or blood tests taken for cardiac enzymes; the results of blood tests that would have indicated a gastrointestinal bleed were, despite numerous opportunities were either not obtained or acted upon. Although requested by Dr Ravi, I can find no haemoglobin result for the 27th August 1999.

Issue vi (lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate and contemporaneous patient records; prescribe only the treatment, drugs, or appliances that serve patients' needs).

On Monday 30th August 1999 at 2.45pm a syringe driver was set up containing diamorphine 40mg and midazolam 20mg SC/24h. A nursing care plan queried whether Mr Packman's left sided abdominal pain was related to his bowels or some other cause. However, no medical assessment was undertaken and thus the cause of the pain and the appropriateness of the use of these two drugs in a syringe driver are unclear. There was no annotation in the nursing or medical notes to suggest that a doctor was involved in this decision, contrary to Dr Barton's stated intention (Statement of Dr Jane Barton) and illustrates the lack of a safeguard in the prescription of these drugs, in these doses, by syringe driver.

Generally, the total 24h oral dose of morphine is divided by three or occasionally by two to determine an appropriate dose, i.e. diamorphine 20–30mg/24h would generally be considered an appropriate conversion for Mr Packman and in this regard a dose of diamorphine 40mg/24h represents a 33–100% increase. In her statement, Dr Barton states that Mr Packman would have 'started to have become inured (tolerant) to the opiate medication' and an increase of this nature was in her view entirely appropriate to ensure that his pain was well controlled (point 35). In my experience and my opinion, rapid tolerance to opioids (he had been on oral morphine for four days) is not a plausible explanation in itself to justify an increase in Mr Packman's opioid dose.

Despite Mr Packman passing a large amount of black faeces on the morning of the 31st August 1999 there was no medical assessment documented.

On the 1st September 1999, Dr Reid noted that Mr Packman was drowsy, had been passing melaena stools and was confused. It is unclear if Dr Reid was aware of the haemoglobin result from the 26th August 1999 but he appeared to consider at that time Mr Packman suitable for TLC (tender loving care) only. The confusion and drowsiness may have been due to the diamorphine, midazolam or his medical condition, as he was likely to have been becoming progressively more anaemic.

Although noted to be comfortable by Dr Reid, the midazolam was increased at 15.45h to 40mg/24h (from 20mg/24h; increase of 100%) with no mention of why this increase was indicated or discussed with a doctor. Later that evening, the dose of diamorphine was increased to 60mg/24h (from 40mg/24h) and midazolam to 60mg/24h (from 40mg/24h) at 19.15h because 'previous dose not controlling symptoms.' However, there is no mention of what these symptoms were or that the increase was discussed with a doctor. The diamorphine increase was 50% and the midazolam dose was effectively trebled within 24h. It is difficult to assess the appropriateness of these increases. The medical and nursing notes do not suggest Mr Packman was in pain or distress. This is another reason why the use of smaller p.r.n. doses of diamorphine and midazolam is helpful; frequent use (e.g. ≥2 extra doses per 24h) suggests the need to titrate the regular medication upwards and also guides the magnitude of the required increase.

Mr Packman was noted to have had a peaceful night. However, the diamorphine was increased to 90mg/24h (from 60mg/24h; a 50% increase) and the midazolam to 80mg/24h (from 60mg/24h; a 33% increase) at

18.40h on the 2nd September 1999. There is no mention of pain or distress in the nursing or medical notes and the justification for the further increase in dose is unclear.

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

Both Dr Barton and Dr Reid had a duty to provide a good standard of medical practice and care. In this regard, Dr Barton and Dr Reid fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient, providing treatment that could be excessive to the patients' needs and willingness to consult colleagues.

Mr Packman was admitted for rehabilitation and it was not anticipated that he was likely to die. Although Dr Barton considered a myocardial infarction more likely than a gastrointestinal haemorrhage, the latter would have been confirmed as the more likely if the haemoglobin result was obtained that evening or the following day. A gastrointestinal haemorrhage (or a myocardial infarction) is a serious medical emergency and requires appropriate and prompt medical attention. The cause of Mr Packman's gastrointestinal bleed is unknown. However, as the most common cause is a peptic ulcer which can be cured with appropriate treatment, it is possible that Mr Packman's deterioration was due to a potentially reversible cause that could have been managed by transfer to the acute hospital for appropriate resuscitation with intravenous fluids, blood transfusion and

further investigation. This view is in keeping with the opinion of a gastroenterologist, Dr Jonathan Marshall (report of 1st April 2005).

Dr Barton considered Mr Packman too unwell to move. In this regard it seems odd that a patient becoming acutely unwell at Gosport War Memorial Hospital would be at a disadvantage compared to if they had become acutely unwell at home. I see no reason that a patient could not be transferred by emergency ambulance if this was in their best interests. When possible they should be medically stabilised beforehand, but the lack of ability to do this should not be the reason not to attempt transfer at all. Even if one accepted the view that Mr Packman was too unwell to move, advice should have been sought on his management from the on-call physicians/geriatricians or cardiologists.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mr Packman by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Packman by failing to adequately assess his condition and taking suitable and prompt action. Mr Packman could have had a potentially treatable and reversible medical condition, which presented with a serious complication (i.e. bleeding). He should have been urgently and appropriately assessed and transferred to an acute medical unit. He was not appropriately assessed, resuscitated with fluids, transferred or discussed with the on-call medical team. In my view, there was no obvious reason why it was not appropriate to provide Mr Packman with this usual course of action.

Morphine and diamorphine are safe drugs when used correctly. The key issue is whether the use and the dose of diamorphine and other sedatives are *appropriate* to the patients' needs. Although some might invoke the principle of double effect (see technical issues), it remains that a doctor has a duty to apply 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 of strong opioid that was *appropriate* and not excessive for a patient's needs. The stat doses of diamorphine could be seen as appropriate for the relief of severe pain. However, in my opinion, the ongoing use of regular morphine and subsequent use of diamorphine and midazolam were inappropriate; their use was not obviously justified and the doses were likely to be excessive to Mr Packman's needs. In my opinion, it is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

9. LITERATURE/REFERENCES

British National Formulary 37 (March 1999).

Prescribing in Terminal Care, pages 11–14

Prescribing for the elderly, pages 15–16

Good Medical Practice, General Medical Council July 1998, 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: _____

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20M

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

Person interviewed: BARTON, JANE ANN

Place of interview: FRAUD SQUAD, NETLEY SUPPORT HQ

Date of interview: 17/11/2005

Time commenced: 0914 Time concluded: 0941

Duration of interview: 27 MINUTES (→) Tape reference nos. CSY/JAB/12

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

Other persons present: MR BARKER , SOLICITOR

Police Exhibit No: CSY/JAB/12A Number of Pages: 21

Signature of interviewer producing exhibit

Tape counter times(↵)	Person speaking	Text
	DC YATES	This interview is being tape recorded. I am DC2479 Chris YATES. My colleague is …
	DC Code A	DC Code A
	DC YATES	… I'm interviewing Doctor Jane BARTON. Doctor will you please give your full name and your date of birth?
	BARTON	Jane Ann BARTON, 19/10/48.

DC YATES — Thank you. Also present is Mr BARKER, who is Doctor BARTON's solicitor. Can you please introduce yourself?

BARKER — Certainly confirm that my name's Ian BARKER and I am Doctor BARTON's solicitor.

DC YATES — Thank you. The time is 09 (coughs) excuse me, 0914 hours and the date is the 17th of November 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 — I've had time thank you.

DC YATES — Thank you. If at any time you do 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 okay. 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 YATES I'll break it up again anyway. It can be broken into three sections. The first is that it is your right not to say anything when asked questions by us. 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 a court may draw, and it is a may draw, well it's called an adverse inference and they'll wonder why you did not mention it earlier when interviewed if it was known to you then. The third and last part is again that's quite simple, the interview is being tape recorded, if it should go to court and it was felt necessary the tapes can be played or a transcript can be read. Is that a fair description? Yeah. On this occasion again this room isn't equipped for remote monitoring so DS GROCOTT who we know is outside so he can't hear anything that's going on in here at all and as before it will be me speaking to you the majority of the time. DC Code A will almost certainly be taking some notes. Mr BARKER I think the last time we met was Thursday the 27th of October?

BARKER That's right.

DC YATES And I handed you by way of advance disclosure for this interview, copies of the medical notes of Geoffrey PACKMAN and a brief synopsis of his care.

BARKER You did indeed.

DC YATES I believe those notes weren't particularly good and you had to be given a further copy is that right?

BARKER That's correct yes one of your colleagues very kindly produced a ...

DC YATES But they were satisfactory?

BARKER ... they were yes.

DC YATES Okay. This investigation is being conducted by Hampshire Constabulary and started in September 2002 it's already 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. Now no decision has been made as to whether an offence or any offence has been committed but it's important to be aware that the offence range being investigated runs from potential murder right the way down to assault. Part of the ongoing 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 Geoffrey PACKMAN. Mr PACKMAN was admitted to Gosport War Memorial Hospital and subsequently died on the 3rd of September 1999. The cause of death was given as Myocardial Infarction. Perhaps Doctor in your own words

you can tell me what you recollect of Mr PACKMAN and the care and treatment that he received whilst at the Gosport War Memorial Hospital. Now you've already passed them out now, I believe you're going to read from a prepared statement.

BARTON That's correct.

DC YATES Is that correct, yeah. Is that statement yours doctor?

BARTON It is.

DC YATES And you've made it?

BARTON I did.

DC YATES Okay if you'd care to read that, thank you.

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, Mr Geoffrey PACKMAN. Unfortunately, at this remove of time I have no recollection at all of Mr PACKMAN. As you are aware, I provided you with a statement on the 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 Mr PACKMAN.

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, though if anything, it had become even more difficult by 1999 when I was involved in the care of Mr PACKMAN.

Mr Geoffrey PACKMAN was a 67 year old man who lived at home with his wife and daughter in Emsworth. It appears that he was visited regularly at home by the District Nurse who in February of 1999 noted that he had a large red weeping area on the shin of his right leg. A Doppler's test was performed, being an ultrasound

measurement of the pressure in the veins of the legs. Mr PACKMAN's GP appears to have referred him to Consultant Urologist Mr Code A at some point after April 1999. The GP referred in his letter to symptoms of prostatism and a raised PSA. He said that Mr PACKMAN had had a negative mid-stream urine test, but rectal examination, presumably to assess the size of the prostrate, had been virtually impossible because of Mr PACKMAN's huge size and inability to lie properly on his side. The GP noted that Mr PACKMAN was grossly obese, and indeed a subsequent measurement of his weight was recorded at 146kg - in excess of 23 stone.

Mr PACKMAN was noted to have a raised random blood sugar and was also due to have a glucose tolerance test to exclude diabetes mellitus.

At the end of June his GP then made a further referral, this time to Consultant Dermatologist Dr Code A in relation to Mr PACKMAN's leg ulceration. Mr PACKMAN had apparently been attending the District Nurse's leg ulcer clinic for many months and had hugely oedematous legs. The District Nurse had drawn the GP's attention to a large granulomatous raised area on the back of his right calf, and Dr Code A 's advice was requested. At this stage it seems that Mr PACKMAN was being visited by the District Nurse 3 times a week in order to dress the leg ulceration, that he had recently become immobile and his condition had worsened. Mr PACKMAN was seen in the dermatology clinic on 30th June 1999, the Senior House Officer reporting back that Mr PACKMAN

had bi-lateral severe oedema with some leg ulceration secondary to venous hypertension. Mr PACKMAN was to be brought in for further Doppler's testing.

On 6th August 1999 Mr PACKMAN was then admitted to the Queen Alexandra Hospita l having suffered a fall. He was unable to mobilise and 2 Ambulance crews were called to assist. It was noted on admission that the GP and the District Nurse were unable to cope with Mr PACKMAN at home. The diagnoses at that stage were bi-lateral leg oedema, with ulcers on the left leg, obesity and it was noted that he was simply not coping.

In the course of clerking-in on 6th August, it appears that Mr PACKMAN was suspected to be in atrial fibrillation. An ECG was arranged which showed atrial fibrillation at the rate of 85. Blood tests revealed that he has a white cell count of 25,000, an ESR of 31 and a CRP of 194. He was felt to have cellulitis in the groin and left lower leg, he was commenced on antibiotics and his diuretic medication was changed to Frusemide. His past medical history was noted to consist of the bi-lateral leg oedema, which he had apparently had for 5 years, hypertension which had been treated since 1985 and arthritis.

It appears that about the time of admission Mr PACKMAN was recorded as having a large black blistered area on his left heel in addition to the leg ulceration.

Following assessment his problems were recorded as cellulitis of the left leg, chronic leg oedema, poor mobility,

morbid obesity, raised blood pressure and possible atrial fibrillation. In relation to the latter and prior to the performance of the ECG, anticoagulants were suggested if atrial fibrillation was confirmed, and the possibility of left ventricular dysfunction was also raised. Shortly thereafter Mr PACKMAN was commenced on Clexane 40mgs twice daily.

At this stage Mr PACKMAN's creatinine level was noted at 173, with urea at 14.9, suggesting that the insult due to the infection in his legs was resulting in compromise of his renal function.

It was also noticed on 6th August that "in view of pre-morbid state + multiple medical problems [Mr PACKMAN was] not for CPR in event of arrest". A Barthel score stated to have been assessed on 5th August (presumably 6th August in error) was recorded as zero, indicating that Mr PACKMAN was completely dependant.

Mr PACKMAN was reviewed by the Specialist Registrar the following day, 7th August, who agreed, presumably on the basis of what was felt to be Mr PACKMAN's poor condition at that stage, that he was not to be resuscitated in the vent of arrest. It was suggested that his anti-hypertensive medication should be changed to an ACE inhibitor in view of the oedema and he was considered for a beta-blocker in view of his atrial fibrillation. His diuretic was changed lest it cause dehydration. Mr PACKMAN was given Flucloxacillin 500 mgs 4 times daily,

supplemented by Penicillin V 500 mgs 4 times a day to combat the cellulitis.

Although steps were apparently taken to prevent the development of pressure sores, on 8th August Mr PACKMAN was noted to have sores to the sacrum, being described as "Grade 3". I believe this would have been a reference to a wound classification system, Grade 3 suggesting that there was full thickness skin loss involving damage of subcutaneous tissue.

Over the next few days it appears that Mr PACKMAN's cellulitis improved but the overall assessment of his suitability of resuscitation did not change - on 11th and again on 13th August it was again specifically noted that he was not for resuscitation - recorded as "Not for 555".

On 13th August Mr PACKMAN was reviewed by a Consultant Geriatrician Dr Jane TANDY . She noted that he had had black stools overnight. The following day a nursing note records that when the dressings on the pressure sores were renewed, the wounds to the left buttock and right lower buttock and thigh were very sloughy and necrotic in places, and very offensive smelling. Clearly by that time, Mr PACKMAN had developed significant pressure sores.

A Barthel score measured on 14th August again recorded a score of zero indicating his complete dependence.

It appears that by 15th August a decision had been made that Mr PACKMAN should be transferred to the Dryad Ward at the Gosport War Memorial Hospital. A note in the nursing records indicates that Staff Nurse HALLMAN at Gosport War Memorial Hospital had indicated that we were not in a position to take Mr PACKMAN at that time. This is likely to have been an indication that there were no beds available and that we would have been under considerable pressure in consequence of the high bed occupancy.

An entry in Mr PACKMAN's records for 20th August by the Specialist Registrar indicates that Mr PACKMAN was due to transfer to Gosport War Memorial Hospital on 23rd August. The Specialist Registrar also noted that Mr PACKMAN remained not for resuscitation. A Barthel score measured on 21st August again recorded a score of zero indicating his complete dependence.

Mr PACKMAN was then admitted to the Gosport War Memorial Hospital on 23rd August 1999. There is a clerking-in note contained within his records, but I do not recognise the handwriting or signature of the doctor who assessed him on this occasion. His problems were noted to be obesity, arthritis, immobility and pressure sores. The episode of melaena on 13th August was noted, with his haemoglobin being stable. At that stage he was said to be in no pain. Cardiovascular and respiratory systems were thought to be normal. The clinician admitting Mr PACKMAN also prescribed medication in the form of Doxazosin 4 mgs daily for hypertension, Frusemide 80 mgs

once a day as a diuretic for Mr PACKMAN's oedema, Clexane 40mgs twice a day for DVT prophylaxis and atrial fibrillation. Paracetamol 1gm 4 times daily for pain relief, Magnesium Hydroxide 10 mls twice daily for constipation, together with Gaviscon for indigestion and cream for his pressure sores.

On this occasion, a Barthel score of 6 was recorded for 23rd August, suggesting that, although Mr PACKMAN might have improved to a degree, he was still significantly dependent.

I anticipate that I would have reviewed Mr PACKMAN the following day as part of my assessment of all the patients on the ward, though it appears that I did not have an opportunity to make any entry in his medical records on this occasion. The prescription chart shows that I prescribed Temazepam for Mr PACKMAN on a PRN basis - as required - at a dose range of 10-20 mgs. 10 mgs of Temazepam was then given on the night of 24th August, with a night nursing record indicating that he slept for long periods.

I anticipate that I would have reviewed Mr PACKMAN the following day, 25th August, although again I did not have an opportunity to make an entry in his records. It appears that Mr PACKMAN then was noted to have passed blood per rectum, and Dr BEASLEY was contacted, Dr BEASLEY presumably being on duty out-of-hours. He advised that the Clexane should be discontinued. Dr BEASLEY also appears to have prescribed

Metoclopromide by way of verbal order, which I later endorsed, together with Loperamide. The Metoclopromide was apparently given at 5.55pm (1755) with good effect. The dressings on the pressure sores were removed on 25th August and were noted to be contaminated with faeces.

I do not know if I reviewed Mr PACKMAN on the morning of 26th August. He was noted by the nurses to have had a fairly good morning. Sister HAMBLIN has recorded that Dr RAVI , locum Consultant Geriatrician, was contacted and he confirmed that the Clexane should be discontinued and the haemoglobin repeated. Again, Mr PACKMAN was noted to be "not for resuscitation". Sister HAMBLIN may have contacted Dr RAVI if I was unavailable that morning. The nursing record goes on to indicate that Mr PACKMAN then deteriorated at about lunchtime, that his colour was poor and that he complained of feeling unwell. I was called to see him, my entry in his records on this occasion reading as followed.

'Called to see, pale, clammy, unwell
Suggest ? MI. treat stat diamorph
And oramorph overnight
Alternative possibility GI bleed but no haematemisis
Not well enough to transfer to acute unit
Keep comfortable
I am happy for nursing staff to confirm death'.

As my note indicates, I was concerned that Mr PACKMAN might have suffered a myocardial infarction and accordingly I decided to administer opiates in the form of

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

My impression when I assessed Mr PACKMAN on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to an acute unit was quite inappropriate. Any such transfer was very likely to have had a further deleterious affect on his health.

The nursing note for 26th August indicates that we were to await blood test results. There was then a further deterioration later in the day, with Mr PACKMAN complaining of indigestion and a pain in his throat, which was not radiating.

The blood count taken on 26th August subsequently showed that Mr PACKMAN's haemoglobin had dropped to 7.7 grams, a substantial drop from the 12 grams which had been recorded 2 days earlier.

It appears that I re-attended to see Mr PACKMAN at 7.00pm (1900) on 26th August. Concerned that he should

have further appropriate medication to relieve his pain and distress, I prescribed Oramorph 10-20 mgs 4 times a day together with 20 mgs at night. 20 mgs of Oramorph was later given at 10.00pm (2200).

I also wrote up prescriptions for Diamorphine 40-200 mgs subcutaneously over 24 hours, together with 20-80 mgs of Midazalam via the same route on an anticipatory basis, concerned that further medication might be required in due course to relieve Mr PACKMAN's pain and distress. It was not my intention that this subcutaneous medication should be administered at that time. The nursing record also indicates that I saw Mr PACKMAN's wife , explaining her husband's condition and the medication we were using. I anticipate I would have indicated to Mrs PACKMAN that her husband was very ill indeed and in all probability that he was likely to die.

I would have reviewed Mr PACKMAN again the following morning and indeed the nursing record confirms that I attended to see him then. Sister HAMBLIN has recorded that there had been some marked improvement since the previous day and that the Oramorph was tolerated well and should continue to be given, though Mr PACKMAN apparently still had some discomfort later that afternoon especially when the dressings were being changed. In spite of the earlier improvement, Mr PACKMAN was said to remain poorly. 10 mgs of Oramorph were administered 4 hourly, together with a further 20 mgs at night as prescribed, so that Mr PACKMAN received a total of 60 mgs that day, though this was seemingly not enough to

remove his pain and discomfort when his dressings were being changed. The nursing records indicate that he appeared to have had a comfortable night.

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

'28-8-99 Remains poorly but comfortable
please continue opiates over weekend'.

The nursing record indicates that Mr PACKMAN remained very poorly with no appetite. However, the Oramorph again seems to have been successful in keeping Mr PACKMAN comfortable at night.

I do not believe I would have seen Mr PACKMAN on Sunday 29th August. The nursing record indicates that he slept for long periods but that he also complained of pain in his abdomen. The sacral wounds were said to be leaking a lot of offensive exudate.

I do not know if I would have seen Mr PACKMAN again the following morning, Monday 30th August, that being a Bank Holiday. I have no way of knowing now if I was on duty then. If I did see him as part of my review of all the patients on the two wards, I did not have an opportunity to make a specific entry in his records on this occasion. A Barthel score was recorded as 4. The nursing record indicates that Mr PACKMAN's condition remains poor and later that day - at 2.45pm (1445) the syringe driver was set

up to deliver 40 mgs of Diamorphine and 20 mgs Midazalam subcutaneously. I anticipate that Mr PACKMAN would have continued to experience pain and clearly in view of the significant sacral sores, it's highly likely that he would have been experiencing further significant discomfort.

In view of his poor condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying. Mr PACKMAN had received 60 mgs of Oramorph daily over the preceding 3 days and the administration of 40 mgs of Diamorphine subcutaneously over 24 hours did not represent a significant increase. Mr PACKMAN would have started to have become inured to the opiate medication and an increase of this nature was in my view entirely appropriate to ensure that his pain was well controlled. Indeed, the nursing record goes on to state that there were no further complaints of abdominal pain and Mr PACKMAN was able to take a small amount of food.

I anticipate that the nursing staff would have liaised with me prior to the commencement of the Diamorphine and Midazalam and that this would have been set up on my instruction, directly if I had been at the hospital, or otherwise by phone.

On the morning of 31st August Mr PACKMAN was recorded as having had a peaceful and comfortable night, though he then passed a large amount of black faeces that morning.

I believe I would have seen Mr PACKMAN again that morning, though again I did not have an opportunity to make an entry in his records. I anticipate his condition would have been essentially unaltered and that he would have remained comfortable. Similarly, I would probably have seen Mr PACKMAN again on the morning of 1st September but would have been unable to record this. I anticipate that his condition was again unchanged. 5 separate pressure sore areas were noted by the nurses. A Barthel score of only 1 was recorded.

Mr PACKMAN was reviewed the same day by Consultant Geriatrician Dr REID . Dr REID noted that Mr PACKMAN was rather drowsy but comfortable. He had been passing melaena stools. His abdomen was noted to be huge but quite soft and Dr REID also recorded the presence of the pressure sores over the buttocks and across the posterior aspects of both thighs. He noted that Mr PACKMAN remained confused and was for "TLC". The Frusemide and Doxazosin were to be discontinued and Mr PACKMAN's wife was said to be aware of his poor prognosis.

The entry by Dr REID that Mr PACKMAN was to have "TLC" - tender loving care - was clearly an indication that Dr REID also considered Mr PACKMAN to be terminally ill. Dr REID had the opportunity to review the medication which Mr PACKMAN was receiving at that time and clearly felt it appropriate.

Sister HAMBLIN recorded later in the nursing records that the syringe driver was renewed at 7.15pm (1915) with 60 mgs of Diamorphine and 60 mgs of Midazalam subcutaneously as the previous dose was not controlling Mr PACKMAN's symptoms. It appears therefore that Mr PACKMAN was experiencing yet further pain and discomfort. I anticipate that the nursing staff would have contacted me and that I authorised this moderate increase in his medication in order to alleviate the pain and distress.

That night, Mr PACKMAN was noted to be incontinent of black tarry faeces but otherwise he had a peaceful night and the syringe driver was said to be satisfactory.

I believe I would have reviewed Mr PACKMAN again the following day, 2nd September. The nursing notes show that his medication was again increased, the Diamorphine to 90 mgs and the Midazalam to 80 mgs subcutaneously. I anticipate again that Mr PACKMAN would have been experiencing pain and distress and that I and the nursing staff were concerned that the medication should be increased accordingly to ensure that he did not suffer pain and distress as he died. That night, Mr PACKMAN was said to remain ill, but was comfortable and the syringe driver was satisfactory.

Sadly, Mr PACKMAN passed away on 3rd September 1999 at 1.50pm (1350). My belief was death would have been consequent on the myocardial infarction.

The Oramorph, Diamorphine and Midazalam were prescribed and in my view administered solely with the aim of relieving Mr PACKMAN's pain and distress, ensuring that he was free from such pain and distress as he died. At no time was any medication provided with the intention of hastening Mr PACKMAN's demise.

DC YATES — Thank you. I must, I don't think there's anything that needs altering on that unless you've made any, again doctor thank you it's a very full prepared statement. Can I ask you if you would to sign it and date it and time it as being handed to me DC YATES? Mr BARKER would you care to countersign it, thanks? Thank you. For the purpose of the tape I'll give this prepared statement an identification reference of JB/PS/11. Doctor we'll call a stop to the interview now so that we can go away and consider the statement that you've just read out. I may well wish to put a number of questions to you about this statement if I do would you be prepared to answer those questions?

BARTON — No.

DC YATES — No okay.

BARKER — Can I just say?

DC YATES — Yeah.

BARKER — That's on the basis of the advice previously tended and for the reasons previously given which I know is ...

DC YATES Okay. Is there anything that you wish to clarify Doctor?

BARTON No thank you.

DC YATES Is there anything you wish to add? Right we'll give you a notice explaining what will happen to the tapes and the tape recording procedure. The time is 9.41 (0941) hours and we'll turn the recorder off.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AI

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

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 0901 Time concluded: 0940

Duration of interview: 39 MINUTES Tape reference nos. (→)

Interviewer(s):

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This interview is being tape recorded. I am DC Code A Chris YATES. My colleague is?
DC Code A	DC Code A
DC YATES	I'm interviewing Doctor Jane BARTON. Doctor will you please give your full name and your date of birth?
BARTON	Jane Ann BARTON, Code A
DC YATES	Also present is Mr BARKER, who is Doctor BARTON's

solicitor. Can you please introduce yourself here for me?

BARKER — Certainly it's Ian Steven Petrie BARKER and I am Doctor BARTON's solicitor.

DC YATES — Thank you. This interview is being conducted in an Interview Room at Fareham Police Station in Hampshire. The time is 0901 hours and the date is the Thursday the 6th of April 2006 (06/04/2006). At the conclusion of the whole interview process doctor, I will give you a notice explaining what will happen to the tapes okay. 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 YATES — If at any time you wish to stop the interview and take legal advice, then if you just say doctor and we will stop the interview and you can do that. I'd also like to point out that you have attended voluntarily and so you're not under arrest, you've come here of your own free will and so if at any time you wish to leave you know you're free to do so okay.

BARTON — Thank you.

DC YATES — 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 and anything you do say may be given in evidence. Do you understand that caution doctor?

BARTON I do.

DC YATES (Inaudible) I'll break it up again anyway. The caution can be broken into three sections. The first, which is the very simple bit, is that it is your right not to say anything when asked questions by us okay. The second part is the slightly more confusing part and that is if this matter should go to court, and as I say 'even 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 a court might think, or draw an inference and say: "Why didn't you say that earlier?" The third and last part again is quite simple, the interview is being recorded and so should the matter go before a court a transcript of the interview can be read out, or the tapes can be played. Are you quite happy with the sound of that?

BARTON Thank you.

DC YATES On this occasion the room is equipped with a remote monitoring facility, it's that red light on top of the tapes there doctor. When that red light is on it means it's being monitored, and it is being monitored at the moment by Detective Inspector GROCOTT. It's being monitored purely just to facilitate any enquiries we might want to do as a result of this interview quickly. When those tapes are

turned off though nothing can be heard in this room throughout the remote facility, so if you want to take legal advice or anything like that you can do in this room, it can't be heard. So that will be me speaking to you the majority of the time, DC Code A will be taking some notes and he will also be asking some questions. Now Operation Rochester, this is an investigation that's being conducted by the Hampshire Constabulary and it started in September 2002, so this particular investigation has been running for over three years now. It is an investigation into allegations of the unlawful killing of a number of patients at the Gosport Ware Memorial Hospital between 1990 and 2000. Now no decision has been made as to whether an offence, or any offence has been committed but it's important for you to be aware that the offence range being investigated runs from potential murder right the way down to assault. Now part of the ongoing enquiries is to interview witnesses who were involved in the care and treatment of the patients at the hospital during that period. You were a clinical assistant at the Gosport War Memorial Hospital at the times of these deaths, so your knowledge of the working of the hospital and the care and the treatment of the patients is very central to our enquiry. Today doctor in this interview we will be concentrating on the patient Geoffrey PACKMAN. He was a 68 year-old-man admitted to Dryad Ward on the 23rd of August 1999 (23/08/1999) from the Queen Alexandra Hospital. He died on the 3rd of September 1999 (03/09/1999). Now I'm going to ask you quite a few questions today and all these groups of questions will come under particular topics and headings, and what I'll try to do is I'll endeavour to explain each

topic at the start.

BARKER Can I just indicate the,...

DC YATES Uh-huh.

BARKER ...just confirm again the nature of the advise that I've given Doctor BARTON that she should make 'no comment' to the questions that you put her and invite her to indicate if she accepts that advise and for the reasons that she's previously stated to.

BARTON (Silent.)

DC YATES Yeah that's okay. Now that's the advice given to you by your solicitor, it's entirely up to you whether you take that advice, but I still have a duty to ask you a number of questions, which I propose to do okay. Right the following questionnaire is designed so that we can try and get an explanation from you as to the role you performed in the care and treatment of Geoffrey PACKMAN. The questions follow on from the initial 'prepared statement' that you tendered during a voluntary interview in 2005. The explanations or lack of that you give will be considered by the senior investigating officer as to whether they will ultimately be sufficient evidence to formulate criminal charges. The asking of each of these questions seems fundamental to the overall investigation of this case and will therefore take some time. Now it is important that you are given sufficient time to understand and reflect on the question and any answer before we ask you further

questions, so there will be gaps after the questions, this is purely so that you can consider your reply. Now you were given copies of Geoffrey PACKMAN's Medical Records back in 2005. Is that correct?

BARTON Correct.

BARKER And I am confirming that as well.

DC YATES Yeah. And you've also got a copy of your own 'prepared statement', is that right?

BARTON (Silent)

DC YATES Right the first topic area I would like to cover today is 'clerking'. Now clerking the patient is essential to ensuring that the patient's needs and treatments are identified and that suitable care plans are put in place. And what I want to establish is what you believe is the purpose of 'clerking' and what your own procedures were? I also want to try and identify what you see as the role of either the nurse or the doctor in clerking? (Pause) The GMC, General Medical Council booklet for Good Medical Practice, which we have a copy of here, a photocopy of, and it's got an identification reference of CSY/HF/2. In here, I'll leave this if you want to consult it doctor, it states that 'Good clinical care must include adequate assessment of the patient's condition based on the history and symptoms and, if necessary, an appropriate examination'. And it goes on after that to say - 'In providing care you must keep clear, accurate, legible and contemporaneous patient records, which report the

relevant clinical findings with decisions made, the information given to patients and any drugs or other treatments prescribed'. And it also goes on to say – 'Good clinical care must include taking suitable, prompt action where necessary', and that's going to form quite an important part of today's questions. Also it says – 'Prescribe drugs, including repeat prescriptions only when you have adequate knowledge of the patient's health and medical needs'. Doctor did you provide a suitable and adequate assessment of Mr PACKMAN's care?

BARTON — No comment.

DC YATES — What is the purpose of the clinical assistant in the context of looking after patients?

BARTON — No comment.

DC YATES — We have here a copy of the Job Description for the Clinical Assistant at the hospital and it's got an identification reference of GJQ/HF/14, and it lists thirteen duties. Have you read this document?

BARTON — No comment.

DC YATES — (Pause) The duties, the thirteen duties are to visit the units on a regular basis and to be available on call as necessary. To ensure that all new patients are seen promptly after admission. To be responsible for the day-to-day medical management of patients. To be responsible for the writing up of the initial case notes and to ensure that follow up

notes are kept up-to-date and reviewed regularly. To complete upon discharge the Discharge Summary, an HRM60. To ensure the prompt preparation of Death Certificates and Cremation Certificates where appropriate. To take part in the weekly consultant rounds. To prescribe, as required, drugs for the patients under the care of the consultant physicians in geriatric medicine. To participate, wherever possible, in the multi disciplinary case conferences and discussions related to the patients on the unit. To provide clinical advice and professional support to other members of the caring team. To identify opportunities to improve services so that a high level of care can be provided within the resources available. To be available, when required, to advise and counsel relatives and to be responsible for liaison with the general practitioners with whom the patient is registered with other clinicians and agencies as necessary. Did you carry out these duties in your role?

BARTON — No comment.

DC YATES — How often doctor would you visit the patients?

BARTON — No comment.

DC YATES — I believe you have said in previous statements that 'you would visit the patients Monday to Friday between half-seven and nine o'clock (that's in the morning), virtually every lunchtime and quite often about 1900, seven o'clock in the evening especially if you were the duty doctor'. Is that correct?

BARTON — No comment.

DC YATES — Doctor could you take me through what your daily routine was?

BARTON — No comment.

DC YATES — As I mentioned before you've implied that 'you visit the hospital between half-past-seven (0930) and nine o'clock every morning'. Is it correct that you then have your GP Practice to attend between nine (0900) and eleven (1100) every morning?

BARTON — No comment.

DC YATES — And quite often don't leave until half-eleven (1130)?

BARTON — No comment.

DC Code A — (Inaudible – mumbles).

DC YATES — Now that was every morning Monday to Friday. Is it correct that you also had other duties at your practice?

BARTON — No comment.

DC YATES — Did you have other clinics to attend?

BARTON — No comment.

DC YATES Did also, on a Tuesday evening, have an evening surgery between half-past-four (1430) and quarter-past-five (1715)?

BARTON No comment.

DC YATES Is that in rotation with your partners?

BARTON No comment.

DC YATES Did you used to conduct post-natal, the post-natal clinic on a Monday afternoon...

BARTON No comment.

DC YATES ...between half-past-one (1330) and half-past-three (1530)?

BARTON No comment.

DC YATES On a Thursday, again in the afternoon, did you attend an anti-natal clinic between half-past-one (1330) and four o'clock?

BARTON No comment.

DC YATES And on a Friday afternoon between half-past-one (1330) and three o'clock and immunisation clinic?

BARTON No comment.

DC YATES Is your name included on the Obstetric list?

BARTON No comment.

DC YATES Doctor (pause) this is information that was requested back in January 1990, it's a questionnaire, a medical list and local directory of family doctors and it actually has an identification reference of...

DC Code A GJQ/HF/1.

DC YATES Oh lovely thank you. Which has been filled in by hand. On Page 13, is that your signature doctor?

BARTON No comment.

DC YATES In relation to Mr PACKMAN, why was he admitted to the Gosport War Memorial Hospital?

BARTON No comment.

DC YATES And what was the purpose of his stay?

BARTON No comment.

DC YATES And why was he admitted to Dryad Ward?

BARTON No comment.

DC YATES Well where did Mr PACKMAN come from before he went to Dryad Ward?

BARTON No comment.

DC YATES — Doctor is it correct that Mr PACKMAN came on the 23rd of August 1999 (23/08/1999) from the Queen Alexandra Hospital?

BARTON — No comment.

DC YATES — Doctor what is 'continuing care'?

BARTON — No comment.

DC YATES — (Inaudible – speaks to DC Code A.

Doctor can I draw your attention to a document...

DC Code A — CSY/HF/4.

DC YATES — HF/4, Portsmouth Health Care NHS Trust. It's the Department Of Medicine For Elderly People Essential Information for Medical Staff. There is an entry here about 'continuing care and long stay', and on the fifth (5th) paragraph it says: "It is often difficult to know on first encounter if the patient on the ward whether they are appropriate for continuing care or not. Patients who are severely physically disabled and require a medical input can go to continuing care for a period of assessment over a few weeks to one month. If at the end of that time they have complex medical problems that need continuing input from nursing, medical and other professionals, and their Barthel score is lower than four our to twenty (4/20) then they should be appropriately cared for on continuing care. Some

of these patients will improve with time, in which case the situation would have to be reviewed. Those patients who do not need regular input from a specialist team would be most appropriate for nursing home care. This assessment should be explained to patients and their families'. Now would you say that that is a fair definition of continuing care?

BARTON No comment.

DC YATES Is that a definition you are familiar with Doctor BARTON?

BARTON No comment.

DC YATES So what is the difference between 'continuing care' and 'rehabilitation'?

BARTON No comment.

DC YATES And 'palliative care'?

BARTON No comment.

DC YATES (Pause) Doctor if I may draw your attention to Page 54 of the medical notes for Geoffrey PACKMAN, which are BJC/34 and they're the clinical notes. On the 23rd of August 1999 (23/08/1999), which is when Mr PACKMAN came into the hospital, he was seen by a doctor. Are they your notes doctor?

BARTON No comment.

DC YATES — Now there's a page of notes here where the patient has been initially seen by a doctor and it was Doctor RAVI...

DC Code A — RAVINDRANE.

DC YATES — RAVINDRANE. There's on full page of notes there. Is that what you would expect to see when the patient was clerked?

BARTON — No comment.

DC YATES — On either admission or transference of a patient to the ward, what process should then take place?

BARTON — No comment.

DC YATES — Is that what clerking is?

BARTON — No comment.

DC YATES — Who should carry out this function?

BARTON — No comment.

DC YATES — Should it be a doctor?

BARTON — No comment.

DC YATES — Should it be a nurse?

BARTON No comment.

DC YATES Were you present at the time of Mr PACKMAN's admission?

BARTON No comment.

DC YATES What notes would be available at the time of Mr PACKMAN's admission?

BARTON No comment.

DC YATES Would the notes from the Queen Alexandra Hospital accompany Mr PACKMAN to the War Memorial Hospital?

BARTON No comment.

DC YATES So what is then the purpose of the initial clerking?

BARTON No comment.

DC YATES What is an adequate assessment for the patient's condition?

BARTON No comment.

DC YATES Again if I show you again Page 54, I've shown you that before, it's a page of notes made by a doctor, that's on Mr PACKMAN's initial attendance at the hospital on the 23rd of August 1999 (23/08/1999). For the rest of his stay there's less than a page. Now in fact I believe you've just made two more entries on there. (Pause) Is that what you

would say was that 'an adequate assessment for the patient when they arrived at the hospital'?

BARTON — No comment.

DC Code A — (Pause) Shall we take the doctor through that entry Chris?

DC YATES — Yeah.

DC Code A — That entry doctor, you have a copy available I believe in front of you, if you just have a look at it. It reads (1) Obesity, (2) Arthritis bilateral knees, (3) Immobility, (4) Pressure sores. On a high protein diet. Query Myeloma 13/08/1999, HP stable, Q15 29, constipated on Doxazosin, MST = very good better in himself, 0JVP, CVS. Now do you think that that was a reasonable example of how to clerk-in a patient?

BARTON — No comment.

DC YATES — Now Mr PACKMAN actually suffered a fall and that's why he was initially admitted to the Queen Alexandra Hospital. Again I'll draw your attentions to Pages 44 and 45 of the medical notes. There's two pages here as an initial assessment for the clerking. Is this what you would expect to see?

BARTON — No comment.

DC YATES — So why is this initial assessment important?

BARTON No comment.

DC YATES What examination did you carry out on Mr PACKMAN?

BARTON No comment.

DC YATES So what baseline were you and your colleagues going to have if Mr PACKMAN's condition changed?

BARTON No comment.

DC YATES Would this one page assessment and clerking on Page 54 of medical notes, is what the baseline is?

BARTON No comment.

DC YATES Is it your normal practice just to write on notes at the time of admission that you're happy for staff to confirm death?

BARTON No comment.

DC YATES Had you formed the opinion that Mr PACKMAN was at the terminal phase of his life?

BARTON No comment.

DC YATES If you had, why?

BARTON No comment.

DC YATES Because after the initial assessment the next entry of his

clinical notes is the 26th of August, and your last sentence on that eight line entry was: "I am happy for the nursing staff to confirm death." What was wrong with Mr PACKMAN?

BARTON — No comment.

DC YATES — (Pause) Again DC Code A read out the initial assessment, or clerking and it appears as obesity, arthritis, immobility and pressure sores and Myeloma. Was there anything else wrong with Mr PACKMAN?

BARTON — No comment.

DC YATES — At that stage doctor, although it was (inaudible) Myeloma, at that stage his HP was stable. Was that significant to you?

BARTON — No comment.

DC YATES — And his mental test score has been recorded as 'very good'. He's not suffering from any pain he's better in himself. It would appear that he is obese, the immobility is probably because of the obesity and he has pressure sores. What else was wrong with the man?

BARTON — No comment.

DC YATES — It directly links to clerkings initial assessments, and I would like to see if I can identify what you consider to be the fundamental purpose of initial assessments of a patient?

BARTON — No comment.

DC Code A — Can I just ask her one more question please?

DC YATES — Yeah sure.

DC Code A — Doctor just going back to that you wrote: "I am happy for nursing staff to confirm death," on the 26/08 after Doctor RAVINDRANE had seen him on the 23rd. What was he dying of?

BARTON — No comment.

DC Code A — You must have thought he was dying for you to have written that surely?

BARTON — No comment. (Somebody coughs)

DC Code A — Okay.

DC YATES — Right so we'll move on to 'initial assessment' then doctor and I'd like to identify what you consider to be the fundamental purpose of the initial assessment with a patient, specifically this will include what routine you follow and the reasons behind the assessment and what the benefit is to both the patient and the medical practitioners. Okay I'm going to quote from the Good Medical Practice from the General Medical Council, which is CSY/HF/2, the copy it's still on my desk there, and that states that 'good clinical care must include adequate assessment for the patient's condition based on the history and symptoms and,

if necessary, an appropriate examination'. Now I believe that the purpose of the initial assessment should be to provide a contemporaneous record of a doctor's interaction with their patient for analysis by all medical staff. What was your standard practice when it came to initial assessments?

BARTON — No comment.

DC YATES — What is the purpose of an initial medical assessment with a patient when they arrive on the ward?

BARTON — No comment.

DC YATES — Who would you expect to make an entry on the medical notes?

BARTON — No comment.

DC YATES — Who would you be expecting to read the entry?

BARTON — No comment.

DC YATES — So as the clinical assistant doctor when would you see a patient for the first time?

BARTON — No comment.

DC YATES — Now the initial assessment in the case of Mr PACKMAN was conducted by another doctor, Doctor RAVINDRANE. When did you first see the doctor, uh first see the patient?

BARTON No comment.

DC YATES Your first notes were recorded on the 26th of August, which is three days later. Why would that be?

BARTON No comment.

DC YATES So what physical examination of Mr PACKMAN did you carry out?

BARTON No comment.

DC YATES What assessment, or examination did you carry out on Mr PACKMAN?

BARTON No comment.

DC YATES Just the basic things then doctor, who took his temperature.

BARTON No comment.

DC YATES Who took his pulse?

BARTON No comment.

DC YATES Who took his blood pressure?

BARTON No comment.

DC YATES Who listened to his heart and lungs etcetera?

BARTON No comment.

DC YATES And where was this recorded?

BARTON No comment.

DC YATES Now just taking Mr PACKMAN, what were you treating him for?

BARTON No comment.

DC YATES You've had access to the medical notes now, do you know what you were treating him for?

BARTON No comment.

DC YATES What medical management did you put in place for Mr PACKMAN?

BARTON No comment.

DC YATES What was your Medical Care Plan for Mr PACKMAN?

BARTON No comment.

DC YATES If I refer to Pages 82 and 83 of Mr PACKMAN's medical notes, BJC/34, it's the Nurses' Care Plan and it's to deal with Mr PACKMAN obviously and his bowels. On the 23rd of August the problem identified is that due to immobility Mr PACKMAN was prone to constipation,

there was then a desired outcome, which is to try to achieve a regular bowel movement pattern. The evaluation date (inaudible) was daily. Well the nursing action was for, to try and encourage adequate fibre in Mr PACKMAN's diet, to encourage adequate fluid intake, to ensure privacy at all times and to administer...

DC Code A (Inaudible)

DC YATES ...(inaudible) as prescribed, and then after that there's all the notes made by the nurses PWO – bowels open. Is that what you would say was a well laid out Nursing Care Plan?

BARTON No comment.

DC YATES And there are Nursing Care Plans then for all sorts of aspects for Mr PACKMAN's care, there's urinary catheter, his personal hygiene and it goes on. Who instructs the nurses and what care plans should be put in place?

BARTON No comment.

DC YATES Well where do the nurses get their directions from?

BARTON No comment.

DC YATES Who sets the care plans?

BARTON No comment.

DC YATES So how do nurses know what care plans to put into place?

BARTON No comment.

DC YATES Is it something that's left to chance and the nurses just put in whatever care plans that they see fit?

BARTON No comment.

DC YATES So what directions are given to them by doctors?

BARTON No comment.

DC YATES Have you got anything?

DC Code A Yeah. (Pause) When Geoffrey PACKMAN came in on the 23rd Doctor RAVINDRANE wrote down a full page from his initial assessment and it looks like the nurses have taken up on that, so they've got a reasonably clear lead as to what they should be doing with Mr PACKMAN and DC YATES has just read out one page of the Nursing Care Plan and it looks as if the Nursing Care Plan is fairly reasonable and there are a few pages of it. You have been told, you have been cautioned at the start of this interview doctor and I think it's important for us to remind you that your solicitor has advised you to go 'no comment', but we will remind you that this is an opportunity for you to tell us what you know about Geoffrey PACKMAN in particular. Now if you look at this, in the absence of a 'no comment' interview, in the absence of anything from you it looks to me, looking at it, as if you just let the nurses get on with caring for Mr PACKMAN with minimal input from you.

BARTON — No comment.

DC Code A — We again you say 'no comment', but that is an interpretation that I can put on that at the moment, there's very very little written by you in these medical notes,...

BARTON — No comment.

DC Code A — ...so do you just rely on the experience of the nurses to just get on and look after Mr PACKMAN as best they can?

BARTON — No comment.

DC Code A — Thank you.

DC YATES — With the clerking and the initial examination, Doctor RAVINDRANE he noted that Mr PACKMAN's ongoing problems were obesity, arthritis in his knees, immobility, pressure sores and constipation. He noted that Mr PACKMAN was on a high protein diet, he queried Myeloma on the 13th of August 1999 (13/08/1999), his haemoglobin was stable, he was better in himself with a good mental test score and no pain. So there was little to find on examination of him, but his obesity, swollen legs and pressure sores, is that correct doctor?

BARTON — No comment.

DC YATES — I can refer you back to Page 54 of the medical notes if you wish.

BARTON No comment.

DC YATES But it does look like yet another example of you relying on nurses to inform you of any changes in the patients' conditions. Is that what was happening at the War Memorial doctor?

BARTON No comment.

DC YATES If I refer you again doctor back to the document GJQ/HF/14, it's a Job Description and other duties. Duties (3) to be responsible for the day-to-day medical management of the patients, and (4) to be responsible for the writing up of the initial case notes and to ensure that follow-up notes are kept up-to-date and reviewed regularly. That's your job description doctor, did you do that?

BARTON No comment.

DC YATES If you didn't, who did?

BARTON No comment.

DC YATES Anything on that?

DC Code A No.

DC YATES Right that tape is on about forty (40) minutes so it will buzz in a minute. What I'll do then is I'll, we'll stop the interview here and put another tape in, so the time by my

watch is 0940 hours and we'll turn the recorder off.

THE INTERVIEW CONCLUDED – THE TAPE MACHINE WAS SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AJ

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

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 0942 Time concluded: 1017

Duration of interview: 35 MINUTES Tape reference nos.
(→)

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

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This is a continuation of the interview with Doctor BARTON. The time is 0942 hours. Doctor can I just ask you to confirm that while the tapes were off there has been no conversation about this matter?
BARTON	None.
DC YATES	Thank you. Right the same people are present. I must remind you doctor that you are still under caution as well. I would like to move, if I may, on to 'existing treatment and conditions', and in this case it is the case of Mr

PACKMAN. What specific ailments was he suffering from? I will ask questions to get an understanding of why you've prescribed various medicines, also to seek an explanation as to what Medical Records would have been available to you and what you would have reviewed, and in order to offer the correct and appropriate care medical practitioners should be aware of pre-existing medical history, prescriptions and care plans. So what notes would have been available to you when a patient arrived at the ward?

BARTON No comment.

DC YATES What process would you normally follow upon a patient's arrival at the Gosport War Memorial Hospital?

BARTON No comment.

DC YATES What was Mr PACKMAN suffering from that necessitated him being admitted to the hospital in the first place?

BARTON No comment.

DC YATES Would it be right in saying obesity, swollen legs and pressure sores?

BARTON No comment.

DC YATES (Pause) What medication was Mr PACKMAN taking at the time of the transfer?

BARTON No comment.

DC YATES (Pause) On the Drug Chart, which is on Page 170 and 168 actually, that reveals that he was on, he was continued on regular Doxazosin 4 milligrams once a day, Frusemide 80 milligrams once a day and (Inaudible) 40 milligrams twice a day, Paracetamol 1 gram four times a day. He was commenced on Magnesium Hydroxide 10 millilitres twice a day, I believe that's a laxative and that was subsequently taken intermittently, which was two doses on the 24th and one dose on the 25th, two doses on the 28th, 29th and one dose on the 30th, and as required Gaviscon. Is that correct doctor?

BARTON No comment.

DC YATES What was the purpose of these drugs?

BARTON No comment.

DC YATES Now later Oramorph was prescribed, why was this?

BARTON No comment.

DC YATES (Pause) On Page 172 of Mr PACKMAN's medical notes (pause), Oramorph was prescribed on the 26th of August. Why was this doctor?

BARTON No comment.

DC YATES (Pause) Where is it recorded what the Oramorph was

prescribed for?

BARTON — No comment.

DC YATES — It's not is it doctor?

BARTON — No comment.

DC YATES — Why isn't it recorded anywhere?

BARTON — No comment.

DC Code A — Doctor I think we've established that it wasn't recorded. This patient came into hospital in 1999 and we are now in the year 2006. If we can't glean from the records why he was on Oramorph then, how could anybody looking at the records in 1999, how can anybody tell what it was for then as well. So if we don't know how did anybody know then?

BARTON — No comment.

DC Code A — How did the nursing staff know what he was on the Oramorph for?

BARTON — No comment.

DC Code A — How would any other medical personnel know what he was on the Oramorph for?

BARTON — No comment.

DC Code A — If somebody was called out during the night or over a weekend when you weren't available, how would they know what the Oramorph was for?

BARTON — No comment.

DC Code A — Similarly when you wrote in your note: 'Happy for staff to confirm death," on the 26th of August. If another doctor had been called out, how would they have known what he was dying from?

BARTON — No comment.

DC Code A — I think that's a fairly reasonable question to ask doctor don't you?

BARTON — No comment.

DC Code A — I think a doctor being called out to examine Geoffrey PACKMAN, after you wrote that note, would be entitled to know why you wrote it.

BARTON — No comment.

DC Code A — Similarly he'd be entitled to know why you prescribed Oramorph.

BARTON — No comment.

DC Code A — Chris.

DC YATES He wouldn't have been just entitled, he would need to know wouldn't he doctor?

BARTON No comment.

DC YATES Right. But on the same point wouldn't Geoffrey PACKMAN be entitled for any doctor treating him to understand what his current condition was?

BARTON No comment.

DC YATES And how could a doctor being called out understand what the current condition was properly assessing if you hadn't written down what you had done?

BARTON No comment.

DC YATES (Pause) Doctor I'd like to move on and talk about the purpose of Mr PACKMAN's stay and of your aims, your plans. Now care plans are put in place to allow a nurse and medical practitioner to follow a particular course of action. The progress of the patient is going to be monitored and the results reviewed and then the care can be altered accordingly. What I want now is to try and get an explanation as to how you were directly involved in the process of establishing care plans. What is the purpose of a 'care plan' doctor?

BARTON No comment.

DC YATES What input do you have in that 'care plan'?

BARTON No comment.

DC YATES What was the 'care plan' that was put into place in respect of Mr PACKMAN?

BARTON No comment.

DC YATES Did that 'care plan' ever change?

BARTON No comment.

DC YATES If it did why did it change?

BARTON No comment.

DC YATES Who was the main nurse for Mr PACKMAN?

BARTON No comment.

DC YATES From the notes I believe that to be Nurse Freda SHAW. What was her role?

BARTON No comment.

DC YATES Now I think Nurse Freda SHAW will be, as the main nurse have more contact than any other nurse with Mr PACKMAN and she certainly would have some sort of direct responsibility. So what did you discuss with her?

BARTON No comment.

DC YATES What have you recorded as the 'care plan'?

BARTON No comment.

DC YATES So was Freda SHAW left to her own devices?

BARTON No comment.

DC YATES Who decided on what the 'care and treatment plan' would be for Mr PACKMAN then?

BARTON No comment.

DC YATES How would the 'care plans' be drawn up?

BARTON No comment.

DC YATES Well doctor who was responsible for the treatment of Mr PACKMAN on a day-to-day basis?

BARTON No comment.

DC YATES Who was in overall charge of the care of Mr PACKMAN?

BARTON No comment.

DC YATES (Sneezes) Excuse me. What planned investigations were you going to carry out?

BARTON No comment.

DC YATES — Geoff do you want to ask anything?

DC Code A — No.

DC YATES — (Sneezing) I'm having a sneezing fit I'm sorry.

BARTON — No comment.

DC Code A — Only this then, (DC YATES sneezes) did you just leave the 'care plans' to the nurses?

BARTON — No comment.

DC YATES — Did you have no input into the 'care plans' at all?

BARTON — No comment.

DC YATES — Well surely the nurses would need some guidance from the doctors, otherwise why have doctors?

BARTON — No comment.

DC Code A — Okay.

DC YATES — Right. Medical Records then doctor. The recordings of interactions with patients, as we've said before, is a fundamental requirement of the Health Care Professional. In the Good Medical Practice, it's set out by the GMC that states that 'a doctor must keep clear, accurate, legible and contemporaneous records which report the relevant clinical

findings and decisions made, the information given to patients and any drugs or other treatment described. That's on Page 3 of the Good Medical Practice, which is left on the desk, CSY/HF/2. So feel free to browse through that doctor. In addition that booklet states, well there's a booklet called Withholding and Withdrawing Life Prolonging Treatments...

DC Code A — GJQ/HF/15.

DC YATES — ...and on Page 30 of this document, or this book, it specifically states that 'the decision making process should be recorded'. Now with these documents in mind, I want to seek an explanation as to how you completed Medical Records, and in particular those records of Mr PACKMAN's? And I'll leave this book here for you as well doctor?

BARTON — No comment.

DC YATES — Doctor what would you record in the Medical Records of a patient, and what importance did you place on the completion of the records?

BARTON — No comment.

DC YATES — What would you expect to see recorded in the patient notes on a day-to-day basis?

BARTON — No comment.

DC YATES And in that question I include the nursing and medical notes doctor?

BARTON No comment.

DC YATES Did you normally complete records to the standards set out by the GMC?

BARTON No comment.

DC YATES In fact in relation to the Good Medical Practice, the GMC booklet CSY/HF/2, doctor can you confirm if you got a copy of this booklet each year when you renewed your subscription?

BARTON No comment.

DC YATES Right the records of Mr PACKMAN. Other than on the Prescription Charts, there are only two pages of clinical notes for the War Memorial Hospital, which you have made entries on the 26th and the 28th of August. Where in those entries doctor have you recorded that Mr PACKMAN was in pain?

BARTON No comment.

DC YATES Would you like to see these?

BARTON No comment.

DC YATES Where on Page 54, which is the initial assessment by

Doctor RAVINDRANE, is it recorded that Mr PACKMAN was in pain?

BARTON — No comment.

DC YATES — In fact would be right to say it was recorded that 'he was not in pain'?

BARTON — No comment.

DC YATES — Doctor what is the Analgesic Ladder?

BARTON — No comment.

DC YATES — Show me your description bit.

DC Code A — Sure.

DC YATES — That yellow piece.

DC Code A — (Pause) Just before we leave that last section doctor...

For the benefit of the tape DC YATES and DC Code A talk amongst each other regarding the Analgesic Ladder.

DC Code A — Before we leave that last section about Mr PACKMAN being in pain and you haven't recorded anywhere in those notes what the pain was or where it was, I'm sure like DC YATES I've seen lots of Medical Records over the years in various cases I've worked on and is it not a common practice for doctors to draw diagrams of parts of the body

indicating where a pain is emanated from, am I right?

BARTON — No comment.

DC Code A — And isn't that, the reason for that is so that it makes it clear to anybody else who picks up on that patient to see where pain is coming from?

BARTON — No comment.

DC Code A — So it indicates, it clears up any ambiguity as to where the pain is coming from, not necessarily what's causing it but where it's coming from?

BARTON — No comment.

DC Code A — For instance where the patient is complaining of the pain?

BARTON — No comment.

DC Code A — I don't think I've seen any diagrams from you regarding patients' pain. I

BARTON — No comment.

DC Code A — Do you not feel that that is a good idea to draw diagrams of patients then?

BARTON — No comment.

DC Code A — Is that a practice that you don't adhere to? I

BARTON No comment.

DC Code A Is it a practice you disagree with or some reason?

BARTON No comment.

DC YATES In fact Page 45 of these medical notes, QA notes there's some diagrams here doctor, these are the sort of things that DC Code A was talking about. Do you make any such diagrams?

BARTON No comment.

DC Code A Doctor we've just asked you about the Analgesic Ladder haven't we, and I am confident that you must be aware of the Analgesic Ladder. Am I right?

BARTON No comment. (Somebody coughs).

DC Code A From exhibit CSY/HF/6, these are blank Gosport medical documents from the War Memorial Hospital this is, I'm showing you a yellow copy, it's a newish document I believe. Can you see that?

BARTON No comment.

DC YATES Would you like to have a look at it?

BARTON No thank you.

DC YATES It sets out the Analgesic Ladder and it says that 'this is adopted from the WHO Analgesic Ladder and it's very very similar to the one available to you in the Wessex Protocol and it starts off (somebody coughs), it's in several steps isn't it? The first step being Step (1) Mild Pain and this is drugs, which are non-opioid such as Paracetamol, Diclofenac, Co-prox (pause), yes sorry Diclofenac etcetera, etcetera, yes, yeah? And then as the pain increases to a moderate pain you move up the ladder to weak opioids such as Codeine with Paracetamol, Co-codamol, Dihydrocodeine, Tramadol, etcetera, and then eventually we end up, if pain increases to severe pain, to Step (3) which are your strong opioids and these are basically your Morphine based drugs aren't they doctor?

BARTON No comment.

DC YATES So these would be your Oramorphs, MSTs, Diamorphine, Morphine. Is that right?

BARTON No comment.

DC YATES Is the Analgesic Ladder something that you follow when prescribing medicines for analgesics and painkillers?

BARTON No comment.

DC YATES Were you aware of the Analgesic Ladder in 1999?

BARTON No comment.

DC YATES So what previous painkillers had Mr PACKMAN been prescribed?

BARTON No comment.

DC YATES Is that right Paracetamol four times a day doctor?

BARTON No comment.

DC YATES Why isn't there any documentation, and I know we keep coming back for this, but why isn't there any documentation relating to why Morphine or other strong analgesics were prescribed?

BARTON No comment.

DC YATES Why was Oramorph prescribed without an alternative?

BARTON No comment.

DC YATES And why isn't there an entry in the Medical Records explaining why Mr PACKMAN was prescribed Diamorphine?

BARTON No comment.

DC YATES Code A?

DC Code A No.

DC YATES (Inaudible) about the topic about Ward Rounds and these

are an opportunity for doctors and nurses to review a patient aren't they to discuss and decide upon further or change treatment? So as such they too are an integral part of a doctor's duties, and what I'd like to do is get an explanation from you as to how you conducted your rounds, and the role that you saw ward rounds played in the care and treatment of a patient and in particular Mr PACKMAN. So how often did you conduct your rounds doctor?

BARTON — No comment.

DC YATES — Will I be right in saying that in the document that we've given an identification reference of GJQ/HF/14, which is the Job Description for the Clinical Assistant at Gosport War Memorial Hospital, Duty (1) was to visit the units on a regular basis and to be available on call as necessary. Did you do a round every time you visited the wards?

BARTON — No comment.

DC YATES — Who would you conduct your rounds with?

BARTON — No comment.

DC YATES — What time of day would you conduct your rounds doctor?

BARTON — No comment.

DC YATES — Now you've previously stated that you visited the ward every morning between half-past-seven (0730) and nine (0900), most afternoons and some evenings. We know that

you had certainly three afternoon commitments with the surgery, but you certainly state that 'you visited the hospital every morning'. Would you conduct a round every morning?

BARTON No comment.

DC YATES What was the purpose of the ward rounds?

BARTON No comment.

DC YATES How long did they take?

BARTON No comment.

DC YATES If you conducted ward rounds, would the nurses accompany you?

BARTON No comment.

DC YATES Would the nurses have any input into the rounds?

BARTON No comment.

DC YATES (Coughs) In what form did the ward rounds take place?

BARTON No comment.

DC YATES Would the ward rounds consist of visiting each patient at their bed, or you conducted in an office with the nursing staff?

BARTON No comment.

DC YATES How often did the consultants conduct, well the consultants conduct their rounds?

BARTON No comment.

DC YATES Again Duty (7) from your Job Description, which is GJQ/HF/14, states that you should take part in the weekly consultant rounds. I would assume from your Job Description that the consultant rounds were weekly. Did you take part?

BARTON No comment.

DC YATES What time of the day did the consultant rounds take place?

BARTON No comment.

DC YATES Was it after nine o'clock?

BARTON No comment.

DC YATES Did you attend a consultant round with regards to Mr PACKMAN?

BARTON No comment.

DC YATES Did you ever attend any consultant rounds?

BARTON No comment.

DC YATES Because I'm having a problem working out your actual daily schedule again doctor. It was a busy day that you had, half-past-seven (0730) until nine o'clock at the hospital, nine (0900) until half-eleven (1130) at the surgery, afternoon clinics. When did you ever have time to do a consultant's round?

BARTON No comment.

DC YATES Was that just a blatant disregard for one of your duties?

BARTON No comment.

DC YATES And if you did attend them, how did their rounds differ from yours?

BARTON No comment.

DC YATES Well did they differ?

BARTON No comment.

DC YATES If you saw Mr PACKMAN every day, why didn't you make an entry in the medical notes each time?

BARTON No comment.

DC YATES Geoff.

DC Code A: What was the nurses' responsibility when it came down to ward rounds?

BARTON: No comment.

DC Code A: The nursing staff?

BARTON: No comment.

DC Code A: We touched on it there whether the ward rounds were an act of you physically walking from bed to bed and physically seeing each patient. Did you actually do that doctor?

BARTON: No comment.

DC YATES: Or did you conduct them more as an office conference perhaps?

BARTON: No comment.

DC YATES: Was it the case that you sat in an office with the nursing staff and discussed the patient?

BARTON: No comment.

DC YATES: The notes already indicate that you placed quite some responsibility on to the nursing staff. Was this another example of how you conducted your rounds or not?

BARTON: No comment.

DC YATES Did you encourage or allow the nursing staff to conduct ward rounds on their own?

BARTON No comment.

DC YATES Did Sister HAMBLIN in particular conduct ward rounds on her own?

BARTON No comment.

DC YATES If you weren't in hospital for some reason and legitimately that would probably happen wouldn't it on some days? Would Sister HAMBLIN conduct (somebody coughs) a ward round on her own?

BARTON No comment.

DC YATES If she did, was that the practice that crept in gradually until she was doing more ward rounds than perhaps she should have been doing?

BARTON No comment.

DC Code A Okay.

DC YATES Doctor what I want to talk about is 'consultants' assessments and their responsibilities'. As we know consultants certainly play and integral part in the care and treatment of patients. I think it's essential that we give you the opportunity to offer an explanation as to how the role and the function of consultants is performed in the respect

of Mr PACKMAN, and also I would like to know if you've had any concerns that you may have raised and raised them to whom. But did you have any concerns and how many consultants supported you at the Gosport War Memorial Hospital?

BARTON No comment.

DC YATES If you did, when did you raise these concerns?

BARTON No comment.

DC YATES Again if you did, how did you raise these concerns?

BARTON No comment.

DC YATES Where would a written record of these concerns be found?

BARTON No comment.

DC YATES Why would you have concerns?

BARTON No comment.

DC YATES Who was the consultant that was responsible for the care of Mr PACKMAN whilst he was a patient on that ward?

BARTON No comment.

DC YATES What did you understand the consultant's responsibilities to be?

BARTON No comment.

DC YATES Well what involvement did the consultant have with Mr PACKMAN to your knowledge?

BARTON No comment.

DC YATES Did you have any concerns as to how the consultants performed their role in respect of this patient?

BARTON No comment.

DC YATES Were you given sufficient support by the consultants in order to carry out your own work?

BARTON No comment.

DC YATES How was this support offered?

BARTON No comment.

DC YATES Did you ever raise concerns with anyone?

BARTON No comment.

DC YATES If you did, whom did you raise these concerns to?

BARTON No comment.

DC YATES (Coughs) And if you did, when did you raise these

concerns?

BARTON — No comment.

DC YATES — And probably more importantly, why did you raise concerns of anyone?

BARTON — No comment.

DC YATES — Geoff?

DC Code A — I think Doctor REID was the consultant...

DC YATES — He was.

DC Code A — ...in this case wasn't he doctor? Yeah and DC YATES has confirmed it by reading from your notes. Did you have any problems with Doctor REID?

BARTON — No comment.

DC Code A — I understand that Doctor RAVINDRANE was involved, and Doctor RAVINDRANE was a registrar above yourself and below Doctor REID. Did you raise any concerns regarding either of those two doctors?

BARTON — No comment.

DC Code A — Did you have any concerns with those two doctors?

BARTON — No comment.

DC Code A — If you had had concerns, how would you have raised them? Would you have known how to raise them?

BARTON — No comment.

DC Code A — You had, part of GJQ/HF/14 your Job Description, a letter accompanying it from Pauline DANCE, and it states in there that 'should you have any grievance relating to your employment, you are entitled to discuss the matter in the first instance with the consultants to whom you are responsible'. Did you ever do that?

BARTON — No comment.

DC Code A — 'And where appropriate, you can consult either in person or in writing with the personnel officer'. That's the nearest hospital. And it goes on to say that 'there is a Section 32 of the General (Inaudible) Council Conditions Of Service that you can also refer to affecting your conditions of service. Did you ever do that?

BARTON — No comment.

DC Code A — And there is an agreed disciplinary procedure available to you in the Personnel Department at St. Mary's. Did you ever have a look at that?

BARTON — No comment.

DC Code A — Did anything happen at Gosport War Memorial that led you

to go down that path?

BARTON — No comment.

DC Code A — Did you have any personal issues with Doctor RAVINDRANE?

BARTON — No comment.

DC Code A — Did you have any personal issues with Doctor REID...

BARTON — No comment.

DC Code A — ...that would prevent you from making a complaint that it was justified?

BARTON — No comment.

DC Code A — Okay.

DC YATES — Again the tapes have about three or four minutes to go, I think we'll change the tapes. In fact we might take a ten minute break now actually.

DC Code A — Yeah.

DC YATES — All right. Is there anything you wish to clarify at the moment doctor?

BARTON — No thank you.

DC YATES Is there anything you wish to add?

BARTON No thank you.

DC YATES The time by my watch is 1017 hours and I am going to turn the recorder off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AK

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

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1034 Time concluded: 1116

Duration of interview: 42 MINUTES Tape reference nos.
(→)

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

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This interview is being tape recorded I am DC Code A Chris YATES and my colleague is?
DC Code A	DC Code A
DC YATES	I am interviewing Doctor Jane BARTON. Doctor will you please give your full name and your dated of birth?
BARTON	Jane Ann BARTON 19/10/48.
DC YATES	Thank you.

BARTON — Also present is Mr BARKER, who is Doctor BARTON's solicitor. Can you please introduce yourself and your full name?

BARKER — Yes certainly. I am Ian Steven Petrie BARKER and I am Doctor BARTON's solicitor.

DC YATES — Thank you. This interview is being conducted in an Interview Room at Fareham Police Station in Hampshire. The time is 1034 hours and the date is the 6th of April 2006 (06/04/2006). At the conclusion of the whole process 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 YATES — If at any time you do wish to stop the interview doctor to take legal advice just say and the interview will be stopped in order that you can do this.

BARTON — Thank you.

DC YATES — 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 okay.

BARTON Thank you.

DC YATES 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 Thank you.

DC YATES Is there any need for it to be broken down again this time?

BARTON No thank you.

DC YATES Okay. As I've said before on this occasion the room that we're in has been equipped with a monitoring facility. Whenever the red light is on that means that somebody is listening to the interview. Today Detective Inspector GROCOTT is monitoring the interview with the lights on. (Somebody clearing throat) Nobody can listen to any conversation in this room when those tapes aren't playing doctor okay. Right if I can just confirm doctor that we've had a quick comfort break, but there's been no conversation about this matter whilst the tape's been off.

BARTON None at all.

DC YATES Thank you. If I can doctor I'd like to move on to issues surrounding the pharmacy and that's the 'prescription and administration of controlled drugs', it's a specialist subject in it's own right and I seek an explanation now as to how

you were involved in pharmaceutical prescriptions. I would also like to know your level of training and understanding of the drugs that you prescribed and their uses. How did you ensure doctor that you were up-to-date in the knowledge that you had in respect of pharmaceutical issues?

BARTON — No comment.

DC YATES — What pharmaceutical training had you received at the time of Mr PACKMAN's admission to hospital?

BARTON — No comment.

DC YATES — What further pharmaceutical training had you received since your initial qualifications?

BARTON — No comment.

DC YATES — How would you know what drugs to prescribe to a patient?

BARTON — No comment.

DC YATES — How would you learn about new drugs that are available for administration?

BARTON — No comment.

DC YATES — How would the pharmacy at the Gosport War Memorial Hospital work in relation to the availability or the suitability of medicines and drugs?

BARTON — No comment.

DC YATES — How many pharmacists worked at the Gosport War Memorial Hospital in 1999?

BARTON — No comment.

DC YATES — Doctor what is the BNF?

BARTON — No comment. (Somebody clears throat)

DC YATES — Have you got a reference number for this?

DC Code A — CSY/HF/12.

DC YATES — Doctor I'll show you the BNF number 42, September 2001. Is this a book that you're familiar with?

BARTON — No comment.

DC YATES — I think I'll leave that on the desk should you wish to refer to it. A similar book, that's the other one, is the NPF, Nurse Prescribers Formulary, and that's got a reference of GJQ/HF/17, this one is dated 2002/2003 (inaudible). Is that a book that you're familiar with?

BARTON — No comment.

DC YATES — What is its purpose?

BARTON No comment.

DC YATES What is the purpose of the BNF?

BARTON No comment.

DC YATES How often would you refer to it?

BARTON No comment.

DC YATES And finally book wise GJQ/HF/18, which is the PCF, which is the Palliative Care Formulary. Is this a book that you are familiar with doctor?

BARTON No comment.

DC YATES What is the purpose of that book?

BARTON No comment.

DC YATES And how often would you refer to it?

BARTON No comment.

DC YATES (Coughs) Were any of the drugs used in the treatment of Mr PACKMAN new or seldom used?

BARTON No comment.

DC YATES What was the purpose of the Wessex Protocols in relation to prescribing medicines to patients?

BARTON — No comment.

DC YATES — Have you got a copy of that one?

DC Code A — Sorry which one?

DC YATES — Wessex Protocols.

DC Code A — (Pause) No I haven't got a copy or it would be here.

DC YATES — No?

DC Code A — No sorry.

DC YATES — (Inaudible)

DC Code A — (Pause)

DC YATES — That's it. (Pause) Have you got a reference number? We're using that as a copy aren't we?

DC Code A — Yeah, which is (pause) CSY/HF/3.

DC YATES — Okay CSY/HF/3 is a copy of the Palliative Care handbook and I have one here, a photocopy, and it's actually a photocopy of this small book Advice On Clinical Management. Is this a book that you're familiar with doctor?

BARTON — No comment.

DC YATES — It's referred to often as the Wessex Protocols, it's a book, it's the 5th addition, Advice On Clinical Management, but this one is Countess Mountbatten House, Southampton University Hospital NHS Trust. That is in association with all the Wessex Specialist Palliative Care Units. How often did you refer to this book?

BARTON — No comment.

DC YATES — (Pause) What was the purpose of the Wessex Protocols in relation to prescribing medicines to patients doctor?

BARTON — No comment.

DC YATES — What pharmacy guidelines were available for prescribing the medicines within the Gosport War Memorial Hospital?

BARTON — No comment.

DC YATES — Where was the pharmacy at the Gosport War Memorial Hospital?

BARTON — No comment.

DC YATES — How accessible was the pharmacy?

BARTON — No comment.

DC YATES — What were the opening times of the pharmacy if any?

BARTON No comment.

DC YATES Geoff?

DC Code A Regarding the pharmaceutical side of things, did you not have a responsibility as a general practitioner to keep up-to-date with drugs administration and prescribing?

BARTON No comment.

DC Code A Do you get provided with training up dates regarding these matters?

BARTON No comment.

DC Code A Did you, at any stage, feel that you needed that sort of training?

BARTON No comment.

DC Code A Did you fully understand (pause) each drug that you were prescribing?

BARTON No comment.

DC Code A In other words did you feel confident that you understood what that drug would do and why you should prescribe it?

BARTON No comment.

DC Code A If you didn't, did you ever take steps to rectify that?

BARTON No comment.

DC Code A Were steps available to you at the time?

BARTON No comment.

DC Code A Did you ever seek advice from anybody in relation to the prescribing of controlled drugs?

BARTON No comment.

DC Code A Were you confident in your ability to ensure that each patient had the correct drug for their needs?

BARTON No comment.

DC Code A Okay.

DC YATES Going back to your Job Description, GJQ/HF/14. Duty number (8) was to prescribe, as required, drugs for the patients under the care of the consultant physicians in geriatric medicine. (Clears throat) So that was one of your duties. Would you not be duty bound to keep up-to-date?

BARTON No comment.

DC YATES Right. Prescriptions. Now prescribing medicines doctor there's a requirement to complete different parts of a Prescription Chart. Now what I want to do now is try and get an explanation as to how the 'clinical assistance' was

involved in the prescription of medicines and what protocols you followed. Now could you please describe the process undertaken in the prescribing and administering of controlled drugs?

BARTON — No comment.

DC YATES — Have you got a reference for this?

DC Code A — CSY/HF/10.

DC YATES — And that identification refers to a (inaudible) in Gosport, an NHS Primary Care Trust Prescription sheet, which I am opening out for the doctor. Could I just take you through this chart and perhaps you can identify certainly if we have anything wrong. Once you open the document out there's three pages, there's an area on the top half of the first place, which is 'for once one and pre-medication drugs'. Who is responsible for completing that part of the form?

BARTON — No comment.

DC YATES — Under that is 'as required prescriptions', which there's a box for the approved name of the drug, the route that is to be taken, the dose, the date and the pharmacy and the signature of the doctor and the special directions, and next to that is the administration record, which I believe the nurses complete is that correct?

BARTON — No comment.

DC YATES Who is responsible for completing the left hand box on the 'as required prescription'?

BARTON No comment.

DC YATES Would that be a doctor?

BARTON No comment.

DC YATES Again on your actual Job Description, GJQ/HF/14, one of your duties is to prescribe 'as required drugs' for the patients under the care of the consultant physicians in geriatric medicine. So would it be fair for me to think, as you accepted the job as 'clinical assistant', that that was one of your responsibilities to complete these?

BARTON No comment.

DC YATES On the middle page, again the left hand side of it, it would appear for the doctors, that's for 'regular prescriptions'. Were you responsible for completing any of this?

BARTON No comment.

DC YATES And that goes on to the next page, and finally the 'daily review prescriptions', what are they?

BARTON No comment.

DC YATES Right on the back there's an area 'for nursing use only, exceptions to prescribed orders'. What is this used for?

BARTON	No comment.
DC YATES	Is this completed by a nurse when, for some reason, a prescribed order hasn't been taken...
BARTON	No comment.
DC YATES	...or has been refused by the patient?
BARTON	No comment.
DC YATES	Or even on occasions vomited?
BARTON	No comment.
DC YATES	(Pause) What was your prescribing policy doctor?
BARTON	No comment.
DC YATES	What medicines and drugs did you prescribe to Mr PACKMAN?
BARTON	No comment.
DC YATES	What is the difference between 'once only drugs', 'as required drugs' and 'regular drugs'?
BARTON	No comment.
DC YATES	(Pause) Why are ranges of drugs prescribed for patients?

BARTON	No comment.
DC YATES	I'm just showing you a Prescription Chart, how do you think that Prescription Chart should be completed?
BARTON	No comment.
DC YATES	So what is a 'Proactive Prescribing Policy'?
BARTON	No comment.
DC YATES	Is this a policy where a range, quite often a large range of drugs is prescribed?
BARTON	No comment.
DC YATES	How did this policy come about?
BARTON	No comment.
DC YATES	What was its purpose?
BARTON	No comment.
DC YATES	Who authorised this policy?
BARTON	No comment.
DC YATES	Was this your policy we're describing?

BARTON No comment.

DC YATES Where could I find this policy?

BARTON No comment.

DC YATES What is meant by 'telephone prescribing' doctor?

BARTON No comment.

DC YATES Am I right in thinking that 'telephone prescribing' would be a nurse phoning the doctor, the doctor making a prescription over the phone, the phone had been passed to a second nurse and the prescription repeated and then both nurses, or one of the nurses would make an entry on the record, countersigned by the second nurse and later signed by the doctor when the doctor comes in. Is that correct?

BARTON No comment.

DC YATES So what is the purpose of a doctor on call?

BARTON No comment.

DC YATES Is part of the purpose of a doctor on call to conduct telephone prescribing?

BARTON No comment.

DC YATES Is it also expected of a doctor on call to, if required, attend the hospital?

BARTON	No comment.
DC YATES	If there is a doctor on call, and if there is the availability of 'telephone prescribing', why was there 'proactive prescribing'?
BARTON	No comment.
DC YATES	What was the necessity of prescribing for such wide ranges of drugs?
BARTON	No comment.
DC Code A	Was 'telephone prescribing' a recommended form of prescribing drugs?
BARTON	No comment.
DC Code A	Was it something that you were encouraged to do?
BARTON	No comment.
DC Code A	Were you ever discouraged from doing it?
BARTON	No comment.
DC Code A	Did you do it frequently?
BARTON	No comment.

DC Code A — (Pause) Did you try to avoid 'telephone prescribing'?

BARTON — No comment.

DC Code A — If you had a Proactive Policy, would that negate the need for anybody to phone you up?

BARTON — No comment.

DC Code A — (Pause) What's the purpose of the 'proactive prescribing'?

BARTON — No comment.

DC Code A — (Pause) Was it something that you used frequently?

BARTON — No comment.

DC Code A — Did you, on a personal level, prefer 'proactive prescribing' to 'telephone prescribing'?

BARTON — No comment.

DC Code A — Okay.

DC YATES — (Pause) With 'proactive prescribing' and the ability to write up prescriptions possibly before they were needed, would that make your busy life easier?

BARTON — No comment.

DC YATES — Will I be correct in thinking with 'proactive prescribing'

that that would negate the need to attend the hospital, and it would negate the need to be telephoned...

BARTON — No comment.

DC YATES — ...or certainly minimise those opportunities?

BARTON — No comment.

DC YATES — Because again as part of your Job Description is you're expected to be on call is that correct?

BARTON — No comment.

DC YATES — Geoff?

DC Code A — Was that a lifestyle issue doctor?

BARTON — No comment.

DC Code A — Did you proactively prescribe purely on medical terms on what was best for the patients...

BARTON — No comment.

DC Code A — ...or was it a lifestyle issue?

BARTON — No comment.

DC Code A — (Pause) Do you think it would have been preferable, particularly with the use of Diamorphine, to have

prescribed in a way that would allow nurses to contact you should the patient need to have his dose varied...

BARTON — No comment.

DC Code A — ...as opposed to the Proactive Prescribing Policy that you adopted?

BARTON — No comment.

DC Code A — Okay.

DC YATES — Who administers the prescribed drugs?

BARTON — No comment.

DC YATES — What training do the nurses have for the administration of the drugs?

BARTON — No comment.

DC YATES — Can any level of nurse administer drugs?

BARTON — No comment.

DC YATES — What is the purpose of the drug registers?

BARTON — No comment.

DC YATES — What has to be recorded in them?

BARTON No comment.

DC YATES Why have there been drugs prescribed but no administered?

BARTON No comment.

DC YATES Geoff?

DC Code A No.

DC YATES Let me move on if I can then doctor to 'syringe drivers'. Now the use of a syringe driver, what we've found so far, is normally dictated by a doctor and that there are different reasons for employing a syringe driver, one of which is once a patient can no longer take oral medicine. I want to seek an explanation now as to why a syringe driver was utilised in this case, in particular in the way in which you would envisage the driver to be used. So we'll start off doctor with what training had you had for the use and deployment of syringe drivers?

BARTON No comment.

DC YATES And what is a syringe driver?

BARTON No comment.

DC YATES How long had syringe drivers been in use in 1999?

BARTON No comment.

DC YATES But why is a syringe driver used?

BARTON No comment.

DC YATES And what kinds of patients are most suitable for syringe drivers?

BARTON No comment.

DC YATES Who talks to the patient, or the family regarding the use of syringe drivers?

BARTON No comment.

DC YATES Well how does a syringe driver work?

BARTON No comment.

DC YATES Who prepares the drugs for administration via a syringe driver?

BARTON No comment.

DC YATES Right. We've got a photocopy now of the instructions for the use of the Ambulatory syringe drivers. This is a notice that was found on the ward in Dryad Ward, it's got a reference number of CSY/HF/8. First of all doctor have you seen this before?

BARTON No comment.

DC YATES — It's titled Graseby Medical Instructions For The Use Of (inaudible) Syringe Drivers, and it depicts that there are three types of syringe drivers, the Variable Syringe Driver MS16, a Fixed Syringe Driver MS18 and the Variable Speed Driver MS26. What are the differences between these syringe drivers?

BARTON — No comment.

DC YATES — What is the difference between the MS16A and the MS26?

BARTON — No comment.

DC YATES — Has one got a boost facility?

BARTON — No comment.

DC YATES — What is a boost facility?

BARTON — No comment.

DC YATES — I believe they are actually both different colours. What colour was the syringe driver used in the case of Mr PACKMAN?

BARTON — No comment.

DC YATES — So why was Mr PACKMAN given drugs by way of a syringe driver?

BARTON — No comment.

DC YATES — And correct me if I'm wrong doctor, but Mr PACKMAN was still able to take oral medicine. Why wasn't he given pills, or Oramorph instead of a sub cut syringe driver?

BARTON — No comment.

DC YATES — (Pause) Why was it necessary to put Mr PACKMAN on a syringe driver?

BARTON — No comment.

DC YATES — (Pause) Why isn't there an entry on the Medical Records that the use of a syringe driver was now deemed necessary?

BARTON — No comment.

DC YATES — Page 55 are the only notes made by you and there's no mention of a need for a syringe driver.

BARTON — No comment.

DC YATES — So who deemed it necessary then?

BARTON — No comment.

DC YATES — Was it you?

BARTON — No comment.

DC YATES Was it Sister HAMBLIN?

BARTON No comment.

DC YATES Did Sister HAMBLIN prescribe drugs?

BARTON No comment.

DC YATES Why is there an entry in the nursing notes that a syringe driver is being used?

BARTON No comment.

DC YATES (Pause) Is the use of a syringe driver a significant factor in the care of a patient?

BARTON No comment.

DC YATES Geoff?

DC Code A Yes. Doctor we've just gone through the suitability and usage of syringe drivers for particular types of patients, and we see that this syringe driver was started on the 30th of August. DC YATES has already asked you one question saying: "Why was a syringe authorised and started on the 30th when Mr PACKMAN was still able to take oral medicine?" Can you remind me why that was?

BARTON No comment.

DC Code A Because not only was he able to take oral medicine, but a

nursing note on the same date, on Page 63 of those notes, (someone coughs) a nursing note states that 'a very small amount of diet taken, mainly puddings'. So that implicates, doesn't it, that Mr PACKMAN was still eating, grant you in smaller doses, but he was still eating. If he was able to eat puddings, was he able to take Oramorph?

BARTON — No comment.

DC Code A — The nursing note goes on to say, amongst other things, 'encourage fluids', which again indicates, does it not, that he was drinking still. Is that right doctor?

BARTON — No comment.

DC Code A — And yet the syringe driver was authorised. Did Mr PACKMAN fit the criteria for the commencement of a syringe driver?

BARTON — No comment.

DC Code A — And the interesting point about that entry on Page 63 is that the nurse who wrote it and says that 'he was taking mainly puddings and he was to be encouraged to have fluids', was the same nurse who started off the syringe driver having apparently discussed it with you and that nurse was Sister HAMBLIN. Have you got any comment to make about that doctor?

BARTON — No comment.

DC Code A — Why would Sister HAMBLIN start a syringe driver on a patient who was still able to drink, who was still able to take oral medicine, who was still able to eat?

BARTON — No comment.

DC Code A — Was she acting on your instructions?

BARTON — No comment.

DC Code A — Did you authorise the use of that syringe driver at that time?

BARTON — No comment.

DC Code A — Was she acting on your authority Doctor BARTON?

BARTON — No comment.

DC Code A — Should you have allowed the use of that syringe driver at that time?

BARTON — No comment.

DC Code A — Have you got any further questions Chris?

DC YATES — Along the same lines, on the 29th of August 1999 (29/08/1999) nocte, which is night, a nurse has written 'slept for long periods, Oramorph given as prescribed', and then 'complaining of left abdominal pain'. And then on the 30th of August, the next day, was Sister HAMBLIN's entry,

which reads exactly 'condition remains poor, syringe driver commenced at 1445, Diamorphine 40 milligrams, Midazolam 20 milligrams, no further complaints of abdominal pain, very small amount of diet taken mainly puddings, re-catherised this afternoon, dressing, draining of the fluids and the dressings also reviewed'. So the whole entry for the 30th of August says, first of all it says 'syringe started' and later still 'still able to eat'. I just find it puzzling doctor; can you shed any light on it?

BARTON — No comment.

DC Code A — Having started off the syringe driver doctor and you apparently having authorised it why then, it being surely a significant factor in the care of Mr PACKMAN, why then did you not make a record in the notes explaining why the syringe driver was started?

BARTON — No comment.

DC Code A — I say it's probably because you felt unable to do so given the note in the Nursing Record,...

BARTON — No comment.

DC Code A — ...because surely your justification for using the syringe driver would have been 'unable to take oral medicine, unable to eat, unable to drink, commence syringe driver', that would go directly against what the sister had written wouldn't it?

BARTON No comment.

DC Code A (Pause) Were you at the hospital when Sister HAMBLIN spoke to you about the syringe driver?

BARTON No comment.

DC YATES (Pause) If Mr PACKMAN was in enough pain to require Diamorphine through a subcutaneous syringe driver, what was causing that pain?

BARTON No comment.

DC YATES I'll come back to that one. Now I'd like to talk to you doctor about some drugs now and there are three drugs in particular that were prescribed and administered to Mr PACKMAN. I just want to see if we can clarify and get a further explanation as to the specific reasons behind the prescribing of these drugs and their uses and effects. Now firstly I would like to talk about Oramorph. Why was this drug, Oramorph, prescribed?

BARTON No comment.

DC YATES Why and when was this drug administered?

BARTON No comment.

DC YATES The drug was administered at 1445 hours, who authorised the drug?

BARTON No comment.

DC YATES (Pause) What time did you see Mr PACKMAN?

BARTON No comment.

DC YATES (Pause) So what was the purpose of this drug?

BARTON No comment.

DC YATES (Pause) Why was no other form of painkiller prescribed as an alternative to a strong opioid?

BARTON No comment.

DC YATES (Pause) A little more interesting, on Page 172 of the Medical Records, which are BJC/34, if I pull the original out for you the very first entry at the doctor it says Oramorph 10 – 20. Because you've prescribed 10 – 20, how does anyone know what to administer?

BARTON No comment.

DC YATES (Inaudible – mumbles) then how much has been administered?

BARTON No comment.

DC YATES Code A?

DC Code A Yeah. If I was a doctor on call and I'd come out to see Mr

PACKMAN after one of those doses was administered, how would I know what amount of Oramorph he'd received?

BARTON — No comment.

DC Code A — Because it doesn't tell me there does it? It could be 10, it could be 20, and presumably it could be 15. Would you expect a doctor to have to go back to the drug book to check it out?

BARTON — No comment.

DC Code A — Why have you prescribed that in such a way then?

BARTON — No comment.

DC YATES — (Pause) (Coughs) Actually what is Oramorph doctor?

BARTON — No comment.

DC YATES — And what is its purpose?

BARTON — No comment.

DC YATES — And where does Oramorph sit on the Analgesic Ladder?

BARTON — No comment.

DC YATES — Again doctor Midazolam, what is Midazolam?

BARTON No comment.

DC YATES Well why is Midazolam used?

BARTON No comment.

DC YATES And more specifically why was it used in relation to Mr PACKMAN?

BARTON No comment.

DC YATES Is it a sedative doctor?

BARTON No comment.

DC YATES Are there any other kinds of sedatives that can be used?

BARTON No comment.

DC YATES This drug appears to be commonly used in patients at the terminal end of an illness, is this why this drug was prescribed to Mr PACKMAN on this occasion?

BARTON No comment.

DC YATES Did you consider Mr PACKMAN was at the terminal phase of his life?

BARTON No comment.

DC YATES How would you know how much Midazolam to prescribe?

BARTON	No comment.
DC YATES	Whom was he diagnosed by as being in need of Midazolam?
BARTON	No comment.
DC YATES	What is the purpose of prescribing a range of parameters for the administration of the drug (TAPE BUZZES).... Hang on. Right we'll have to turn the tapes off.
	INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AL

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

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1121 Time concluded: 1155

Duration of interview: 34 MINUTES Tape reference nos.
(→)

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

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This is a continuation of the interview with Doctor BARTON. I am DC Chris YATES, the other officer present is?
DC Code A	DC Code A.
DC YATES	Thank you. The time by my watch is 1121 hours. The last tape finished before we could actually give an end time and that was 1116 hours that the last tape ended. It's just really been a change over of tapes. Doctor can you confirm it's the same people in the room?

BARTON I can.

DC YATES Would you care to confirm whether there's been any conversation about this matter while the tapes have been off?

BARTON None at all.

DC YATES Okay doctor. I must still remind you that you are still under caution. We were talking about Midazolam weren't we?

BARTON (Silent)

DC YATES Right. What is the purpose doctor of prescribing a range of parameters for the administration of this drug, Midazolam, i.e. 20 – 80 milligrams?

BARTON No comment.

DC YATES Is this what is known as 'proactive prescribing'?

BARTON No comment.

DC YATES Why doctor did you prescribe a range of this drug to Mr PACKMAN?

BARTON No comment.

DC YATES How would the nurses know where to start within this range?

BARTON No comment.

DC YATES Where is it recorded within the medical notes your prescribing instructions to the nurses as to why, when and by how much the dose can be altered within this range?

BARTON No comment.

DC YATES And by whom?

BARTON No comment.

DC YATES How would a nurse know why to alter the dose?

BARTON No comment.

DC YATES How would a nurse know when to alter the dose?

BARTON No comment.

DC YATES And very importantly, how would a nurse know how much to alter the dose by?

BARTON No comment.

DC YATES Doctor would you expect to see an entry in the notes as to the justification for this drug being administered?

BARTON No comment.

DC YATES What safe guards were in place to ensure that Mr PACKMAN did not receive an excessive dose of Midazolam?

BARTON No comment.

DC YATES What part did the Wessex Protocols play in the prescription of Midazolam?

BARTON No comment.

DC YATES Did they play any part at all?

BARTON No comment.

DC YATES (Pause) Why didn't you follow the guidelines for the prescription of Midazolam, i.e. arrange starting at 5 milligrams a day?

BARTON No comment.

DC YATES Code A?

DC Code A No.

DC YATES Doctor Diamorphine. What is Diamorphine?

BARTON No comment.

DC YATES Why is Diamorphine used?

BARTON No comment.

DC YATES (Interference on tape) What kinds of analgesics are normally used (inaudible interference on tape) Diamorphine?

BARTON No comment.

DC YATES Where does Diamorphine fit within the Analgesic Ladder?

BARTON No comment.

DC YATES Why didn't you record what the purpose was for Diamorphine on the records?

BARTON No comment.

DC YATES Why was the Diamorphine written up to 200 milligrams?

BARTON No comment.

DC YATES Would you have allowed a nurse to administer this much without you reviewing the patient?

BARTON No comment.

DC YATES How would you stop this happening?

BARTON No comment.

DC YATES Why was a Proactive Prescribing Policy needed if you were seeing the patients every day?

BARTON No comment.

DC YATES (Pause) In your Job Description, GJQ/HF/14, your very first duty is 'to visit the units on a regular basis and to be available on call as necessary'. If you complied with this duty, what was the necessity for proactive prescribing?

BARTON No comment.

DC YATES Duty (4) to be responsible for the writing up of initial case notes and to ensure that follow-up notes are kept up to date and reviewed regularly. Why haven't you performed this duty doctor?

BARTON No comment.

DC YATES Where is it recorded, bearing in mind that duty, on how much the nurses can increase the dosage of any drug when arranged as prescribed?

BARTON No comment.

DC YATES (Coughs) (Pause) What checks and valve safes were put in place to prevent overdosing?

BARTON No comment.

DC YATES (Pause) Why was Diamorphine prescribed to Mr PACKMAN?

BARTON No comment.

DC YATES Is it normal to prescribe Diamorphine as a required drug?

BARTON No comment.

DC YATES Was Mr PACKMAN in his terminal phase in your view?

BARTON No comment.

DC YATES How was he diagnosed as being in need of Diamorphine?

BARTON No comment.

DC YATES How would you decide how much Diamorphine to prescribe?

BARTON No comment.

DC YATES What is the purpose of prescribing a range of parameters for the administration of a drug, i.e. 20 – 80 milligrams?

BARTON No comment.

DC YATES And why did you prescribe a range of this drug to Mr PACKMAN?

BARTON No comment.

DC YATES And very importantly, how would the nurses know where to start within this range?

BARTON No comment.

DC YATES (Pause) Where is it recorded then within the medical notes the prescribing instructions to the nurses as to why, when and by how much that those can be altered within this range and by whom?

BARTON No comment.

DC YATES Would you expect to see an entry in the notes as to the justification for this drug being administered?

BARTON No comment.

DC YATES What would you consider to be an excessive dose of Diamorphine for Mr PACKMAN?

BARTON No comment.

DC YATES What safeguards were in place to ensure that Mr PACKMAN did not receive an excessive dose of Diamorphine?

BARTON No comment.

DC YATES What part did the Wessex Protocols play in the prescription of Diamorphine?

BARTON No comment.

DC YATES That's that little book that's already been produced on the table doctor. Did it play any role at all?

BARTON No comment.

DC YATES Why didn't you follow the guidelines for the prescription of Diamorphine, i.e. arrange starting it at 10 milligrams a day?

BARTON No comment.

DC YATES (Pause) Did you ever seek advice from anyone regarding your prescribing regime in respect of Mr PACKMAN?

BARTON No comment.

DC YATES Why didn't you?

BARTON No comment.

DC YATES (Coughs) How do you know that you're prescribing regime did not lead to a worsening of Mr PACKMAN'S condition?

BARTON No comment.

DC YATES Where is the reasoning behind this recorded?

BARTON No comment.

DC YATES Why wasn't this recorded?

BARTON No comment.

DC YATES Doctor there's no justification documented in the medical notes for the use of Diamorphine or Midazolam and the syringe driver, why is that?

BARTON No comment.

DC YATES Why isn't there any record of an ongoing assessment?

BARTON No comment.

DC YATES There weren't any documentation notes to explain why Mr PACKMAN required increases in the doses of Diamorphine from 40 up to eventually 90 milligrams over a three-day period.

BARTON No comment.

DC YATES When did you consider that Mr PACKMAN had entered the terminal phase of his life?

BARTON No comment.

DC YATES Why did you consider Mr PACKMAN had entered the terminal phase of his life?

BARTON No comment.

DC YATES What change had taken place of Mr PACKMAN for you to reach this conclusion?

BARTON No comment.

DC YATES Where did you record this (coughs)?

BARTON No comment.

DC YATES Were you qualified to make this diagnoses doctor?

BARTON No comment.

DC YATES Were you qualified to diagnose and provide palliative care to Mr PACKMAN?

BARTON No comment.

DC YATES Was that your responsibility?

BARTON No comment.

DC YATES Did you refer these decisions to a consultant?

BARTON No comment.

DC YATES Did you ever refer to a consultant?

BARTON No comment.

DC YATES — Geoff?

DC Code A — Yeah. Regarding the lack of notes on on-going assessment, I think it's quite appropriate with analgesics, but particularly with Diamorphine, which is, is that the strongest one you can prescribe doctor?

BARTON — No comment.

DC Code A — Don't you have a duty to regularly review that (somebody coughs) dosage on the patients?

BARTON — No comment.

DC Code A — Because otherwise how do you know what effect it's having on them?

BARTON — No comment.

DC Code A — Did you ever go back to him to find out whether the Diamorphine was having a good effect,...

BARTON — No comment.

DC Code A — ...or bad effect?

BARTON — No comment.

DC Code A — Did you ever check him for his, do that simple pupil check that I understand some doctors do...

BARTON	No comment.
DC Code A	...whereby you can state, you can see from the state of the pupils whether the Diamorphine is having the right effect, or too much effect, i.e. if it makes them drowsy?
BARTON	No comment.
DC Code A	Well let's go back then to (pause) when you originally prescribed to him... Can I just take the BNF?
DC YATES	Yeah it's here.
DC Code A	Does, in the BNF, tell me if I'm reading it right, I would like you to have a look at it, does it not indicate that 'you should start at 5 milligrams of Diamorphine subcutaneously'?
BARTON	No comment.
DC Code A	Because he was on 10 milligrams of Oramorph wasn't he?
BARTON	No comment.
DC Code A	But the starting dose in the syringe driver was 40 wasn't it?
BARTON	No comment.
DC Code A	Well you prescribed it...

BARTON No comment.

DC Code A ...and you apparently authorised it.

BARTON No comment.

DC Code A Well I'll tell you then it started at 40 on your prescription and apparently on your authorisation. Is that right?

BARTON No comment.

DC Code A Or are you saying that a nurse has now administered that without authority?

BARTON No comment.

DC Code A Well let me show you, this is a blow up from the Prescribing For The Elderly, which is in the BNF, and you will see on there that for the Morphine Sulphate 10 milligrams every four hours. If you go across it goes to 20 milligrams of Diamorphine. Well you didn't even start there did you, I asked you just now 'why didn't you start at 5 milligrams?', or suggested you could have done, but you don't start there you go right to 40. So if I show you that and I'll introduce that as GJQ/HF/21, if I show you that you can see that that's quite a dramatic jump isn't it?

BARTON No comment.

DC Code A — Not only is it a dramatic jump to 40, so it looks as if it is completely out of the guidelines, is that right?

BARTON — No comment.

DC Code A — I'm just wondering why Morphine Sulphate wasn't used because you've missed that.

BARTON — No comment.

DC Code A — Now let's just go back to the 10 milligrams of Morphine - yes? And let's just think about the date when you prescribed the Diamorphine (somebody coughs), because if you look at the prescription charts on Page 171 you'll see that you prescribed the Diamorphine 40 – 200, again in a huge range on the 26th and at that stage you had also prescribed the Oramorph 10 – 20 so you didn't, presumably that was arranged where you're authorising the nurses to administer up to 20 milligrams of Oramorph. Is that right or wrong?

BARTON — No comment.

DC Code A — Going on your prescription, would the nurse have been wrong to give Geoffrey PACKMAN 20 milligrams of Oramorph?

BARTON — No comment.

DC Code A — That was on the 26th and that was the same day that you authorised the Diamorphine.

BARTON — No comment.

DC Code A — So how did you know what the correct dose of Diamorphine would be before he had even started on that Oramorph prescription...

BARTON — No comment.

DC YATES — ...because that was a variable range wasn't it according your prescription?

BARTON — No comment.

DC Code A — Well we've told you doctor this is your opportunity to tell us things if we've got the wrong end of the stick and so we repeat: "This is your opportunity to tell us." What was the thinking behind that?

BARTON — No comment.

DC Code A — Because how do you know what his requirement would be in terms of Diamorphine before you had given the Oramorph its chance?

BARTON — No comment.

DC Code A — Well I'll take you back to when the Diamorphine was started on the subcutaneous dosage. Did you authorise the commencement of the syringe driver?

BARTON No comment.

DC Code A Did you need to authorise the commencement of a syringe driver?

BARTON No comment.

DC Code A (Pause) If a nurse lets, for arguments sake you are in the hospital at the time, could a nurse start that syringe driver of her own accord?

BARTON No comment.

DC Code A A significant factor in the treatment of Geoffrey PACKMAN is just about to start. Should that nurse have contacted you?

BARTON No comment.

DC Code A Did that nurse contact you?

BARTON No comment.

DC Code A If the nurse had contacted you, should that be recorded?

BARTON No comment.

DC Code A Well I suggest it should have done, it should have been recorded by the nurse shouldn't it?

BARTON No comment.

DC Code A And then it should have been recorded by you.

BARTON No comment.

DC Code A Well why wasn't it recorded by you?

BARTON No comment.

DC Code A It wasn't recorded by the nurse either was it?

BARTON No comment.

DC Code A She said that 'she started the syringe driver', but she doesn't say in her note that she's had a conversation with yourself, or any other doctor come to that.

BARTON No comment.

DC YATES In fact it's for that doctor, in your own prepared statement you wrote: "I anticipate that the nursing staff would have liaised with me prior to commencing with the Diamorphine and Midazolam and that this would have been set up on my instruction directly if I had been at the hospital, or otherwise by phone," but you don't know do you?

BARTON No comment.

DC Code A Well given there's 'no comment' from you again doctor, I am now thinking along the lines that what about this for

something that may have happened? The nurse has started that syringe driver without your authority and a dose far exceeding the guidelines and using the table in the BNF. Is that what happened?

BARTON — No comment.

DC Code A — Would that explain why you did not make a record afterwards?

BARTON — No comment.

DC Code A — If that was the scenario and you came into the hospital and saw that Geoffrey PACKMAN had been started on a syringe driver without your authority and on too high a dose range, what could you have done? What were your options?

BARTON — No comment.

DC Code A — Could you have made an entry in the nursing notes, in the medical notes saying 'a mistake had been made'?

BARTON — No comment.

DC Code A — Could you have stopped the syringe driver?

BARTON — No comment.

DC Code A — We've already seen that he was able to eat and drink and take oral medicine, so could you have gone a different route and changed his medication?

BARTON — No comment.

DC Code A — Were you covering up for Sister HAMBLIN Doctor REID, Doctor BARTON?

BARTON — No comment.

DC Code A — Do you think that you and Sister HAMBLIN, at this time, followed the guidelines and the procedures correctly?

BARTON — No comment.

DC YATES — (Pause) Doctor if I can take you back to Page 54, Page 55 of these notes (pause), it will be Page 55, the Medical Records, PJC/34, your very first entry on the 26th of August 1999 (26/08/1999), the very last line of that entry which was signed by you doctor. Can you confirm that?

BARTON — Confirmed.

DC YATES — "I am happy for nursing staff to confirm death." What does that mean doctor?

BARTON — No comment.

DC YATES — And why is it recorded there?

BARTON No comment.

DC YATES Is there a difference between confirming and verifying and certifying death?

BARTON No comment.

DC YATES If there are, what are the differences?

BARTON No comment.

DC YATES And what was the normal practice to be followed by nurses upon the death of a patient?

BARTON No comment.

DC YATES And why is this statement written a number of days prior to Mr PACKMAN's death?

BARTON No comment.

DC YATES In fact this statement was written on the 26th of August doctor, Mr PACKMAN didn't die until the 3rd of September, it's a week. More is the point that this will appear, as far as the notes are concerned, the clinical notes, in your first interaction with Mr PACKMAN, the previous note on the 23rd of August said: "No pain," and then yours he is almost written off: "I am happy for nursing staff to confirm death." Why would that be written that early on?

BARTON No comment.

DC YATES — Geoff?

BARTON — No comment.

DC Code A — (Pause) Doctor when you wrote: "Happy for staff to confirm death," what brought you to the conclusion, what were the inferences on you that led you to that conclusion to write that?

BARTON — No comment.

DC Code A — You clearly felt that he was dying, or could die. Is that correct?

BARTON — No comment.

DC Code A — And possibly when you're not in the hospital. Is that correct?

BARTON — No comment.

DC Code A — What were you aware of when he had his treatment at the QA Hospital?

BARTON — No comment.

DC Code A — Well we know that Doctor RAVINDRANE had obviously read the notes because of his clerking-in of Mr PACKMAN on the day he came in on the 23rd, and in those notes at the

QA he had been written up, at least once, 'not for resus'. Were you aware of that?

BARTON — No comment.

DC Code A — Did that influence you in writing: "Happy for staff to confirm death."?

BARTON — No comment.

DC Code A — What is your understanding of that term 'not for resus'?

BARTON — No comment.

DC Code A — Well to put it crudely it doesn't mean 'to let the patient die' does it?

BARTON — No comment.

DC Code A — My understanding is that if the patient would say fall into cardiac arrest, something along those lines, he would not be considered for resuscitation in that circumstance, is that right?

BARTON — No comment.

DC Code A — (Somebody coughs) So did that term influence you when you wrote that?

BARTON — No comment.

DC Code A — Well what made you write it then?

BARTON — No comment.

DC Code A — What did you feel he was dying from?

BARTON — No comment.

DC Code A — What were the signs of him dying?

BARTON — No comment.

DC Code A — Okay Chris.

DC YATES — (Pause) I'm going to do a bit more on that. (Pause) 'Not for resuscitation', paragraph 25 of your statement. 'It was my impression that when I assessed Mr PACKMAN on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to the (inaudible) was quite inappropriate. Any such transfer was very likely to have had a further serious effect on his health'. So you're saying in your statement that you were influenced by previous decisions that he was not for resuscitation. Is that correct doctor?

BARTON — No comment.

DC YATES — The meaning of 'not for resuscitation' is quite specific isn't it? I believe a medical judgement has been made that 'in the event of the patient's heart or breathing stopping

unexpectedly, cardio respiratory arrest, there is little or not chance of cardiopulmonary resuscitation being successful, that is it being medically futile and should not be attempted. This is usually on a background of a progressive life threatening illness or other significant medical problems'. What was Mr PACKMAN's progressive life threatening illness?

BARTON — No comment.

DC YATES — And the status of 'not for resuscitation', that does not mean that the patient is automatically excluded from receiving appropriate treatment for other medical problems that may arise. I mean even patients that are suffering from really advanced cancer who may be admitted seriously unwell with an infection, they would be treated for the infection wouldn't they doctor?

BARTON — No comment.

DC YATES — (Pause) I find it (clears throat) hard with the medical notes as they are that on Page 54 Doctor RAVINDRANE is saying 'his mental score is very good, he's better in himself, there's no pain' and that's on the 23rd of August, and on the 26th of August you're writing him off doctor aren't you?

BARTON — No comment.

DC YATES — Geoff?

DC Code A — That's quite a line there doctor. Had you given up hope of saving Mr PACKMAN's life...

BARTON — No comment.

DC Code A — ...at that stage?

BARTON — (Silent)

DC Code A — At that stage doctor?

BARTON — No comment.

DC YATES — (Pause) But what was his progressive life threatening illness?

BARTON — No comment.

DC YATES — Obesity, arthritis in both knees, immobility, pressure sores? I just don't see the life threatening illness so far? Cellulitis. (Pause) (Clears throat) (Inaudible – mumbles).

DC Code A — Yeah.

DC YATES — I don't want to move on to, if we start something else we'll probably get into too big a subject,...

DC Code A — Yeah sure.

DC YATES ...so I think now would be a good time to actually end this interview and take a lunchtime break shall we say, okay. Is there anything you wish to clarify doctor?

BARTON No thank you.

DC YATES Is there anything you wish to add?

BARTON No thank you.

DC YATES Okay. As I said before I'll give you the notice explaining what will happen to the tapes at the end of the whole process. The time is now 1155 hours and we will turn the recorder off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AM

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

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2004

Time commenced: 1311 Time concluded: 1349

Duration of interview: 38 MINUTES Tape reference nos.
(→)

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

Other persons present: Mr BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This interview is being tape recorded, I am DC Code A Chris YATES. My colleague is?
DC Code A	DC Code A.
DC YATES	I am interviewing Doctor Jane BARTON. Doctor will you please give me your full name and your dated of birth?
BARTON	Jane Ann BARTON, Code A
DC YATES	Also present is Mr BARKER, who is Doctor BARTON's

solicitor. Can you please introduce yourself and your full name?

BARKER — Certainly. It's Ian Steven Petrie BARKER and I am Doctor BARTON's solicitor.

DC YATES — Thank you. This interview is being conducted in an Interview Room at Fareham Police Station in Hampshire. The time is 1311 hours and the date is Thursday the 6th of April 2006 (06/04/2006). At the end of the whole procedure that's when I'll sort out the paperwork for the tapes okay. 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 YATES — Okay. 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 have come here of your own free will. So if at any time that you wish to leave you're free to do so okay.

BARTON — Thank you.

DC YATES — 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 and anything you do say maybe given in evidence. Do you

understand that caution doctor?

BARTON — I do.

DC YATES — I broke it down earlier this morning, is there any need for me to break that caution down now?

BARTON — No thank you.

DC YATES — Likewise, the same as this morning, on this occasion the room that we're in has been equipped with a monitoring facility. Whenever that red light there is on it means that somebody is listening to the interview, this afternoon it's Detective Inspector GROCOTT who will be monitoring the interview. When the tapes aren't running and it's not in record mode, no conversation can be heard in this room by that facility okay. Right (clears throat) now we've had a break for lunch doctor, can I just ask you to confirm that there's been no conversation between us, the police, and yourself regarding this matter when the tapes haven't been running?

BARTON — None at all.

DC YATES — Thank you. What I would like to move on to now doctor is Death Certificates. The completion of a Death Certificate is a formal legal requirement that can only be undertaken by a medical practitioner. There are specific guidelines to be followed and what I'd like to try and get is an explanation from you as to your understanding of what was required of you in the completion of this process. Now I

have in front of me the Medical Certificate Of Cause Of Death for Geoffrey PACKMAN. We'll have to give that an identification reference I believe won't we?

DC Code A — Yeah. The next one will be 22.

DC YATES — So it's CSY/HF/22. Can you see this doctor?

BARTON — (Silence)

DC YATES — Who completed this Death Certificate with regard to Geoffrey PACKMAN?

BARTON — No comment.

DC YATES — (Pause) At the bottom of this certificate doctor is a, well there is a certificate saying: "I hereby certify that I was in medical attendance during the above named deceased's last illness and that the particulars and cause of death above written are true to the best of my knowledge and belief." And it has a signature; can I ask you to confirm if that is your signature?

BARTON — (Pause) Yes.

DC YATES — And underneath is written J. A. BARTON with your address. And the cause of death, which took place on the 3rd of September 1999 (03/09/1999) has been recorded as 'myocardial infarction' and the approximate interval between the onset of this illness and death you recorded as five days. Is that correct?

BARTON No comment.

DC YATES (Coughs) What procedure did you follow when certifying or recording the death of this patient?

BARTON No comment.

DC YATES What procedure did you follow in certifying or recording the death of any patient?

BARTON No comment.

DC YATES Who informed the registrar or coroner?

BARTON No comment.

DC YATES Who decided the cause of death?

BARTON No comment.

DC YATES Why was the death recorded as myocardial infarction?

BARTON No comment.

DC YATES (Pause)

For the benefit of the tape DCs YATES and Code A alk between themselves, which is inaudible.

DC YATES Isn't that right doctor that this process should be carried out

by the consultants or senior clinician?

BARTON — No comment.

DC YATES — Why were you completing the certificates?

BARTON — No comment.

DC YATES — (Pause) Here on this certificate there doctor it states that 'a post-mortem was not being held and the patient was seen after death by you'.

For the benefit of the tape, DCs YATES and Code A talk between themselves, which is inaudible.

DC YATES — Supervision doctor, and this gives you an opportunity to explain how the line management operated at the hospital and whether the supervision that you were provided with was efficient. What supervision were you given or provided with in respect of the care of Geoffrey PACKMAN?

BARTON — No comment.

DC YATES — Were you happy with the level of supervision?

BARTON — No comment.

DC YATES — Were you happy with the training that you had been provided with in order to care for patients whilst a Clinical Assistant at the War Memorial Hospital?

BARTON No comment.

DC YATES If there were any deficiencies what were they?

BARTON No comment.

DC YATES If there were any deficiencies how did you try to address them?

BARTON No comment.

DC YATES At the time of Mr PACKMAN's admission to the Gosport War Memorial Hospital, did you have any concerns regarding your personal workload?

BARTON No comment.

DC YATES How would you report whether you had any concerns regarding staff or workload issues?

BARTON No comment.

DC YATES What concerns, if any, did you have about the Gosport War Memorial Hospital at this time?

BARTON No comment.

DC YATES What training, in respect of any issues whether they were medical or pharmaceutical, did you raise in (inaudible due to banging in background)?

BARTON No comment.

DC YATES Who was your line manager?

BARTON No comment.

DC YATES And who did you supervise yourself?

BARTON No comment.

DC YATES What would have been the correct route for you to take if you had any concerns about the level of supervision at that hospital?

BARTON No comment.

DC YATES Did you have an appraisal system in operation there?

BARTON No comment.

DC YATES How was your contract renewed at GWMH?

BARTON No comment.

DC YATES Did you have, if you had an appraisal system or something like that, did you have the opportunity to discuss with your supervisors your role, how things were going etcetera?

BARTON No comment.

DC YATES Did you, in any way; discuss your role and how it was going with any supervisors?

BARTON No comment.

DC YATES Did you have any concerns about the way your role was going?

BARTON No comment.

DC YATES You've already discussed previously, I believe, your (clears throat) role at the hospital and how things had not significantly changed from you starting there. In actual fact I think I was able to show you that the number of beds had decreased in the late '90s compared to the number that you were expected to supervise and be responsible for when you first took the role up, and yet you say in your first 'prepared statement' that 'things were getting too much'. Did you discuss that with anybody there at the hospital?

BARTON No comment.

DC YATES Do you think that it had an impact on your ability to do your job at the hospital...

BARTON No comment.

DC YATES ...sufficiently?

BARTON No comment.

DC YATES Efficiently?

BARTON No comment.

DC YATES Professionally?

BARTON No comment.

DC YATES Competently?

BARTON No comment.

DC YATES Adequately?

BARTON No comment.

DC YATES Code A?

DC Code A No.

DC YATES What I'll do now is to try and take you chronologically through the Medical Records for the period that Mr PACKMAN was on Dryad Ward. And probably the most simple place to start is with Page 54 and this is the initial assessments or clerking by Doctor RAVINDRANE. Now the clerking doctor noted that Mr PACKMAN's ongoing problems were obesity, arthritis in his knees, immobility, pressure sores and constipation. It was noted that Mr PACKMAN was 'on a high protein diet, queried melaena which was on the 13th of August 1999 (13/08/1999), his

haemoglobin was stable, he was better in himself with a good mental test score and no pain. There was little to find here on this doctor, Page 54 which is in front of you if you want to examine it, that there was anything wrong with Mr PACKMAN bar obesity, the swollen legs and pressure sores. Do you agree?

BARTON — No comment.

DC YATES — We can move on possibly to the nursing notes now on Page 62. Do feel free doctor to have a look at any of these pages if you wish. Now they record that Mr PACKMAN was transferred from Ann Ward, I think it's at the Queen Alexandra Hospital following an episode of immobility and (inaudible sounds like sickle) sores, he was catherised, on a profile bed hoist only, able to feed himself and Mrs PACKMAN is waiting decision (inaudible) at the QA Hospital tomorrow'. Now several nursing plans, or Nursing Care Plans were produced, Page 78, Page 82, Page 84, Page 96 and these plans were for his immobility, in fact he was prone to constipation. There was a care plan for the urinary catheter. Another care plan for the pressure sore areas. Who instigated these care plans?

BARTON — No comment.

DC YATES — If the nursing staff had these care plans, whose directions were they following?

BARTON — No comment.

DC YATES (Pause) I think it's Page 170, which is a Drug Chart, that reveals he was continued on regular Doxazosin 4 milligrams once a day, Frusemide 80 milligrams once a day, (inaudible – Clexane?) 40 milligrams twice a day, Paracetamol 1 gram, or 1g four times a day. He was commenced on Magnesium Hydroxide 10 millilitres twice a day, which is a laxative and that was subsequently taken intermittently and as required Gaviscon. So that was the drugs that he was taking on the 23rd of August. So where doctor, when you look at the Nursing Care Plans, you look at the clerking, you look at the medication, where does it say that there is anything wrong with Mr PACKMAN bar his obesity, swollen legs and pressure sores?

BARTON No comment.

DC YATES (Pause) On the 24th of August Mrs, this is quite interesting, on Page 90 is a handling profile (pause) and in this section for pain it is noted 'pain needs to be controlled'. Now this is at odds with the medical notes, or the clerking, where it says that 'there was no pain'. Can you explain how this entry came to be?

BARTON No comment.

DC YATES Pain is not mentioned anywhere else. 'His bowels were well open, there's no melaena specified and swabs were taken from his pressure sores from Microbiology'. (Pause) Right Page 207 (pause) should be a blood test result. The blood test revealed a haemoglobin of 12 grams/DL. The white cell count was 12.2x10 (inaudible – mumbles), it's

on Page 207. Have you got that?

DC Code A — Yeah.

DC YATES — What does that mean?

BARTON — No comment.

DC YATES — I think it also states that 'there's a marginally (inaudible) of 8.9 and a reduced albumin'. Now both these forms had been signed just there doctor J.A.B. Is that your initials?

BARTON — No comment.

For the benefit of the tape DCs YATES and Code A talk between themselves, which is inaudible.

DC YATES — Page 190 of the Medical Records doctor is (pause) a Biochemistry Report authorised on the 26th of August 1999. Again there is the initials of J.A.B. written there. Is that your initials?

BARTON — No comment.

DC Code A — I am going to hold it up in front of you doctor so that you can see it.

BARTON — No comment.

DC YATES — Doctor would a doctor initial these reports to say that he or she had seen the results?

BARTON No comment.

DC YATES What would those results indicate to you?

BARTON No comment.

DC YATES Do you want to say anything Geoff?

DC Code A Why do doctors initial those reports Doctor BARTON?

BARTON No comment.

DC Code A Is it not to acknowledge that they have seen the report?

BARTON No comment.

DC YATES (Pause) On the 25th of August doctor Mr PACKMAN was noted to have bowels open, melaena formed, leaking some fluid and later several loose bowel actions throughout the afternoon and evening, some fresh blood present, query due to medication, (inaudible) stopped to review later'. That's Pages 82 and 83. (Pause) Now the 'nursing summary notes' record that 'Mr PACKMAN had been passing fresh blood and queried. Was it due to the (inaudible) or the Clexane? And a verbal order from Doctor BEASLEY was to withhold the six o'clock in the evening dose and review with Doctor BARTON in the morning'. Did you review this the next morning?

BARTON No comment.

DC YATES — Page 171 says that 'Mr PACKMAN was also vomiting and Metoclopramide, 10 milligrams, was given at five-to-six (1755) in the evening. Mr PACKMAN was taking Temazepam 20 milligrams at five-past-ten (2205) that night and Loperamide 4 milligrams, which I believe is for diarrhoea as a one off dose' and it's a time that I can't quite work out I must admit, it's on Page 168. (Pause) On the 26th of August the 'nursing summary notes' record 'a fairly good morning, no further vomiting. Doctor RAVI contacted re' (inaudible) or the Clexane and advised to discontinue and will repeat haemoglobin today and tomorrow, not for resuscitation, unwell at lunchtime, colour poor, complaining of feeling unwell. (Pause sounds like door being shut) This was seen by Doctor BARTON this afternoon, await result of haemoglobin, further deterioration complaining, query indigestion, pain in throat, not radiating, vomited again this evening'. Now verbal order from Doctor BARTON 'Diamorphine 10 milligrams stat', which was given at six o'clock that evening. Did you see Mr PACKMAN on the 26th of August in the afternoon?

BARTON — No comment.

DC YATES — What were you expecting from the results of the haemoglobin?

BARTON — No comment.

DC YATES — Why did you give the verbal order for Diamorphine?

BARTON No comment.

DC YATES Again on Page 55 I think it is, these should be your notes I think.

DC Code A Yeah.

DC YATES 'Called to see pale, clammy, unwell. Suggest query myocardial infarction. Treat stat Diamorphine and Oramorph overnight. Alternative possibility gastro intestinal bleed, or GI bleed, but no haematemisis'. What made you think that it was possibly a myocardial infarction doctor?

BARTON No comment.

DC YATES What is a myocardial infarction?

BARTON No comment.

DC YATES Did Mr PACKMAN have any previous medical history of myocardial infarction?

BARTON No comment.

DC YATES If Mr PACKMAN had suffered a myocardial infarction, what benefits would 10 milligrams of Diamorphine be?

BARTON No comment.

DC YATES (Pause) You've got 'suggest query myocardial infarction'.

Does that mean it was just a possibility it was a mycocardial infarction?

BARTON — No comment.

DC YATES — The same with the 'alternative a possibility of a GI bleed'. With those two possible diagnoses, what did you do to treat Mr PACKMAN?

BARTON — No comment.

DC YATES — You also state 'he was not well enough to transfer to an acute unit, keep comfortable and I am happy for nursing staff to confirm death'. (Pause) Have you got any questions on that Geoff?

DC Code A — My understanding doctor is that when a doctor puts a question mark in front of something, that is because something has happened to the patient that leads that person to believe that whatever follows the question mark may be occurring or may have occurred. Is that right?

BARTON — No comment.

DC Code A — The fact that you put the question mark in front of myocardial infarction and then queried the gastro internal bleed in the case that you felt that that's what might be happening to Mr PACKMAN, is that right?

BARTON — No comment.

DC Code A — Now presumably a doctor wouldn't just think 'the person might be having this, the person might be having that' and then not do something to find out whether that person was having this or that. Is that right?

BARTON — No comment.

DC Code A — What investigations did you then commence to find out what that patient, Mr PACKMAN, was suffering from?

BARTON — No comment.

DC YATES — All right that takes us up to the 26th where you're queering the myocardial infarction or a GI bleed. What I am going to do then is just take you to some of the questions around your 'prepared statement'. (Pause) Geoff have you got a calendar? (Pause) Have you got an identification reference?

DC Code A — CSY/HF/23.

DC YATES — Thank you. Paragraph (3) of your statement doctor, I can see you have it in front of you, in that statement (clears throat) 'I indicated when I'd first taken up the post the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores and there was significant bed

occupancy. The demands on my time and that of the nursing staff were considerable. I was, in effect, left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998. I confirm that these comments are indeed a fair and accurate summary of the position then though, if anything, it had become even more difficult by 1999 when I was involved in the care of Mr PACKMAN'. Geoff do you want to...

BARTON — No comment.

DC Code A — Yeah, okay. Doctor so we look at this exhibit, which we're calling now CSY/HF/23, and it's a printout of the calendar months for August and September of 1999 and you can see from that that I'm showing you look that on the 23rd of August Geoffrey PACKMAN was admitted to the ward, Dryad Ward, and on the 24th you made an entry on his records, on the 26th sorry not the 24th you made an entry didn't you on his records and you made entries into, I can't remember what the 24th was Chris, do you know what it was?

BARTON — No comment.

DC YATES — Yes on the Drug Chart.

BARTON — No comment.

DC Code A — On the Drug Chart that's right. But in the main records you've only made two entries, the 26th and the 28th, the 28th being a Saturday. Now going on your previous history of what you've told us and what we've worked out of your daily routines, if we count out the number of days Mr PACKMAN was in hospital, at your hospital, he came in on the 23rd, one, two, three, four, five, six, seven, eight, nine, ten, he was in for ten days in total. Now you say that 'you visited the hospital three times a day maximum, so that makes a total of thirty possible visits doesn't it? Thirty possible times you could have seen Mr PACKMAN given that you think on the 26th, as early as the 26th you think he's possibly had a myocardial infarction or a GI bleed. You only have one other visit to him after that recorded. Is that right?

BARTON — No comment.

DC Code A — How can you account for the fact that despite this man being go gravely ill that you have recommended the nurses to, or happy for them to confirm death. You've got no entries, very relative entries, very few entries in the notes, only two in his medical notes (somebody coughs) the 26th and the 28th. Can you explain that doctor?

BARTON — No comment.

DC Code A — Explain, can you explain to us what the Speciality History sheet is for then?

BARTON — No comment.

DC Code A — (Pause) Well can you tell us which of those days from the 23rd up to his death on the 3rd of September, can you tell us which of those days you were not available for?

BARTON — No comment.

DC YATES — You say in your statement that 'the pressure is put on you on how busy you were and had become considerable in 1999'. The Dryad Ward Admissions book, which is BJC/89, which I will put in front of you, it shows quite clearly that between the 17th of August 1999 (17/08/1999) and the 31st of August 1999 (31/08/1999), that's fourteen days, two patients were admitted to that ward Mr PACKMAN and a Margaret MORRIS. Now I accept that the other beds may be full, but you had two new admissions. Now part of your Job Description says that 'you must see new admissions'. Is that correct?

BARTON — No comment.

DC YATES — Does that register indicate that that was a busy time?

BARTON — No comment.

DC Code A — (Pause) It doesn't seem to doctor, or you tell us otherwise?

BARTON — No comment.

DC Code A — (Pause) The last patient before Mr PACKMAN was almost a week before. Is that right?

BARTON No comment.

DC Code A And the next patient after Mr PACKMAN was the day after. (Pause) Is that right?

BARTON No comment.

DC Code A And does that represent a really busy time at the hospital for you...

BARTON No comment.

DC Code A ...compared to other times?

BARTON No comment.

DC YATES You see Paragraph (22) in your statement says that 'you state that you anticipate that you would have reviewed Mr PACKMAN on the basis that you prescribed drugs for him on the 24th of August, that's Page 168 of your medical notes. Now you state in your generic statement on pages 3 and 4 that 'you visited patients every day and you would admit and write up charts etcetera. In addition you'd return to the hospital every evening to continue with these duties'. DC Code A s just showing you the calendar there, why then did it take you three days to make an entry in Mr PACKMAN's medical notes?

BARTON No comment.

DC YATES Why isn't there any reference to his general condition, or comment re.: care plans or drugs?

BARTON No comment.

DC YATES Let me take you back doctor to Paragraphs (12) and (13) of your statement. Paragraphs (4) to (11) are pretty much Mr PACKMAN's previous medical history, so if we go to Paragraph (12) 'it was also noted on the 6th of August that in view of pre-morbid state/multiple medical problems, Mr PACKMAN was not for CPR in event of arrest. A Barthel score was stated to have been assessed on the 5th of August (presumably the 6th of August in error) was recorded as zero, indicating that Mr PACKMAN was completely dependent'. Paragraph (13) 'Mr PACKMAN was reviewed by the specialist registrar the following day, 7th of August, who agreed, presumably on the basis of what was felt to be Mr PACKMAN's poor condition at that stage, that he was not to be resuscitated in the event of arrest. It was suggested that his anti-hypertensive medication should be changed to an ACE inhibitor in view of the oedema and he was considered for a beta-blocker in view of his atrial fibrillation. His diuretic was changed lest it caused dehydration. Mr PACKMAN was given Flucloxacillin 500 milligrams 4 times daily, supplemented by Penicillin 500 milligrams four times a day to combat the cellulites'. Now this cardiac arrest and resus policy, I think we spoke about this earlier on this morning, what is the resus policy, or not for resus policy?

BARTON No comment.

DC YATES — Am I right in thinking that should somebody have a heart attack, or stop breathing, then for those purposes they're not for resuscitation?

BARTON — No comment.

DC YATES — What about any illnesses they may have, should you still be treating those?

BARTON — No comment.

DC YATES — I mean Paragraph (19) 'an entry in Mr PACKMAN's records for 20th of August by the specialist registrar indicates that Mr PACKMAN was due for transfer to the Gosport War Memorial Hospital on the 23rd of August. The Specialist Registrar also noted that Mr PACKMAN remained not for resuscitation. A Barthel score measured on the 21st of August again recorded a score of zero indicating his complete dependence'. Yet on his arrival at the Gosport War Memorial Hospital it was six. Was that not an improvement?

BARTON — No comment.

DC YATES — Any questions Code A?

DC Code A — No.

DC YATES — The tape is about to come to an end so the time is 1359 hours, I am going to turn the recorder off.

RESTRICTED

DOCUMENT RECORD PRINT

INTERVIEW CONCLUDED. TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AN

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

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1354 Time concluded: 1355

Duration of interview: 1 MINUTE Tape reference nos. (→)

Interviewer(s): DC2479 Chris YATES / DC **Code A**

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	(Tape faulty) Right there's been an interruption in that tape (tape faulty). TAPE ENDS

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AO

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

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1359 Time concluded: 1443

Duration of interview: 44 MINUTES Tape reference nos. (→)

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

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This is a continuation of the interview with Doctor BARTON. The time is 1359 hours. The reason we've had this second break was the fault in the tape machine, which hopefully has been rectified by changing it. Can I just ask you doctor to confirm that that is the reason why we took that break?
BARTON	It is.
DC YATES	And has there been any conversation about the matter whilst the tape has been off?

BARTON None at all.

DC YATES Thank you. Doctor we'll try and pick up where we left off and we were referring to Paragraph (24). This states, this is your statement, 'I do not know if I reviewed Mr PACKMAN on the morning of 26th August. He was noted by the nurses to have had a fairly good morning. Sister HAMBLIN has recorded that Doctor RAVI, locum consultant geriatrician, was contacted and he confirmed that the Clexane should be discontinued and the haemoglobin repeated. Again, Mr PACKMAN was noted to be "not for resuscitation". Sister HAMBLIN may have contacted Doctor RAVI if I was unavailable that morning. The nursing record goes on to indicate that Mr PACKMAN then deteriorated at about lunchtime, that his colour was poor and that he complained of feeling unwell. I was called to see him, my entry in his records on this occasion reading as followed:- 26th of August 1999 (25/08/1999) called to see, pale, clammy, unwell. Suggest, query MI, treat stat Diamorph and Oramorph overnight. Alternative possibility GI bleed but no haematemisis. Not well enough to transfer to acute unit. Keep comfortable. I am happy for nursing staff to confirm death. As my note indicates, I was concerned that Mr PACKMAN might have suffered a myocardial infarction and accordingly I decided to administer opiates in the form of Diamorphine for pain and distress consequent on the possible mycocardial infarction, at a dose of 10 milligrams intramuscular. In addition, I would have been conscious that he had large pressure sore areas on his sacrum and thighs, which would have been

causing him significant pain and discomfort. I prescribed 10 milligrams Diamorphine intramuscularly to be given immediately, which is recorded on the Drug Chart as a verbal instruction. An alternative diagnosis, which I recorded was that Mr PACKMAN had had a gastro intestinal bleed'. Now you state that 'you were called to see Mr PACKMAN on the 26th'. This must have been after six o'clock in the evening. There's an entry on Page 168 that shows you gave a verbal order at that time to Sister HAMBLIN for Diamorphine. This is now nearly four days since Mr PACKMAN arrived. Well why is that the first time that you've seen him?

BARTON — No comment.

DC YATES — On Page 168 of the medical notes (pause), (inaudible) Page 172 (pause) there are two entries for Oramorph there. Why is that?

BARTON — No comment.

DC YATES — And also on Page 168 'once only and pre-medication drugs'. There are two prescriptions for Diamorphine on there. Why is that?

BARTON — No comment.

DC YATES — That will be the only one that was given?

BARTON — No comment.

DC Code A — Mr BARKER can I just say something here that obviously all questions are important, but we feel that the questioning around the Prescription Chart is very important to your client and can you just confirm that your client has had an opportunity to consult with those original charts?

BARKER — You've provided the original Prescription Chart to Doctor BARTON, it's available for her to consider, but I don't think it's appropriate for me to comment...

DC Code A — No thank you...

BARKER — ...further.

DC Code A — ...that's fine, thank you very much for that cheers.

DC YATES — What other drugs did you prescribe on the 26th?

BARTON — No comment.

DC YATES — (Pause) Now the Drug Chart shows that he received Diamorphine, 10 milligrams at six o'clock in the evening and that was the verbal order. As I pointed out the prescription was repeated below this one, it doesn't appear to have been given. 'Or a Morphine solution, Oramorph was commenced regularly, 10 – 20 milligrams every four hours with 20 milligrams at night', which meant Mr PACKMAN had continued until ten o'clock on the 30th of August 1999 (30/08/1999). Regular Oramorph solution 10 milligrams every four hours was also prescribed in the Daily Review Prescription. Is that where it should be?

BARTON — No comment.

DC YATES — Because it appears as though it's duplication doctor, I just wonder if you could clarify?

BARTON — No comment.

DC YATES — (Pause) Diamorphine 40 – 200 milligrams and Midazolam 20 – 80 milligrams subcutaneously over a twenty-four period were also prescribe on the 26th of August 1999 (26/08/1999) (coughs), that's on Page 171. Why was this doctor?

BARTON — No comment.

DC YATES — Why did you prescribe these drugs?

BARTON — No comment.

DC YATES — On Page 171 doctor...
Have you got it there Geoff?

DC Code A — (Inaudible)

DC YATES — ...what explanation can you give as to why Jill HAMBLIN has completed a prescription for Oramorph on Page 171 and you have countersigned it? That signifies it is blatantly not in your handwriting although signed by you with the blue pen, that Jill HAMBLIN's used elsewhere.

BARTON No comment.

DC YATES Should she fill in that part of the prescription sheet?

BARTON No comment.

DC YATES Did Jill HAMBLIN prescribe it?

BARTON No comment.

DC YATES Was this given as a verbal order?

BARTON No comment.

DC YATES (Pause) You know that on the 26th of August 1999 (26/08/2006) doctor that the nurses contacted Doctor RAVI, who is a locum consultant geriatrician who advised that the Clexane be discontinued and that Mr PACKMAN's haemoglobin to be checked on the 26th and 27th of August 1999 (26-27/08/1999). The haemoglobin level on the 26th of August was 7.7, it's on Page 205.

For the benefit of the tape DCs YATES and QUADE talk between themselves, which is inaudible.

DC YATES If you can just bear with me doctor.

For the benefit of the tape there is a long pause whilst DCs YATES and Code A talk between themselves, which is inaudible.

DC YATES — We'll have to come back to that Code A.

DC Code A — Yeah come back.

DC YATES — We'll come back to that doctor. (Pause) Right still moving on here though throughout your statement doctor you refer to Mr PACKMAN being 'not for resuscitation', several times in your statement. What explicitly is your understanding of the meaning and implications of that term?

BARTON — No comment.

DC YATES — (Inaudible) that a medical judgement has been made that in the event of a patient's heart or breathing stopping unexpectedly, cardio respiratory arrest, there is little or no chance of cardiopulmonary resuscitation being successful or medically futile and therefore it should not be attempted. Is that right doctor?

BARTON — No comment.

DC YATES — Is this usually on the background of a progressive life threatening illness, or other significant medical problems?

BARTON — No comment.

DC YATES — Does this status mean that the patient is automatically excluded from receiving all appropriate treatment for other medical problems that may arise?

BARTON — No comment.

DC YATES — (Pause) You know that Mr PACKMAN deteriorated about lunchtime on the 26th of August 1999 (26/08/1999) as he was reported 'to have had a fairly good morning'. This would have represented an acute deterioration in his condition. Your entry note that Mr PACKMAN was 'pale, clammy and unwell'. Does this suggest he was shocked?

BARTON — No comment.

DC YATES — And I will invite you to look at these Medical Records yourself doctor if you wish, but why weren't his basic observations such as his temperature, heart rate and blood pressure recorded?

BARTON — No comment.

DC YATES — What would these observations have told you?

BARTON — No comment.

DC YATES — Why did you feel that it wasn't necessary to perform or record these findings?

BARTON — No comment.

DC YATES — The nursing notes/entries suggest that 'he was complaining of indigestion with pain in the throat, which was not radiating', again associated with vomiting. Why did you

query a myocardial infarction?

BARTON — No comment.

DC YATES — What were the medical findings that led you to consider that he had a myocardial infarction?

BARTON — No comment.

DC YATES — What examination, or tests did you undertake that would lead you to consider that he had a myocardial infarction?

BARTON — No comment.

DC YATES — You also recorded that 'an alternative possibility was a gastro intestinal bleed, but note that Mr PACKMAN had not vomited blood', given Mr PACKMAN's history of possible melaena, reported at the QA Hospital, which is on Page 54, and the fresh bleeding the day before. Why didn't you make any further enquiries to determine whether Mr PACKMAN was suffering from a GI bleed?

BARTON — No comment.

DC YATES — What is a GI bleed?

BARTON — No comment.

DC YATES — (Pause) How should it be treated?

BARTON — No comment.

DC YATES (Pause) How was it diagnosed?

BARTON No comment.

DC YATES So what medical findings led you to consider he may have had a gastro intestinal bleed?

BARTON No comment.

DC YATES All that together doctor, on what basis did you satisfy that a myocardial infarction was the more likely diagnosis?

BARTON No comment.

DC YATES Why was Mr PACKMAN prescribed Diamorphine for the treatment of pain due to his pressure sores?

BARTON No comment.

DC YATES (Pause) At the Queen Alexandra Hospital his only analgesic was Paracetamol. In the medical clerking whilst transferred to Dryad Ward, which is on Page 55 I think, and in the Nursing Care Plan relating to his pressure sores he only need Paracetamol. Why then was there a need to significantly increase the opioid levels?

BARTON No comment.

DC YATES Why wasn't this decision making process recorded, especially as you were called in to specifically treat Mr

PACKMAN?

BARTON — No comment.

DC YATES — (Pause) Geoff do you want to ask anything?

DC Code A — No not at the moment Chris.

BARTON — No comment.

DC YATES — Paragraphs (25), (26) and (27) then doctor. Paragraph (25) – 'My impression when I assessed Mr PACKMAN on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to an acute unit was quite inappropriate. Any such transfer was very likely to have had a further deleterious affect on his health'. (26) – 'The nursing note for the 26th of August indicates that we were to await blood test results. There was then a further deterioration later in the day, with Mr PACKMAN complaining of indigestion and a pain in his throat, which was not radiating'. Paragraph (27) – 'The blood count taken on the 26th of August subsequently showed that Mr PACKMAN's haemoglobin had dropped to 7.7 grams, a substantial drop from the 12 grams, which had been recorded two days earlier'. Now the part where you state that 'Mr PACKMAN was very ill and in view of his condition and a previous decision that he was not for resuscitation, transfer to an acute unit was quite inappropriate'. Could you explain that to me doctor?

BARTON No comment.

DC YATES (Pause) Why, although ill and deemed not for resuscitation, does this exclude Mr PACKMAN from receiving appropriate medical care?

BARTON No comment.

DC YATES (Pause) Why, given your clinical description of Mr PACKMAN being shocked, did you not undertaken simple observations such as temperature, pulse and blood pressure?

BARTON No comment.

DC YATES (Pause) If you were convinced that a myocardial infarction was likely, why didn't you perform an ECG to help make the diagnosis for a myocardial infarction?

BARTON No comment.

DC YATES (Pause) Given that you considered the possibility of a gastro intestinal haemorrhage why not, in addition to the simple observation, get into contact with the laboratory to obtain a result of the haemoglobin taken earlier that day?

BARTON No comment.

DC YATES Because as we know, and you've put in your statement doctor, it turns out we've revealed the drop of haemoglobin to 7.7., a considerable drop. (Pause) During Mr

PACKMAN's acute deterioration, which was considered significant, why didn't you discuss it with Doctor RAVI, or Doctor REID, or the medical team on call at the QA Hospital?

BARTON — No comment.

DC YATES — If a patient becomes unexpectedly, or acutely unwell doctor, wouldn't it generally be appropriate to identify the reason for it and to investigate appropriate medical management?

BARTON — No comment.

DC YATES — (Pause) And taken into account this patient's particular circumstances, could this include insuring they are cared for in an environment best suited to meet their medical needs?

BARTON — No comment.

DC YATES — So what you said doctor is 'he was so ill that he couldn't be transferred'? (Pause) What would happen if Mr PACKMAN had been at home and his wife found him in this way?

BARTON — No comment.

DC YATES — Would it have been reasonable to expect that an ambulance would be called and he would be taken to a hospital where he would be cared for?

BARTON No comment.

DC YATES Well would a doctor make a decision that he's so ill moving him would be deleterious to his condition so we'll leave him at home?

BARTON No comment.

DC YATES Because surely the same would apply at the Gosport War Memorial Hospital. If the hospital is not set up to deal with the man's condition, would it not be appropriate to move him doctor?

BARTON No comment.

DC YATES Having made the diagnoses that he was suffering from myocardial infarction, or a gastro intestinal bleed, both serious but both treatable, why did you choose to leave him on Dryad Ward?

BARTON No comment.

DC YATES Why didn't you perform an ECG?

BARTON No comment.

DC YATES We know that there was an ECG available at the hospital. Where was it doctor?

BARTON No comment.

DC YATES — (Pause) Actually doctor let me show you the Lab Report that we couldn't find just now. (Pause) His specimen was taken on the 26th of August 1999 (26/08/1999) and this shows the drop (pause) in the haemoglobin had dropped to 7.7 grams from 12 grams from two days earlier. Is that your signature on that doctor?

BARTON — No comment.

DC Code A — I know you've seen that doctor because you mentioned it in your own prepared statement, so I am showing you it again it is Page 205 of the copy file.

DC YATES — Code A could, what you've got in your hand, could you read the bit there for the doctor?

DC Code A — Yes it says Comment – Many attempts were made to phone these results, no answer from Gosport War Memorial switchboard.

DC YATES — So the lab had obviously realised that there's a drop, they want to get those results through. Why didn't you phone the lab when you suspected a GI bleed?

BARTON — No comment.

DC YATES — What attempts did you make to treat either of the illnesses that you diagnosed?

BARTON — No comment.

DC YATES What would the treatment for myocardial infarction be?

BARTON No comment.

DC YATES And what is the treatment for a GI bleed?

BARTON No comment.

DC YATES Do you know what a GI bleed is?

BARTON No comment.

DC YATES Would I be correct in thinking that even a medical student would understand that a GI bleed could be a medical emergency?

BARTON No comment.

DC YATES In fact it has been mentioned to me, and I did put it to test, that you can put GI Bleed into Google and find out that it's a medical emergency.

BARTON No comment.

DC YATES If you weren't sure, why didn't you take advice?

BARTON No comment.

DC YATES (Pause) What are the specific guidelines on the usual management of acutely ill patients at the Gosport War

Memorial Hospital?

BARTON — No comment.

DC YATES — Were there any guidelines, or protocols, or practices in existence that would specifically prevent, or encourage the transfer of acutely ill patients to the main hospital?

BARTON — No comment.

DC YATES — (Pause) What facilities for general resuscitation were available, e.g. the ability to obtain venous access, (inaudible) venous infusion or fluid?

BARTON — No comment.

DC YATES — For blood transfusions, things like that?

BARTON — No comment.

DC YATES — When did you become aware, doctor, of the full blood count result from the 26th of August?

BARTON — No comment.

DC YATES — Because we can see you were aware of it at some time because you initialled it doctor.

BARTON — No comment.

DC YATES — (Pause) Why wasn't it documented in his medical notes?

BARTON	No comment.
DC YATES	Did you notify Doctor RAVI or Doctor REID with the result?
BARTON	No comment.
DC YATES	You signed that Lab Report doctor, which is Page 205, and given that a large drop of haemoglobin had been demonstrated, on what grounds did you continue to consider a myocardial infarction more likely?
BARTON	No comment.
DC YATES	Not only did you regard it as 'more likely', it was recorded as the cause of death.
BARTON	No comment.
DC YATES	What made that the stronger diagnosis than your alternative diagnosis of a gastro intestinal bleed?
BARTON	No comment.
DC YATES	So that was in light of the Lab Report that you received showing that significant drop in blood?
BARTON	No comment.
DC YATES	Geoff.

DC Code A — Doctor you've recorded 'query melaena', myocardial infarction sorry 'and possible GI bleed', and Chris has just asked you 'what steps you took to eliminate one or the other'. So in other words to find out what was wrong with Geoffrey PACKMAN. You've got an opportunity now, today, to tell us what steps you took to find out what was wrong with Geoffrey PACKMAN. What steps did you take doctor?

BARTON — No comment.

DC Code A — What steps could you have taken doctor?

BARTON — No comment.

DC Code A — For instance regarding myocardial infarction, could you have arranged for an ECG to be performed?

BARTON — No comment.

DC Code A — And would that have indicated to you that he had or didn't have myocardial infarction?

BARTON — No comment.

DC Code A — Similarly we've just discussed GI bleed and as I understand it if somebody is bleeding lower in the intestine you're stools would come out red. Is that right?

BARTON — No comment.

DC Code A And if it's higher they come out black tarry. Is that right?

BARTON No comment.

DC Code A And it is one of the simpler diagnoses to make I believe isn't it...

BARTON No comment.

DC Code A ...for even a junior doctor?

BARTON No comment.

DC Code A How would you go about investigating whether a patient had a GI bleed?

BARTON No comment.

DC Code A Well you can ask for blood results, blood tests couldn't you?

BARTON No comment.

DC Code A And in fact bloods were asked for weren't they?

BARTON No comment.

DC Code A Doctor REID, Doctor RAVI had asked for the blood tests.

BARTON No comment.

DC Code A — And was it not your plan to await lab results...

BARTON — No comment.

DC Code A — ...for Mr PACKMAN?

BARTON — No comment.

DC Code A — Well you did wait for blood results didn't you?

BARTON — No comment.

DC Code A — And when I say that you just waited. Is that right?

BARTON — No comment.

DC Code A — What else could you have done to establish whether Mr PACKMAN had a GI bleed?

BARTON — No comment.

DC Code A — Did you consider and endoscopy?

BARTON — No comment.

DC Code A — What are the considerations for an endoscopy with a patient suffering (somebody coughs), suffering from a GI bleed?

BARTON — No comment.

DC Code A You'd put it down on the paperwork that 'he might have a GI bleed' and yet it looks as if you haven't followed this up.

BARTON No comment.

DC Code A Well the lab obviously recognised that he was a medical emergency and tried to contact the hospital, but couldn't get through. We can't blame you for not answering the phone can we? No one is seeking to, but what steps did you take to get the results of those blood tests?

BARTON No comment.

DC Code A Well when did you see those tests then?

BARTON No comment.

DC Code A You signed them didn't you?

BARTON No comment.

DC Code A We've already asked you 'why you didn't feel that he could go to the QA Hospital'. In Mr PACKMAN's case doctor. No let me start again, if you had gone out to a patient at home with the same symptoms that Mr PACKMAN had, i.e. you queried whether that patient lying in their bed at home had an myocardial infarction or possibly a GI bleed. Would you have just left them in their bed at home?

BARTON No comment.

DC Code A I take it you wouldn't, and I take it you would have caused him to treble nined (999) to the nearest hospital. Would you have done that?

BARTON No comment.

DC Code A Why didn't you do that with Mr PACKMAN?

BARTON No comment.

DC Code A Do you feel that Geoffrey PACKMAN was at a disadvantage because he was already in your hospital then?

BARTON No comment.

DC Code A If you weren't willing to have him transferred to an acute bed, do you feel he was at a disadvantage?

BARTON No comment.

DC YATES Right now we'll move on then to Paragraph 28. You state that 'you were concerned that Mr PACKMAN should receive appropriate medication to relieve his pain and distress, and therefore gave him Oramorph 10 – 20 milligrams four times a day and 20 milligrams at night'. So what dose of drug was given to Mr PACKMAN during the day?

BARTON No comment.

DC YATES Was it 10, or was it 20 doctor?

BARTON No comment.

DC YATES Page 172 of the notes show that a range was available, but the record does not show what dose was given. Why is this?

BARTON No comment.

DC YATES When this range is given, who decides on the size of the dose given?

BARTON No comment.

DC YATES (Pause) And what safeguards were in place preventing the inadvertent, or inattentive administration of these drugs to Mr PACKMAN?

BARTON No comment.

DC YATES So what doses of Morphine did Mr PACKMAN actually receive that day?

BARTON No comment.

DC YATES I'll change it slightly then, what explicitly was the pain and distress that Mr PACKMAN was in?

BARTON No comment.

DC YATES — It's this range of drug again doctor isn't it? 10 – 20 milligrams four times a day, 20 milligrams at night. If I was to pick up those medical notes as a nurse, how would I know whether to give 10 or whether to give 20 milligrams?

BARTON — No comment.

DC YATES — Or would the choice just be mine?

BARTON — No comment.

DC YATES — Code A do you want to ask anything?

DC Code A — Yeah. Not only that doctor, we showed you earlier on this 'prescribing elderly medicine' blown up chart taken from the BNF GJQ/HF/21, and we showed you, did we not, that we had the 10 milligrams Morphine Sulphate oral solution and you'd prescribed 40 milligrams of Diamorphine, which was beyond the guidelines, above the guidelines, you should have been prescribing say 20 milligrams, and Chris has just said: "What safeguards did you put in place to make sure that Mr PACKMAN didn't receive the wrong drugs, or too much of the drugs?" because as we pointed out with the Oramorph how would a nurse know whether to give the 10 or the 20?

BARTON — No comment.

DC Code A — And similarly how would a nurse know whether to give 10 milligrams of Oramorph and on this chart it's second in the

table on the weaker side, or 200 milligrams of Diamorphine which is way down here look on the right hand side.

BARTON — No comment.

DC Code A — What prevents a nurse from doing that doctor...

BARTON — No comment.

DC Code A — ...because that is the open range you've prescribed isn't it...

BARTON — No comment.

DC Code A — ...on the same day that you prescribed the Oramorph?

BARTON — No comment.

DC Code A — Do you think that is an acceptable way to write up a Prescription Chart?

BARTON — No comment.

DC YATES — In answer to what DC Code A has just been asking, Paragraph (29), you actually say 'I also wrote up prescriptions for Diamorphine 40 – 200 milligrams subcutaneously over 24 hours, together with 20 – 80 milligrams of Midazalam via the same route on an anticipatory basis, concerned that further medication might be required in due course to relieve Mr PACKMAN's pain and distress. It was not my intention that this

subcutaneous medication should be administered at that time. The nursing record also indicates that I saw Mr PACKMAN's wife explaining her husband's condition and the medication we were using. I anticipate I would have indicated to Mrs PACKMAN that her husband was very ill indeed and in all probability that he was likely to die'. As DC Code A said 'you've written up prescriptions with Diamorphine 40 – 200 milligrams on the same day as you've written Oramorph 'on an anticipatory basis'. If that was the correct way of doing things doctor, where in the medical notes does it say that?

BARTON — No comment.

DC YATES — Well where in the medical notes does it say 'to advise the nurses that this is just on an anticipatory basis and that you would require contacting'?

BARTON — No comment.

DC YATES — I can't see any safeguard.

DC Code A — Well let's just take that on a little bit further doctor, let's expand on that because 'safeguard' is the appropriate word I think because when the Diamorphine syringe driver was started it was started, was it not, by Sister HAMBLIN?

BARTON — No comment.

DC Code A — And yet you haven't recorded your authority anywhere for her to start that?

BARTON No comment.

DC Code A It's possible isn't it that she didn't have your authority to start it specifically?

BARTON No comment.

DC Code A 'It was not my intention that this subcutaneous medication should be administered at that time'. So at what time was it to be administered?

BARTON No comment.

DC Code A And how was that to be conveyed to the nurses?

BARTON No comment.

DC Code A Because it seems it was started with nothing down on paper from you even post a decision. Did you give verbal authority for that medication to be started at that time?

BARTON No comment.

DC Code A What I say it doesn't look as if (TAPE BUZZES), it doesn't look as if you have does it? And what is to stop, well I'll let you answer that question first, it doesn't look as if you have does it?

BARTON No comment.

DC Code A — And what was to stop that nurse from prescribing anywhere between the 20 milligrams of Diamorphine up to the 200?

BARTON — No comment.

DC Code A — She seemed to start it where she thought fit?

BARTON — No comment.

DC Code A — What was to stop her from prescribing, from administering 200 milligrams from the start?

BARTON — No comment.

DC YATES — The buzzer sound, if we change the tapes over. Is there anything you wish to clarify?

BARTON — No thank you.

DC YATES — Is there anything you wish to add?

BARTON — No thank you.

DC YATES — And are you happy to continue straight on?

BARTON — (Silent)

DC YATES — Yeah. Okay the time is 1443 hours and I am turning the recorder off.

INTERVIEW CONCLUDED – TAPE MACHINE

RESTRICTED

DOCUMENT RECORD PRINT

SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AP

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

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1453 Time concluded: 1537

Duration of interview: 44 MINUTES Tape reference nos.
(→)

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

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This is a continuation of the interview with Doctor BARTON. The time is 1453 hours and a short break was taken at the end of the last tape for comfort reasons etcetera. Can you just confirm doctor that the same people are present?
BARTON	Yes.
DC YATES	And also that there has been no conversation whilst the tapes have been off about this matter?

BARTON None at all.

DC YATES Thank you. Geoff you were.

DC Code A Yes where was I? (Pause)

BARKER Well if it helps at all you had asked: "What was to stop her...

DC Code A Yes.

BARKER ...administering 200 from the start?" Doctor BARTON indicated: "No comment," and the tape ended.

DC Code A Thank you very much.

DC So just to pick up on that last question then doctor, on that chart what was to stop Sister HAMBLIN or any of the other nurses from going straight to 200 milligrams of Diamorphine on setting up that syringe driver?

BARTON No comment.

DC Code A What were the guidelines in place for commencing a syringe driver at the hospital at the time?

BARTON No comment.

DC Code A If you had authorised Sister HAMBLIN, say for arguments sake over the phone, how should she have recorded that in the notes?

BARTON No comment.

DC Code A Would she have needed another nurse with her to record what you had said?

BARTON No comment.

DC Code A Did you trust Sister HAMBLIN to carry out your instructions?

BARTON No comment.

DC Code A Would Sister HAMBLIN 'anticipate' - to use one of your words, would Sister HAMBLIN anticipate your instructions?

BARTON No comment.

DC Code A Were there ever times when Sister HAMBLIN did things thinking that you were authorising post, i.e. she would do something and then get your authorisation after it had been done?

BARTON No comment.

DC Code A Was this something you allowed her to do? (Somebody coughs)

BARTON No comment.

DC Code A — We know that you placed great trust in the nursing staff, or it seems that you placed great trust in the nursing staff. Was this yet another example of it?

BARTON — No comment.

DC Code A — Chris.

DC YATES — Just to continue on the Diamorphine aspect of things. Is it correct doctor that a drug such as Diamorphine is licensed?

BARTON — No comment.

DC YATES — And within that licence there are particular ways that you can use that drug?

BARTON — No comment.

DC YATES — Can you use a drug like Diamorphine in an unlicensed way?

BARTON — No comment.

DC YATES — And if you were (clears throat), what would you be expected to do in order to record that?

BARTON — No comment.

DC YATES — (Clears throat) Again on Diamorphine doctor, when you visited Mr PACKMAN on the 26th of August 1999

(26/08/1999) you were concerned that Mr PACKMAN may have suffered a myocardial infarction and accordingly you decided to administer opiates in the form of Diamorphine for pain and distress consequent on the possible myocardial infarction at a dose of 10 milligrams intramuscularly. Well first of all (inaudible) myocardial infarction is. My understanding is it is a heart attack, is that correct?

BARTON — No comment.

DC YATES — And my understanding is that Diamorphine can be administered for pain from a heart attack, but what would the correct dosage be?

BARTON — No comment.

DC YATES — You'd prescribed a dose of 10 milligrams intramuscularly. Is it right that that is double the licence dose?

BARTON — No comment.

DC YATES — Should that not have been a 5 milligram intramuscularly?

BARTON — No comment.

DC YATES — Was that a mistake?

BARTON — No comment.

DC YATES — (Pause – clears throat) But having diagnosed a possible heart attack, how important is the previous medical history

in making such a diagnosis?

BARTON — No comment.

DC YATES — What previous medical history has Mr PACKMAN got with heart problems?

BARTON — No comment.

DC YATES — (Clears throat) Well what are the symptoms for a heart attack?

BARTON — No comment.

DC YATES — Could that be chest pains?

BARTON — No comment.

DC YATES — Nausea and/or abdominal pain?

BARTON — No comment.

DC YATES — Anxiety?

BARTON — No comment.

DC YATES — Light headiness, cough?

BARTON — No comment.

DC YATES — Nausea with or without vomiting?

BARTON	No comment.
DC YATES	So if some of these symptoms were present and you made a diagnosis of a possible heart attack, what tests should you do?
BARTON	No comment.
DC YATES	An electrocardiogram or an ECG as most people know it, when should that be obtained?
BARTON	No comment.
DC YATES	You are an experienced doctor and you have to undergo an awful lot of training to get to the position you are doctor and we are just detectives with no medical training, but my understanding is is that an ECG should be obtained as soon as possible after presentation to the examining doctor. ...
BARTON	No comment.
DC YATES	...Why didn't you get an ECG?
BARTON	No comment.
DC YATES	Is it right that approximately one half of patients have diagnostic changes on their initial ECG?
BARTON	No comment.

DC YATES — Would it be right that an ECG should be preformed on any patient who is older than forty-five years and is experiencing any form of chest or stomach discomfort?

BARTON — No comment.

DC YATES — And would that included new epigastro or nausea?

BARTON — No comment.

DC YATES — (Pause) So again just carrying on from what DC QUADE was asking, on what basis did you determine a dose range of Diamorphine 40 – 200 milligrams over twenty-four hours and Midazolam at 20 – 80 milligrams over twenty-four hours and it would be necessary for Mr PACKMAN?

BARTON — No comment.

DC YATES — Why was it necessary to adopt a more proactive prescribing policy in this case?

BARTON — No comment.

DC YATES — Doctor you've been called into the hospital specifically to attend to Mr PACKMAN and it was seven in the evening, so you don't have to deal with anyone else in the ward it's just Mr PACKMAN and you'd be returning to the ward twelve hours later, so why was it therefore necessary to prescribe that range of drug?

BARTON — No comment.

DC YATES — Code A?

DC Code A — At the end of Paragraph (29) doctor the last sentence is: "I anticipate I would have indicated to Mrs PACKMAN that her husband was very ill indeed and in all probability that he was likely to die." Now it's a question I've asked before today that that line demands the questions again, what was he likely to die of?

BARTON — No comment.

DC Code A — What was causing his likely death?

BARTON — No comment.

DC Code A — You'd written that day: "Possibly had GI bleed or may have been myocardial infarction." You hadn't even established what was wrong with him had you?

BARTON — No comment.

DC Code A — If you felt at that stage that his life was being threatened, why didn't you cause some form of investigation into his symptoms?

BARTON — No comment.

DC Code A — But you're quite willing to tell a wife that 'her husband is dying' and at that stage you don't even know what is wrong with him.

BARTON	No comment.
DC Code A	As I understand it both conditions are serious, but are they not both reversible with correct treatment?
BARTON	No comment.
DC Code A	Would you expect somebody with a GI bleed to die?
BARTON	No comment.
DC Code A	Do you expect any patient with myocardial infarction to die?
BARTON	No comment.
DC Code A	But you did in this case didn't you?
BARTON	No comment.
DC Code A	So what was the difference between Mr PACKMAN?
BARTON	No comment.
DC Code A	How did you form the opinion that he was likely to die?
BARTON	No comment.
DC Code A	Chris.

DC YATES — You see again with your note on the 26th of August (pause) 'query MI – treat stat Diamorph, unless it's query a heart attack, and Oramorph overnight. Alternative possibility GI bleed but no haematemisis'. Did you do anything to find out which, if any of these symptoms, which of, if any of these diagnoses was correct?

BARTON — No comment.

DC YATES — Because I can't see it recorded anywhere else in your notes. Now Doctor REID, the consultant, reviewed this patient, I think it was on the 1st of September, we will come on to that, how was he to know what you've done and what you think?

BARTON — No comment.

DC YATES — How about 30 then doctor?

DC Code A — Could we just go back to 29 again Chris?

DC YATES — Yeah go on.

DC Code A — Sorry. Paragraph (27), the blood count taken on the 26th of August subsequently shows that Mr PACKMAN's haemoglobin (HB) had dropped to 7.7 grams. You obviously feel that that is significant and it probably was significant wasn't it? But I am interested in to why you've put that at Paragraph (27) before Paragraph (29) where you're talking about his wife. Presumably you're seeing his wife the same day you wrote up the Diamorphine,

which was the 26th of August and you're seeming to link 29, Paragraph (29) to Paragraph (27) aren't you?

BARTON — No comment.

DC Code A — But you can't have your cake and eat it doctor can you (somebody coughs) because we have asked you: "When did you see that Lab Report with the 7.7 grams on it?" If you recall we showed it to you, it's open for you to have a look at again, we showed it to you and it states on there that 'the lab were trying to contact the War Memorial Hospital, but couldn't get through' and the date is the 26/08, so which way round is it doctor? Did you know about the lab result on the 26/08?

BARTON — No comment.

DC Code A — If you had of known about the lab result on the 26/08 you could have linked it with his possible GI bleed obviously and you could have informed Mrs PACKMAN that her husband was badly ill, very poorly, but even so was it still, was it the case that that was a reversible condition at that time?

BARTON — No comment.

DC Code A — I say to you you wouldn't have known would you at that time?

BARTON — No comment.

DC Code A — How could you have known when you spoke to Mrs PACKMAN that her husband probably had a condition that was likely to lead to death?

BARTON — No comment.

DC YATES — I mean you certainly seem to be pretty convinced that Mr PACKMAN had suffered a heart attack or possibly a GI bleed. If we go to the Death Certificate, the Cause Of Death, in the box you actually noted that 'Mr PACKMAN had been suffering from myocardial infarction five days prior to his death', that was the 29th of August. So what made your mind up then that on the 29th of August you knew that Mr PACKMAN was having a heart attack or suffering with heart problems?

BARTON — No comment.

DC YATES — So where was this recorded in the notes?

BARTON — No comment.

DC YATES — You had already decided that that's when he, that's when it was diagnosed and that's when he was suffering from this. How were you going to treat this?

BARTON — No comment.

DC YATES — So what changed between your note on the 26th of August then and the 29th of August when according to the MCCD, when the myocardial infarction was diagnosed, and on the

26th it was 'query myocardial infarction – query GI bleed'.

BARTON — No comment.

DC YATES — How do you know he had a heart attack on the 29th of August?

BARTON — No comment.

DC YATES — Well I've been through the treatment, what I believe the treatment for a suspected heart attack is. What would you say this treatment should be?

BARTON — No comment.

DC YATES — As in this report how would Doctor REID know, the consultant, the doctor who has overall responsibility for this patient, how on earth could he be aware of your diagnosis if you haven't even written this down?

BARTON — No comment.

DC YATES — Did you discuss it verbally with Doctor REID?

BARTON — No comment.

DC YATES — Did you discuss it with anyone?

BARTON — No comment.

DC YATES — And again moving on to Paragraph (30) of your statement

doctor. 'On the morning of the 27th of August 1999 (27/08/1999) Mr PACKMAN appeared to have stabilised somewhat'. Right 'I would have reviewed Mr PACKMAN again the following and indeed the Nursing Record confirms that I attended to see him then, therefore relying on the nurses' notes. Sister HAMBLIN had recorded that there had been some marked improvement since the previous day and that the Oramorph was tolerated well and should continue to be given, though Mr PACKMAN apparently still had some discomfort later that afternoon especially when the dressings were being changed. In spite of the earlier improvement, Mr PACKMAN was said to remain poorly. 10 milligrams of Oramorph were administered four hourly, together with a further 20 milligrams at night as prescribed, so that Mr PACKMAN received a total of 60 milligrams that day, though this was seemingly not enough to remove his pain and discomfort when his dressings were being changed. The nursing records indicate that he appeared to have a comfortable night'. So (pause) we are now on the 27th doctor. So by the morning of the 27th of August Mr PACKMAN appeared to have stabilized somewhat more. In addition, you would have had ample of opportunity to have obtained the result of the haemoglobin taken the day before. Why then at a time when Mr PACKMAN could have transferred more safely was this not done then?

BARTON — No comment.

DC YATES — If his condition had stabilised or he was suffering, possibly suffering from a GI bleed or a heart attack and you and the

hospital are not capable of treating this, would it not have been better to have sent him to a hospital that could?

BARTON — No comment.

DC YATES — DC Code A pointed this out earlier that 'it would appear that Mr PACKMAN was actually disadvantaged by being on your ward when suffering from these illnesses that were treatable, very serious conditions but treatable. What did you do to treat them?

BARTON — No comment.

DC YATES — What did you do in order that anyone could help Mr PACKMAN?

BARTON — No comment.

DC YATES — When did you discuss with Doctor RAVI, or Doctor REID, or the gastroenterologists, or medical team on call Mr PACKMAN's condition in particular the drop in his haemoglobin?

BARTON — No comment.

DC YATES — Why didn't you discuss him?

BARTON — No comment.

DC YATES — Paragraph (31). 'I reviewed Mr PACKMAN again the following morning and on this occasion I made a note in

his records, which read reads as follows:- The 28th of August 1999 (28/08/1999) remains poorly but comfortable, please continue opiates over weekend'. Were you aware of the blood results at this time?

BARTON — No comment.

DC YATES — What action did you take?

BARTON — No comment.

DC YATES — His blood results are here and they are saying that 'there is a significant drop' and we know you were aware of them at some time because you've signed the Lab Report. If you weren't aware and you hadn't received the Lab Report why didn't you phone the lab?

BARTON — No comment.

DC YATES — You queried a GI bleed. Wouldn't these results have been important?

BARTON — No comment.

DC YATES — The 28th, that was a Saturday, you didn't have the practice pressures on you, why didn't you write a more detailed note then?

BARTON — No comment.

DC YATES — Now this was coming up to the August bank holiday, so

you were aware that the Monday was going to be a bank holiday. If this being the case, who was going to review Mr PACKMAN if his condition deteriorated?

BARTON — No comment.

DC YATES — You stated: "Please continue opiates over the weekend." How were the nurses to know how and when to increase the drugs?

BARTON — No comment.

DC YATES — What safeguards have you put in place this time?

BARTON — No comment.

DC YATES — Paragraph (34) doctor. You write 'I do not know if I would have seen Mr PACKMAN again the following morning, Monday the 30th of August, that being a bank holiday. I have no way of knowing now if I was on duty then. If I did see him as part of my review of all the patients on the two wards, I did not have an opportunity to make a specific entry in his records on this occasion. A Barthel score was recorded as 4. The nursing record indicates that Mr PACKMAN's condition remained poor and later that day at 2.45pm (1445) the syringe driver was set up to deliver 40 milligrams of Diamorphine and 20 milligrams of Midazolam subcutaneously. I anticipate that Mr PACKMAN would have continued to experience pain and clearly in view of the significant sacral sores, it was highly likely that he would have been experiencing further

significant discomfort'. So you state that 'Monday the 30th of August was a bank holiday and you have no way of knowing whether you were on duty, but you know that at 2.45pm (1445) a syringe driver was set up containing Diamorphine 40 milligrams and Midazolam 20 milligrams subcutaneously over twenty-four hours'. Why was a syringe driver considered necessary?

BARTON No comment.

DC YATES Why were these drugs prescribed?

BARTON No comment.

DC YATES But why isn't there anything in either the doctors' or nurses' records to suggest that this decision was discussed with a doctor?

BARTON No comment.

DC YATES Right you stated that 'Mr PACKMAN would have been experiencing pain from his abdomen or sacral sores'. The notes do not suggest that the sores were a significant cause of pain do they doctor?

BARTON No comment.

DC YATES In fact the Nursing Care Plan for sleeping, entry on the 29th of August, it records that Mr PACKMAM complained of left sided abdominal pain and queried whether this was related to his bowels'. Why therefore is Mr PACKMAN

commenced in these drugs?

BARTON — No comment.

DC YATES — I see you're there on a Saturday, you went on the Sunday, you possibly went on a Monday. Who authorised this?

BARTON — No comment.

DC YATES — Geoff?

DC Code A — No.

DC YATES — (Pause) Paragraph (35) of your statement doctor. 'In view of his poor condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying. Mr PACKMAN had received 60 milligrams of Oramorph daily over the preceding three days and the administration of 40 milligrams of Diamorphine subcutaneously over twenty-four hours did not represent a significant increase. Mr PACKMAN would have started to have become inured to the opiate medication and an increase of this nature was, in my view, entirely appropriate to ensure that his pain was well controlled. Indeed, the nursing record goes on to state that there were no further complaints of abdominal pain and Mr PACKMAN was able to take a small amount of food'. Like you said 'Mr PACKMAN received 60 milligrams of Morphine each day over the preceding three days, and on this basis the administration of Diamorphine, which was 40 milligrams subcutaneously over twenty-four

hours, did not represent a significant increase'. How do you personally calculate an appropriate dose of subcutaneous Diamorphine based on a patient's previous oral Morphine dose?

BARTON — No comment.

DC YATES — Now DC Code A s been through this with you as well. Are you aware of that chart?

BARTON — No comment.

DC YATES — (Pause) As we understand it the total twenty-four hour oral dose of Morphine is divided by three or occasionally by two, hey Geoff?

DC Code A — That's right.

DC YATES — So an appropriate dose, i.e. Diamorphine at 20 milligrams over twenty-four hours would generally be considered an appropriate conversion on this occasion. Is that correct doctor?

BARTON — No comment.

DC YATES — Why was Mr PACKMAN's doubled therefore?

BARTON — No comment.

DC YATES — The first three lines of that paragraph, 'In view of his condition I anticipate that I considered him to be terminally

ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying'. What was he dying of?

BARTON — No comment.

DC YATES — Was he dying of a myocardial infarction?

BARTON — No comment.

DC YATES — Did he need to die of a myocardial infarction?

BARTON — No comment.

DC YATES — Isn't myocardial infarction for a heart attack? Is it treatable?

BARTON — No comment.

DC YATES — Well what did you do to treat it?

BARTON — No comment.

DC YATES — Did you do anything?

BARTON — No comment.

DC YATES — You say 'it was your second diagnosis of a GI bleed'. Is that treatable?

BARTON — No comment.

DC YATES — What can you do to save a person that is suffering a GI bleed?

BARTON — No comment.

DC YATES — Is it always a terminal condition?

BARTON — No comment.

DC YATES — But you were concerned to ensure that he did not suffer pain and distress as he was dying. Would it not have been better doctor to have tried to cure the underlying cause rather than increase the dose of the Diamorphine?

BARTON — No comment.

DC YATES — Geoff?

DC Code A — Well doctor you have been given a copy of those Medical Records, a full copy of the Medical Records that are available and you've had some time to read them through and then make this statement that you've presented to us and in this Paragraph (35) I'll draw your attention to five words 'poor condition, terminally ill and dying'. Not anywhere there does it say what his poor condition was, what he was terminally ill with or what he was dying from. Even now, seven years later, when you read this Hospital Record, even now you cannot state, can you, what was causing his death.

BARTON No comment.

DC Code A I am saying to you, I put it to you that at that stage you did not know what his condition was did you?

BARTON No comment.

DC Code A But you were content to assume that he was dying,...

BARTON No comment.

DC Code A ...so content that you told his wife that he was dying according to you,...

BARTON No comment.

DC Code A ...so content that you failed to find, or to investigate the cause of his condition,...

BARTON No comment.

DC Code A ...so content that you merely ramped up the analgesic to keep him pain free,...

BARTON No comment.

DC Code A ...but you had already suspected that he might have one of two reversible and treatable conditions.

BARTON No comment.

DC Code A — Why in Paragraph (35) have you not said what he was dying from?

BARTON — No comment.

DC YATES — Right Paragraph (36) then doctor. 'I anticipate that the nursing staff', it's 'I anticipate' again isn't it? 'I anticipate that the nursing staff would have liaised with me prior to the commencement of the Diamorphine and Midazolam and this would have been set up on my instruction directly if I had been at the hospital, or otherwise by phone'. Doctor this is a direct contrast to Paragraph (34). You state that 'nursing would have liaised with you and that the Diamorphine and Midazolam would have been commenced on your instruction'. So therefore did you authorise the commencement of that Diamorphine?

BARTON — No comment.

DC YATES — If you did, why didn't you put an entry in the notes when you next came on duty as you had previously?

BARTON — No comment.

DC YATES — Did you have an arrangement with Sister HAMBLIN that she could commence patients on syringe drivers with Diamorphine when she deemed it suitable?

BARTON — No comment.

DC YATES — Well who therefore made the decision to increase Mr

PACKMAN's Diamorphine by at least double the amount?

BARTON — No comment.

DC YATES — Well that is a significant increase, it's double the amount doctor.

BARTON — No comment.

DC YATES — Well what is the purpose of medial practitioners reviewing patients and deciding on levels of prescriptions then?

BARTON — No comment.

DC YATES — (Pause) You said 'this would have been on your instruction directly if you had been at the hospital, or otherwise by phone'. What's the effect then of doubling the Diamorphine?

BARTON — No comment.

DC YATES — Geoff?

DC Code A — Yeah. 'I anticipate that the nursing staff bla, bla, bla. This would have been set up on my instruction directly, or otherwise by phone'. Well let's take 'directly' shall we. If it was directly, I'm assuming that you are there in the ward. Let's take 'directly', let's assume it was 'directly', you were there in the ward. Why didn't you make a record there and then on the notes that you had authorised the setting up of that driver?

BARTON	No comment.
DC Code A	No you didn't did you? So let's assume that it wasn't directly.
BARTON	No comment.
DC Code A	Let's go then for 'or otherwise by phone' then surely (somebody coughs) if it was by phone again there would be some record wouldn't there?
BARTON	No comment.
DC Code A	But there isn't is there?
BARTON	No comment.
DC Code A	So let's go for another possibility, which you haven't put down in Paragraph (36) and that is that Sister HAMBLIN set up the syringe driver on her own...
BARTON	No comment.
DC Code A	...without speaking to you?
BARTON	No comment.
DC YATES	Had you had an arrangement with Sister HAMBLIN that she could put up the syringe driver when she felt it was the right time to do so?

BARTON No comment.

DC Code A Was that an arrangement that was common practice between the two of you?

BARTON No comment.

DC Code A Was that an acceptable arrangement do you think?

BARTON No comment.

DC Code A Okay. Well let's go for another option then and let's say: "Is it possible that Sister HAMBLIN did that of her own accord without any consultation with you?"

BARTON No comment.

DC Code A And what was to stop her, you had prescribed the Diamorphine and the Midazolam; you'd given the broad range. Was she entitled to set up the syringe driver because you had already prescribed it?

BARTON No comment.

DC Code A And if that last one was the case, is that why there's no record of it?

BARTON No comment.

DC Code A Well is it doctor? Is it: "Let's leave well alone and let's

hope it doesn't get noticed."

BARTON — No comment.

DC Code A — (Pause) Obviously if it had been done on the telephone, if authority had been given over the telephone there would be more likely I suppose to be an entry because the policy says that 'it would have to be signed by two nurses'. Is that not correct doctor?

BARTON — No comment.

DC YATES — Let's take Paragraph (37) and Paragraph (38) then doctor. 'On the morning of the 31st of August Mr PACKMAN was recorded as having had a peaceful and comfortable night, though he then passed a large amount of black faeces that morning. I believe I would have seen Mr PACKMAN again that morning, though again I did not have an opportunity to make an entry in his records. I anticipate his condition would have been essentially unaltered and that he would have remained comfortable. Similarly, I would probably have seen Mr PACKMAN again on the morning of 1st of September, but would have been unable to record this. I anticipate that his condition was again unchanged. Five separate pressure sore areas were noted by the nurses. A Barthel score of only 1 was recorded'. So you stated that 'on the morning of the 31st of August Mr PACKMAN was recorded as passing a large amount of black faeces'. Isn't this a pure indication of one of your queried diagnosis, of your indication of a gastro intestinal bleed?

BARTON — No comment.

DC YATES — And I will ask you again next to the dates that we have got. When did you obtain or review that full blood count that you signed?

BARTON — No comment.

DC YATES — Why didn't you refer Mr PACKMAN to a more senior colleague at this point?

BARTON — No comment.

DC YATES — So according to you doctor Mr PACKMAN was either suffering from a heart condition, or a GI bleed according you're your entry on the 26th of August. You've commenced him on varying, increasing doses of Diamorphine. You say that you, you stated somewhere, on the 26th, the 27th, the 28th, the 31st and the 1st of September you've made two entries in the notes and neither of which reasons why he has been given any medication. There was no evidence that an ECG, or any tests to address his heart condition had been thought about or carried out. And in relation to his GI bleed you wrote 'A large form of haemoglobin levels, passing of black stools' and yet again there was no record of investigations for treatment plans, or referrals to senior colleagues, why not?

BARTON — (Silent)

DC YATES — Doctor why not?

BARTON No comment.

DC YATES So what care were you providing for Mr PACKMAN?

BARTON No comment.

DC YATES (Pause) Were you just allowing him to die?

BARTON No comment.

DC YATES Anything Geoff?

DC Code A Yeah. And it's very similar to a set of questions I asked you a few moments ago doctor. Paragraph (37) – 'He then passed a large amount of black faeces that morning'. Paragraph (27) I think it was when 'you agree that you signed the Lab Report with a 7.7 reading on (inaudible). Previous to this you've written into this statement that 'you queried myocardial infarction plus you queried 'possible GI bleed', and now you have got the clearest indication that that is probably what he has got a GI bleed because you've put on here 'passed a large amount of black faeces'. Black faeces plus the 7.7, what is that an indication of doctor?

BARTON No comment.

DC Code A Well we both know don't we that that is an indication of a GI bleed, and yet even now at this stage, in this prepared statement, prepared statements you've had time to write it, we haven't asked you to do it in five minutes, even now

Chapter 30, or Paragraph (37) you still haven't written down what is wrong with Mr PACKMAN and that's the clearest indication yet that we've got so far and we'll carry on with the questioning, but expect another question on that in a minute doctor.

BARTON — No comment.

DC YATES — Right doctor we'll move on to Paragraph 41. 'Sister HAMBLIN recorded later in the Nursing Records that the syringe driver was renewed at 7.15pm (1915) with 60 milligrams of Diamorphine and 60 milligrams of Midazolam subcutaneously as the previous dose was not controlling Mr PACKMAN's symptoms. It appears therefore that Mr PACKMAN was experiencing yet further pain and discomfort. I anticipate that the nursing staff would have contacted me and that I authorised this moderate increase in his medication in order to alleviate the pain and distress'. So on the evening of the 1st of September now then 'the first Diamorphine was increased to 60 milligrams and Midazolam to 60 milligrams over a twenty-four hour period', that's at quarter-past-seven (1915) in the evening because the previous dose wasn't controlling the symptoms (coughs). Sister HAMBLIN has recorded this, you haven't. Who has authorised the change in dosage?

BARTON — No comment.

DC YATES — So that's a Diamorphine increase of 50% and the Midazolam dose was trebled. Why was this?

BARTON — No comment. (TAPE BUZZES)

DC YATES — Where is it recorded in the records that Mr PACKMAN was in pain or distress?

BARTON — No comment.

DC YATES — So you're going to say that 'you anticipate that the nursing staff would have contacted you and you have authorised this moderate increase in his medication'. Well moderate is 50% of Diamorphine and trebling the Midazolam, but where have you authorised this?

BARTON — No comment.

DC YATES — Was it over the telephone?

BARTON — No comment.

DC YATES — In which case an entry would have been made by the nurses. Is that correct?

BARTON — No comment.

DC YATES — Were you there?

BARTON — No comment.

DC YATES — In which case you have signed it yourself?

BARTON — No comment.

DC YATES Or did Sister HAMBLIN just authorise it herself?

BARTON No comment.

DC YATES I'll let you think about that for a moment doctor because I'm going to take this opportunity to change the tape. The time is 1537 hours and I am going to turn the recorder off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AQ

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

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1538 Time concluded: 1605

Duration of interview: 27 MINUTES Tape reference nos.
(→)

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

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This is a continuation of the interview with Doctor Jane BARTON. The time is 1538 hours and the date is the 6th of April 2006 (06/04/2006). Doctor can you just confirm that it's the same people present in the room please?
BARTON	It is.
DC YATES	And has there been any conversation about this matter while the tapes have been off?
BARTON	None at all.

DC YATES — Okay. Just so that we can (pause – clears throat) re-cap on this, we were discussing Paragraph (41) and who actually authorised this increase in the medication. (Pause) So where was it recorded in the records that Mr PACKMAN was in pain?

BARTON — No comment.

DC YATES — And where was it in the records who authorised this?

BARTON — No comment.

DC YATES — Am I right in thinking had it been a telephone authorisation that two nurses would have signed the records?

BARTON — No comment.

DC YATES — Am I right in thinking that had you been at the hospital you would have signed the prescription sheet?

BARTON — No comment.

DC YATES — Geoff.

DC Code A — No not at the moment.

DC YATES — No. Paragraphs (42) and (43) then. 'That night Mr PACKMAN was noted to be incontinent of black tarry faeces, but otherwise he had a peaceful night and the syringe driver was said to be satisfactory. I believe I would

have reviewed Mr PACKMAN again the following day, the 2nd of September. The nursing records show that his medication was again increased, the Diamorphine to 90 milligrams and the Midazolam to 80 milligrams subcutaneously. I anticipate again that Mr PACKMAN would have been experiencing pain and distress and that I and the nursing staff were concerned that the medication should be increased accordingly to ensure that he did not suffer pain and distress as he died. That night Mr PACKMAN was said to remain ill, but comfortable and the syringe driver was satisfactory'. So Mr PACKMAN was noted to have had a peaceful night, however Diamorphine was increased to 90 milligrams over a twenty-four period from 60 and the Midazolam to 80 from 60 and that was at 1840 hours on the 2nd of September. Why was this doctor?

BARTON No comment.

DC YATES However there is no mention of pain and distress from the nursing or medical notes. Who authorised this increase?

BARTON No comment.

DC YATES Did you authorise it?

BARTON No comment.

DC YATES Personally?

BARTON No comment.

DC YATES Or by phone?

BARTON No comment.

DC YATES Or was it unauthorised?

BARTON No comment.

DC YATES (Pause) Also it's mentioned in Paragraph (42) – 'That night Mr PACKMAN was noted to be incontinent of black tarry faeces otherwise he had a peaceful night'. What is that significant to?

BARTON No comment.

DC YATES So we've gone from the 26th of August where you've query a GI bleed and you queried a heart attack. Well we are now on, I believe, the 1st of September (pause), overnight on the 1st of September I believe. So four or five days and you have quite a few pointers now as to what might be wrong with Mr PACKMAN haven't you?

BARTON No comment.

DC YATES (Clears throat) And this last one 'the black tarry faeces', am I right in thinking that that is indicative of a GI bleed?

BARTON No comment.

DC YATES — Albeit it could be indicative of a lot of things I'm sure, but you suspected a GI bleed, and why did you suspect a GI bleed doctor?

BARTON — No comment.

DC YATES — And not only did you suspect a GI bleed on the 26th of August you, at some stage, had seen that Lab Report and you'd seen the drop in the haemoglobin. You must be pretty damn sure now that he was suffering from a GI bleed.

BARTON — No comment.

DC YATES — So what did you do about it?

BARTON — No comment.

DC YATES — (Pause) Geoff?

DC Code A — Was it too late to do anything about it?

BARTON — No comment.

DC Code A — Well we're now up to, what was that Chapter what, Paragraph what Christopher was it?

DC YATES — That was Paragraph, well that main bit with the faeces was Paragraph (42), but we're doing (42) and (43).

BARTON — No comment.

DC Code A — Okay. So we've got Paragraph (39) 'passing melaena stools'. The end of Paragraph (39) 'poor prognosis'. Paragraph (40) 'terminally ill'. (Pause) Paragraph (42) 'incontinent of black tarry faeces'. (43) end of that sentence 'pain and distress as he died'. 'Mr PACKMAN was said to remain ill'. So several mentions to the things that were happening to Mr PACKMAN the stools, terminally ill, ill, pain and distress as he died and again right up to that including all the way up to Paragraph (43), you have failed to tell us in this prepared statement what was wrong with Mr PACKMAN.

BARTON — No comment.

DC Code A — You've been using hindsight, I think it's quite clear, throughout this prepared statement and even now you are not telling us what was clearly wrong with Mr PACKMAN.

BARTON — No comment.

DC YATES — (Pause) Okay Paragraph (44) doctor. 'Sadly Mr PACKMAN passed away on the 3rd of September 1999 (03/09/1999) at 1.50pm (1350). My belief was that death would have been consequent for myocardial infarction'. So there you've pinned your colours to the mast and you said that it was a 'myocardial infarction'. So from the 26th of August until the 3rd of September at no stage did you say in your statement or in your notes what Mr PACKMAN was dying of, but when he's died you've said: "Yeah it was a

myocardial infarction." What evidence is there that the cause of death was due to a heart condition?

BARTON — No comment.

DC YATES — Because you have repeatedly referred to symptoms that suggest a GI bleed, and even with the benefits of hindsight doctor and the review of case notes that contained details that Mr PACKMAN had a digestion like pain, he was passing fresh blood and melaena stools and the drop in his haemoglobin. Do you really think, bearing all that in mind, was your diagnosis of Mr PACKMAN correct?

BARTON — No comment.

DC YATES — I mean was it really a diagnosis other than you've given what you believe to be a cause of death?

BARTON — No comment.

DC YATES — Possibly an incorrect cause of death.

BARTON — No comment.

DC YATES — Even if PACKMAN had died of a heart attack or a myocardial infarction and you were correct in your suspicions on the 26th of August, what did you do about it?

BARTON — No comment.

DC YATES — Why didn't he have an ECG?

BARTON	No comment.
DC YATES	When was his heart listened to?
BARTON	No comment.
DC YATES	When were any tests done?
BARTON	No comment.
DC YATES	Well we actually feel that everything might point towards a GI bleed, so when were any tests done for that?
BARTON	No comment.
DC YATES	We had the blood test. When did you sign that and become aware of the drop in haemoglobin?
BARTON	No comment.
DC YATES	Something that you record in your statement 'a significant drop'.
BARTON	No comment.
DC YATES	Accompanying that with the black faeces and the passing of fresh blood, all this etcetera. What do you think Mr PACKMAN died of?
BARTON	No comment.

DC YATES — Why haven't you written any reference to the reason behind the prescription of any drug, not only in these records but also in any of the ten records that we've had?

BARTON — No comment.

DC YATES — I admit it I'm just, I'm going to push the drugs to one side, but before I do that do you want to say anything?

DC Code A — Only when you get to Paragraph (44) doctor, when you were writing that where were you when you typed that?

BARTON — No comment.

DC Code A — Well I think you were up against the wall weren't you, backed into a corner with nowhere to go because you realise what you've put on that Death Certificate and yet the evidence is pointing, and it has been pointing for several paragraphs now that it has been pointing to the other diagnosis that you did consider at one stage, but seemingly ignored and that was that he had the GI bleed and yet you failed to investigate didn't you?

BARTON — No comment.

DC Code A — You failed to investigate the myocardial infarction possibility didn't you?

BARTON — No comment.

DC Code A — Can you tell me even now, through this prepared statement, your evidence that indicates that he had a myocardial infarction?

BARTON — (Silence).

DC Code A — Can you?

BARTON — No comment.

DC Code A — And can you, through this prepared statement, justify your entry on the Death Certificate?

BARTON — No comment.

DC YATES — (Pause) So poor old Mr PACKMAN he came into hospital and his ongoing problems were obesity, arthritis, immobility, pressure sores and constipation. So to put it bluntly he was a fat man with arthritis in his knees, his immobility was possibly due to his size, pressure sores because he wasn't getting about and he was constipated and he's died of what you consider to be a myocardial infarction. Now forget the drugs at the moment, forget the Diamorphine and the Midazolam and all the other drugs, there was two diagnoses that you made on the 26th of August, two possible diagnoses myocardial infarction or a GI bleed, now forget which one was right, but what did you do about either?

BARTON — No comment.

DC YATES What basic tests did you put in place?

BARTON No comment.

DC YATES If you were unable to treat or look after Mr PACKMAN, why didn't you move him somewhere where he could be?

BARTON No comment.

DC YATES We mentioned before that Mr PACKMAN seemed to be hampered by being in hospital, he was disadvantaged by being in hospital, he could have just as easily have been at home except then somebody could have called an ambulance couldn't they doctor?

BARTON (Silent)

DC YATES Did you consider anything, I mean of all the options that were open to you ECGs, all the different tests etcetera, didn't you consider anything that could have been done for Mr PACKMAN?

BARTON No comment.

DC YATES Had he been suffering from a GI bleed or a heart attack on the 26th of August, was the terminal?

BARTON No comment.

DC YATES Could that have been treated?

BARTON	No comment.
DC YATES	And could his life have been saved?
BARTON	No comment.
DC YATES	Now if you bring the drugs back into it the Diamorphine and that, was the proactive prescribing done in order that you didn't have to be bothered with nighttime call out?
BARTON	No comment.
DC YATES	But why such a range?
BARTON	No comment.
DC YATES	And with what eventually becomes, it could be either I suppose, but I would say quite high doses of Diamorphine etcetera, was that a way of covering up the inadequate care and the treatment Mr PACKMAN received?
BARTON	No comment.
DC YATES	Just keep him quiet, out of pain and he would just eventually die of whatever was wrong with him?
BARTON	No comment.
DC YATES	Geoff?

DC Code A — (Pause) Doctor a GI bleed is consider, you tell me if I'm wrong, is considered as a serious and life threatening medical emergency is it not?

BARTON — No comment.

DC Code A — And as such it should require urgent and appropriate care?

BARTON — No comment.

DC Code A — On the 25th of August Doctor BEASLEY was called wasn't he?

BARTON — No comment.

DC Code A — And for out-of-hours and that was because Mr PACKMAN was passing fresh blood per rectum wasn't he?

BARTON — No comment.

DC Code A — Now (pause) Doctor BEASLEY, as a consequence what did he do? He ordered that the Clexane should be stopped didn't he?

BARTON — No comment.

DC Code A — Now was the Clexane, that was to stop DVT wasn't it, deep vein thrombosis wasn't it?

BARTON — No comment.

DC Code A — So it's an anti coagulum isn't it for blood?

BARTON — No comment.

DC Code A — It stops the blood from clotting doesn't it?

BARTON — No comment.

DC Code A — So what Doctor BEASLEY did was quit reasonable wasn't it stopping that?

BARTON — No comment.

DC Code A — Now we mentioned this GI bleeding before and if we get a lower bowel GI bleeding it comes out as red doesn't it?

BARTON — No comment.

DC Code A — Or it can do. And why is that doctor?

BARTON — No comment.

DC Code A — That's because the blood hasn't had the time, has it, to be digested from stomach to rectum (somebody coughs) and turn it into that horrible black smelly melaena. Is that right?

BARTON — No comment.

DC Code A — (Pause) So coupled with that and the fact that he had vomited, he was unwell, wasn't he at lunchtime? You were

called to see him at lunchtime, then indigestion and he was becoming more unwell and that's why Mrs PACKMAN was called and we know that the HB was 7.7 from that day, but that came through later. We're pointing there, aren't we, that it was quite reasonable for you to have known that he had the GI bleed (pause) and you already knew that Doctor TANDY had asked for that haemoglobin to be chased up on the 13/08 because she suspected it. You knew that Doctor RAVINDRANE had request HB to be reviewed later on in the week when he looked at him on the 23rd (pause), so it's all pointing that was isn't it?

BARTON — No comment.

DC Code A — So why didn't you investigate that further yourself?

BARTON — No comment.

DC Code A — Neither of those were properly investigated were they? Neither the myocardial infarction nor the GI bleed.

BARTON — No comment.

DC YATES — (Pause) Was that done (inaudible)?

DC Code A — Sorry?

DC YATES — Was that done (inaudible)?

DC Code A — No you put...

DC YATES None of that?

DC Code A No.

DC YATES (Inaudible). There's just a couple more things I want to ask you then, it's general things really doctor. What was your duty of care towards Mr PACKMAN?

BARTON No comment.

DC YATES Was it to treat him with his medical condition to make sure everything's done to treat his illnesses and things like that?

BARTON No comment.

DC YATES Isn't that what the public would assume the role of a doctor to be?

BARTON No comment.

DC YATES To diagnose, to treat, to make better, and guidance is provided, isn't it, by things like your Job Description of what you've got to do, the extensive training you must have gone through to become a doctor in the first place, there's all sorts of other guides and policies, there's the BNF to assist you in providing that duty of care isn't there doctor?

BARTON No comment.

DC YATES So is it reasonable to say that a person going into hospital would think: "I'm going to hospital, a doctor will try and

make me better." Is that a reasonable assumption for a member of the public?

BARTON — No comment.

DC YATES — Right well if you have a duty of care such at that, what would you consider then doctor to be a breach of that duty?

BARTON — No comment.

DC YATES — Would you consider failing to examine Mr PACKMAN a breach?

BARTON — No comment.

DC YATES — Would you consider failing to keep records a breach?

BARTON — No comment.

DC YATES — Well how about not following drug prescription guidelines?

BARTON — No comment.

DC YATES — What about the failure to follow up those blood results?

BARTON — No comment.

DC YATES — What about thinking he may have a GI bleed, but doing nothing about it?

BARTON — No comment.

DC YATES What about thinking he may have been having a heart attack, but not doing anything about that?

BARTON No comment.

DC YATES What about not carrying out an ECG when the machine's available?

BARTON No comment.

DC YATES There's a handful of things. Would you consider any one of those to be a breach of duty of care doctor?

BARTON No comment.

DC YATES Or all of them?

BARTON No comment.

DC YATES (Pause) I mean people at times of negligent aren't they for any number of reasons. Were you negligent?

BARTON No comment.

DC YATES Well what is negligence? Is it any of those things I mentioned before failing to examine Mr PACKMAN?

BARTON No comment.

DC YATES Failing to keep the records?

BARTON No comment.

DC YATES Need I go through them all again?

BARTON No comment.

DC YATES Can you explain why you failed to conduct any of the above, any of the things I've mentioned?

BARTON No comment.

DC YATES You see sometimes negligence can have tragic consequences can't it doctor? Is this what happened here?

BARTON No comment.

DC YATES You see on top of all the breaches that I've mentioned about duty care and care of Mr PACKMAN, there was no referral to another hospital was there, or a doctor, or transferring Mr PACKMAN to another hospital?

BARTON No comment.

DC YATES (Pause) How many single deviations doctor would you say, or devious good practice would you say was acceptable?

BARTON No comment.

DC YATES Do you think could the failure to treat his GI bleed have contributed to his death?

BARTON No comment.

DC YATES Could failure to identify whether he was suffering from myocardial infarction or a heart attack have contributed to his death?

BARTON No comment.

DC YATES Could the failure to seek help or assistance from more experienced doctors or a consultant have contributed to his death?

BARTON No comment.

DC YATES (Coughs) Could the rapid increase in Morphine based drugs have contributed to his death?

BARTON No comment.

DC YATES Could the combined failure of all of the ones I've just mentioned, all the things I've just mentioned, including the rapid increase in Morphine based drugs, have contributed to the death of Geoffrey PACKMAN?

BARTON No comment.

DC YATES So then what doctor, as a doctor with over thirty years' experience, what would you consider to be an act of medical negligence?

BARTON No comment.

DC YATES Let's turn that round then, how would you deal with one act of negligence that you saw in either a junior or senior doctor?

BARTON No comment.

DC YATES How would you deal with repeated breaches of good practice in the medical treatment of one patient?

BARTON No comment.

DC YATES When would you consider a doctor to be grossly negligence in carrying out their duties doctor?

BARTON No comment.

DC YATES Geoff?

DC Code A (Pause) I don't have anymore.

DC YATES No. Is there anything you wish to clarify doctor?

BARTON No thank you.

DC YATES Is there anything you wish to add?

BARTON All right. We'll give you a notice explaining what will happen to the tapes and the tape recording procedure. The time is 1605 hours and I am going to turn the recorder off.

THE INTERVIEW CONCLUDED – THE TAPE MACHINE WAS SWITCHED OFF.

Copy JB/PS/11

STATEMENT OF DR JANE BARTON

RE: GEOFFREY PACKMAN

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

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Geoffrey Packman. Unfortunately, at this remove of time I have no recollection at all of Mr Packman. As you are aware, I provided you with a statement on the 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 Mr Packman.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998.

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

4. Mr Geoffrey Packman was a 67 year old man who lived at home with his wife and daughter in Emsworth. It appears that he was visited regularly at home by the District Nurse who in February of 1999 noted that he had a large red weeping area on the shin of his right leg. A Doppler's test was performed, being an ultrasound measurement of the pressure in the veins of the legs. Mr Packman's GP appears to have referred him to Consultant Urologist Mr Chiverton at some point after April 1999. The GP referred in his letter to symptoms of prostatism and a raised PSA. He said that Mr Packman had had a negative mid-stream urine test, but rectal examination, presumably to assess the size of the prostate, had been virtually impossible because of Mr Packman's huge size and inability to lie properly on his side. The GP noted that Mr Packman was grossly obese, and indeed a subsequent measurement of his weight was recorded at 146 kg - in excess of 23 stone.

5. Mr Packman was noted to have a raised random blood sugar and was also due to have a glucose tolerance test to exclude diabetes mellitus.

6. At the end of June his GP then made a further referral, this time to Consultant Dermatologist Dr Keohane in relation to Mr Packman's leg ulceration. Mr Packman had apparently been attending the District Nurse's leg ulcer clinic for many months, and had hugely oedematous legs. The District Nurse had drawn the GP's attention to a large granulomatous raised area on the back of his right calf, and Dr Keohane's advice was requested. At this stage it seems that Mr Packman was being visited by the District Nurse 3 times a week in order

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

7. On 6th August 1999 Mr Packman was then admitted to the Queen Alexandra Hospital having suffered a fall. He was unable to mobilise and 2 Ambulance crews were called to assist. It was noted on admission that the GP and the District Nurse were unable to cope with Mr Packman at home. The diagnoses at that stage were bi-lateral leg oedema, with ulcers on the left leg, obesity, and it was noted that he was simply not coping.

8. In the course of clerking-in on 6th August, it appears that Mr Packman was suspected to be in atrial fibrillation. An ECG was arranged which showed atrial fibrillation at a rate of 85. Blood tests revealed that he has a white cell count of 25,000, an ESR of 31, and a CRP of 194. He was felt to have cellulitis in the groin and left lower leg, he was commenced on antibiotics, and his diuretic medication was changed to Frusemide. His past medical history was noted to consist of the bi-lateral leg oedema, which he had apparently had for 5 years, hypertension which had been treated since 1985, and arthritis.

9. It appears that about the time of admission Mr Packman was recorded as having a large black blistered area on his left heel in addition to the leg ulceration.

10. Following assessment his problems were recorded as cellulitis of the left leg, chronic leg oedema, poor mobility, morbid obesity, raised blood pressure and possible atrial fibrillation. In relation to the latter, and prior to the performance of the ECG, anticoagulants were suggested if atrial fibrillation was confirmed, and the possibility of left ventricular dysfunction was also raised. Shortly thereafter Mr Packman was commenced on Clexane 40mgs twice daily.

11. At this stage Mr Packman's creatinine level was noted at 173, with urea at 14.9, suggesting that the insult due to the infection in his legs was resulting in compromise of his renal function.

12. It was also noted on 6th August that "in view of pre-morbid state + multiple medical problems [Mr Packman was] not for CPR in event of arrest". A Barthel score stated to have been assessed on 5th August (presumably 6th August in error) was recorded as zero, indicating that Mr Packman was completely dependant.

13. Mr Packman was reviewed by the Specialist Registrar the following day, 7th August, who agreed, presumably on the basis of what was felt to be Mr Packman's poor condition at that stage, that he was not be resuscitated in the event of arrest. It was suggested that his anti-hypertensive medication should be changed to an ACE inhibitor in view of the oedema, and he was considered for a beta-blocker in view of his atrial fibrillation. His diuretic was changed lest it cause dehydration. Mr Packman was given Flucloxacillin 500 mgs 4 times daily, supplemented by Penicillin V 500 mgs 4 times a day to combat the cellulitis.

14. Although steps were apparently taken to prevent the development of pressure sores, on 8th August Mr Packman was noted to have sores to the sacrum, being described as "Grade 3". I believe this would have been a reference to a wound classification system, Grade 3 suggesting that there was full thickness skin loss involving damage of subcutaneous tissue.

15. Over the next few days it appears that Mr Packman's cellulitis improved, but the overall assessment of his suitability of resuscitation did not change - on 11th and again on 13th August it was again specifically noted that he was not for resuscitation - recorded as "Not for 555".

16. On 13th August Mr Packman was reviewed by a Consultant Geriatrician Dr Jane Tandy. She noted that he had had black stools overnight. The following day a nursing note records that when the dressings on the pressure sores were renewed, the wounds to the left buttock and right lower buttock and thigh were very sloughy and necrotic in places, and very offensive smelling. Clearly by that time, Mr Packman had developed significant pressure sores.

17. A Barthel score measured on 14th August again recorded a score of zero indicating his complete dependence.

18. It appears that by 15th August a decision had been made that Mr Packman should be transferred to the Dryad Ward at the GWMH. A note in the nursing records indicates that Staff Nurse Hallman at GWMH had indicted that we were not in a position to take Mr Packman at that time. This is likely to have been an indication that there were no beds available, and that we would have been under considerable pressure in consequence of the high bed occupancy.

19. An entry in Mr Packman's records for 20th August by the Specialist Registrar indicates that Mr Packman was due for transfer to the GWMH on 23rd August. The Specialist Registrar also noted that Mr Packman remained not for resuscitation. A Barthel score measured on 21st August again recorded a score of zero indicating his complete dependence.

20. Mr Packman was then admitted to the GWMH on 23rd August 1999. There is a clerking-in noted contained within his records, but I do not recognise the handwriting or signature of the doctor who assessed him on this occasion. His problems were noted to be obesity, arthritis, immobility and pressure sores. The episode of melaena on 13th August was noted, with his haemoglobin being stable. At that stage he was said to be in no pain. Cardiovascular and respiratory systems were thought to be normal. The clinician admitting Mr Packman also prescribed medication in the form of Doxazosin 4 mgs daily for hypertension, Frusemide 80 mgs once a day as a diuretic for Mr Packman's oedema, Clexane 40 mgs twice a day for DVT prophylaxis and atrial fibrillation. Paracetamol 1gm 4 times daily for pain relief, Magnesium Hydroxide 10 mls twice daily for constipation, together with Gaviscon for indigestion and cream for his pressure sores.

21. On this occasion, a Barthel score of 6 was recorded for 23rd August, suggesting that, although Mr Packman might have improved to a degree, he was still significantly dependent.

22. I anticipate that I would have reviewed Mr Packman the following day as part of my assessment of all the patients on the ward, though it appears that I did not have an opportunity to make any entry in his medical

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

23. I anticipate that I would have reviewed Mr Packman the following day, 25th August, though again I did not have an opportunity to make an entry in his records. It appears that Mr Packman then was noted to have passed blood per rectum, and Dr Beasley was contacted, Dr Beasley presumably being on duty out-of-hours. He advised that the Clexane should be discontinued. Dr Beasley also appears to have prescribed Metoclopramide by way of verbal order, which I later endorsed, together with Loperamide. The Metoclopromide was apparently given at 5.55 pm with good effect. The dressings on the pressure sores were removed on 25th August and were noted to be contaminated with faeces.

24. I do not know if I reviewed Mr Packman on the morning of 26th August. He was noted by the nurses to have had a fairly good morning. Sister Hamblin has recorded that Dr Ravi, locum Consultant Geriatrician, was contacted and he confirmed that the Clexane should be discontinued and the haemoglobin repeated. Again, Mr Packman was noted to be "not for resuscitation". Sister Hamblin may have contacted Dr Ravi if I was unavailable that morning. The nursing record goes on to indicate that Mr Packman then deteriorated at about lunchtime, that his colour was poor and that he complained of feeling unwell. I was called to see him, my entry in his records on this occasion reading as follows.

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

and oramorph overnight
Alternative possibility GI bleed but no
haematemisis
not well enough to transfer to acute unit
keep comfortable
I am happy for nursing staff to confirm death."

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

25. My impression when I assessed Mr Packman on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to an acute unit was quite inappropriate. Any such transfer was very likely to have had a further deleterious affect on his health.

26. The nursing note for 26th August indicates that we were to await blood test results. There was then a further deterioration later in the day, with Mr Packman complaining of indigestion and a pain in his throat, which was not radiating.

27. The blood count taken on 26th August subsequently showed that Mr Packman's haemoglobin had dropped to 7.7 grams, a substantial drop from the 12 grams which had been recorded 2 days earlier.

28. It appears that I re-attended to see Mr Packman at 7.00 pm on 26th August. Concerned that he should have further appropriate medication to relieve his pain and distress, I prescribed Oramorph 10-20 mgs 4 times a day together with 20 mgs at night. 20 mgs of Oramorph was later given at 10.00 pm.

29. I also wrote up prescriptions for Diamorphine 40-200 mgs subcutaneously over 24 hours, together with 20-80 mgs of Midazalam via the same route on an anticipatory basis, concerned that further medication might be required in due course to relieve Mr Packman's pain and distress. It was not my intention that this subcutaneous medication should be administered at that time. The nursing record also indicates that I saw Mr Packman's wife, explaining her husband's condition and the medication we were using. I anticipate I would have indicated to Mrs Packman that her husband was very ill indeed, and in all probability that he was likely to die.

30. I would have reviewed Mr Packman again the following morning, and indeed the nursing record confirms that I attended to see him then. Sister Hamblin has recorded that there had been some marked improvement since the previous day and that the Oramorph was tolerated well and should continue to be given, though Mr Packman apparently still had some discomfort later that afternoon especially when the dressings were being changed. In spite of the earlier improvement, Mr Packman was said to remain poorly. 10 mgs of Oramorph were administered 4 hourly, together with a further 20 mgs

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

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

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

32. The nursing record indicates that Mr Packman remained very poorly with no appetite. However, the Oramorph again appears to have been successful in keeping Mr Packman comfortable at night.

33. I do not believe I would have seen Mr Packman on Sunday 29th August. The nursing record indicates that he slept for long periods, but that he also complained of pain in his abdomen. The sacral wounds were said to be leaking a lot of offensive exudate.

34. I do not know if I would have seen Mr Packman again the following morning, Monday 30th August, that being a Bank Holiday. I have no way of knowing now if I was on duty then. If I did see him as part of my review of all the patients on the two wards, I did not have an opportunity to make a specific entry in his records on this occasion. A Barthel score was recorded as 4. The nursing record indicates that Mr Packman's condition remained poor, and later that day - at 2.45 pm the syringe driver was set up to deliver 40 mgs of Diamorphine and 20 mgs Midazalam subcutaneously. I anticipate that Mr Packman would have continued to experience pain, and clearly in view of the significant sacral

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

35. In view of his poor condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying. Mr Packman had received 60 mgs of Oramorph daily over the preceding 3 days, and the administration of 40 mgs of Diamorphine subcutaneously over 24 hours did not represent a significant increase. Mr Packman would have started to have become inured to the opiate medication, and an increase of this nature was in my view entirely appropriate to ensure that his pain was well controlled. Indeed, the nursing record goes on to state that there were no further complaints of abdominal pain and Mr Packman was able to take a small amount of food.

36. I anticipate that the nursing staff would have liaised with me prior to the commencement of the Diamorphine and Midazalam and that this would have been set up on my instruction, directly if I had been at the Hospital, or otherwise by phone.

37. On the morning of 31st August Mr Packman was recorded as having had a peaceful and comfortable night, though he then passed a large amount of black faeces that morning.

38. I believe I would have seen Mr Packman again that morning, though again I did not have an opportunity to make an entry in his records. I anticipate his condition would have been essentially unaltered, and that he would have remained comfortable. Similarly, I would probably have seen Mr Packman again on the morning of 1st September but would have been unable to record this. I anticipate that his condition was again

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

39. Mr Packman was reviewed the same day by Consultant Geriatrician Dr Reid. Dr Reid noted that Mr Packman was rather drowsy but comfortable. He had been passing melaena stools. His abdomen was noted to be huge but quite soft, and Dr Reid also recorded the presence of the pressure sores over the buttocks and across the posterior aspects of both thighs. He noted that Mr Packman remained confused and was for "TLC". The Frusemide and Doxazosin were to be discontinued, and Mr Packman's wife was said to be aware of his poor prognosis.

40. The entry by Dr Reid that Mr Packman was to have "TLC" - tender loving care - was clearly an indication that Dr Reid also considered Mr Packman to be terminally ill. Dr Reid had the opportunity to review the medication which Mr Packman was receiving at the time, and clearly felt it appropriate.

41. Sister Hamblin recorded later in the nursing records that the syringe driver was renewed at 7.15 pm with 60 mgs of Diamorphine and 60 mgs of Midazalam subcutaneously as the previous dose was not controlling Mr Packman's symptoms. It appears therefore that Mr Packman was experiencing yet further pain and discomfort. I anticipate that the nursing staff would have contacted me and that I authorised this moderate increase in his medication in order to alleviate the pain and distress.

42. That night, Mr Packman was noted to be incontinent of black tarry faeces, but otherwise he had a peaceful night and the syringe driver was said to be satisfactory.

43. I believe I would have reviewed Mr Packman again the following day, 2nd September. The nursing records show that his medication was again increased, the Diamorphine to 90 mgs and the Midazalam to 80 mgs subcutaneously. I anticipate again that Mr Packman would have been experiencing pain and distress, and that I and the nursing staff were concerned that the medication should be increased accordingly to ensure that he did not suffer pain and distress as he died. That night, Mr Packman was said to remain ill, but was comfortable and the syringe driver was satisfactory.

44. Sadly, Mr Packman passed away on 3rd September 1999 at 1.50 pm. My belief was that death would have been consequent on the myocardial infarction.

45. The Oramorph, Diamorphine and Midazalam were prescribed and in my view administered solely with the aim of relieving Mr Packman's pain and distress, ensuring that he was free from such pain and distress as he died. At no time was any medication provided with the intention of hastening Mr Packman's demise.