Code A

GENERAL MEDICAL COUNCIL

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Code A

DR BARTON

LESLIE PITTOCK

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DR BARTON

LESLIE PITTOCK

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GENERAL MEDICAL COUNCIL

DR BARTON

Index to Leslie Pittock's File

File 1

1. Summary of Evidence. M

2. Report prepared by Dr Andrew Wilcock dated 25 April 2005. ✓

3. Draft report prepared by Dr Andrew Wilcock dated 26 April 2005. ✓

4. Interview of Dr Jane Ann Barton dated 3 March 2005 at 09:15. ✓

5. Statement of Dr Jane Barton regarding Leslie Pittock. Code A

6. Witness List and Witness Statements given to Hampshire Constabulary. ✓

   (a) Fiona Lorraine Walker dated 23 January 2003. Code A

   (b) Fiona Lorraine Walker dated 1 December 2004. Code A

   (c) Gillian Elizabeth Hamblin dated 2 February 2003. Code A

   (d) Gillian Elizabeth Hamblin dated 10 September 2004. Code A

   (e) Gillian Elizabeth Hamblin dated 1 December 2004. Code A

   (f) Lynne Joyce Barrett dated 7 March 2003. Code A

   (g) Lynne Joyce Barrett dated 11 August 2004. Code A

   (h) Lynne Joyce Barrett dated 4 January 2005. Code A

   (i) Freda Vaughan Shaw dated 12 June 2003. Code A

   (j) Freda Vaughan Shaw dated 6 August 2004. Code A

   (k) Code A

(l) Code A

(m) Tina Marie Douglas dated 12 August 2004. Code A

(n) Mary Elizabeth Martin dated 18 August 2004. Code A

(o) Code A

(p) Althea Everesta Geradette Lord dated 28 September 2004. Code A

(q) Sharon Barbara Ring dated 25 October 2004. Code A

(r) Code A

(s) Code A 4.

(t) Lynda Marion Wiles dated 8 November 2004. Code A

(u) Jane C Tandy dated 20 December 2004. Code A

(v) Victoria Anne Banks dated 4 February 2005. Code A

(w) Michael Brigg dated 16 February 2005. Code A

(x) Christopher Scott Yates dated 3 March 2005. Code A

(y) Geoffrey James Quade dated 6 April 2005. Code A

REPORT

regarding

LESLIE PITTOCK (BJC/71)

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 Pittock was a frail 82 year old man admitted to Mulberry Ward, Gosport War Memorial Hospital due to depression. He was withdrawn, agitated and irritable and required the help of two others to mobilise. Despite the admission and a reduction or discontinuation in some of his medication, his low mood and poor mobility persisted. He developed a chest infection and urinary retention. After about three weeks in hospital, his condition remained poor and he started to develop pressure sores. Mr Pittock was referred to Dr Lord, Consultant Geriatrician, for a medical review and was subsequently transferred to Dryad Ward.

During this admission, the medical care provided by Dr Barton fell short of a good standard of clinical care as defined by the General Medical Council that included the lack of clear note keeping, adequate assessment of the patient and providing treatment that was excessive to a patients' needs. The reason for the prescription of drugs was not clear. If pain was a problem, it was not recorded or assessed. Most significantly, the dose range of diamorphine prescribed for the 'as required' syringe driver, and the dose finally administered (80mg), far exceeded that generally considered to be an appropriate starting dose (10–15mg) based on Mr Pittock's existing opioid usage.

Mr Pittock was described as tense and agitated several times following the syringe driver being commenced. In this regard the use of midazolam, haloperidol and levomepromazine could be seen as justified. However, an assessment of the possible causes of his agitation should have been carried out. This would have included considering if drugs, such as the diamorphine, were a possible contributing factor to his agitation. At the very least, given that

diamorphine in a dose that is excessive to a patients needs can cause agitation and confusion, it should have prompted a review of the appropriateness of Mr Pittock's dose of diamorphine.

There appears little doubt that Mr Pittock was 'naturally' coming to the end of his life. At best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mr Pittock a peaceful death, albeit with what appears to be an excessive use of diamorphine due to a lack of sufficient knowledge.

It is my opinion however, that given the lack of documentation to the contrary, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mr Pittock by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Pittock by unnecessarily exposing him to excessive doses of diamorphine that could have resulted in a worsening of his agitation. Dr Barton's response to this was to further increase Mr Pittock's dose of diamorphine. Despite the fact that Mr Pittock was dying 'naturally', it is difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton leaves herself 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

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5. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Leslie Pittock, including the death certificate.

[2] Full set of medical records of Leslie Pittock on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

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

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

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

[7] Portsmouth Health Care NHS Trust Policies:

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

ii) Prescription Writing Policy (July 2000).

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

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

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

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

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

[9] British National Formulary (BNF). Section on Prescribing in Terminal Care (March 1995).

[10] British National Formulary (BNF). Section on Prescribing in the Elderly (March 1995).

6. CHRONOLOGY/CASE ABSTRACT

Events at the Gosport War Memorial Hospital, Mulberry Ward, 13th December 1995 until 5th January 1996

Mr Leslie Pittock, an 82 year old man who lived in Hazeldene residential home was admitted on the 13th December 1995 to Mulberry Ward, Gosport War Memorial Hospital under the care of Dr Banks, consultant in old age psychiatry (pages 62 of 181). He was depressed and reported feeling hopeless and suicidal. He had been verbally aggressive towards his wife and the staff at the residential home. He was staying in bed all day and not eating well (pages 62 and 125 of 181). He was known to Dr

Banks having suffered from chronic depression for over 30 years resulting in multiple admissions to hospital. He also had an underactive thyroid gland and problems with constipation (page 62 of 181). His medication consisted of sertraline 100mg once a day, lithium carbonate 400mg once a day, thioridazine 50mg four times a day, diazepam 10mg twice a day, temazepam 10mg at night, thyroxine 50microgram once a day, magnesium hydroxide 10ml at night and codanthrusate 2 capusles at night (pages 62 and 88 of 181). Examination revealed him to be withdrawn, a little agitated and irritable. He had a slight tremor on moving, a shuffling gait and required the help of two others to mobilise (page 63 of 181). It was considered that depression was his main problem (page 63 of 181).

Over the next few days he experienced a fall and problems with diarrhoea. His laxatives were discontinued and an abdominal x-ray carried out. This revealed distension of the large bowel with only a small gas bubble seen in the region of the rectum. The report concluded that these features could represent distal large bowel obstruction but as there was no faecal residue, the changes may be due to pseudo-obstruction (page 116 of 181). His low mood and poor mobility persisted. As thioridazine can cause Parkinsonism (i.e. a collection of features similar to those seen in patients with Parkinson's disease, e.g. difficulty initiating movements, rigidity, tremor etc.) the dose was reduced to 25mg four times a day and procyclidine 5mg twice a day was commenced (page 64 of 181). Procyclidine is an antimuscarinic drug that can help with Parkinsonism.

After about one week, on the 22nd December 1995 he was found to have a chest infection and erythromycin, an antibiotic, was commenced (page 64 of 181). On review by Dr Banks on the 27th December 1995, Mr Pittock

was noted to be 'chesty, poorly, abusive and not himself at all' (page 65 of 181). As he had not responded to the erythromycin, another antibiotic, cefaclor was commenced and the procyclidine was discontinued. He had been catheterised for urinary retention the week before (page 65 of 181). Microbiology tests of his sputum revealed a pseudomonas infection (page 112 of 181). A chest x-ray showed no evidence of focal lung disease (page 116 of 181). It was decided to reassess his mood once his medical problems had been addressed.

After about three weeks in hospital, on the 2nd January 1996 it was reported that he remained poorly, lethargic, his skin was breaking down and he was now nursed on a Pegasus bed. He was reported to be asking 'why don't you let me die?' (page 65 of 181). Blood test results on the 2nd January 1996 were mostly normal. There was a raised white blood cell count. $15.7x10^9$/L, due to an increase in neutrophils, $14.4x10^9$/L, in keeping with an infection (page 114 of 181). Liver enzymes were mildly abnormal with raised alkaline phosphastase of 110 IU/L, AST (aspartate aminotransferase) of 127 IU/L and a low albumin of 27g/L (upper limit of normal 95, 40 and lower limit of 37 respectively)(page 85 of 181). Rather than attribute his deterioration purely to his depression, Mr Pittock was referred to a geriatrician to see if any medical problems were contributing to his decline (page 65 of 181). A referral letter was written in the notes to Dr Lord, Consultant Geriatrician, on the 2nd January 1996 that noted Mr Pittock's mobility had deteriorated drastically during his admission and although his chest infection was now improving, he remained bed bound, expressing the wish to die. It also noted Mr Pittock's complaints of intermittent abdominal pain (page 66 of 181).

When reviewed by Dr Banks on the 3rd January 1996, it was again noted that Mr Pittock was deteriorating, with a poor food intake and some breaks in his skin (page 66 of 181). In case undesirable effects of some of his medication were contributing to his decline, the diazepam was reduced to 2mg three times a day and the thioridazine and temazepam discontinued (pages 67 and 81 of 181).

He was seen by Dr Lord on the 4th January 1996. She listed Mr Pittock's problems as 'chronic resistant depression – very withdrawn, completely dependent (Bartell 0), catheter by-passing, superficial ulceration of left buttock and hip, and hyoproteinaemic'. She suggested high protein drinks, bladder washouts twice a week, dressing to his skin ulcers and transfer to a long stay bed. Dr Lord felt his residential home place could be given up as he was unlikely to return (page 67 of 181). In the typed letter of the 8th January 1996, that summarised this review, Dr Lord stated that Mr Pittock's prognosis was poor and that he was unlikely to return to Hazeldene Rest Home (page 5 of 49).

Events at Gosport War Memorial Hospital, Dryad Ward, 5th January 1996 to 24th January 1996

On transfer to Dryad Ward on the 5th January 1996, the medical notes record Mr Pittock's problems as consisting of 'immobility, depression, a broken sacrum with small superficial areas of the right buttock, a dry lesion on his left ankle and both heels suspect. Catheterised, transfers with hoist, may help to feed himself. Long standing depression on lithium and sertraline' (page 13 of 49). Mr Pittock's medication was continued unchanged on transfer: sertraline 50mg twice a day, lithium carbohydrate

400mg at night, diazepam 2mg three times a day, thyroxine 50microgram once a day and daktacort cream (page 16 of 49). The nursing notes suggest that Mr Pittock settled into the ward well and went on to detail his pressure sores (page 25 of 49).

On the 8th January, a pain relief preparation 'arthortec' one tablet twice a day, containing a non-steroidal anti-inflammatory drug, diclofenac, was commenced and continued until the 10th January 1996 (page 16 of 49).

On the 9th January 1996 the medical notes entry reads 'painful right hand held in flexion, try *hot water* (this should be clarified as the handwriting is difficult to decifer). Also increasing anxiety and agitation,?sufficient diazepam, ?needs opiates' (page 13 of 49). The nursing notes record that he was very sweaty but was apyrexial (temperature not elevated) and that Mr Pittock stated that he had generalised pain (page 25 of 49).

On the 10th January 1996, oramorph (morphine solution, 10mg/5ml) 2.5ml (5mg) every four hours was prescribed but none given until the 11th January (page 17 of 49). Possibly also on the 10th January, diamorphine 40–80mg and hyoscine (hydrobromide) 200–400microgram SC (subcutaneous) in 24 hours were also prescribed (page 17 of 49). These were not used on the 10th or 11th January, and the drug chart appears to have been rewritten sometime on the 11th January (pages 18 and 19 of 49). The diamorphine was rewritten as 80–120mg along with hyoscine (hydrobromide) 200–400microgram and midazolam 40–80mg SC (subcutaneous) in 24 hours. The nursing notes for this day record 'Condition remains poor. Seen by Dr Tandy and Dr Barton. To commence on oramorph 4 hourly. This evening Mrs Pittock seen and is aware of poor condition. To stay in long stay bed' (page 25 of 49).

On the 11th January 1996 the diazepam was increased from 2mg to 5mg three times a day and the oramorph given as 5mg every 4 hours, with 10mg at night until the morning of the 15th January 1996 (page 19 of 49). On the 12th January 1996, the sertraline and lithium carbonate were discontinued.

On the 13th January 1996 the nursing notes record 'Catheter bypassing. Mr Pittock appears distress, suby g washout given. However, catheter continues to bypass heavily. Catheter removed, tip of same looks very mucky...' (page 25 of 49).

A medical notes entry on the 15th January 1996 summarises 'For TLC (tender loving care). Discussed with wife, agrees in view of the poor quality for TLC' (page 13 of 49). A syringe driver was commenced at 08.25am on the 15th January containing diamorphine 80mg, hyoscine hydrobromide, 400microgram and midazolam 60mg SC over 24 hours (pages 18,25,26 of 49). The nursing notes for that day detail 'Seen by Dr Barton. Syringe driver commenced....' and at 19.00pm 'Daughter informed of father's deterioration during the afternoon. Now unresponsive. Unable to take fluids and diet. Pulse strong and regular' (page 26 of 49).

On the 16th January 1996 haloperidol 5–10mg SC over 24 hours was prescribed (page 20 of 49) with Mr Pittock receiving haloperidol 5mg on the 16th January 1996 and 10mg on the 17th January 1996. The nursing notes entry reads 'Condition remains very poor. Some agitation was noticed when being attended to. Seen by Dr Barton. Haloperidol 5–10mg to be added to the driver' (page 26 of 49).

On the 17th January 1996, the dose of diamorphine was increased to 120mg and the midazolam to 80mg SC over 24 hours and both then

remained unchanged for the remainder of Mr Pittock's life. The dose of hyoscine hydrobromide was increased twice on the 17th January to 600microgram then 1200micrograms SC over 24 hours; as was the dose of haloperidol, increasing to 10mg and then to 20mg SC over 24 hours (pages 6, 7 and 20 of 49). The dose of hyoscine hydrobromide then remained unchanged for the remainder of Mr Pittock's life. There are several entries in the nursing notes on the 17th January: (09.00am) 'Seen by Dr Barton, medication increased 08.25am as patient remains tense and agitated. Chest very 'bubbly'. Suction required frequently this morning. Patient bed bathed, mouth care tolerated well. Skin marking easily despite hourly turning and use of Pegasus mattress and remains distressed on turning.' (14.30pm) 'Seen by Dr Barton, medication reviewed and altered. Syringe driver renewed at 15.35pm (two drivers).....Daughter informed of deterioration.' (20.30pm) 'Further deterioration in already poor condition. Appears more settled although still aware of when he is being attended to....' (page 27 of 49).

On the 18th January 1996 the medical notes report 'further deterioration, SC (subcutaneous) analgesia continues, difficulty controlling symptoms, try nozinan' (levomepromazine) (page 15 of 49). This was commenced at a dose of 50mg SC over 24 hours (page 6 of 49). The nursing notes report 'poorly condition, continues to deteriorate.....' (page 27 of 49). Wife has visited for most of the day. Appears comfortable in between attention. Oral suction given with some effect' (page 28 of 49).

On the 19th January 1996 the nursing notes read 'A marked deterioration in an already poorly condition.....Breathing very intermittent, colour poor' (page 28 of 49). On the 20th January 1996 the medical notes entry reads

'Has been unsettled on haloperidol in syringe driver. Discontinue and change to higher dose nozinan, increase nozinan 50→100mg in 24 hours (verbal order)' (pages 6, 7 and 15 of 49). The nursing notes for the 20th January 1996 read 'Mrs Pittock and both daughters have visited. Dr Brigg contacted regards to regime. Verbal order taken to double nozinan and omit haloperidol. Syringe driver recharged at 18.00hours. Appears comfortable at time of report...' (page 28 of 49).

On the 21st January 1996, the medical notes entry reads 'Much more settled. Quiet breathing. Respiratory rate 6 per minute. Not distressed, continue' (page 15 of 49). Nursing entry for this day reads 'Very settled today' (page 28 of 49). On the 22nd January 1996 the nursing notes record 'poorly but very peaceful' (page 29 of 49). On the 23rd January 1996, the nursing notes record 'Poorly condition remains unchanged, has remained peaceful' (page 29 of 49). An untimed entry then reads 'Patients condition deteriorated suddenly at 01.40am and Mr Pittock died at 01.45am' (page 29 of 49). A verification of death entry was made in the medical notes (page 15 of 49).

On the death certificate, cause of death was given as 1a Bronchopneumonia.

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Syringe drivers, diamorphine, midazolam, haloperidol, levomepromazine (nozinan) and hyoscine hydrobromide

A syringe driver is a small portable battery-driven pump used to deliver medication subcutaneously (SC) via a syringe, over 24hours. 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 number 29 (March 1995)). Others sometimes suggested 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 24hour dose. Hence for someone receiving 30mg of diamorphine in a syringe driver over 24hours, a breakthrough dose would be 5mg. One would expect it to have a 2–4hour duration of effect, but the dose is often prescribed to be given hourly if 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 (March 1995) recommends 20–100mg SC over 24hours. The Wessex protocol suggests a range with the lowest dose of 5mg a day. The regular dose would then be titrated every 24hours 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 24hours, the 'as required' dose would be 5mg given as a stat SC injection. The duration of effect is generally no more than 4hours, 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.

Haloperidol is an antipsychotic. It is frequently used in syringe drivers for its antipsychotic and anxiolytic effects in patients with terminal delirium/agitation or as an anti-emetic. Compared to other antipsychotics, like levomepromazine, it is less sedative but can cause more problems with extrapyramidal effects and should be used with caution in patients with parkinsonism or Parkinson's disease. Extrapyramidal effects include parkinsonism, acute dystonia, acute akathesia and tardive dyskinesia. Parkinsonism consists of tremor, rigidity and slowing of movements; acute dystonia is spasm of muscles including those involving the eyes, head,

neck, trunk and limbs. They are usually abrupt in onset and associated with anxiety; acute akathesia is a form of restlessness of the muscles in which the person is compelled to move or change position and is associated with variable degrees of patient distress; tardive dyskinesia typically presents as involuntary chewing movements of the face and orofacial muscles.

A typical starting dose of haloperidol for an adult is 3–5mg a day with an upper dose range of 10–30mg orally or SC. A smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The BNF (March 1995) recommends 5–30mg SC over 24hours. The Wessex protocol suggests a range of 1.5–3mg up to three times a day orally. It is usual to prescribe additional doses for use 'as required' often in the dose range of 2.5–5mg SC. The dose is often prescribed so that it can be given hourly if required.

Levomepromazine is an antipsychotic. It is frequently used in syringe drivers for its antipsychotic and anxiolytic effects in patients with terminal delirium/agitation or as an anti-emetic. It is more sedative than haloperidol.

A typical starting dose of levomepromazine for an adult is 50mg SC over 24 hours, with an upper dose range of 300mg SC. A smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The BNF (March 1995) recommends 50–200mg SC over 24hours. The Wessex protocol suggests a range of 25–200mg SC over 24hours. It is usual to prescribe additional doses for use 'as required' often in the dose range of 6.25–25mg SC. The dose is often prescribed so that it can be given hourly if required.

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 600–2400micrograms SC over 24hours (BNF (March 1995)) or 400–600micrograms as a stat SC dose. The Wessex protocol gives a dose range of 400–1200micrograms over 24hours.

The titration of the dose of analgesic, antipsychotic or sedative medication is guided by the patients symptom control needs. The number and total dose of 'as required' doses required over a 24hour 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 24hour period is generally seen as acceptable.

ii) The principle of double effect.

The principle of double effect states that:

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

This is a universal principle without which the practice of medicine would be impossible, given that every kind of treatment has an inherent risk. Many discussions on the principle of double effect have however, involved the use of morphine in the terminally ill. This gives a false impression that

the use of morphine in this circumstance is a high risk strategy. When correctly used (i.e. in a dose appropriate to a patient's need) morphine does not appear to shorten life or hasten the dying process in patients with cancer. Although a greater risk is acceptable in more extreme circumstances, it is obvious that effective measures which carry less risk to life will normally be used. Thus, in an extreme situation, although it may occasionally be necessary (and acceptable) to render a patient unconscious, it remains unacceptable (and unnecessary) to cause death deliberately. As a universal principle, it is also obvious that the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care.

8. OPINION

Events at Gosport War Memorial Hospital, Mulberry Ward 13th December 1995 to 5th January 1996

Mr Pittock was an 82 year old man who suffered from chronic depression. Deterioration in his mental and physical state led to his admission for assessment on Mulberry Ward under the care of Dr Banks. Examination revealed him to be depressed and withdrawn and a little agitated and irritable. He had signs of Parkinsonism which may have been due to undesirable effects of his medication. Despite a reduction in his medication his situation failed to improve. He developed a chest infection that required two different sorts of antibiotic to treat. Despite this, his physical deterioration and poor mental state continued. Rather than attribute his deterioration purely to depression, Mr Pittock was appropriately referred to a geriatrician, Dr Lord. It was documented that

his mobility had deteriorated drastically during his admission and that he had become bedbound, was complaining of intermittent abdominal pain and expressing the wish to die. His diazepam was reduced and thioridazine and temazepam discontinued, but still Mr Pittock failed to improve. Dr Lord's review indicated that Mr Pittock's prognosis was poor and that he was unlikely to return to Hazeldene Rest Home. This implies that his transfer to Dryad Ward was for terminal care. There are no issues relating to the standard of care or treatment proferred to Mr Pittock during his admission to Mulberry Ward.

Events at Gosport War Memorial Hospital, Dryad Ward 5th January 1996 to 24th January 1996

Compared to the notes during Mr Pittock's stay on Mulberry Ward, infrequent entries in the medical notes during his stay on Dryad Ward make it difficult to closely follow Mr Pittock's progress over the last three weeks of his life. There are seven entries taking up just one and a half pages in length. In summary and in approximate chronological order, Mr Pittock was prescribed Arthrotec, a non-steroidal anti-inflammatory drug. There was no record or assessment of pain in the medical notes, but the nursing notes recorded that he stated that he had generalised pain. He later complained of a painful right hand held in flexion for which *?hot water* (to be clarified) was suggested. Increasing anxiety and agitation were also noted. Dr Barton queried whether he was receiving sufficient diazepam or required opiates. The possible cause of his painful right hand held in flexion is not documented in the medical notes.

The Arthrotec was discontinued after two days and he was commenced on morphine regularly. It is not clear from the notes what pain this was prescribed for, why the Arthrotec was stopped or why a 'weak' opioid like codeine was not felt appropriate. On the same day, a syringe driver was prescribed containing diamorphine 40–80mg and hyoscine (hydrobromide) 200–400microgram in 24hours to be used 'as required'. This was never given but when the drug chart was rewritten, apparently the next day, the dose range of diamorphine was increased to 80–120mg and midazolam 40–80mg added without reason.

His diazepam was increased on the 11th January 1996 and his sertraline and lithium carbonate discontinued on 12th January 1996 both without reason. On the 13th January 1996 the nursing notes record Mr Pittock to appear distressed. It is unclear if this was related to his urinary catheter bypassing or was more generalised.

On the 15th January 1996 a syringe driver was commenced containing diamorphine 80mg, hyoscine hydrobromide 400micrograms and midazolam 60mg. The indication for this is not clear. Once the syringe driver was commenced he became unresponsive and his family informed.

On the 16th January 1996 the nursing notes stated that he was agitated when being attended to. Haloperidol 5mg was prescribed and administered, although there was no entry in the medical notes. On the 17th January 1996 the dose of diamorphine was increased to 120mg, the haloperidol to 10mg (subsequently 20mg), the midazolam to 80mg and the hyoscine hydrobromide to 600microgram (subsequently 1200microgram). No reason is given in the medical notes, although the

nursing notes report Mr Pittock to be tense and agitated and have a very 'bubbly' chest.

The medical notes entry on the 18th January 1996 report symptoms were difficult to control but does not specify which symptoms. Levomepromazine was then commenced at a dose of 50mg SC over 24hours. On the 20th January 1996 an entry in the medical notes report Mr Pittock to be unsettled and the dose of levomepromazine was increased from 50 to 100mg and the haloperidol was then discontinued. Thereafter Mr Pittock appeared to be settled until his death in the early hours of the 24th January 1996. Given the nature of Mr Pittock's decline and problems with respiratory tract secretions, bronchopneumonia appears to be the most likely cause of his death, as stated on the death certificate.

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 overall care given to Mr Pittock whilst on Mulberry Ward, Gosport War Memorial Hospital was not substandard.

The medical care provided by Dr Barton to Mr Pittock 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.

Specifically:

i) The notes relating to Mr Pittock's transfer to Dryad Ward are inadequate. On transfer from one service to another, a patient is usually reclerked highlighting in particular the relevant history, examination findings and any planned investigations to be carried out.

ii) Pain is the most likely reason for prescribing the non-steroidal anti-inflammatory drug (Arthrotec). However, pain was not documented in the notes, nor was any pain assessed.

iii) Mr Pittock's painful right hand held in flexion does not appear to have been appropriately assessed. From its description it may have been tetany causing carpopedal spasm and the common causes of this should have been considered, e.g. a low serum calcium or magnesium deficiency. Less likely is a dystonia but given that some of his medications could cause extrapyramidal effects (see technical background) this possibility should also have been considered. As hypocalcaemia is reported to cause mood disturbance such as anxiety and agitation, it would have been particularly relevant to consider.

iv) It should be clarified why Dr Barton felt Mr Pittock needed opioids. From the medical notes, it appears to relate to his increasing anxiety and agitation. This

is not an appropriate indication for the use of opioids. If opioids were being suggested for his painful hand, this would also be inappropriate. The medical notes state no other pain. The nursing notes do state he had generalised pain, but the lack of a full pain assessment makes it difficult to know what pain this represented; for example, was it related to muscle and/or joint stiffness from immobility, his pressure sores or abdomen?

v) It is not clear from the medical notes the indication for which the morphine was commenced. If it was for pain then this should have been documented and assessed. It was a reasonable starting dose for someone of his age and morphine is used in palliative care for generalised pain related to muscle or joint stiffness due to immobility or painful pressure sores.

vi) It is not clear what the indications were for prescribing the syringe driver on the 10th January 1996 and for the medications it contained. It is not usually necessary to utilise the SC route unless a patient is unwilling or unable or to take medications orally (e.g. difficulty swallowing, nausea and vomiting). From the drug chart Mr Pittock did not appear to have these problems (page 18 of 49). No instructions were given on the drug chart on when the syringe driver should be commenced, how this would be decided and by whom. The dose of diamorphine was initially written as a dose range of 40–80mg, only to be subsequently rewritten the next day as 80–120mg without explanation of why a higher dose range was necessary. Based on Mr Pittock's existing opioid dose, all of the doses of diamorphine are likely to be excessive for his needs. Given his total dose of oramorph (morphine solution) of 30mg in 24hours, an appropriate dose of diamorphine using a 1:2 or the more usual 1:3 dose conversion ratio, would have been 10–15mg in 24hours. There is no justification given for

this in the medical notes. Similarly, the indications for including the hyoscine hydrobromide and midazolam should have been documented. The dose range of midazolam of 40–80mg would generally be seen as excessive for someone of Mr Pittock's age. However, taking into account he was a long term user of benzodiazepines, a higher than usual starting dose would likely be necessary.

vii) The dose of diazepam was increased on the 11th January 1996 with no mention of this in the medical notes.

viii) The sertraline and lithium carbonate were discontinued on the 12th January 1996 with no mention of this in the medical notes. It was unclear if this was on the advice of the psychogeriatricians or not; my understanding is that sertraline should not be discontinued abruptly as this is associated with a withdrawal syndrome that can include anxiety, agitation and delirium. A gradual withdrawal of lithium is also advised (BNF).

ix) A syringe driver was ultimately commenced on the 15th January 1996. It is not documented why it had become necessary to give these medications via a syringe driver. Mr Pittock appeared to have been taking his oral medications and the medical entry noted that he 'will eat and drink'. There was no mention in the medical or nursing notes of pain, retained secretions, agitation or anxiety that day. If he was more drowsy and unable to take his medication it would have been reasonable, particularly if he required morphine for pain relief. However, taking into account Mr Pittock's dose of morphine, the starting dose of diamorphine (80mg) was likely to be excessive for his needs as detailed above. The reasons for including the hyoscine hydrobromide (400microgram) and midazolam (60mg) over 24hours were not documented. The dose of midazolam of 60mg over 24hours is an above average starting

dose for somebody of Mr Pittock's age (see technical issues). He had however, been on long term benzodiazepines and in these patients a larger than usual starting dose may be necessary.

x) On the 16th January 1996 the nursing notes reported some agitation when Mr Pittock was being attended to. Haloperidol 5mg SC over 24hours was added to the syringe driver. Haloperidol is a reasonable part of the approach to treating delirium or terminal agitation in someone of Mr Pittock's age. It should be given with caution, given Mr Pittock's parkinsonism, as it can cause extrapyramidal effects (see technical issues). However, it is not clear from the notes that his agitation had been assessed and hence the possible underlying causes of the agitation considered. Drugs (or their withdrawal) are one of the common causes of agitation or terminal restlessness. Of particular relevance to Mr Pittock, these would include the use of opioids, particularly in inappropriate and excessive doses, hyoscine hydrobromide and benzodiazepines (Wessex Protocol, pages 30, 34). It is possible that a reduction in the dose of diamorphine may have helped Mr Pittock's agitation.

xi) On the 17th January 1996 the dose of diamorphine was increased to 120mg and the midazolam to 80mg SC over 24hours with no reason given in the notes. The nursing notes suggest that Mr Pittock remained tense and agitated. There is no documentation that a medical assessment was undertaken to determine whether his being 'tense' related to muscle and joint stiffness, possible extrapyramidal effects from the haloperidol or that other causes of agitation had been considered. Again, rather than increase the diamorphine, a reduction may have been more appropriate. Similarly, the discontinuation or reduction in the dose of haloperidol, or substitution for

an antipsychotic with a lower risk of causing extrapyramidal effects, e.g. levomepromazine, may have been appropriate.

The nursing notes suggest that Mr Pittock was 'bubbly' due to retained secretions and this appears to be the reason for the hyoscine hydrobromide dose being increased twice in one day from 400 to 600microgram then to 1200microgram SC over 24hours.

xii) The medical notes entry on the 18th January 1996 suggested that Mr Pittock's symptoms were difficult to control but did not document which symptoms. Levomepromazine 50mg SC over 24hours was commenced. This is an appropriate drug to use for terminal agitation when haloperidol is insufficient. The dose is in keeping with that recommended by the BNF and the Wessex Protocol. However, it would have been usual to substitute it for the haloperidol rather than use it concurrently.

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

In relation to the above:

Issue i (lack of clear documentation that an adequate assessment has taken place)

A medical assessment usually consists of information obtained from the patient or others (the history) and the findings of a physical examination that is documented in a structured fashion. Although the history can be restricted to the most salient points, it is unusual to omit relevant sections, e.g. past medical history, drug history, etc.) and given Mr Pittock's medical problems, in

my view, a general examination should have been undertaken and documented.

Reclerking of a patient when a different medical team takes over responsibility of care, helps to ensure that they are aware of the patient's current problems, relevant medical history and physical condition. If new problems subsequently develop, and abnormal physical findings are found on examination, it can be helpful for the doctor when considering the differential diagnosis and management to know if the findings are really new or old. A clear assessment and documentation of subsequent medical care are particularly useful for on-call doctors who may have to see a patient whom they have never met for a problem serious enough to require immediate attention.

Issue ii (lack of adequate assessment and documentation of Mr Pittock's pain and use of Arthrotec).

There should have been an adequate assessment of the patients' condition. If Mr Pittock complained of pain, this should have been noted and attempts made to assess as a minimum the site, severity, aggravating/relieving factors and likely cause of the pain. This is undertaken in order to identify the most likely underlying cause of the pain. Different pain relieving approaches can be helpful for some pains and not others. Knowledge of the cause of the pain thus provides a rational basis to how the pain is managed. Without a documented pain assessment I am unable to comment on the appropriateness of the use of Arthrotec.

The prescribing of drugs should be documented in the notes in keeping with the GMC guidelines.

Issue iii (lack of adequate assessment and documentation of Mr Pittock's painful right hand)

There should have been an adequate assessment of the patients' condition. If a patient is experiencing what sounds like tetany (painful muscle spasms), the possible causes of this should be considered and appropriate investigations carried out. As a minimum, in my view, blood levels of calcium should have been measured, as if low, simple replacement of calcium could have improved a distressing symptom. It would be a reasonable course of action to be taken by all but the junior of doctors.

Issue iv (possible inappropriate use of opioids for Mr Pittock's anxiety and agitation)

It should be clarified for what reason Dr Barton was considering the use of opioids. Opioids are not indicated for the relief of anxiety and agitation per se. The prescribing of drugs should be documented in the notes in keeping with the GMC guidelines.

Issue v (lack of adequate documentation regarding the use of oral morphine/lack of adequate assessment and documentation of Mr Pittock's pain)

There should be clear documentation in the medical notes of why and when the morphine was commenced. If it were for pain, attempts should have been made to assess as a minimum the site, severity, aggravating/relieving factors and likely cause of the pain.

Issue vi (lack of adequate documentation regarding the prescription of the syringe driver 'as required' on 10th January/ prescription of treatment that may exceed the patients' needs)

There should have been clear documentation in the medical notes as to why a syringe driver was prescribed 'as required'. It is unusual to prescribe a syringe driver 'as required' especially containing drugs with a range of possible doses. 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. It is not usual in my experience for such decisions to be left for nurses to make alone.

If there were concerns that a patient may experience, for example, episodes of pain, anxiety or agitation, it would be much more usual, and indeed seen as good practice, to prescribe appropriate doses of morphine/diamorphine, diazepam/midazolam and levomepromazine respectively that could be given intermittently 'as required' 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, the appropriate starting dose and subsequent dose titration.

The daily dose of diamorphine 40mg–80mg, rewritten one day later as 80–120mg is not justified at all in the notes. It is likely to be excessive for Mr Pittock's needs. An appropriate dose of diamorphine would have been 10–15mg in 24hours. Doses of opioids excessive to a patient's needs are associated with an increased risk of drowsiness, delirium, nausea and vomiting and respiratory depression.

The reasons for the inclusion of midazolam and hyoscine hydrobromide in the syringe driver should also have been documented. Decisions made and the prescribing of drugs should be documented in the notes in keeping with the GMC guidelines.

Issues vii and viii (lack of adequate documentation regarding the change in medication)

There should be clear documentation in the medical notes of why the diazepam was increased and the sertraline and lithium carbonate were discontinued. Decisions made and the prescribing of drugs should be documented in the notes in keeping with the GMC guidelines.

Issue ix (lack of adequate documentation regarding the prescription of the syringe driver on 15th January/prescription of treatment that may exceed the patients' needs)

There should be clear documentation in the medical notes of why the syringe driver was commenced containing those drugs. In particular, why a dose of diamorphine, that exceeded his current opioid requirements was justified. An appropriate dose of diamorphine would have been 10–15mg in 24hours. Doses of opioids excessive to a patient's needs are associated with an increased risk of drowsiness, delirium, nausea and vomiting and respiratory depression. Decisions made and the prescribing of drugs should be documented in the notes in keeping with the GMC guidelines.

Issue x (lack of adequate assessment and documentation of Mr Pittock's agitation)

There should have been an adequate assessment of Mr Pittock's agitation. This would have included considering, as a minimum, if any of the common causes of agitation were possibly contributing to his agitation (e.g. as listed in the Wessex protocol pages 30, 34). The assessment should have been documented in the medical notes. Such an approach should have allowed consideration if drugs (or their withdrawal) were a possible contributory factor to Mr Pittock's agitation. In particular, whether the dose of opioid was appropriate and not excessive to his needs.

Issue xi (lack of adequate documentation regarding the change in dose of drugs in the syringe driver on the 17th January 1996)

There should be clear documentation in the medical notes as to why the dose of diamorphine was increased to 120mg, the midazolam to 80mg SC over 24hours and the hyoscine hydrobromide dose increased twice from 400 to 600 microgram then to 1200microgram SC over 24hours.

Issue xii (lack of adequate assessment and documentation of Mr Pittock's symptoms, willingness to consult colleagues)

If symptoms are 'difficult to control', this should prompt an adequate (re)assessment to carefully (re)consider the possible contributing factors to ensure that all reasonable steps had been taken to attend to any underlying causes as appropriate.

If, despite the initial management plan, symptoms are 'difficult to control', it would also be seen as good practice for a doctor to seek additional

information or advice. There is no documentation in the notes that suggests that Dr Barton did this, for example, seeking additional information or advice from the Wessex protocol, one of the consultants, another colleague or a member of the palliative care team.

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

Dr Barton had a duty to provide good palliative and terminal care and an integral part of this is the relief of pain and other symptoms to ensure the comfort of the patient. In doing so, as in every form of medical care provision, she would be expected to demonstrate a good standard of practice and care. In this regard, Dr Barton fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, October 1995 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient, providing treatment that was excessive to the patients' needs and willingness to consult colleagues.

Most significantly, the dose range of diamorphine prescribed for the 'as required' syringe driver, and the dose finally administered (80mg), far exceeded that generally considered to be an appropriate starting dose (10–15mg) given Mr Pittock's existing opioid usage. It is unclear how Dr Barton determined or justified this dose. A dose of diamorphine excessive to Mr Pittock's needs would be associated with an increased risk of drowsiness, confusion, agitation, nausea and vomiting and respiratory depression.

Mr Pittock was described as tense and agitated several times following the syringe driver being commenced. This may have been due to a number of reasons, e.g. his depression, the developing pneumonia or a terminal

agitation. In this regard the use of midazolam, haloperidol and levomepromazine could be seen as justified. However, an assessment of the possible causes of his agitation should have been carried out, particularly if seen as difficult to manage. This would have included considering if drugs, such as the diamorphine, were a possible contributing factor to his agitation. At the very least, it should have prompted a review of the appropriateness of Mr Pittock's dose of diamorphine.

In patients with cancer, the use of diamorphine and other sedative medications (e.g. midazolam, haloperidol, levomepromazine) when appropriate for the patients needs, do not appear to hasten the dying process. This has not been examined in patients dying from other illnesses to my knowledge, but one would have no reason to suppose it would be any different. The key issue is whether the use and the dose of diamorphine and other sedatives are *appropriate* to the patients needs. In situations where they are inappropriate or excessive to the patients needs, it would be difficult to exclude with any certainty that they did not contribute more than minimally, negligibly or trivially to the death of the patient. Although the principle of double effect could be invoked here (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.

There appears little doubt that Mr Pittock was 'naturally' coming to the end of his life. His death was in keeping with a progressive irreversible physical

decline, documented over several weeks by different medical teams, accompanied in his terminal phase by a pneumonia. At best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mr Pittock a peaceful death, albeit with what appears to be an excessive use of diamorphine. This may have been due to an apparent lack of sufficient knowledge, illustrated, for example, by the prescription and use of doses of diamorphine by syringe driver that were inappropriately large for Mr Pittock's circumstances and did not reflect his current opioid requirements; the reliance on large dose ranges of diamorphine by syringe driver rather than a fixed dose along with the provision of smaller 'as required' doses that would allow Mr Pittock's needs to guide the dose titration; and a lack of consideration that the opioids may have been aggravating his agitation. It is my opinion however, that given the lack of documentation to the contrary, Dr Barton could also be seen as a doctor who breached the duty of care she owed to Mr Pittock by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Pittock by unnecessarily exposing him to excessive doses of diamorphine that could have resulted in a worsening of his agitation. Dr Barton's response to this was to further increase Mr Pittock's dose of diamorphine. Despite the fact that Mr Pittock was dying 'naturally', it is difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton leaves herself open to the accusation of gross negligence.

9. LITERATURE/REFERENCES

British National Formulary 29 (March 1995).

Prescribing in Terminal Care, pages 12–15.

British National Formulary 47 (March 2004).

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

Palliative Care Handbook, Guidelines on Clinical Management, Third Edition

'Wessex Protocol' Salisbury Palliative Care Services May 1995.

10. EXPERTS' DECLARATION

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

11. STATEMENT OF TRUTH

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

Signature: Code A Date: 25th April 2005

DRAFT REPORT

regarding

STATEMENT OF DR JANE BARTON

RE: LESLIE PITTOCK (BJC/71)

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

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of Dr Jane Barton re: Leslie Pittock. In particular, if it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This Report is based on the following documents:

[1] Statement of Dr Jane Barton RE: Leslie Pittock as provided to me by Hamsphire police (signed and dated 3-3-05).

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

[3] Report regarding Leslie Pittock (BJC/71) Dr A Wilcock, 25th April 2005.

3. COMMENTS

Having compared and contrasted the above documentation, I make the following comments that in my view may be relevant. They are in the order in which they arise in the Statement of Dr Jane Barton RE: Leslie Pittock.

Points 3 and 4

In the statement of Dr Jane Barton, Dr Barton outlines that in 1998, the demands on her time were such that firstly her note keeping suffered in consequence and that the medical records did not set out each and every review with a full assessment of a condition of a patient at any given point. Secondly, in relation to prescribing she felt obliged to adopt a policy of proactive prescribing. In the statement Dr Jane Barton RE: Leslie Pittock, Dr Barton states that this also applied to 1996.

Point 13

Dr Barton states that given the very considerable interval of time she now has no real recollection of Mr Pittock. Given the lack of adequate documentation in the medical records, subsequently a number of the points she makes are based on what she believed she would have done (e.g. points 15, 18, 21, 23, 24, 25, 29, 31, 34, 41, 42).

Point 16

Dr Barton clarifies that the illegible words in the medical notes entry of the 9th of January 1996 were not '*try hot water*' but 'try arthrotec'. It remains unclear what assessment Dr Barton made of Mr Pittock's painful hand, the possible cause(s) of it and therefore why arthrotec was deemed an appropriate treatment.

Point 18

Dr Barton highlights that the arthrotec was prescribed on the 8th January 1996 prior to her entry regarding the pain in Mr Pittock's hand on the 9th January 1996. She states she does not know if the date is an error or she had seen him the previous day and prescribed the arthrotec, and made a substantive note the following day.

She also states that she noted Mr Pittock had increased anxiety and agitation and raised the possibility that it might be necessary to increase the diazepam and prescribe opiates. Dr Barton should be asked to clarify exactly why she felt the opioids were indicated. In my view opioids are not indicated for the primary relief of anxiety or distress.

Point 19

Dr Barton states that Dr Tandy noted Mr Pittock's dementia. I think this should be depression. Mr Pittock's depression was a major problem and well documented. However, dementia was not previously mentioned anywhere in his medical records.

Point 21

Dr Barton states that she prescribed oramorph for Mr Pittock on the 10th January 1996, 'no doubt in consequence of liasing with Dr Tandy at the time of the ward round'. She indicates that it would have been for the relief of pain, anxiety and distress. Dr Barton does not clarify which pain this refers to. In my view opioids are not indicated for the primary relief of anxiety or distress.

Dr Barton also states that she proactively wrote up a prescription for diamorphine and a dose range of 40–80mg subcutaneously over 24hours, together with the 200–400microgram of hyoscine and 20–40microgram of midazolam. She states that 'we were concerned that the oramorph might be insufficient and that further medication should be available just in case he needed it'. Dr Barton does state who 'we' refers to, clarifies the basis for the concern that the oramorph might be insufficient, nor justifies why that dose of diamorphine was considered necessary. Dr Barton should be asked to explain why, given her stated concern, 'as required' oral or SC doses of (dia)morphine or a benzodiazepine (e.g. diazepam/midazolam) were not considered appropriate.

Point 23

Dr Barton states that the following day she rewrote the proactive prescription for the hyoscine, diamorphine and midazolam, with the latter two drugs at a slightly greater level than had been written the previous day, i.e. diamorphine 80–120mg and midazolam 40–80mg. Dr Barton states that she would have been concerned that although it was not necessary to administer the medication at that stage, Mr Pittock's pain, anxiety and distress might develop significantly and that appropriate medication should be available to relieve this if necessary. I do not understand the logic behind this explanation. Mr Pittock had not required the syringe driver prescribed from the day before and so Dr Barton would have no way at all of knowing or in anyway anticipating that an even greater level of these two drugs would be necessary.

Points 24, 25 and 26

Dr Barton states that she believes she would have seen Mr Pittock on Monday 15th January 1996 and that she may have been told that his condition had deteriorated considerably over the weekend and 'he appeared to be experiencing marked agitation and restlessness and to be in significant pain and distress'. She anticipates that due a lack of time she did not make a clinical entry in the notes but that diamorphine 80mg, midazolam 60mg and hyoscine hydrobromide 400microgram were commenced via syringe driver at 08.25am that day.

Dr Barton has not described why she considered a syringe driver to have become necessary when Mr Pittock appeared to have been taking his oral medications. There was no mention in the nursing notes of pain, retained secretions, agitation or anxiety that day. Dr Barton does not state for what pain

the diamorphine was used. Dr Barton states that she 'tried to judge the medication, including the increase in the level of opiates, to ensure that there was appropriate and necessary relief of his (Mr Pittock's) condition, whilst not administering an excessive level, and to ensure that this relief was established rapidly and maintained through the syringe driver'. These are reasonable aims. However, Dr Barton does not illustrate in a clear way how the dose of diamorphine was determined and it would be helpful for Dr Barton to specifically state on what basis a dose of 80mg was selected.

She states that she had to take into account the fact that the lithium and sertraline with their additional sedative effects had previously been discontinued and that he would have developed some tolerance to the oral regime. Dr Barton should be asked to clarify which aspects of Mr Pittock's oral regime she believes tolerance would have developed to. Tolerance to a drug means that over time an increasing dose would be required to have the same effect. It is likely he would have developed tolerance to benzodiazepines as he had been a long-term user of diazepam. As such it would be seen as reasonable to use a larger than usual starting dose of the midazolam particularly when taking the discontinuation of the lithium and sertraline into account. However, as Mr Pittock had only been receiving opioids for four days, tolerance is unlikely to have developed and would not in my view be an acceptable reason to justify such a relatively large increase in his opioid dose.

Points 28 and 29

On the 16th January 1996, Dr Barton states that 'Mr Pittock's condition remained very poor and that there had been some agitation when he was being attended to. It would appear therefore that the medication commenced the

previous day had been largely successful in relieving Mr Pittock's condition, but not entirely. At the same time, it would seem that Mr Pittock's pain, distress and agitation had been such that he was indeed tolerant to the medication given, including the level of diamorphine I felt appropriate'. I do not understand fully Dr Barton's final sentence and she should be asked to clarify exactly what she means by it.

It remains unclear if Dr Barton assessed the cause of Mr Pittock's agitation and considered the possible underlying cause(s). Of particular relevance to Mr Pittock would be drugs (or their withdrawal) particularly the use of opioids, hyoscine hydrobromide and benzodiazepines (e.g. midazolam).

Whilst haloperidol is a reasonable part of the approach to treating delirium for terminal agitation, its use should not be a substitute for considering other causes of agitation that may need to be addressed.

Point 31

On the 17th January 1996 Dr Barton states that due to Mr Pittock being tense and agitated she increased the level of his diamorphine to 120mg. She states this was with the specific aim of relieving the agitation. Dr Barton should be asked to state on what basis, recommendation or guidelines she was using diamorphine for the specific aim of relieving agitation. Diamorphine is not indicated for the relief of agitation and is not mentioned as a treatment for such in contemporary guidelines such as the Wessex Protocol or the BNF Prescribing in Palliative Care section. Again from the medical, nursing notes and Dr Barton's statement it remains unclear if an assessment of the possible causes of his agitation was undertaken. Increasing the haloperidol to 10mg and

the hyoscine to 600microgram were reasonable steps based on his agitation and retained respiratory secretions.

Points 34 and 35

Dr Barton states that in the entry dated the 18th January 1996 she noted 'difficulty controlling symptoms, try nozinan' (levomepromazine). Which symptoms were difficult to control are not specified but Dr Barton believes that it was for Mr Pittock's agitation. Haloperidol was increased to 20mg and levomepromazine 50mg was added to the syringe driver. Increasing the dose of antipsychotic medication for terminal agitation is reasonable but Dr Barton should be asked to explain why the levomepromazine was given in addition to the haloperidol rather than substituted for it. It remains unclear if Dr Barton undertook an assessment of Mr Pittock's agitation.

Point 36

Dr Barton states that the nursing notes record that Mr Pittock appeared comfortable in between attentions. She infers from this that he had adequate relief from symptoms but would experience pain, distress and agitation when receiving care. Dr Barton should be asked to clarify why if this was the case the syringe driver not modified again; why smaller doses of the diamorphine, midazolam, levomepromazine or haloperidol and hyoscine hydrobromide were not prescribed 'as required' to be administered prior to turning Mr Pittock; and if, given that the symptoms were difficult to control, whether she sought advice?

Points 38, 39 and 40

Dr Barton states that 'Dr Briggs would have been advised of Mr Pittock's condition and the drug regimen. The only modification was in the antipsychotic medication (levomepromazine), it would seem that Dr Briggs did not consider the general regimen to be inappropriate.....'. Dr Briggs should be asked for his view of this.

4. CONCLUSION

Dr Barton admits to poor note keeping and proactive prescribing due to time pressures in 1996. Even with significant episodes in Mr Pittock's care however, no entry was made. Having read Dr Barton's statement regarding Mr Pittock, I believe that the main issues raised in my report (BJC 71), dated 24th April 2005, remain valid and have not yet been satisfactorily addressed due to a lack of clarity regarding:

- the nature of Mr Pittock's pain and its possible cause(s)
- the justification for the proactive prescribing of a syringe driver containing diamorphine, hyoscine and midazolam 'just in case he needed it'
- the lack of use of 'as required' doses of the above drugs instead of, or subsequently, alongside the syringe driver
- the basis for Dr Barton's use of diamorphine specifically for the relief of agitation
- the lack of assessment of the possible cause(s) of Mr Pittock's agitation
- how the dose of diamorphine Mr Pittock ultimately received (80mg) was calculated in a way that can be clearly related to his existing dose of opioid
- given the difficulty of controlling the symptoms, whether Dr Barton sought advice.

As some of the above points relate directly to Dr Barton's knowledge of the management of pain and other symptoms in a palliative care setting it would be helpful if she could state what specific training she had received in relation to

this. In particular, where she obtained her understanding from with regards to the indications for the use of morphine/diamorphine, the phenomenon of tolerance to opioids, the methods of determining an appropriate dose of diamorphine given a patients oral morphine dose and what prescribing guidelines she was aware of and/or followed.

Specific implications of the statement of Dr Barton regarding Mr Pittock regarding my report (BJC 71), dated 24th April 2005

Dr Barton's statement clarifies that the 'arthrotec' (and not 'hot water') was prescribed for Mr Pittock's painful right hand held in flexion. This relates to specific issue ii (pages 23 and 28) in my report.

Form MG15(T)

RESTRICTED

RECORD OF INTERVIEW

Number: Y20E

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

Person interviewed: BARTON, JANE ANN

Place of interview: FRAUD SQUAD OFFICE NETLEY

Date of interview: 03/03/2005

Time commenced: 0915 Time concluded: 0940

Duration of interview: 25 MINS Tape reference nos. (→)

Interviewer(s): DC2479 YATES & DC162 QUADE

Other persons present: MR BARKER SOLICITOR

Police Exhibit No: CSY/JAB/4A Number of Pages: 22

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 QUADE	DC Code A Geoff QUADE.
DC YATES	I'm interviewing Doctor Jane BARTON, Doctor can you please give your full name and your date date of birth.
BARTON	Doctor Jane Anne BARTON **Code A**
DC YATES	Also present is Mr BARKER who is Doctor BARTON'S Solicitor. Can you please give your full name.

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SOLICITOR — Yes certainly it's Ian Stephen Petrie BARKER.

DC YATES — If you have a role about your, or if you have sorry a statement about your role here today maybe now.

SOLICITOR — No I'm just Doctor BARTON'S Solicitor.

DC YATES — Okay. This interview is being conducted in an office within the Fraud Squad at Netley Support Headquarters in Hampshire . The time is 09:15 hours and the date is the 3rd of March 2005 (03/03/2005). At the conclusion of the interview I'll give you a notice explaining what will happen to the tapes. I must remind you Doctor that you are entitled to free legal advice, you have Mr BARKER with you, have you had enough time to speak to him before this interview started.

BARTON — Yes thank you.

DC YATES — Okay. If at any time you want to speak to Mr BARKER then just say and we'll stop the interview so that you can consult in private. I must also tell you that you've attended voluntarily, you are not under arrest, you have come here of your own freewill, therefore if at any time you wish to leave then your completely free to do so. 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. That's what's called the Caution Doctor, do you understand that Caution.

BARTON — I do.

DC YATES — Could you just for our peace of mind explain what you think that Caution means.

SOLICITOR — Well Officer again perhaps you could explain that so that Doctor BARTON'S absolutely clear sometimes it's rather difficult for people in this situation to put it across.

DC YATES — The Caution comes in, in three parts really. The first part is your right in law you don't have to say anything and the last bit is quite obvious, and anything you do say maybe given in evidence it's being tape recorded and should this matter ever go to Court the tapes can be played or a transcript could be read. It's the, the bit in the middle where it says it may harm your defence if you do not mention when questioned something, which you later rely on in Court. In a nutshell if you don't say something now but you later give a reason or an answer if this matter goes to Court then the Court may and it is only a may put an inference on that and wonder why you didn't say that earlier. Do you understand what I'm saying.

BARTON — I do.

DC YATES — Does that sound a reasonable explanation Mr BARKER.

SOLICITOR — I think we can have small trite arguments but the essense of what you've said.

DC YATES — Okay. Alright. This interview is not being monitored today so nobody else is listening, listending in if it was being monitored there would a red light situated somewhere which would, which would illuminate. Now during the interview I'll probably ask most of the questions but my colleague DC QUADE will be making notes, don't let that worry you it's just so that we've got a reference straight away of what's been said. Mr BARKER can I just cover something with you. I believe you've been given some advance disclosure on the 4th of November which is the last time that we met.

SOLICITOR — Yes that's right.

DC YATES — And the disclosure consisted of a set of medical notes pertaining to Mr PITTOCK and a summary is that correct.

SOLICITOR — That's correct yes.

DC YATES — Excellent. This investigation as you're no doubt already aware is being conducted by the Hampshire Constabulary it started in September 2002, I accept that it's over two years now but the investigation will probably continue for some considerable time still. It's an investigation into allegations of the unlawful killing of a number of patients at the Gosport War Memorial Hospital between 1990 and 2000. No decision has been made as to whether an offence or any offences have been committed but it's important to be aware that the offence range being investigated runs from an assault all the way up to murder and part of the ongoing enquiries 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 the these deaths, so your knowledge of the working and of the hospital and the care and treatment of the patients is very central to this enquiry. The interview today will be concentrating on Leslie Charles PITTOCK, who was an 82 year old man and he died on Dryad Ward on the 24th of January 1996 (24/01/1996). Now I've done most of the speaking now but perhaps in your own words Doctor you can tell me your recollection of Leslie PITTOCK and the care and treatment.

SOLICITOR — Officer can I say that Doctor BARTON has produced a pre prepared statement so that she can convey to you all the information that she thinks she can about Mr PITTOCK and his case. I would invite if your content with this Doctor BARTON to read that out as her account responding to your invitation just now. I have to say for the reasons that I articulated on the previous occasion though my advice to Doctor BARTON is that she should then make no further comment to questions.

DC YATES — Right.

SOLICITOR — Put to her and hopefully this is a detailed pre prepared statement, which will take care of necessary information you seek.

DC YATES — As you mention that yes if you could read it Doctor BARTON but you you're indicating that once you've read the prepared statements your not going to answer any

further questions put to you about this matter. Is that correct.

BARTON — Correct.

DC YATES — Okay. If you, if you could it read then please Doctor.

SOLICITOR — It's simply the form as I do have a copy of the statement for you.

DC YATES — That would be ever so handy.

SOLICITOR — Of course no problem at all it will save you making notes.

DC YATES — Yeah. Thank you.

BARTON — I am Doctor 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 Leslie PITTOCK. 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 PITTOCK.

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 bartel 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.

Whilst the demands on my time were probably slightly less in 1996 than the position which then pertained in 1998 and beyond, certainly even by 1996 there had been a significant increase in dependency, increase in bed occupancy, and consequent decrease in the ability to make notes of each and every assessment and review of a patient. These difficulties clearly applied both to me and the nursing staff at the time of our care of Mr PITTOCK. Similarly I had by this stage felt obliged to adopt the policy of pro-active prescribing to which I have made reference in my previous statement to you, given the constraints and demands on time.

In any event, it is apparent from Mr PITTOCK'S medical records that he was 83 years of age and had been suffering from depression since his 50's. Mr PITTOCK had been

living in a residential home, Hazeldene and also had been an in-patient at the Knowle Hospital where he had received Electro Convulsive Therapy as treatment for severe depression. Having returned to Hazeldene, early in 1995 it is recorded that by September that year Mr PITTOCK had taken to his bed and was no longer eating and drinking properly. In view of his general condition and depression, he then appears to have been admitted to Mulberry Ward at the Gosport War Memorial Hospital having been seen at Hazeldene by a Community Psychiatric Nurse in September 1995.

The note of the Community Psychiatric Nurse for the 1st September 1995 records that she had been asked to review Mr PITTOCK'S mood and behaviour. She said that he had lost 1 pound 1 stone 2 pounds in two months and appeared physically frailer, anxious and had fallen at times. She recorded the drug regime at that time, and her view that the best course of action was to arrange an admission to Mulberry Ward for assessment of the regime and to provide interim intensive support for Mr PITTOCK.

From Mr PITTOCK'S records it appears then that he was admitted to Mulberry Ward on the 14th September 1995 (14/09/1995) under the care of Consultant in Old Age Psychiatry, Dr Vicki BANKS . Mulberry Ward is the long stay elderly mental health ward at the Gosport War Memorial Hospital. On admission it was recorded that there had been a deterioration of Mr PITTOCK'S mood and physical capabilities over recent months. Whilst on Mulberry Ward, Mr PITTOCK'S depression was treated

with Lithium, Sertraline, and he also received Diazepam and Thioridazine.

Mr PITTOCK was then discharged from Gosport War Memorial Hospital on 24th October 95 (24/10/1995). The subsequent discharge letter to Mr PITTOCK'S GP from Dr Rosie BAYLY , Registrar to Dr BANKS, stated that Mr PITTOCK had scored 8 out of 10 on a mental health score, and that he had been offered ECT for his depression but had turned it down as it had not been very effective previously. Dr BAYLY referred to his frail physical condition, but said that his mood had improved quite a bit during his admission and that he seemed to have more energy. He was apparently to be followed up as a day patient.

Mr PITTOCK was then re admitted to Mulberry Ward from Hazeldene on 13th December 1995 (13/12/1995). The nursing staff at the residential home were said to have found it increasingly difficult to manage him as he had become both physically and verbally aggressive. On 20th December his physical condition was described as poor, and he later developed a chest infection and areas of pressure ulceration.

With his condition remaining poor, Dr BAYLY wrote a note on 2nd January 1996 (02/01/1996) requesting Dr Althea LORD, Consultant Geriatrician, to see Mr PITTOCK. In her note Dr BAYLY said that on admission Mr PITTOCK'S mobility had initially deteriorated rapidly and that he had developed a chest infection. She reported

that his chest was now clearing, but he remained bed bound, expressing the wish to die. The following day, Mr PITTOCK was said to be deteriorating.

Dr LORD then undertook an assessment on 4th January. In Mr PITTOCK'S records she said that she would be happy to take Mr PITTOCK to a long stay bed in the hospital. Recording the position at this time when then writing formally to Dr BANKS on 8th January, Dr LORD said she noted that he had suffered from a chronic resistant depression and long courses of ECT in the past had not been effective. He had recovered from a recent chest infection but was completely dependent with a Bartel score of zero, his urinary catheter was bypassing and he had ulceration of the left buttock and hip. He had hypoproteinaemia with an albumin of 27 and was eating very little although he would drink moderate amounts with encouragement. She felt that he would need high protein drinks as well as a bladder wash out but overall felt that his prognosis was poor and would be happy to arrange transfer to Dryad on 5th January. She gathered that Mrs PITTOCK was also aware of his poor prognosis.

In noting that his prognosis was poor I believe that Dr LORD felt that Mr PITTOCK was unlikely to get better and sadly he was not likely to live for a significant period.

Accordingly, Mr PITTOCK was admitted to Dryad ward the following day, 5th January, though under the care of Consultant Geriatrician Dr Jane TANDY , and I undertook his assessment. Unfortunately, given the very considerable

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interval of time I now have no real recollection of Mr PITTOCK, but my admission note in his records reads as follows:

"5th January 96 Transfer to Dryad Ward from Mulberry
Present problem
Immobility depression
Broken sacrum. Small superficial areas
Ankle dry lesion Left ankle
Both heels suspect

Catheterised
transfers with hoist
may help to feed himself

Long standing depression on Lithium and Sertraline"

I also prescribed medication for Mr PITTOCK, continuing the Sertraline, Lithium, Diazepam, and Thyroxine which had been given during his stay on Mulberry Ward, together with Daktacort cream for his pressure sores.

I believe that I would have seen Mr PITTOCK each weekday when on duty at the hospital. 5th January 1996 (05/01/1996) being a Friday, I would have seen him again on 8th January and reviewed his condition. I have not made a note, but anticipate that his condition may have been essentially unchanged.

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I saw Mr PITTOCK again on Tuesday 9th January and made the following entry in his notes:

"9-1-96 Painful Right hand held in flexion
Try arthrotec
Also increasing anxiety and agitation
? sufficient diazepam
? needs opiates"

The nursing note for 9th January documents that Mr PITTOCK had taken a small amount of diet. He was noted to be very sweaty that morning, but apyrexial. He stated that he had generalised pain and it was noted that he would be seen by me that morning.

The prescription chart shows that I prescribed Arthrotec, which would have been for the pain in Mr PITTOCK'S hand as recorded by me in the notes. The prescription is in fact dated for the previous day. I do not know now if the date is an error or if I had prescribed and seen him the previous day, and made a substantative note the following day, 9th January. In any event on 9th January I noted that Mr PITTOCK had increased anxiety and agitation, and raised the possibility that it might be necessary to increase the diazepam and prescribe opiates. I would have been conscious that a ward round with Dr TANDY was to take place the following day, and that a change in medication could sensibly be considered then.

The notes show that Dr TANDY and I then saw Mr PITTOCK the following day, 10th January. Dr TANDY

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noted his dementia, that he was catheterised, had superficial ulcers, his Barthel score remained zero, and he would eat and drink. She wrote that Mr PITTOCK was "for TLC" (Tender loving care). This indicated that Dr TANDY effectively agreed with Dr LORD'S assessment and felt Mr PITTOCK was not appropriate for attempts at rehabilitation but was for all appropriate nursing care and treatment only. She noted that she had had discussion with Mr PITTOCK'S wife who had agreed that in view of his very poor condition this was appropriate.

The nursing note for the same day confirmed that we had seen Mr PITTOCK and that his condition remained poor, with Mrs PITTOCK being aware of this.

The prescription chart shows that I prescribed Oramorph for Mr PITTOCK the same day, no doubt in consequence of liaison with Dr TANDY at the time of the ward round. This would have been for relief of pain, anxiety and distress. The dose is recorded at 2.5 mls in what is a 10mg/5ml ratio, 4 hourly. The regime was written up for doses at 6.00 a.m., 10.00 a.m., 2.00 p.m. (14:00) and 6.00 p.m. (18:00). It appears that I also proactively wrote up a prescription for diamorphine , in a dose range of 40-80mgs subcutaneously over 24 hours, together with 200-400mcgs of hyoscine and 20-40mgs of midazolam via the same route. I anticipate we were concerned that the Oramorph might be insufficient and that further medication should be available just in case he needed it.

Sister HAMBLIN recorded in the nursing notes the same day that Mrs PITTOCK was seen and was aware of her husband's poor condition. He was to occupy a long-stay bed. It was clear that his condition was such that he would not recover and in essence all that could be given was palliative care, with his death expected shortly.

I anticipate that I would have seen Mr PITTOCK again the following day. Although I did not make a clinical entry in Mr PITTOCK'S records, I wrote up a further prescription chart for the various medications Mr PITTOCK was then receiving. In addition I increased the Oramorph available for Mr PITTOCK'S pain, anxiety and distress, by adding an evening dose of 5mls to the four daily dose doses, to tide Mr PITTOCK overnight. I also provided a further prescription for hyoscine, diamorphine and midazolam, with the latter two drugs being at a slightly greater level than I had written the previous day, at 80-120 and 40-80mgs respectively. I would have been concerned that although it was not necessary to administer the medication at that stage, Mr PITTOCK'S pain, anxiety and distress might develop significantly and that appropriate medication should be available to relieve this if necessary. The Sertraline and lithium were discontinued from this point, given Mr PITTOCK'S poor condition.

I anticipate that I would then have seen Mr PITTOCK on the Friday morning, but I would then have been away from the hospital over the weekend. I returned on the morning of Monday 15th January, and would have reviewed all of the patients on both Dryad and Daedalus wards in the usual

way, including Mr PITTOCK. I believe I may have been told that his condition had deteriorated considerably over the weekend and he appeared to be experiencing marked agitation and restlessness and to be in significant pain and distress, through his mental and physical condition. Unfortunately, I did not have an opportunity to make a clinical entry in Mr PITTOCK'S notes, I anticipate due to lack of time, but the nursing note indicates that I saw Mr PITTOCK and that 80mgs of diamorphine, 60 of midazolam, and 400mcgs of hyoscine over 24 hours were commenced subcutaneously via syringe driver at 08.25 (08:25) that morning.

The previous medication, including the Oramorph, was clearly insufficient in relieving Mr PITTOCK'S condition. He had been transferred to the ward in a poorly condition, and had been considered by consultants at about that time to be in terminal decline. Dr TANDY in particular had noticed noted that he should have "TLC" - in other words palliative care in circumstances in which he was clearly dying. Since then Mr PITTOCK had deteriorated yet further. My concern therefore was to ensure that he did not suffer anxiety, pain and mental agitation as he died. I believe my assessment of Mr PITTOCK'S condition at this time was also that he was in terminal decline.

I tried to judge the medication, including the increase in the level of opiates to ensure that there was the appropriate and necessary relief of his condition, whilst not administering an excessive level, and to ensure that this relief was established rapidly and maintained through the syringe

driver. This had to take into account the fact that the lithium and Sertraline with their additional sedative effects had previously been discontinued and that he would have developed some tolerance to the oral regime.

Although the nursing notes suggest that Mr PITTOCK continued to deteriorate, his pulse was noted to be stronger and regular, and he was said to be comfortable during the night.

The notes continue that the following day, 16th January, Mr PITTOCK'S condition remained very poor and that there had been some agitation when he was being attended to. It would appear therefore that the medication commenced the previous day had been largely successful in relieving Mr PITTOCK'S condition, but not entirely. At the same time, it would seem that Mr PITTOCK'S pain, distress and agitation had been such that he was indeed tolerant to the medication given, including the level of diamorphine I had felt appropriate.

In view of the agitation I decided to add between 5-10mgs of haloperidol to the syringe driver, with 5mgs being given at that time. The fact that I saw Mr PITTOCK and prescribed is recorded in the nursing notes, but again I anticipate my commitments in attending to patients at that time meant that I did not have an opportunity to make an entry in Mr PITTOCK'S notes.

Mr PITTOCK'S daughter apparently visited later that day and was said now to be aware of her father's poorly condition.

I believe I saw Mr PITTOCK again the following morning, 17th January. It appears from the nursing notes that Mr PITTOCK was tense and agitated and so I decided to increase the level of his medication. I wrote a further prescription for 120mgs of diamorphine, noted by me on the drug chart to have been at about 08.30 (08:30). This was with the specific aim of relieving the agitation, and from concern that as Mr PITTOCK would be becoming inured to the medication and tolerant of it, so he might experience further agitation, and the pain and distress might return. I also increased the haloperidol to 10mgs and the hyoscine to 600mcgs, the latter to dry the secretions on his chest, suction being required that morning.

I returned to review Mr PITTOCK in the early afternoon. The nursing note suggests that the medication was revised at that stage, and it is possible that the changes I had recorded earlier were instituted at about this time.

Unfortunately, Mr PITTOCK appears to have deteriorated further that evening. He was however said by Sister HAMBLIN now to be settled and aware of when he was being attended to. My inference was that the increase in the medication had not seemingly caused Mr PITTOCK to be excessively sedated.

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I believe I saw Mr PITTOCK again the following morning, Thursday 18th January. The nursing note indicates that his poorly condition continued to deteriorate. I made an entry in his records on this occasion, as follows:

"18th January 96 Further deterioration
subcutaneous analgesia continues
difficulty controlling symptoms
try nozinan".

I believe from my note that Mr PITTOCK'S agitation had returned and we were having difficulty controlling his symptoms. I therefore increased the Haloperidol to 20mgs and decided to add 50mgs of nozinan to the syringe driver to run over 24 hours, nozinan being an antipsychotic, used also in palliative care for pain and severe restlessness.

The nursing note states that he appeared comfortable in between attentions, from which I would infer that he had adequate relief from symptoms, but he would experience pain, distress and agitation when receiving care, such as being turned, that being necessary to prevent the further development of bed sores.

Later that day a marked deterioration in Mr PITTOCK'S condition was noted by the nurses. Clearly Mr conditions Mr PITTOCK'S condition continued to deteriorate given the fact that he was in the process of dying. His breathing was noted to be intermittent and his colour poor.

I would not have been on duty over the weekend, and it appears that one of my GP partners, Dr Michael BRIGG , was available. The records show that on Saturday 20th January, he was consulted about Mr Michael Mr PITTOCK, and he advised that the nozinan should be increased to 100mgs and the haloperidol discontinued. My expectation is that Dr BRIGG would have been advised of Mr PITTOCK'S condition and the drug regime. The only modification being in the antipsychotic medication, it would seem that Dr BRIGG did not consider the general regime to be inappropriate in view of Mr PITTOCK'S condition.

Dr BRIGG sufficient specifically recorded in the notes that Mr PITTOCK had been unsettled on haloperidol, that it should be discontinued and changed to a higher dose of nozinan.

It seems that Dr BRIGG then saw Mr PITTOCK the following day. He has made a record in the notes for 21st January, in addition to the entry for the verbal advice given the previous day. Dr BRIGG noted that Mr PITTOCK was much more settled, with quiet breathing and a respiratory rate of 6 breaths per minute. Dr BRIGG said that he was not distressed, and stated "continue". Again, it would seem that Dr BRIGG did not disagreed with the overall medication which was being administered in view of Mr PITTOCK'S condition.

I would have seen Mr PITTOCK again on the Monday morning, 22nd January. I have not made a note, but the

nursing records indicate that Mr PITTOCK was poorly but peaceful.

I would have seen Mr PITTOCK again on 23rd January, when again it was said by the nurses that his poorly condition remained unchanged and that he remained peaceful. In view of the fact that the medication was apparently relieving his symptoms, it was not necessary to alter either the nature or the amounts being given.

Sadly, in the early hours of 24th January, Mr PITTOCK deteriorated suddenly, and he died at 01:45 (01:45).

DC YATES — Thank you Doctor again that's very full, very informative. Can I just ask you is this statement made by you Doctor. This prepared statement. Can I ask you if you could sign it and endorse it with the fact that you've handed it to me, possibly sign that one and time and date it please.

BARTON — This one.

DC YATES — Yeah the one you read from would be the best one.

BARTON — On, on the back page or on the front.

DC YATES — Is there room on the last page, yeah just put it on the last page please.

BARTON — Is today's date the 3rd.

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DC YATES — Yes. And if you could just put on there handed to DC YATES, it's Y A T E S. Lovely thank you. Would you consider countersigning Mr BARKER, you did the other one.

SOLICITOR — Yes no problem.

DC YATES — Right for the purpose of the tape I'm going to give this prepared statement an Identification Reference and I'm going to call it JB/PS/3 that's by Doctor Jane BARTON, Prepared Statement and that's the third one we've had from you. Right I intend to call a halt to the interview pretty much now so that we can go away and consider all this information that you've told us. Before is there anything you want to ask Geoff.

QUADE — No there isn't.

DC YATES — No okay. Well we'll going to go away and have a read through. Before we turn the tapes off Doctor is there anything you wish to say, anything you wish to clarify.

BARTON — Nothing.

DC YATES — Mr BARKER.

SOLICITOR — No thank you.

DC YATES — Okay well we'll give you a notice explaining the tape recording procedure, feel free to use the canteen and if you

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want get a breath of fresh air and we'll come back. The time is 09:40 and we'll turn the recorder off.

PITTOCK

MG 9

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URN:

WITNESS LIST

Date of completion:

✱ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✱	◆
1	Name: LYNDA MARION WILES Address (HOME): Code A Occupation: RETIRED RMN Date of Birth: Code A Telephone: HOME Code A E-mail address:			
2	Name: MARTIN SCOTT ASBRIDGE Address (WORK): Code A Occupation: GENERAL PRACTITIONER Date of Birth: Telephone: WORK Code A E-mail address:			
3	Name: VICTORIA ANNE BANKS Address (HOME): Code A Occupation: DOCTOR Date of Birth: Code A Telephone: HOME Code A E-mail address:			
4	Name: DAVID VICTOR MORGAN Address (HOME): Code A Occupation: REGISTERED MENTAL NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
5	Name: ALTHEA EVERESTA GERADETTE LORD Address (HOME): Code A Occupation: CONSULTANT GERIATRICIAN Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
6	Name: JANE C TANDY Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: WORK Code A E-mail address:			
7	Name: MICHAEL I BRIGG Address (HOME): Code A Occupation: DOCTOR Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
8	Name: GILLIAN ELIZABETH HAMBLIN Address (HOME): Code A Occupation: NURSING SISTER G GRADE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
9	Name: PAMELA SUSAN RIGG Address (HOME): Code A Occupation: COMMUNITY STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
10	Name: LYNNE JOYCE BARRETT Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✱ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v _____

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✱	◆
11	Name: FREDA VAUGHAN SHAW Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
12	Name: TINA MARIE DOUGLAS Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
13	Name: BRIDGET AYLING Address (HOME): Code A Occupation: STAFF NURSE GRADE E Date of Birth: Code A Telephone: HOME Code A E-mail address:			
14	Name: SHARON BARBARA RING Address (HOME): Code A Occupation: TEAM LEADER SOCIAL SERVICES Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
15	Name: FIONA LORRAINE WALKER Address (HOME): Code A Occupation: SENIOR STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✱ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✱	◆
16	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
17	Name: MARY ELIZABETH MARTIN Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
18	Name: POLICE CHRISTOPHER SCOTT YATES Address (): Occupation: Detective Constable Code A Date of Birth: Telephone: E-mail address:			
19	Name: POLICE GEOFFREY JAMES QUADE Address (): Occupation: Detective Constable Code A Date of Birth: Code A Telephone: E-mail address:			

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: ASBRIDGE, MARTIN SCOTT

Age if under 18: (if over 18 insert 'over 18') Occupation: GENERAL PRACTITIONER

This statement (consisting of 5 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Martin ASBRIDGE Date: 03/11/2004

I am a practising General Practitioner at the Bridgemary Medical Centre, Gosport . I have been so employed as a GP at this practice since May 1989.

As a GP I had qualified as BMBCh Bachelor of Medicine, Bachelor of Surgery. I obtained these qualifications in August 1984.

From August 1984 to February 1985 I was pre registration house officer in surgery at John Radcliffe House situated in Oxford. From February 1985 to July 1985 I was pre registration house officer in General Medicine at Poole General Hospital.

I obtained full registration with the General Medical Council in July 1985.

My registration number is **Code A**

From October 1985 until February 1986 I was the Senior House Officer in Casualty Department also at Poole General Hospital.

From March 1986 until February 1989 I was a Senior House Officer on the Bournemouth and Poole Vocational Training Scheme for General Practice.

A General Practitioner deals with the day to day care of ill health.

The catchment area for this surgery is the PO12 and PO13 post code areas.

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I am employed by the Gosport and Fareham Primary Care Trust.

I have been asked to detail my involvement with the care of the late Leslie PITTOCK.

Although Mr PITTOCK was not registered with me but with my partner I was his general medical practitioner from May 1989.

I remember Mr PITTOCK as I saw him frequently in the surgery.

Mr PITTOCK suffered from a chronic depressive illness which necessitated him being on anti depressant medication on a long term and continual basis.

A review of his General Practical Medical notes show that he had suffered from depression at least since 1962. Despite him being on medication for depression his mental condition deteriorated from time to time necessitating hospital admissions.

The GP medical notes show that Mr PITTOCK was admitted to Knowle Hospital for in patient treatment on (8) eight occasions during the period 1967 to 1992.

Following hospital admission in April 1992 Mr PITTOCK was discharged to Hazledene Rest Home as his wife felt that she could no longer cope with him at home.

She thought that he had always been a selfish and obsessional person and she had had enough of him.

He was admitted to Hazledene Rest Home in January 1993.

During the 9 months that Mr PITTOCK was an in patient at Knowle Hospital he had 30 (ECT) Electro Convulsive Therapy treatments without any change of his mental state. There were numerous changes in his medication and he was finally discharged on six (6) different types of

psycho copic medication.

Despite this medication Mr PITTOCK's agitation remained to a certain extent.

In March 1993 Mr PITTOCK was reviewed by Doctor BANKS , her medical team together with Mr and Mrs PITTOCK.

Because he remained anxious and depressed it was agreed that he should remain at the rest home with regular review by the community psychiatric nurse (CPN).

He was assessed by Dr BANKS Consultant Psychiatrist on the 26th May 1993 (26/05/21993) when she wanted to try a change in the medication he was receiving. To this end he was again admitted to Knowle Hospital between the 21st June 1993 (21/06/1993) and the 9th July that year.

During this admission the notes states that he seemed to settle well with the new drug regime and appeared less agitated and restless.

On the 3/9/93 (03/09/1993) I visited Mr PITTOCK after he had fallen in the rest home. He had received a soft tissue back injury which required no treatment.

On the 25/9/93 (25/09/1993) Mr PITTOCK was seen by Dr BANKS who at that time recommended no change in his medication.

On the 18/11/93 (18/11/1993) I visited Mr PITTOCK at Hazledene Rest Home when he received treatment for a rash on his groin.

He was next seen by Dr BANKS and her medical team on the 25/4/1994 (25/04/1994) again she found him anxious and depressed but recommended no change in his medication.

In August 1994 he was again reviewed by Dr BANKS who found him chronically depressed

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and again made no changes.

On the 11/10/94 (11/10/1994) Mr PITTOCK was given a flu jab by a colleague from this practice.

Mr PITTOCK was assessed in January 1995 when it was felt that his mental state was deteriorating and new medication was introduced by a locum consultant in old age psychiatry.

He was seen again in Feb and March 1995 but with little change in his mental state.

On the 18th August 1995 (18/03/1995) I was asked to assess Mr PITTOCK by the Hazledene Rest Home staff because of concern about a slow deterioration in his general condition. A physical examination of him showed no abnormalities.

Blood tests were taken at this time which subsequently proved to be normal.

A review of the correspondence in his medical notes shows that he was admitted informally by Dr BANKS to the Mulberry A Ward on the 14/9/1995 (14/09/1995).

According to the notes Mr PITTOCK was discharged on the 24/10/1995 back to Hazledene Rest Home.

During this admission he appeared to improve.

I had no further dealings with Mr PITTOCK after my visit on the 18/8/1995 (18/08/1995).

To summarise Mr PITTOCK's condition he had a chronic intractable depression for which he received continual treatment.

It was apparent in the 5 months before Mr PITTOCK died that his physical condition had also begun to deteriorate.

Signed: Martin ASBRIDGE

Signature Witnessed by:

RESTRICTED

Continuation of Statement of: ASBRIDGE, MARTIN SCOTT

Taken by:DC Code A GREENALL

Signed: Martin ASBRIDGE

Signature Witnessed by:

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: AYLING, BRIDGET

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: STAFF NURSE GRADE E

This statement (consisting of 5 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: B M AYLING Date: 29/10/2004

I am employed by the Fareham and Gosport Primary Care Trust at the Gosport War Memorial Hospital , Gosport. My current role is as staff nurse (grade E). I have held this position since 1996 (I cannot remember the exact month that I obtained this grade).

I undertook pupil nurse training at Southampton University Hospitals of the Royal South Hants and the Southampton General Hospitals from January 1983 to October 1985 where I qualified as an Enrolled Nurse (EN).

My Nursing Midwifery Council No. is Code A which is due for renewal in August 2006.

I only worked for a short period in 1985 before I gave up work later that year to have a family.

I returned to work as an EN in 1989 where I worked at Ashview, a home for mentally handicapped people situated in Bury Road, Gosport.

I then worked at Hollam House Nursing Home.

I commenced working at the Gosport War Memorial Hospital as a C Grade EN on the female ward in June 1990. At this time the ward consisted of 24 beds, the patients were mainly elderly women. This included 6 beds which were allocated for patients undergoing minor surgical work.

Whilst I was working on the ward I upgraded to a D Grade Enrolled Nurse.

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I believe it was in April 1994 that the female ward was transferred to the new building at the Gosport War Memorial Hospital and was renamed Sultan Ward. The male ward was also relocated and was called Daedalus Ward (GWMH).

At the same time Redcliffe Annex transferred all their patients to the new wards at the GWMH which was called Dryad Ward.

As a D Grade EN my responsibilities increased on the ward, these included dispensing medication to patients, liaising with GP's, social workers, occupational therapists.

I was responsible for the direct care of the patients on the ward. I also supervised the nursing auxiliaries and student nurses that worked on the ward.

It was part of my responsibilities to keep myself updated with regards to training in basic procedures such as basic life support, fire procedures, manual handling of patients (ie, lifting patients in and out of bed).

Between October 1994 and November 1995 I completed a conversion course from an EN to a Registered General Nurse (RGN). I qualified as a D Grade. I continued working on Sultan Ward as a D Grade RGN. My responsibilities remained the same.

The sister of Sultan Ward at this time was Joan LOCK. I believe it was sometime in 1996 that I applied for and was successful in obtaining E Grade Staff Nurse.

My responsibilities as an E Grade included managing/running the ward (in the absence of an F or G Grade RGN, ie, senior staff nurse or manager). This included the administration of medication, liaising with the multi-disciplinary team, ie, occupational therapists, physiotherapists, GP's, consultants, social workers and relatives.

Sultan Ward is currently divided into the two teams which are called the green team and the

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blue team.

I am the staff nurse in charge of green team.

The reason the ward has been divided into two teams is to make it easier for the continuity of care and to make it easier for the patients.

In my role as a staff nurse I would accompany the doctor on their ward rounds. I would record/note any changes in mediation into the nursing notes within the patients records. This included any changes to the patients care plan or suggestions made by the Doctor whilst on the ward round. I would also handover the patients care to the next shift. I would detail any changes to patients care or to their medication.

As previously mentioned I have worked at the Sultan Ward for the past 14 years.

There has been a few occasions when I have worked on other wards when there has been a staff shortage.

I have been asked to detail my involvement with regards to the patient Leslie PITTOCK.

I do not remember this patient or any care that may have been administered to him.

I have been shown the drug register, exhibit JD/CDRB/21 for controlled drugs relating to the patient Leslie PITTOCK dated the 19/1/96 (19/01/1996) page 7 and page 16 refer.

I can confirm that I have witnessed the entry by Staff Nurse BARRATT confirming that 20mgs of diamorphine has been drawn up together with 100mgs of the same drug on the 19/1/96 (19/01/1996) for the patient Leslie PITTOCK.

It is policy that two (2) trained nurses must check and record firstly that the quantities of the controlled drugs have been accurately recorded. That the amount remaining that is recorded in

the controlled drug register is correct.

Once this has been established the patients prescription chart would be checked by both nurses to ensure the amount of controlled drug to be given to the patient is appropriate.

Should I note that there was a large discrepancy from the previous dosage administered I would firstly not agree to give the amount out to the patient and then document the reason on the prescription chart and in the nursing notes why this had been done. I would also try to contact the Doctor who had prescribed the drugs initially. However if the initiating Doctor was not available then I would contact the on call Doctor.

If the patient was able to understand I would inform them of the reason for not giving the medication. If this was not possible I would contact the next of kin.

I can confirm that I witnessed the entry by Staff Nurse BARRATT where 100mgs of diamorphine (1x100mg ampoule) has been drawn up, this entry is dated the 19.1.96 (19/01/1996) @ 1500 for the patient Leslie PITTOCK.

Although I was working on Sultan Ward it is apparent to me that I was called down to Dryad Ward to witness S/N BARRATT checking and giving controlled drugs to a patient. There was obviously only one trained nurse working on Dryad Ward at that time.

As S/N BARRATT had signed for the controlled drugs together with other medication to be given via the syringe driver , I would be required to witness the whole procedure. That is I would physically check each ampoule of medication for the amount, the expiry date and the name of the drug to ensure that the correct dosages are drawn up and given to the patient.

I have been using syringe drivers since starting as an enrolled nurse at the female ward at Gosport War Memorial Hospital since 1990.

I was initially given training by other staff nurses competent to use syringe drivers. I would

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have watched/observed trained staff administering medication via a syringe driver. Then I would have administered drugs via a syringe driver under direct supervision of a trained nurse.

I have since attended study sessions on use of the syringe driver at various places. The training has normally been given by the palliative care team.

We were given updates with regards to the new syringe drivers which were introduced approximately 2 years ago.

It is one of my responsibilities to keep myself updated with regards to any changes in procedures.

I had no other dealings with the patient Leslie PITTOCK.

Taken by:DC Code A GREENALL

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: MORGAN, DAVID VICTOR

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: REGISTERED MENTAL NURSE

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

Signed: D V MORGAN Date: 09/09/2004

I live at an address known to the Police.

I am a Registered Mental Nurse (RMN); my General Medical Council number is Code A I qualified in 1991 at Southampton University. I did my training at Knowle Hospital, Wickham, Southampton .

My qualification is the same as a Registered General Nurse, but is specialised in mental health. I am not qualified to work on a general ward.

Upon qualifying in 1991, I worked at Knowle hospital on GALBRAITH ward. This was an acute ward.

In 1995 I moved to ALVERSTOKE ward within the same hospital and when ALVERSTOKE ward moved location to the GOSPORT WAR MEMORIAL HOSPITAL (GWMH) and became MULBERRY ward, I moved with it. This ward is an elderly mental health ward, its patients are aged 65 and over. The ward was divided into three sections, these were 'A' which contained patients who were 'functionally ill'. By this I mean were suffering from something like depression or grief, they were expected to be treated and then discharged. Section 'B' which contained patients who were suffering from the early stages of dementia but would have periods of lucidness and Section 'C'. These patients were suffering from dementia; they would be incontinent, not eating and regressed. They were highly dependant. At this time I would have been involved with the everyday care of the patients, I would have been a 'named nurse' for some of them. By this I mean that I would have been responsible for identifying that individual

patient's problems in relation to their care needs, as apposed to their medical needs. Determining the over all goal in relation to the problem and devising the action plan, the method by which that goal would be attained. I would also be more available for the patient by that I mean I would spend time chatting with them and being the person who they recognised as being 'their' nurse.

As a trained member of staff I would have been responsible for the dispensing of medication to the patients. If the medication was a controlled drug then two members of trained staff would check a patient's prescription and then take the drug out of the controlled drug cupboard, enter the amount taken in the controlled drug book and make an entry on the patient's drug card. Both members of staff would then witness the patient taking their medication.

If the drugs required were not controlled drugs then I would dispense them by myself.
Whilst working on MULBERRY ward I worked an 'in house' shift system. I worked a 0700 - 2100 shift three days a week and then had four days off. I always worked days.

In June 1996, due to disability, I was unable to continue working on the ward and upon my return to work in December 1996, I took up my current post.

I am currently working as a RMN E grade, at Lee Grove House, Gosport. This is an eight bed adult mental health rehabilitation ward. My responsibilities are to teach everyday living skills to people who have become institutionalised, in order to determine the most appropriate environment for them to live in.

I have been asked if I can recall a patient by the name of Leslie PITTOCK .
I do recall this gentleman, I first met him when I was working on ALVERSTOKE ward as a student. It would have been between July and September 1990, I was 21 in the September and this is why I can place the time. I also recall him because he was the father of a lady who worked within the mental health field, a Linda WILES . I had worked with her at HEWITT HOUSE, where she ran the day hospital.

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I remember Les as being a stocky, strong man with grey hair and a beard. I remember him as being chatty but I can not recall anything about his illness. I do remember that he was well known to the team I worked with and was admitted on a regular basis.

I next met Les some 5 to 6 years later when he was admitted to MULBERRY ward from a nursing home. . I cannot remember if I was his named nurse or the nature of his illness at that time.

I recall that he had lost a lot of weight and seemed to be frail and thin in comparison to when I had last met him.

I have been shown a copy of a document identified as BJC/71/pg11. This is the front page of a transfer details form. I can identify the handwriting as mine. This document is filled in when a patient is moved from one ward to another location. This could be another ward in the same hospital or to another hospital or to a care or nursing home
This transfer form relates to Leslie PITTOCK and I have written the following under Section One, Personal Details. MULBERRY ward area A, DRYAD ward. This means that the patient was moved from Mulberry ward 'A' section to Dryad ward at the GWMH.

I have noted his pre-admission address as HAZLEDENE REST HOME, BURY RD, GOSPORT. P.527153

P. means Phone.

I have noted the date and time of transfer as being FRI-5-1-96 (05/01/1996), the patients name as PITTOCK, his forename as LESLIE and that he likes to be known as LES.

Under reason for admission I have put LOW IN MOOD-VERBAL AND PHYSICAL AGGRESSION.

I cannot remember the actual circumstances of Les's admission but from this entry I assume this

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relates to his behaviour in the nursing home. Under date of admission to hospital, I have written 13-12-95 (13/12/1995). This would have been the date that Les came to Mulberry Ward.

Under name of Patient's Advocate, I have written MRS.LINDA WILES (DAUGHTER) Code A

Code A

Under Section Two, Medical Details I have written the following.

Consultant, DR BANKS , Named Nurse, DAVID MORGAN S/N.

From this I can see that I was Les's named nurse but I have no recollection of this.

The S/N stands for Staff Nurse.

I have noted Les's GP as DR ASBRIDGE , telephone number 511541.

Under Relevant Medical History, I have written PARKINSON'S DISEASE. This means that Les was suffering from Parkinson's disease.

Under Current Medication I have written the following, SERTRALINE 100MG NOCTE. This drug is an anti-depressant and was given at night (nocte) LITHIUM CARBONATE 400MG NOCTE. This drug is a mood stabilizer, it would be given for manic depression and mood swings and was again given at night. DIAZAPAM 2MG, T.D.S(8AM 5PM 10PM) (0800 1700 2200). This is a muscle relaxant and sedative and was given three times a day at 8am (0800), 5pm (1700) and 10pm (2200). THYROXINE 15MCG AM ONLY. This is given to people with a thyroid problem and was given in the morning. CEFACLOR 250mg- T.D.S. This is an anti-biotic and was given three times daily. SUBY G- BLADDER WASHOUT-TWICE WEEKLY. This is a brand name for a solution used to clean a patient's bladder.

I have been shown a copy of a document BJC/71/pg12. This is the continuation of the transfer

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details form and the handwriting is mine.

This page is headed Section Three, Nursing Needs.

Under Physical I have written, POOR PHYSICAL CONDITION-BROKEN PRESSURE AREAS TO BUTTOCKS AND HIP. This means that Les had open wounds on his bottom and his hip. FULLY CATHERTERIZED SINCE FLUID RETENTION ON 23-12-95 (23/12/1995). This means that he had been fitted with a catheter on 23-12-05 because he had difficulty passing urine. BROKEN SKIN ON SCROTUM. This means that he had open sores on his scrotum. NURSED ON A PEGASIS MATTRESS. This means that Les had a special pressure relieving mattress. WEIGHT BEARING TO A VERY MINIMAL DEGREE. This means that Les could stand and bear his own weight to a small degree.

From this entire entry I get the impression that Les would only get out of bed to stand next to it with support and that he was nursed in bed most of the time. There is no mention of him requiring a sheep skin in a wheelchair.

Under Psychological I have written, LOW IN MOOD FOR MANY YEARS-ON ANTI-DEPRESSANTS. VERY SETTLED IN BEHAVIOUR DUE TO POOR PHYSICAL CONDITION.

By this I mean that Les had been depressed for many years and that he was prescribed antidepressants for this and that He remained constant in what he did due to his poor physical state.

Under Nutritional I have written, POOR FLUID + DIET INTAKE ALTHOUGH FLUTTUATES AT TIMES AND SOMETIMES BECOMES QUITE GOOD. NEED TO PUSH 'FORTISIPS' DRINK-LES LIKES STRAWBERRY FLAVOUR. LES NEEDS FULL HELP WITH FEEDING/DRINKING. LES SOMETIMES REQUIRES/USES A STRAW TO DRINK.

By this I mean that Les was not eating and drinking much, but this could change and he would improve his intake. Where I have written 'need to push Fortisips drinks.' I mean that Les was to

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be encouraged to drink these milkshake type drinks as they contained vitamins and nutrients.

Where I have written Les needs full help with feeding/drinking I mean that he required help with his meals. This may just take the form of sitting with him and encouraging him to eat or it could mean that he needed to be physically fed.

Where I have written Les sometimes requires/uses a straw to drink. By this I mean that Les would sometimes use a straw to drink with. The ' requires/ uses' would indicate to me that sometimes he may need physical help to drink using the straw and sometimes he would drink by himself using the straw.

Under Social Domestic I have written ALWAYS HAS BEEN A BIT OF A LONER BUT SOMETIMES ASKS STAFF TO SIT WITH HIM. By this I mean that Les didn't mix with the other patients but occasionally would request the company of a member of staff.

I have signed and dated this form 5/1/96 (05/01/1996). I would have completed it on the day of his transfer to Dryad ward.

Taken by:DC Code A ROBINSON

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Form MG11(T)

WITNESS STATEMENT

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

Pittock - No. E1

Statement of: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: Code A

This statement (consisting of 4 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 23/09/2004

I am Code A currently working on Sultan Ward at the Gosport War Memorial Hospital which is under the Fareham and Gosport Primary Care Trust.

Code A

Signed: Code A Signature Witnessed by:

2004(1)

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Code A

I do not remember the patient Leslie PITTOCK .

Code A

Sultan Ward at that time was a GP medical ward. Dryad Ward was a continuing care ward. Daedalus was a stroke rehabilitation ward.

I have been shown a photocopy of the microfiche exhibit ref BJC71, page 15.

Code A

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Continuation of Statement of: Code A

I recognise Staff Nurse MARTIN's handwriting stating that the patient's death Code A Code A Death is verified following a set procedure which is that Staff Nurse MARTIN would have shone a light into the deceased's eyes to ascertain if there was any reaction to the light. She would have checked to see if there was any pulse on the patient's carotid artery. She would have then checked with her stethoscope the patient's/deceased heart.

Once all the vital signs had been checked Staff Nurse MARTIN would Code A Code A Once this was established that there were no signs of life, Staff Nurse MARTIN verified the death of the deceased Leslie PITTOCK.

Code A

Signed: Code A

Signature Witnessed by:

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Continuation of Statement of: Code A

The deceased's personal property was then taken to the Patients Affairs Office where they secured and the room locked.

I cannot remember whether this patient, Mr PITTOCK, was transferred to the mortuary Code A

Code A

I had no other involvement in dealing with this patient.

Code A

It was the responsibility of the Staff Nurse to notify the next of kin of the death.

Taken by:DC Code A GREENALL

Signed: Code A

Signature Witnessed by:

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: Code A

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

Signed: Code A Date: 13/10/2003

I am the above named person and I live at an address known to Hampshire Police.

Code A

I would describe the standard of general patient care at the hospital as excellent, in fact second to none.

Code A

I have no concerns about the use of syringe drivers or diamorphine Code A Code A They are both very effective ways of giving pain relief. If I had had any concerns I would have brought this to the attention of my line manager immediately and if this had not been to my satisfaction I would have gone to the union.

I have no knowledge of any internal investigations at the hospital. I am aware of an ongoing police investigation at the hospital as are all the staff. I only know what I have seen in the papers or on television.

Signed: Code A Signature Witnessed by:

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Continuation of Statement of: Code A

The effect of this investigation on the morale at the hospital is terrible.

Signed: Code A

Signature Witnessed by: