Code A

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

Code A

ELSIE LAVENDER

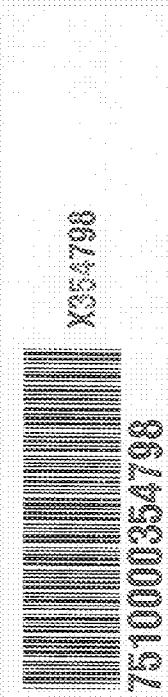
Code A

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

ELSIE LAVENDER



Code A

GENERAL MEDICAL COUNCIL

DR BARTON

Index to Elsie Lavender's File

File 1

1. Summary of Evidence. Missing.
2. Report prepared by Dr Andrew Wilcock dated 1 May 2005. ✓
3. Interview with Dr Jane Ann Barton dated 24 March 2005 at 09:17. ✓
4. Statement of Dr Jane Barton regarding Elsie Lavender. Code A
5. Witness List and Witness Statements given to Hampshire Constabulary. ✓

   (a) Margaret Wigfall dated 11 October 2002.

   (b) Margaret Wigfall dated 20 November 2004.

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

   (d) Fiona Lorraine Walker dated 1 December 2004.

   (e) **Code A**

   (f)

   (g) Sheelagh Ann Joines dated 12 February 2003. ✓

   (h) Sheelagh Ann Joines dated 13 October 2004. ✓

   (i) **Code A**

   (j)

   (k) Catherine Jean Marjoram dated 12 June 2003.

   (l) Catherine Jean Marjoram dated 28 October 2004.

(m) Wendy Ann Edgar dated 22 August 2003.

(n) Wendy Ann Edgar dated 26 October 2004.

(o) Alan William Lavender dated 19 May 2004.

(p) Mary Elizabeth Martin dated 22 September 2004.

(q) Yvonne Ann Astridge dated 25 October 2004.

(r) Yvonne Ann Astridge dated 23 February 2005.

Code A

(s) Code A

(t) Code A

(u) Christine Joice dated 10 November 2004. Code A

(v) Irene Margaret Dorrington dated 2 December 2004. Code A

(w) Code A

(x) Althea Everesta Geradette Lord dated 10 December 2004.

(y) Margaret Rose Couchman dated 15 December 2004.

Code A

(z) Code A

(aa) Patricia Elizabeth Wilkins dated 3 February 2005. Code A

(bb) Pamela Susan Rigg dated 10 February 2005.

(cc) Code A

(dd) Christopher Scott Yates dated 4 April 2005. Code A

(ee) Geoffrey James Quade dated 6 April 2005.

1

2

REPORT

regarding

ELSIE LAVENDER (BJC/30)

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

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

Mrs. Lavender was a frail 83 year old with significant medical problems. She was admitted to the Royal Naval Hospital, Hasler, Gosport, following a fall down her stairs, following which she found it difficult to walk or move her hands or wrists. She complained of pain across her shoulders and down her arms. A hypoglycaemic episode (low blood sugar) was considered a possible cause of her fall. She was seen by Dr Tandy 11 days later who documented some improvement in her mobility and abnormal neurological findings. Her conclusion was that Mrs Lavender had suffered a brain stem stoke and she was transferred to Gosport War Memorial Hospital, Daedalus Ward for rehabilitation.

During this admission, the medical care provided by Dr Barton was suboptimal: there was a failure to keep clear, accurate, and contemporaneous patient records; there was inadequate assessment of Mrs Lavender's condition, in particular her pain; symptoms and signs that warranted an examination were not acted upon (e.g. search for a possible infection due to raised white cell count, increased blood sugars and insulin requirements; a neurological examination due to her increasing back pain, urinary retention; and faecal incontinence). The morphine prescribed for Mrs Lavender's pains, may have been inappropriate (the type of pains she had may not have been that responsive to opioids) or excessive (as the dose was increased or as her kidney function deteriorated) and the possible role this may have had in her deterioration was not considered. Treatments were continued that may have aggravated her condition (e.g. the diuretic). Ultimately Mrs Lavender was prescribed doses of diamorphine and midazolam that were excessive for her needs.

If it were that Mrs Lavender had naturally entered the terminal phase of her life, at best Dr Barton could be seen as a doctor who whilst failing to keep clear, accurate, and contemporaneous patient records had in good faith been attempting to allow Mrs Lavender a peaceful death, albeit with what appears to

be an inappropriate and excessive use of medication due to a lack of sufficient knowledge. However, in my opinion, based on the medical and nursing records, there is reasonable doubt that Mrs Lavender had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lavender by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lavender by not carefully assessing the possible causes of her decline that may have been reversible with appropriate treatment (e.g. antibiotics for an infection, stopping the diuretics, reducing the dose of morphine) and unnecessarily exposing her to possibly inappropriate and excessive doses of morphine and ultimately excessive doses of diamorphine and midazolam that could have contributed more than minimally, negligibly or trivially to her 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 her death against the acceptable standard of the day. Where appropriate, if the care is felt to be suboptimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

3. ISSUES

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

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

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

4. BRIEF CURRICULUM VITAE

Code A

5. DOCUMENTATION

This Report is based on the following documents:

[1] Set of medical records on paper and CD-ROM of Elsie Lavender (BJC-30).

[2] Set of medical records on paper of Elsie Lavender (JR-11A).

[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) 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).

[11] Medical report regarding Elsie Lavender (BJC/30) Dr James Gillespie.

6. CHRONOLOGY/CASE ABSTRACT

Events at the Royal Naval Hospital

Mrs Elsie Lavender, an 83 year old widow who lived alone, was admitted on the 5th February 1996 to the Royal Naval Hospital, Hasler, Gosport under the care of Surgeon Commander Taylor, following a fall down her stairs at home. Mrs Lavender had no recollection of the fall but a pool of blood was found at the top of her stairs (page 154 of 695) and she was found at the bottom. She sustained a full thickness (down to the bone) laceration to her forehead that required suturing and a more superficial one to her right shin (page 145 of 695). She complained of pain in both shoulders, but not initially of neck or back pain (page 141 of 695). She reported that she was unable to move her right fingers. When examined by the casualty officer her cervical spine was apparently normal (page 141 of 695), she was tender over the right shoulder and upper left arm (page 143 of 695) and although able to move her right fingers the strength was reduced (graded 3/5; active movement against gravity (but not resistance)) The plantar reflex (elicited by firmly stroking up along the outer edge of the sole of the foot and across the base of the toes) was abnormal in her right foot as it was 'up-going', i.e. the big toe ± other toes extend upwards, when normally they flex downwards (page 145 of 695). This suggests damage to the nerves responsible for muscle movements somewhere along their path from the brain and down the spinal cord. X-rays of her chest, skull and both shoulders were performed. All were regarded as normal (page 145 of 695). In his report, Dr Gillespie states that the chest X-ray was essentially

normal but that the skull x-ray was missing from the x-ray packet. Given the severity of the fall and uncertain nature of its cause, Mrs Lavender was admitted under the medical team for observation and investigation. Her past medical history revealed her to be an insulin dependent diabetic for many years, asthmatic, registered blind and to have atrial fibrillation (an irregular heart rhythm). She had been admitted 11 months earlier following a collapse most likely due to hypoglycaemia (low blood sugar) (page 479 of 695). A neurological examination carried out by the medical senior house officer reported normal tone, power 4/5 (active power against gravity and resistance (but reduced from normal)) in her arms and legs, and 'can move fingers and thumb' (page 152 of 695). No sensory deficit is recorded, but this may reflect a cursory examination; previously reduced sensation in Mrs Lavender's hands and feet had been found in keeping with damage to her nerves, most likely from her diabetes (pages 48, 295 of 695). Reflexes were recorded as normal in both her arms. In her legs, her knee reflexes were normal, both ankle reflexes were absent and her right plantar reflex was up-going (page 152 of 695). Results of blood tests suggested an iron-deficiency anaemia with a haemoglobin of 9.7g/dl. There were no other signs or symptoms suggestive of chronic blood loss. White cell and platelet counts were normal (page 154 of 695). Her son reported that recently her blood sugars had been on the low side and she had experienced a very low sugar one month earlier (hypoglycaemic episode) that required treatment by the district nurses (page 154 of 695). Hypoglycaemia was thus considered a possible cause of her fall (page159 of 695).

On the 6th February, Mrs Lavender complained of pain in right arm. Examination revealed tenderness over the bone and muscles of the arm

and her hands were swollen (page 155 of 695). Later that day, she developed a raised temperature and was commenced on antibiotics empirically, as no obvious source of infection was found (page 156 of 695). Mrs Lavender temperature settled and she received 2 weeks of antibiotics, finishing on 19th February 1996 (page 687 of 695). On the 7th February, she complained of left shoulder/upper arm pain (page 156 of 695). On the 8th February, she was seen by the physiotherapist who noted that Mrs Lavender would not make any voluntary active movement when requested due to pain in both shoulders. When the physiotherapist moved her arms for her (passive/assisted movement) there was a full range of movement in both shoulders. She was only able to stand with the help of two others and took a few steps only. The physiotherapist concluded that the pain in the shoulders was a major problem (page 157 of 695). She was prescribed coproxamol 2 tablets every 6 hours and dihydrocodeine 30mg every four hours as required (page 690 of 695). The use of both of these analgesics was very variable. The most taken in one day was on the 12th February when 3 doses of coproxamol and 2 doses of dihydrocodeine were given (page 690 of 695).

Entries on the 9th and the 12th February report that pain in the arms/shoulders continued (page 158 of 695). Her blood sugars were low and her dose of insulin was reduced. A repeat haemoglobin on the 12th February was 10.1g/dl, platelet and white cell counts were normal (but the lymphocyte count reduced at 1.21×10^9/L)(page 205 of 695). Biochemistry revealed a low sodium 132mmol/l (lower limit 134mmol/l), total protein 60g/l (lower limit 63g/l) albumin 30g/l (lower limit 39g/l) and a raised urea 9.3mmol/l (upper limit 6.1mmol/l), alkaline phosphatase 401IU/l (upper limit

126IU/l) and gamma-glutamyl transferase 139IU/l (upper limit 78IU/l)(page 179 of 695). Apart from the haemoglobin, alkaline phosphatase and gamma-glutamyl transferase (latter two not tested) the remaining haematological and biochemical abnormalities were present at least 11 months earlier (pages 175 and 183 of 695).

On the 13th February she was referred for a geriatrician review and was seen by Dr Tandy, Consultant in Geriatrics on the 16th February 1996 (pages 159 and 162 of 695). In the letter summarising that assessment, Dr Tandy noted that Mrs Lavender complained of weakness in both her hands and difficulty standing since her fall along with pain across her shoulders and down her arms. Mrs Lavender felt that the mobility was starting to improve in her hands. She had stood with the help of the physiotherapist but was still requiring two nurses to help transfer (page 5 of 103). The iron-deficiency anaemia and long-standing stress incontinence were noted (page 5 of 103).

Examination by Dr Tandy confirmed weakness of both hands and wrists, (power of 4/5; active power against gravity and resistance (but reduced from normal))(page 163 of 695). Sensation to light touch was reduced in the right hand in the area supplied by the median nerve (thumb, index, middle and adjacent half of the ring finger) that Dr Tandy considered due to long-standing entrapment of the median nerve at the level of the wrist (carpel tunnel syndrome). Reflexes were generally reduced and her ankle jerks were absent. Her plantar reflex was up-going on the left but not the right (page 163 of 695 and page 5 of 103). *This is opposite to what was found before.*

Dr Tandy was under the impression that Mrs Lavender's neck (cervical spine) had been x-rayed and assumed this was normal. This is incorrect, Mrs Lavender had had only skull, shoulder and chest x-rays. Dr Tandy's assessment was that she had most likely experienced a brain stem stroke leading to her fall (page 163 of 695 and page 5 of 103). Atrial fibrillation is a risk factor for stroke as small blood clots can form in the heart that then travel to the brain to cause a stroke. Dr Tandy placed Mrs Lavender on the waiting list for transfer to Gosport War Memorial Hospital for rehabilitation to try and get her home (page 164 of 695).

Physiotherapy and medical entries on the 20th February 1996 noted that Mrs Lavender's upper limb function was improving as she was starting to feed herself (but not able to use cutlery) but that she still complained of shoulder pain. Mrs Lavender still required the help of two people to stand and could not use a walking aid because of hand weakness. Iron was prescribed for her anaemia (pages 165 and 166 of 695).

A repeat full blood count on the 21st February revealed an increased haemoglobin of 11.0g/dl (normal) and a fall in her platelet count to $120x10^9/l$ (lower limit $150x10^9/l$). This result was signed, but not dated by one of the medical team (page 201 of 695). There is no entry in the notes commenting upon this result.

Over the course of Mrs Lavender's admission her blood sugars remained variable, either too high or too low, and the dose of insulin had to be altered several times (pages 665, 666, 660, 659 and 687, 689, 681, 682 of 695).

Events at Gosport War Memorial Hospital

Mrs Lavender was transferred to Daedalus Ward, Gosport War Memorial Hospital on the 22nd February 1996, under the care of Dr Lord. The Royal Naval Hospital nursing transfer form noted that Mrs Lavender's medication consisted of digoxin 125microgram once a day (for her atrial fibrillation), co-amilofruse (frusemide 40mg and amiloride 5mg) 1 tablet once a day (a diuretic or 'water tablet'), salbutamol inhaler 2 puffs four times a day, becotide inhaler, 2 puffs twice a day, mixtard insulin 24 units in the morning, 12 units in the evening and iron sulphate 200mg twice a day (page 71 of 103). She was however, also still taking coproxamol 2 tablets or dihydrocodeine 30mg as required, and had taken a total of 2 coproxamol and 30mg of dihydrocodeine on the 21st February 1996 (page 684 of 695). Mrs Lavender required minimal assistance with feeding but full assistance with her hygiene needs. There were ulcers on both legs dressed every other day. Her pressure areas were intact although the skin over the buttocks was red (page 71 of 103).

There are six entries in the medical notes that cover a period of 13 days, taking up just over one page in length (pages 44 and 45 of 103). They are brief and make events difficult to follow in any depth. What follows is a record of events summarised from the medical notes, summary notes and nursing care plan.

The entry in the medical notes dated 22nd February 1996, reads 'Transferred to Daedalus Ward, GWMH. PMH (past medical history) fall at home from the top to the bottom of the stairs, laceration on head. Leg ulcers, severe incontinence needs a catheter. IDDM (insulin dependent diabetes mellitus) needs mixtard insulin bd (twice a day), regular series

B.S. (blood sugars), transfers with 2, incontinence of urine, help to feed and dress. Bartell 2. Assess general mobility. ?suitable rest home, if home found for cat' (page 45 of 103). Pain was not mentioned nor assessed in the medical notes. In the summary notes, it was noted that Mrs Lavender experienced pain in her arms and shoulders (page 91 of 103). Her medication was continued unchanged (pages 65, 66, 67 of 103), apart from an increase in the dose of dihydrocodeine to 60mg to be taken as required (page 65 of 103).

The medical notes entry on the 23rd February 1996 reported that Mrs Lavender was catheterised the previous night and that there was some residual urine. The summary notes report that 750ml of urine was drained in the first hour (page 91 of 103) and the nursing care plan reports that one litre or more of urine was drained within 1½ hours after catheterisation (page 75 of 103). This suggests that Mrs Lavender was in urinary retention with 'overflow' incontinence of urine. Blood and protein was found in the urine and trimethoprim (an antibiotic) prescribed for a presumed urinary tract infection (pages 45, 67 and 91 of 103). It is unclear if a sample of urine was sent for microbiology; I could find no results in the notes. Blood for routine haematology and biochemistry testing was taken on 23rd February 1996 (page 91 of 103). The blood count revealed a further drop in the platelet count ($36x10^9$/L)(page 58 of 103). It was commented on the results form that as it was a very small sample, the validity of the platelet count was in question and an early repeat was suggested (page 58 of 103). The main findings of the biochemistry testing were a low sodium at 133mmol/L (stable; probably due to her diuretic therapy) and a raised alkaline phosphatase at 572 IU/L (increasing). As the

alkaline phosphatase can be increased in liver or bone problems, identifying the liver or bone isoenzyme can help differentiate between the two. The isoenzyme test was 'to follow' but I can find no result in the notes (pages 41 and 42 of 103). However, the recent finding of a raised gamma-glutamyl transferase suggests it was more likely liver.

On the 24th February 1996 the summary sheet reports that pain was not controlled properly by DF118 (the dihydrocodeine). Mrs Lavender had received four doses of dihydrocodeine 60mg on the 23rd February and one dose at 06.03 on the 24th February 1996 (page 65 of 103). She was seen by Dr Barton and commenced on MST 10mg twice a day (pages 67 and 91 of 103). MST is a slow release formulation containing morphine. There is no medical notes entry on the 24th February 1996 that details the pain problem or the commencement of the morphine.

No additional dihydrocodeine was requested by/offered to Mrs Lavender on the 25th February (she only had two further doses, one on the afternoon of the 3rd March and one on the morning of the 5th March 1996), but the summary sheet entry at 19.00 hours on the 25th February reports that Mrs Lavender appears to be in more pain, screaming "my back" when moved but uncomplaining when not (page 92 of 103).

On the 26th February 1996, the medical notes reported 'not so well over weekend. Family seen and well aware of prognosis and treatment plan. Bottom very sore, needs Pegasus mattress, institute SC (subcutaneous) analgesia if necessary' (page 45 of 103). The summary notes report that Dr Barton increased the MST to 20mg twice a day (page 92 of 103). At 14.30 hours they note Mrs Lavender's son and his wife were seen by Dr Barton '...prognosis discussed. Son is happy for us to just make Mrs

Lavender comfortable and pain free, syringe driver explained' (page 92 of 103). Mrs Lavender was prescribed on the 'as required' section of the drug chart a syringe driver containing diamorphine 80–160mg and midazolam 40–80 mg (page 65 of 103). There was no explanation in the medical or nursing notes of why it was that Mrs Lavender's prognosis was apparently limited. This dose of diamorphine approximately equates to a 6–12-fold increase in Mrs Lavender's dose of morphine. It was however, never used. The summary sheet noted that due to a high blood sugar, Mrs Lavender's dose of insulin had to be increased (pages 62 and 92 of 103).

The full blood count was repeated on the 27th February 1996 and revealed a further fall in the platelet count 22 x 10^9/L, an increased white blood cell count 13 x 10^9/L, due to an increase in neutrophils (10.8 x 10^9/L) and a normal haemoglobin 12.5g/dL (page 57 of 103). The biochemistry tests for renal function were also repeated on the 27th February 1996. The urea and creatinine had both increased, to 14.6mmol/L and 120micromol/L respectively, in keeping with a deterioration in kidney function (page 42 of 103). There is no mention of these results in the medical notes and no further investigation or consideration for the causes of the low platelet count, raised white cell count or deteriorating renal function. On the 27th February 'painful shoulders and upper arms' became part of the nursing plan (page 84 of 103). An entry reports 'analgesia administered, fairly effective' (page 84 of 103).

On the 29th February 1996, the summary sheet noted that due to a high blood sugar, Mrs Lavender received an additional dose of human actrapid insulin (pages 62 and 92 of 103). Mrs Lavender received two doses in all, before the prescription was crossed off (page 62 of 103).

Entries in the 'painful shoulders and upper arms' nursing care plan each day between 28th February and 4th March 1996 seem to suggest that the pain was mainly on movement and on the 2nd and 3rd of March it was described as 'slight' (page 83 of 103).

Nursing care plan notes from 1st March to the 6th March 1996 reported leakage of faecal fluid, despite rectal digital examination (excluding faecal impaction), suppositories and a manual evacuation (pages 85 and 87 of 103).

There is no mention of pain in the summary notes or medical notes again until the 4th March 1996. The summary notes reported 'Patient complained of pain and having extra analgesia p.r.n (as required). Oramorph sustained release tablets dose increased to 30mg b.d. (twice a day) by Dr Barton (pages 62 and 92 of 103). The Oramorph SR tablets are a different brand of slow release morphine, similar to MST. There is no medical notes entry on the 4th March 1996 that details the pain problem or the increase in the morphine. In the nursing plan notes, the entry for the 4th March 1996 reads 'seen by physio- exercises:- 3 turns of head to right + 5 neck retractions every 2 hours. Elsie needs reminding. Analgesia increased' (page 83 of 103).

The next entry in the medical notes, on the 5th March 1996, reads 'Has deteriorated over the last few days. Not eating or drinking. In some pain, therefore start SC analgesia. Let family know' (page 45 of 103). The summary note entry for the 5th March 1996 reads 'patients pain uncontrolled, very poor night. Syringe driver commenced 5th March 1996 at 09.30 hours, containing diamorphine 100mg and midazolam 40mg...' (page 92 of 103). Both drugs were written as a range, i.e. diamorphine

100–200mg and midazolam 40–80mg; although neither dose needed adjusting (page 65 of 103). A dose of diamorphine 100mg approximately equates to a 5-fold increase in Mrs Lavender's dose of morphine. The nursing care plan notes 'pain uncontrolled, patient distressed, syringe driver commenced 09.30, son informed' (page 83 of 103).

On the 6th March 1996 the medical notes entry reads 'Further deterioration. SC analgesia commenced. Comfortable and peaceful. I am happy for nursing staff to confirm death' (page 45 of 103). The summary sheet entry for the 6th March 1996 reads 'seen by Dr Barton. Medication other than through syringe driver discontinued as patient unrousable' (page 93 of 103). The next entries in the medical notes and summary sheet were at 21.28 hours, the pronunciation of Mrs Lavenders death (pages 45 and 93 of 103). I am advised that on the death certificate, the cause of death was stated as 1a Cerebrovascular accident and 2 Diabetes Mellitus.

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Syringe drivers, diamorphine and midazolam

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 2–4 hour 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 patient's 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 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.

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

Mrs Lavender was a frail 83 year old with insulin dependent diabetes mellitus who was admitted following a serious fall from the top to the bottom of her stairs. Initially, it was considered likely that the fall was due to a hypoglycaemic episode (low blood sugar). She was at risk of hypoglycaemia as her blood sugars had recently been running low. Following the fall, Mrs Lavender complained of pain across her shoulders and down her arms and was unable to use her hands or to stand. Examination confirmed weakness in the right hand and an 'up going' plantar reflex in her right foot. Investigations revealed iron deficiency anaemia. Pain in her shoulder and arms continued, although there had been some improvement in the use of her hands by the time Dr Tandy saw her (11 days after admission). On examination she found weakness of both hands and wrists and an 'up going' plantar reflex in the left foot. Dr Tandy's opinion was that Mrs Lavender had suffered a brain stem stroke. Mrs Lavender's diabetes and atrial fibrillation would increase her risk of having a stroke. In my current practice I no longer see patients who are admitted with a stroke and Dr Tandy's experience will be greater than mine. However, given that Mrs Lavender had recently experienced a severe fall, I am unsure how certain one could be in attributing all of Mrs

Lavender's symptoms and signs as being caused by a brain stem stroke, particularly as her neurological findings could also be in keeping with cervical spinal cord and nerve root trauma sustained in the fall down the stairs. I would have thought it prudent whatever the findings on the initial examination of the cervical spine in casualty to have obtained a cervical spine X-ray. Whatever the cause of her fall, when considering Mrs Lavender's pain, it is my opinion that:

1. Mrs Lavender's pain across her shoulders and into her arms was most likely to be related to her fall.
2. Her pain was likely to be a 'mixed' pain; that is originating from damage to muscles and soft tissues (e.g. ligaments) of the neck and, possibly from impingement on the nerve roots and spinal cord within the cervical spine. Muscle and nerve injury pain respond poorly to strong opioids.
3. As her injuries healed over subsequent weeks, it is reasonable to expect that the pain would also settle. As such, failure of the pain to settle or any worsening of the pain should, in my view, prompt a careful reassessment that includes appropriate investigation, e.g. a cervical spine imaging (given her neurological findings) and certainly the area of the spine causing Mrs Lavender to scream out in pain "my back" (page 92 of 103). I am unable to find in the notes which part of her back this pain was.

Events at Gosport War Memorial Hospital

Infrequent entries in the medical notes make it difficult to closely follow Mrs Lavender's progress over the last two weeks of her life. There are six entries, taking up just over one page in length.

Mrs Lavender's most relevant problems during her stay, in summary and in approximate chronological order, appear to have consisted of weak hands and

wrists, poor mobility, pain in her shoulders and arms that was mainly on movement for which she went on to receive increasing doses of morphine; urinary retention and a probable urinary tract infection; a falling platelet count; being generally 'unwell'; increased blood sugars and insulin requirements; increasing white cell count, deteriorating renal function; leakage of faecal fluid; worsening of her pain and further deterioration. A syringe driver was then commenced with doses of diamorphine and midazolam sufficient to render her unresponsive until she died 36 hours later. Her cause of death was registered as cerebrovascular accident. A lack of assessment and documentation make the validity of this difficult to comment upon, but her final deterioration as outlined in the nursing and medical notes does not appear in my opinion to be typical of a cerebrovascular accident. Based on the sequence of events and biochemical and haematological findings, it seems more likely that her immobility resulting from her fall, led to an infection. Given that Mrs Lavender had suffered a recent accident that may have contributed in some way to her death, it is usual practice to discuss such deaths with the coroner.

There is a lack of documentation to demonstrate that there had been an adequate assessment of many of the problems Mrs Lavender had through the undertaking of an appropriate history, physical examination and investigation.

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

The medical care provided by Dr Barton to Mrs Lavender following her transfer to Gosport War Memorial Hospital, Daedalus Ward is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (General Medical Council, Good Medical Practice, 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; providing or arranging investigations or treatment where necessary; taking suitable and prompt action when necessary; referring the patient to another practitioner when indicated
- in providing care you must keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs or appliances that serve the patients' needs.

Specifically:

i) The notes relating to Mrs Lavender's transfer to Daedalus Ward are inadequate. On transfer from one service to another, a patient is usually re-clerked highlighting in particular the relevant history, examination findings and planned investigations to be carried out.

ii) The cause of Mrs Lavender's urinary retention was not assessed.

iii) Mrs Lavender was treated for a urinary tract infection with the antibiotic trimethoprim. Neither a diagnostic urine specimen nor a check urine specimen (to see if the infection had cleared) were sent for microbiology. It is therefore unclear if the urinary tract infection was successfully treated or not. This should have been considered when Mrs Lavender was noted to be 'not so well' (see point v).

iv) There is a lack of medical notes relating to the pain or its assessment and the commencement of morphine (MST 10mg) twice a day on the 24th February 1996.

v) On the 26th February 1996 the medical notes report Mrs Lavender to be 'not so well over weekend'. There is a lack of detail that explains in what way she was not so well. There are no records that an appropriate history, examination or investigations had been undertaken to try and determine the reason for Mrs Lavender feeling less well. Instead, without any assessment of the pain, the MST was increased to 20mg twice a day and a syringe driver prescribed to be used 'as required' that contained diamorphine and midazolam in doses that would be excessive to Mrs Lavenders needs.

vi) Blood tests from the 27th February 1996 revealed a low platelet count and deteriorating kidney function. There is no mention of this in the medical notes, and no action was taken.

vii) On the 29th February 1996 there is no mention in the medical notes that Mrs Lavender's blood sugars were high requiring additional doses of insulin. The fact that this could have been due to an untreated infection does not appear to have been considered.

Despite entries in the nursing care plan and summary sheets relating to Mrs Lavender's pain there is no mention of this in the medical notes.

viii) The nursing care plan reports leakage of faecal fluid. There is no mention of this problem in the medical notes or consideration of the possible significance of this symptom given Mrs Lavenders history of trauma.

ix) The morphine was increased again on the 4th March 1996. There is no pain assessment or entry in the medical notes that relates to this increase.

x) The entry in the medical notes of the 5th March reports that Mrs Lavender had deteriorated over the last few days. It is not clear in what way she had deteriorated. There is no history or examination that considers the possible reasons for her decline.

xi) Mrs Lavender's pain appeared poorly controlled on the night of the 4th March but there is no assessment of the pain in the medical notes prior to a syringe driver containing diamorphine 100mg and midazolam 40mg being commenced. The doses of diamorphine and midazolam used in response to Mrs Lavender's worsening pain, are excessive for her needs, even if it were considered that her pain was morphine responsive and she was dying from natural causes.

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

Issue i (failure to take an adequate history and examination on transfer; failure to keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed)

Upon her transfer to Daedalus Ward there should have been an adequate assessment of Mrs Lavender's condition based on the history and clinical signs and, if necessary, an appropriate examination. In my view there is inadequate documentation of Mrs Lavender's relevant history, in particular a lack of an assessment of her pain. As the Wessex guidelines (page 2) point out, an accurate pain assessment is essential both for diagnostic and therapeutic purposes. An assessment should have included as a minimum the noting of the site, severity, aggravating/relieving factors that together with a physical examination would help identify the most likely cause(s) of the

pain(s). This was important as it was likely that Mrs Lavender would have been experiencing several different types of pain as a result of her injury. There may have been soft tissue, muscle and nerve injury pains. Muscle and nerve injury pains are less likely to respond to opioid analgesics. This is highlighted in the Wessex protocol (page 3) 'remember some pains are opioid responsive, others are only opioid semi-responsive and need other approaches'.

There was no physical examination of Mrs Lavender on her transfer. This would be important to act as a baseline against which to compare any future changes. A thorough neurological examination would have been particularly important given the history of her fall, the possibility of a brain stem stroke being raised and the abnormal neurological findings mentioned in Dr Tandy's letter.

Issue ii (failure to adequately assess the patient's condition)

Urinary retention is rare in women and should have prompted an assessment to explore the possible causes of it in Mrs Lavender. Long-standing diabetes can cause damage to the nerves controlling bladder function and may have been responsible. Another cause of urinary retention is injury to the spinal cord. Given Mrs Lavender's history of a severe fall and complaints of back pain, in my opinion she should have been reassessed, including a careful neurological examination. This would have included assessment of anal tone and perineal sensation.

Issue iii (failure in providing or arranging investigations or treatment where necessary; taking suitable and prompt action when necessary; failure to adequately assess the patient's condition)

A urinary tract infection is sometimes treated 'blind' with antibiotics such as trimethoprim, without obtaining a sample of urine for microbiology. The risk with this practice is that the bacteria causing the infection may be resistant to the antibiotic. If there are reasons to doubt that the infection is responding to

treatment, e.g. patient remains unwell, urinary symptoms persist, then a urine specimen should be sent for microbiology testing and/or consideration given to changing the antibiotic.

Issues iv and ix (failure to adequately assess the patient's condition; failure to keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed)

Given that Mrs Lavender's pain required frequent 'as required' doses of dihydrocodeine immediately after her transfer, it was reasonable to provide her with analgesia on a regular basis. An assessment of the pain should however have been done in order to determine the cause(s) of her pain(s) as this would influence the way the pain(s) were managed. For example, were non-drug methods such as positioning, massage, TENS (transcutaneous electrical nerve stimulation) appropriate? If drug measures were considered appropriate, and the pain was considered to be opioid responsive one option would have been to combine the use of paracetamol (step 1 analgesic) with the dihydrocodeine (step 2 analgesic) regularly. If reasonable doses of dihydrocodeine were not relieving the pain some practitioners may well commence a small dose of morphine as Dr Barton did. However, if the pain was not particularly opioid responsive, the dihydrocodeine or morphine may do little or nothing for the pain but could expose the patient to unwanted effects of opioids, e.g. drowsiness, delirium, nausea, vomiting etc. This is relevant, as given her traumatic fall, muscle or nerve injury pain that generally respond poorly to opioids may have been significant factors in Mrs Lavender's pain. Further, it was commented upon that Mrs Lavender was comfortable at rest, only to be in pain when moved (termed 'incident' pain). These can be difficult pains to manage, even if opioid responsive, as the dose of opioid required to improve the pain on movement can be excessive for the patient whom for the

majority of the time is resting and pain free. Typically in this situation the patient becomes increasingly drowsy as the dose of opioid increases.
Despite increasing the morphine dose, a thorough pain assessment was not carried out.

Issues v, vi and vii (failure to adequately assess the patient's condition; failing in providing or arranging investigations or treatment where necessary; taking suitable and prompt action when necessary; failure to keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed; failure to prescribe only the treatment, drugs or appliances that serve the patients needs)

There was a failure to adequately assess and document clearly why Mrs Lavender was less well around the 26th February. This should have been based on a history, examination (e.g. temperature, chest) and findings of appropriate investigations (e.g. urine specimen for microbiology). Mrs Lavender was at increased risk of infection due to her immobility and diabetes, and this should have specifically been considered as a cause for her being less well. Other findings that pointed to the possibility of there being an infection, e.g. the raised blood sugars, increased insulin requirements, raised white cell count and falling platelet count do not appear to have been acted upon.

In the absence of a diagnosis that explained why Mrs Lavender was less well, it is unclear what information Dr Barton was in a position to give Mrs Lavender's son regarding his mother's situation and prognosis. Unless Mrs Lavender was clearly entering her terminal stage and was actively dying, it would have been appropriate to have made reasonable efforts to identify the cause of her feeling less well as it could have been treatable. Even if she were considered to be dying, it would be unusual to respond by prescribing a

syringe driver 'as required' that contained doses of diamorphine and midazolam that were excessive to her needs (see technical issues).

The causes of Mrs Lavender's low platelet count and deteriorating kidney function should have been considered in light of her overall situation. There are many causes of a fall in platelet count, and infection is one. It does not appear that Dr Barton discussed this finding (or Mrs Lavender's situation at any point) with a consultant or obtained advice specifically about the low platelet count from a haematologist. The decline in kidney function could have been due to a urinary tract infection not responding to the antibiotics and this should have been actively considered. Alternatively, as she was less well, she may have been drinking less and as a result had become dehydrated. Mrs Lavender's diuretic (water tablet) that could aggravate the situation was continued unchanged when stopping it should have been considered. With a deterioration in her kidney function, the possibility that cummulation of the metabolites of morphine could have been contributing to her decline was not considered.

Issue viii (failure to adequately assess the patient's condition)

There is no mention of the problem of faecal leakage in the medical notes. There are a number of possible reasons why Mrs Lavender may have been experiencing this, including her age, diabetes, immobility and diarrhoea. As it can also be caused by injuries to the brain or spinal cord, this symptom is significant given Mrs Lavenders history of a severe fall, her other symptoms and complaints of back pain. There should have been a neurological examination that would have included assessment of anal tone and perineal sensation.

Issue x (failure to adequately assess the patient's condition; failing in providing or arranging investigations or treatment where necessary; taking suitable and prompt action when necessary; failure to keep clear, accurate, and

contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed; failure to prescribe only the treatment, drugs or appliances that serve the patients needs)

Although Mrs Lavender was reported to have further declined, there was no clear documentation in what way this was. There should have been a search for the possible causes in case these were reversible. In particular, an infection should have been ruled out.

Given the expectation that the pain should improve as her injuries healed, a reason for the pain worsening on the evening of 4th March should have been sought. For example, were there new findings on examination? Had her neurology altered?

As the pain had got worse despite increasing the morphine, consideration should have been given to the fact that the pain was not responding to the morphine. This should have prompted an assessment of the causes of her pain and review of her treatment. If her pain was not responsive to morphine, was the amount she was taking too much? Was this playing a part in her deterioration?

Issue xi (failure to keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed; failure to prescribe only the treatment, drugs or appliances that serve the patients needs)

The medication used in response to Mrs Lavender's worsening pain, detailed below, appears excessive for her needs, even if it were considered that her pain was morphine responsive and she was dying from natural causes. Medication to control symptoms is usually commenced at a starting dose appropriate to the patient (e.g. considering age, frailty etc.) and their particular

symptom control needs and titrated upwards only to control these symptoms without necessarily rendering the patient unresponsive. There is no justification given for how the doses of diamorphine and midazolam were determined for Mrs Lavender. Using a 1:2 or 1:3 dose conversion ratio to calculate the dose of subcutaneous diamorphine from her oral morphine dose, Mrs Lavender's dose should have been in the order of 20–30mg of diamorphine per day. A daily dose of diamorphjne of 100mg (with scope to increase the dose to 200mg a day) is likely to be excessive for Mrs Lavender's needs and to cause drowsiness. Increasing doses of opioids excessive to a patients needs are also associated with an increasing risk of delirium, nausea and vomiting and respiratory depression. There are no 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 any drug as a range is generally discouraged. Doctors, based upon an assessment of the clinical condition and needs of the patient should decide on and prescribe any change in medication. Such decisions should not be left to a nurse.

The daily dose of midazolam was prescribed as 40–80mg. There is no justification within the medical notes for the use of midazolam. Although the nursing care plan notes that Mrs Lavender was distressed, this appeared to relate to her uncontrolled pain. It is usual practice in this situation to concentrate on providing pain relief rather than on sedating the patient. If a patient is particularly distressed, small doses of sedative are sometimes given, but usually on an 'as required basis' whilst awaiting any changes made to the analgesia to become effective. In this regard, midazolam 2.5mg by intermittent SC injection would have been reasonable. The dose of 40mg of midazolam is likely to lead to drowsiness in a frail elderly patient. If Mrs

Lavender was considered to have muscle spasm, terminal agitation, or anxiety then a smaller daily dose such as 10mg may have sufficed. Again, there are no prescribing instructions on why, when and by how much the dose can be altered within this range and by whom.

If there were concerns that a patient may experience, for example, episodes of pain or anxiety, it would be much more usual, and indeed seen as good practice, to prescribe appropriate doses of morphine/diamorphine, or diazepam/midazolam 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.

In short, the diamorphine and midazolam appear to have been prescribed without sufficient safeguard in relation to altering the dosage and in a way that exceeded Mrs Lavender's needs. In regard to the latter, Mrs Lavender was unrousable after the syringe driver had been commenced and no alteration in the dose of diamorphine or midazolam was required.

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 does not appear to have provided Mrs Lavender a good standard of clinical care as defined by the GMC (General Medical Council, Good Medical Practice, October 1995, pages 2–3).

Although it is possible that Mrs Lavender was dying 'naturally', it is also possible that her physical state had deteriorated in a temporary or reversible way and that she was not in her terminal phase. In this regard, there should have been a more thorough assessment and clearer documentation of the

possible contributing factors, such as an infection, to Mrs Lavender becoming 'less well'.

A failure to assess Mrs Lavender's pain correctly could have resulted in her receiving increasing doses of morphine for pain(s) that occurred mainly on movement and that were not fully opioid responsive (e.g. muscle and nerve injury pains). This may have provided little pain relief but exposed her to the adverse effects of opioids such as drowsiness. That this may have contributed to her further deterioration was not considered or acted upon. The effect of deteriorating kidney function on morphine metabolites that may have exacerbated the above was not considered or acted upon.

There were symptoms, signs and investigations in keeping with deteriorating kidney function, a possible infection and possible spinal cord injury that should have prompted a more thorough assessment of Mrs Lavender's condition, including a neurological examination.

In the absence of a thorough assessment that could confirm whether Mrs Lavender was likely to be experiencing a reversible or irreversible decline, it is difficult to know what could have been said to her son with any certainty. However, the prescribing of a syringe driver, even though never used, with large doses of diamorphine and midazolam to be used 'if required' appeared excessive and premature. The syringe driver started some days later also contained doses of diamorphine and midazolam that were excessive for Mrs Lavender's needs.

In patients with cancer, the use of diamorphine and midazolam when appropriate for the patients needs does 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 midazolam 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.

If it were that Mrs Lavender had naturally entered the terminal phase of her 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 Mrs Lavender a peaceful death, albeit with what appears to be an inappropriate and excessive use of medication due to a lack of sufficient knowledge.

However, in my opinion, based on the medical and nursing records, there is reasonable doubt that she had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lavender by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lavender by failing to adequately assess the cause of her pain and deterioration, failing to take suitable and prompt action when necessary and exposing her to inappropriate and/or excessive doses of diamorphine and midazolam that could have contributed more than minimally, negligibly or trivially to her 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).

Palliative Care Handbook, Guidelines on Clinical Management, Third Edition

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

'Wessex Protocol' Salisbury Palliative Care Services May 1995 pages 3–4, 30–31.

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: 1.5.05

3

Form MG15(T)

RESTRICTED

RECORD OF INTERVIEW

Number: Code A

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, NETLEY

Date of interview: 24/03/2005

Time commenced: 0917 Time concluded: 0939

Duration of interview: 22 MINS Tape reference nos. (→)

Interviewer(s): DC Code A YATES & DC QUADE

Other persons present: MR BARKER SOLICITOR

Police Exhibit No: Code A Number of Pages: 19

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This interview is being tape recorded, I'm DC Code A Chris YATES my colleague is -
DC QUADE	DC Code A Jeff QUADE.
DC YATES	I'm interviewing Doctor Jane BARTON. Doctor would you please give your full name and your date of birth.
BARTON	Jane Anne BARTON, Code A
DC YATES	Thank you. Also present is Mr BARKER who is Doctor BARTON'S Solicitor, can you please introduce yourself.

RESTRICTED

SOLICITOR — Yes certainly, I confirm my name is Ian BARKER and I'm Doctor BARTON'S Solicitor.

DC YATES — Thank you. Okay if you've got a statement about your role now is your time to say it.

SOLICITOR — No I am Doctor BARTON'S Solicitor that's fine thanks.

DC YATES — This interview is being conducted in an office within the Fraud Squad at Netley its the Superintendent's office at the Support Headquarters. The time is 0917 hours and the date is Thursday the 24th of March 2005 (25/03/2005). 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 your still entitled to free legal advice, I know Mr BARKER'S here as your Legal Advisor. If you want to stop the interview at any time just say so and we'll stop and give you time to, to speak in private and more importantly at the moment have you had enough time to confer with each before the interview.

BARTON — Yes thank you.

DC YATES — And you're happy to go on at the moment. Also point out that you've attended freely, completely voluntarily, your not under arrest so as you've come here of your own free will if at any time you feel you want leave then your free to do so. Do you understand that? Okay. I've also got to tell you though that 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. And that's what's called a Caution. Do you understand that Caution?

BARTON — Yes.

DC YATES — Okay. I will break it down just, just to make sure. The first part is, is, is quite easy you don't have to say anything and the middle part is the bit that needs a little bit of concentration in that, if you do no mention something while your being questioned, which you later rely on in Court, that is if you don't say something now should this matter go to Court, if it goes to Court and you say something then, then the Court may be allowed to draw an inference okay, obviously it's being recorded so should it go to Court then the tapes or a transcript could be heard. Are you happy with that explanation.

BARTON — Thank you.

DC YATES — Yeah.

SOLICITOR — (Inaudible...).

DC YATES — Right on this occasion the room that were in here it has not been equipped with any monitoring so nobody can listen from any other room, if it had been there's normally a little red light I think you've seen it before and it displays. As before I will be speaking to you or asking most of the questions Doctor and my colleague DC QUADE he will be almost certainly taking some notes, don't let that worry you.

Can I just confirm with you though Mr BARKER last time we met I think was Thursday the 3rd of March but we handed to you by way of advance disclosure ready for this interview copies of the medical notes of Elsie LAVENDER and a brief synopsis of her case is that correct.

SOLICITOR — Yes that is correct.

DC YATES — Okay. Right this, this investigation is called Operation Rochester it's being conducted by the Hampshire Constabulary and started in September 2002, so it's already been running in excess of 2 years and again it's still going to run for probably some time yet. It's an investigation into allegations of the unlawful killing of a number of patients at the Gosport War Memorial Hospital between 1990 and 2000, and no decision has been made as to whether an offence or any offence has been committed but it's important to be aware that the offence range being investigated runs from potential murder right the way down to assault, and part of the ongoing enquiries to interview witnesses who were involved in the care and treatment of the patients during that time between 1990 and 2000. You were a Clinical Assistant at the Gosport War Memorial Hospital at the time of these deaths so your knowledge of the working of the Hospital and the care and treatment of the patients is, it's very central to our enquiry, and today I'd like to ask you about the care and treatment of Elsie Ester LAVENDER, who was an 83 year old lady admitted to Daedalus Ward on 22nd February 1996 (22/02/1996) with a suspected brain stem stroke. Elsie died at 28 minutes past 9 (2128) on the night of 6th March 1996 (06/03/1996), and

the cause of death on the death certificate was stated as cerebral vascular accident and diabetes mellitus. Perhaps Doctor in your own words can you tell me what you recollect of the patient Elsie LAVENDER.

BARTON — I am Doctor Jane BARTON of the Forton.

DC YATES — Can I just obviously just for the purpose of the tape because it's not being videoed you got a prepared statement there is that correct?

BARTON — I have. I have a prepared statement.

DC YATES — Yeah fine we again, did you make the statement yourself?

BARTON — I did.

DC YATES — Would you care to read it I only had to stop you there because I realised what you were doing, there is nothing to show what I've done.

SOLICITOR — I was, I was about to intervene accordingly in exactly the same way.

DC YATES — Yeah.

SOLICITOR — Just to say that Doctor BARTON was going to read the prepared statement out.

DC YATES — Yeah. Well if you could now read the prepared statement then please Doctor. Thank you.

RESTRICTED

BARTON

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

I understand you are concerned to interview me in relation to a patient at the Gosport War Memorial Hospital, Mrs Elsie LAVENDER. As you are aware, I provided you with a statement on the 4th November 2004 (04/11/2004), which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the Gosport War Memorial Hospital . I adopt that statement now in relation to general issues insofar as they relate to Mrs LAVENDER.

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 Mrs LAVENDER. 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.

Mrs LAVENDER aged 83 was transferred to Daedalus Ward at Gosport War Memorial Hospital on 22nd February 1996 (22/02/1996) under the care of consultant Geriatrician Dr Althea LORD . Her past medical history was of diabetes for over 40 years, and she had been registered blind since 1988. She had apparently lived alone since the death of Code A and had a Code A who would do her shopping. She had fallen down the stairs at home two weeks previously and been admitted to a medical bed in Royal Naval Hospital Haslar with general weakness and immobility. She was referred to Dr Jane TANDY consultant Geriatrician at Portsmouth Healthcare Trust by her consultant physician, Surgeon Commander TAYLOR although I do not have the benefit of the referral letter nor any of her Haslar notes. Dr TANDY had seen her on a ward A4 at Haslar and dictated a letter to Surgeon Commander TAYLOR on 16th February 1996 (16/02/1996).

Dr TANDY had recorded that she had examined Mrs LAVENDER. She felt that the most likely problem was a brain stem stroke which had led to the fall. In addition, she had noted Mrs LAVENDER had insulin dependent diabetes mellitus, was registered blind, was now immobile and had atrial fibrillation.

There was weakness in both hands and Mrs LAVENDER had been unable to stand, although, though was able to do so with physios. She was 'a bit battered' and had pain across her shoulders and down her arms. She still required 2 people to transfer her. She had longstanding stress incontinence and mild iron-deficiency anaemia. Dr TANDY had confirmed the atrial fibrillation on examination, but had heard no murmurs. She had made mention of further investigation of her iron deficiency anaemia and her stroke but had agreed to take her over to Daedalus ward for "rehab" as soon as possible.

To assist with the transfer, one of the nursing staff on Ward A4 completed a nursing referral form on 21st February recording that Mrs LAVENDER's main problem was now immobility. She confirmed the pain in the arms and shoulders, and recorded that Mrs LAVENDER had ulcers on both legs. At that stage all pressure areas were said to be intact although her buttocks were very red. The referral form also set out the various medications Mrs LAVENDER was receiving at the time of discharge to Gosport War Memorial Hospital.

RESTRICTED

I then admitted Mrs LAVENDER to Daedalus Ward the following day. Unfortunately, given the very considerable interval of time I now have no real recollection of Mrs LAVENDER, but my entry in her records for the assessment on her admission reads as follows:

"22.2.96 Transferred to Daedalus Ward Gosport War Memorial Hospital
Past Medical History fall at home top to bottom of stairs
Laceration on head
Leg ulcers
Severe incontinence needs a catheter
Insulin Dependent Diabetes Melitus needs Mixtard Insulin bd
Regular series Blood Sugars
Transfers with 2
Incontinent of urine
Help to feed and dress. Bartell 2
Assess general mobility
? suitable rest home if home found for cat"

A nurse apparently recorded that Mrs LAVENDER had a barthel score of 4, but the difference with my assessment is of no real significance. Mrs LAVENDER was clearly profoundly dependent. A Waterlow pressure sore score on admission was recorded at 21, a score of 20 or more being 'very high risk'. Mrs LAVENDER's prognosis in view of her condition, being blind, diabetic, with a brain stem stroke and being immobile was not good, but the hope was that we might be able to rehabilitate her.

Following the information in the referral form in relation to Mrs LAVENDER's medication, I prescribed Digoxin for her atrial fibrillation, Co-amilofruse (a Frusemide and Amiloride combination) for congestive cardiac failure, Insulin Mixtard for her diabetes to be given in the morning if the blood sugar was above 10 and the same medication at night at a slightly different dose, again if her blood sugar was above 10. I also prescribed Ferrous Sulphate for her anaemia, Becomthasone as an asthma preventer, and Salbutamol as an asthma reliever.

I do not know now if Mrs LAVENDER was receiving pain relieving medication whilst at Haslar, but in view of the pain she was experiencing on admission, I also prescribed Dihydrocodeine, two 30mg tablets, 4 times a day.

I saw Mrs LAVENDER again the following day, probably in the morning, and would have reviewed her condition again. My note on this occasion reads as follows:

"23.2.96 Catheterised last night 500ml residue
blood and protein Trimethoprim"

The nursing note for the previous day in fact recorded that 750mls of urine had been catheterised, but the important feature was that the subsequent urine test revealed the presence of blood and protein in the urine, suggestive of a urinary tract infection. I therefore prescribed an appropriate antibiotic, Trimethoprim, on a precautionary basis in case of infection.

Bloods had been taken on 22nd February, and the nursing notes for the following day suggest that the platelet level was found to be abnormal and that the blood sample was too small. I was apparently informed of this and was to review the position in the morning.

The nursing notes record that I did see Mrs LAVENDER again the following morning, Saturday 24th February, and that her pain was not controlled by the Dihydrocodeine. The nursing notes show that she had a red and broken sacrum. I therefore prescribed Morphine Sulphate, 10mgs twice a day, in addition to the Dihydrocodeine. Although I did not normally see patients at Gosport War Memorial Hospital over weekends, when others were usually on duty, I may have been on duty the previous night, and would have been concerned to attend to Mrs LAVENDER if she was in pain at the time.

The nursing notes suggest that in consequence of the Morphine Sulphate Mrs LAVENDER had a comfortable night, but had deteriorated again by the following evening. It was said that she appeared to be in more pain, screaming "my back" when moved, although she was uncomplaining when not. Mrs LAVENDER's son apparently wanted to see me. The nursing notes also indicate that the sacral area was now weak and blistered and that there were red and sore and broken areas.

I would have reviewed Mrs LAVENDER's condition again on the Monday morning, 26th February. In view of the fact that the previous dosage of Morphine Sulphate had become

insufficient for Mrs LAVENDER's pain, I increased the dose to 20mgs twice a day, again with the Dihydrocodeine continuing. I believe Mrs LAVENDER's bottom was very sore, and I was concerned that she should have a Pegasus mattress in the hope of reducing pressure sores. I was probably made aware of the fact that Mrs LAVENDER's son wanted to see me and arranged to return to Gosport War Memorial Hospital at 2pm for that purpose.

The nursing notes record that I saw Mr LAVENDER and his wife at the hospital that afternoon. I have no recollection of this meeting, but I anticipate he was understandably concerned at the fact that his mother had been suffering in pain over the weekend. I think that by this stage Mrs LAVENDER's appetite was poor. I would probably have explained that pain relief was becoming more difficult, that there was skin breakdown, and that his mother was deteriorating.

Sadly it is the case that in elderly frail people with pre-existing illness, such as Mrs LAVENDER, significant events such as a major fall with transfer to one hospital and then another can in themselves have a very serious deleterious effect on their health, leading to death.

It may be the case that in the circumstances I indicated to Mrs LAVENDER's son that his mother might be dying, this simply being a feature of what can happen to elderly people in such circumstances, with the trauma of stroke, a major fall, and transfer to one hospital and another. I believe I would have discussed the options for pain relief with Mrs

LAVENDER's son and probably explained that it might become necessary to use a syringe driver and administer Diamorphine if the pain continued to be inadequately controlled. I think I would have explained that it was possible the administration of proper pain relieving medication might have the incidental and undesired effect of hastening death.

I believe Mrs LAVENDER's son was concerned that his mother should have adequate, proper pain relief, including medication administered via syringe driver if necessary, so that his mother was free from pain.

In any event, my note for 26th February in Mrs LAVENDER's notes reads as follows:

"26.2.96 not so well over weekend
family seen and well aware of prognosis
and treatment plan
bottom very sore needs Pegasus mattress
institute subcutaneous analgesia if necessary"

I think that following my discussion with Mrs LAVENDER's son, I wrote up a proactive prescription for further pain relief should Mrs LAVENDER experience uncontrolled pain when I was not immediately available. I prescribed Diamorph in a dose range of 80 - 160mgs, together with Midazolam 40 - 80mgs and Hyoscine 400 - 600mcgs. I would have anticipated that the nursing staff would contact me in such an event, so that I could then

have authorised administration as necessary within that dose range.

I believe that I would have seen Mrs LAVENDER again the following morning, though I have not made an entry in her records. The nursing notes record that bloods were taken. An area, I believe on Mrs LAVENDER's sacrum, was now said to be blackened and blistered.

I would have seen Mrs LAVENDER again the following day, 28th February, but again I did not make an entry in her notes on this occasion. The nursing notes show that the black areas on the sacrum recovered with Inadine. It appears that over the period 26th - 28th February Mrs LAVENDER had required no insulin in the morning and 20 units in the evening, suggesting poor nutritional intake.

Again, although I do not believe I had an opportunity to note it, I would have seen Mrs LAVENDER on 29th February, and 1st March, to review her condition. Sadly, I think she was slowly deteriorating over this period. The nursing notes suggest that on 29th February, Mrs LAVENDER's blood sugar was elevated and that I was contacted, ordering a quick acting insulin to be administered. I would not then have seen her again until the following Monday 4th March.

Unfortunately, Mrs LAVENDER was again suffering in pain by the of 4th March. The drug chart and the nursing notes show that I therefore increased the Morphine Sulphate, in the form of Oramorph slow release tablets, to

30mgs twice a day. I think the Dihydrocodeine was still continued at this stage.

I would have reviewed Mrs LAVENDER again the following morning, and it was clear that the pain relief was again inadequate. The nursing notes record that Mrs LAVENDER's pain was now uncontrolled. She had had a very poor night and was said to be distressed. She was now not eating or drinking and had deteriorated over the last few days. In the circumstances I felt that it was necessary now to set up subcutaneous analgesia via syringe driver and to administer Diamorphine together with Midazolam in order to relieve Mrs LAVENDER's pain and distress. I recorded the medication on her drug chart, with the Diamorphine in a range of 100 - 200mgs over 24 hours, Midazolam in a range of 40 - 80mgs over the same period, and Hyoscine at 400 - 800mcgs.

The syringe driver was then set up at 9.30 that morning, with the Diamorphine and the Midazolam at the lower end of the range, 100 and 40mgs respectively. It was not necessary to administer Hyoscine at that stage as there were no secretions. I considered these doses appropriate in view of the fact that Mrs LAVENDER's pain was now uncontrolled and she was reported to be in distress. In spite of the previous increases, it had become necessary to increase the medication still further. A further reasonable increase to the level prescribed by me was now necessary to ensure that Mrs LAVENDER was free from pain and distress in circumstances in which it was clear that she had continued to deteriorate and was now likely to be dying.

This medication was given solely with the aim of relieving that pain and distress.

My note on this occasion in Mrs LAVENDER's medical records reads as follows:

"5.3.96 Has deteriorated over last few days
not eating or drinking
In some pain therefore start subcutaneous analgesia
Let family know"

As suggested in my note and confirmed by the nursing records, Mrs LAVENDER's son was contacted by telephone and the situation explained to him.

The medication appears to have been successful in relieving the pain and distress. The following day the nursing notes indicate that the pain was well controlled and the syringe driver was renewed at 9.45a.m. I reviewed Mrs LAVENDER again that morning and my note reads as follows:

"6.3.96 Further deterioration
subcutaneous analgesia commenced
comfortable and peaceful
I am happy for nursing staff to confirm death"

As indicated, Mrs LAVENDER was now comfortable and peaceful. It was apparent that the medication had been successful in relieving the significant pain and distress which she had suffered. Aware that she was dying, I

indicated that I was happy for nursing staff to confirm death and that it would not be necessary for a duty doctor to be asked to attend for this purpose.

It appears then that Mrs LAVENDER died in the course of the evening of 6th March, and she was found to have passed away peacefully shortly before 9.30p.m.

SOLICITOR — Can I just indicate my advice to Doctor BARTON and I adopt the, adopted from the previous indicated on previous occasions in terms of her ability to cope with the process, so she should from this point make no further comment to questions put.

DC YATES — Okay. Well thank you for that, I think that's again a full informative statement. Can I again ask though can you please sign it and then time and date it and hand it over to myself DC YATES.

SOLICITOR — Of course there was one particular addition that Doctor BARTON made that was at paragraph 6 where she added the word 'heard' would you like her to add that in as well.

DC YATES — You can do yeah. Do you want to

SOLICITOR — (Inaudible...). You turn you sign each page.

BARTON — Sign each page.

DC YATES — It doesn't, it doesn't necessarily matter.

RESTRICTED

SOLICITOR — Okay. We'll just move to, just there I think you added 'heard', and if you just sign that. Now if you want to sign the end and date it.

DC BARTON — Handed to DC YATES.

DC YATES — Please yes.

DC YATES — Do you mind counter signing that Mr BARKER.

SOLICITOR — Not at all.

DC YATES — Thank you very much. Again for the purpose of the tape I'm going to give this an Identification Reference of JB/PS/4 I think yeah 4. Right as before we're going to call a stop to the interview at the moment, so we can go away and consider this. I may well wish to put a number of questions to you about this statement I've heard what Mr BARKER'S said and from what Mr BARKER'S said can I just ask you will you be prepared to answer any questions that I may wish to put to you.

BARTON — No.

DC YATES — Is there anything you wish to clarify at the moment.

BARTON — No.

DC YATES — Is there anything you wish to add.

BARTON — No.

RESTRICTED

DC YATES — Okay we'll hand you another one of those notices that explains the tape recording procedures. The time is 9:39, 09:39 and we'll turn the recorder off.

4

5

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	*	◆
1	Name: ALAN WILLIAM LAVENDER Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
2	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: HOME Code A E-mail address:			
3	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:			
4	Name: SHEELAGH ANN JOINES Address (HOME): Code A Occupation: RETIRED RGN Date of Birth: Code A Telephone: HOME Code A E-mail address:			
5	Name: YVONNE ANN ASTRIDGE Address (HOME): Code A Occupation: 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	✱	◆
6	Name: CHRISTINE JOICE Address (HOME): Code A Occupation: STAFF NURSE E GRADE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
7	Name: JUDITH COOKE Address (HOME): Code A Occupation: RETIRED NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
8	Name: PATRICIA ELIZABETH WILKINS Address (HOME): Code A Occupation: SENIOR STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK 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: CHRISTINE MARY DOLAN 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: MARY ELIZABETH MARTIN Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
12	Name: MARGARET ROSE COUCHMAN Address (HOME): Code A Occupation: STAFF NURSE E GRADE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
13	Name: GERALDINE BROUGHTON Address (HOME): Code A Occupation: RETIRED NURSING SISTER Date of Birth: Code A Telephone: HOME Code A E-mail address:			
14	Name: FIONA LORRAINE WALKER Address (HOME): Code A Occupation: SENIOR STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
15	Name: IRENE MARGARET DORRINGTON Address (HOME): Code A Occupation: Code A 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: MARGARET WIGFALL Address (HOME): Code A Occupation: STATE ENROLLED NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
17	Name: CATHERINE JEAN MARJORAM Address (HOME): Code A Occupation: SENIOR STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			
18	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:			
19	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:			

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	✸	◆
20	Name: Code A Address (WORK): Code A Occupation: Date of Birth: Code A Telephone: MOBILE Code A WORK Code A E-mail address:			
21	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:			
22	Name: Code A Address (): Occupation: Code A 2479 Date of Birth: Telephone: E-mail address:			
23	Name: Code A Address (): Occupation: Code A 1162 Date of Birth: Code A Telephone: E-mail address:			

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rule

Code A

Statement of: Code A

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

This statement (consisting of 3 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: 07/12/2004

I live at the overleaf address with Code A

Code A

I was so employed for 20 years or so. I suppose I was responsible for four or five clients per day, male and female.

One of these clients was Elsie LAVENDER , who I called Mrs LAVENDER. I would call and see her at Code A

Code A

I would generally call on Code A

I recall that she was generally in good health and fiercely independent.

Code A she suffered with Diabetes which did affect her sight. I would say that she was partially sighted, and had a white stick. I believe she had arthritis in her legs and I recall she may have had a back problem. However she was a fairly active old lady who went out shopping on her own often.

Signed: Code A Signature Witnessed by: Code A

2004(1)

RESTRICTED

Continuation of Statement of: Code A

Code A

Code A

Code A The Ambulance arrived and took her to Haslar Hospital .

Taken by: Code A

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Code A

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: 24/01/2005

I am Code A and I live at an address known to the Police. I am a Code A at the Queen Alexandra Hospital Cosham Portsmouth. I qualified Code A I am a member of the Code A my membership number is Code A My Health Professions Council membership no is Code A My membership number Code A Code A

Code A

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

Continuation of Statement of: Code A

Code A

Signed: Code A

2004(1)

Signature Witnessed by: Code A

RESTRICTED

Code A

At the time of this investigation in February 1996, I was working as a Code A

Signed: Code A
2004(1)

Signature Witnessed by: Code A

RESTRICTED

Continuation of Statement of: Code A

Code A

I have never heard of the term the Wessex Protocols.

Code A

I have been asked to detail my involvement in the care and treatment of Elsie LAVENDER . I do not recall this patient but from referral to entries in a copy of her medical notes exhibit reference Code A I can confirm that on Code A dated the Code A

Code A

Code A

Signed: Code A

Signature Witnessed by: Code A

RESTRICTED

Continuation of Statement of: Code A

Code A

Code A

Code A

I can also confirm that on Code A of the medical notes Code A I have written Code A

Code A

Code A

Signed: Code A

Signature Witnessed by: Code A

2004(1)

RESTRICTED

Continuation of Statement of: Code A

Code A

I have signed this entry as Code A

Signed: Code A

2004(1)

Signature Witnessed by: Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 198

Code A

Statement of: RIGG, PAMELA SUSAN

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

This statement (consisting of 3 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: P S RIGG Date: 10/02/2005

I am the above named person and I live at the address shown overleaf. I am a Community Staff Nurse and I work at the Gosport Health Centre. I have worked here for nearly two years, prior to that I worked at the Gosport War Memorial Hospital for a period of ten years.

I was a student nurse between 1976 and 1979 at West Suffolk General in Bury St Edmonds. I qualified as a State Registered Nurse and in order to practice I am registered with the Nursing and Midwifery Council. My registration number is Code A

Having qualified I went to Scotland and worked at the Royal Infirmary (Unit), Edinburgh. I was a medical ward staff nurse, I was there for a year prior to joining Decoress Hospital where I worked for another year. I then worked at the Queen Elizabeth Hospital in Kings Lynn where I worked on the intensive therapy unit and also on the coronary unit. I was there for about one year prior to working at St Columbus in Edinburgh. I was there for about four years. I was a staff nurse in the unit which dealt with palliative care issues.

In 1986 I moved to Gosport and worked as an agency nurse till 1993 when I began work at the Gosport War Memorial Hospital.

The first ward I worked on was the Redcliffe annexe. I was working as a Grade D Staff Nurse. In 1995 Redcliffe Annexe patients and staff were moved to a purpose built ward within the main hospital named Dryad Ward. I worked there till about 1997 when I started work on Sultan Ward.

Signature Witnessed by:

RESTRICTED

I remained at Sultan until I left the GWMH in April 2003. Looking back at my time with the GWMH I can only describe what I saw and that is general patient care was excellent. I think everyone did the best they could and I have no particular concerns about any member of staff or patient cases that I wish to raise.

I am not familiar with the term the Wessex Protocols. I was only aware of the term analgesic ladder in my last few years but the basic knowledge was there. I had previous instructions with regard the use of syringe drivers whilst I worked at St Columbus Hospice. I do feel that the general level of training at the GWMH was not as patient specific as it might have been.

I would say that in my opinion there was a good understanding of palliative care and syringe drivers and diamorphine was used in the right and proper circumstances.

I have been asked if I can recall a lady called Elsie LAVENDER . I have no recall of this patient. I have been asked to look at her medical records, exhibit BJC/30.

I have reviewed the notes for Elsie LAVENDER, I have not made any entries upon it. The patient was in fact on Daedalus Ward where I worked for one day only to cover.

Taken by:DC Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

LAVENDER

Statement of: COOKE, JUDITH

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

This statement (consisting of 3 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: Judith COOKE Date: 10/02/2005

I am the above named person and I live at the address shown overleaf. I was trained as a state enrolled nurse in Haverford West Hospital in 1959 or thereabouts. This was a two year course. When I finished I registered with the Nursing Council, I don't recall my registration number.

I worked at a local hospital in Haverford West, St Brides, then at Sommerlands Hospital in Yeovil. After a short break of 2½ years I worked at a hospital in Plymouth I do not recall the name of this hospital. I moved around quite a bit because my husband was in the Royal Navy. I followed him and his postings.

In 1974 I started work at the Northcote Annexe which is part of the Gosport War Memorial Hospital . This ward dealt with elder care. Prior to working at the Gosport War Memorial Hospital I had not worked with geriatrics. I was still working as enrolled nurse.

When the annexe closed, I don't recall when this was, I worked at the main hospital on the relief team. This meant I worked on various wards apart from maternity. After working on the relief team for about three years I worked on Daedalus Ward for about three years prior to my retirement in 1997.

Looking back I would say the hospital was a happy place to work, the level of care for the patients was excellent and I enjoyed my 25 years. I had no concerns about patient care as individuals, staff or patients.

I have never heard the term 'Wessex Protocols'.

Signed: Judith COOKE Signature Witnessed by:

RESTRICTED

I had what I would call on the job training with syringe drivers these had to be set up by a State Registered Nurse although I would assist them in doing this. Normally the drivers were for Morphine or Diamorphine , although other drugs could be given this way.

Syringe drivers were used on patients who were in the later stages of life to assist with palliative care. The families were informed by a GP or the sister of the ward. Medical staff would seek the agreement of the family and not proceed without. I am unable to recall a family saying no when it was properly explained.

I have been asked about a lady called Elsie LAVENDER , I have no recall of this patient. I can confirm that I have made and signed on the medical notes of Elsie LAVENDER.

On page 113 I have written catheter drained satisfactorily". This would indicate that the patient was able to urinate and was properly hydrated.

On page 115 I have made an entry dated 25/02/96 (25/02/1996) "Sacral area blade and blistered, betemadine spray applied".

This meant some skin areas had broken down, I don't know why she could have been like that on arrival or as a result of her lying still, it is impossible to say which as I have no recall of the patient. I can not see any other notes I have made regarding this patient.

Taken by:DC Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.7

Code A

Statement of: Code A

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

This statement (consisting of 1 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: 22/08/2003

I am the above named person and I live at the address overleaf. From November 1994 - September 2000 I worked as a Code A on days on Daedelus Ward at the GWMH.

Code A

I would describe general patient care at the hospital as good and I never had any concerns about the use of syringe drivers or drugs that were being used. Code A

Code A

I am aware of investigations of the GWMH via the local press. I have no other issues or concerns that I wish to express.

Signed: Code A

Signature Witnessed by:

RESTRICTED

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: EDGAR, WENDY ANN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: STAFF 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: W EDGAR Date: 26/10/2004

I am Wendy Ann EDGAR and I live at an address known to the police. Further to my previous statement Code A I would like to add that I am currently employed as a Staff Nurse at Haslar Royal Naval Hospital Gosport ; I have been qualified since October 2003.

Code A

Between October 2003 and January 2004 I was a Staff Nurse at the Queen Alexandra Hospital at Cosham.

I started at Haslar Hospital as a Staff Nurse in February 2004.

When I was at Gosport War Memorial I worked on Daedalus Ward which provided continuing

RESTRICTED

care and slow stream stroke rehabilitation for frail elderly patients. In 1996 my duties were to assist in the general care of patients, washing, dressing and feeding, as well as assisting the qualified nursing staff who supervised me. I did not make any decisions as to how a patient was nursed, nor was I involved in decisions concerning medication. I did not administer IV drugs and consequently I have never had any form of training.

I have never heard of the term Wessex Protocols.

I had not received training nor ever used syringe drivers in 1996.

My understanding of the term Named Nurse is the person who deals with an individual patients care, and also who can advise the relatives of the patient's prognosis.

All entries in the medical notes are usually made at the time, or as soon as convenient, but on some occasions at the end of the tour of duty.

In 1996 I worked 32 hours a week. My duty tours were similar to: early shift, 0730 - 1330, late shift, 1315- 2030.

I have a diploma in Adult Health Care.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I have no recollection of this patient, but from referral to this patient's medical notes (exhibit reference BJC/30) page 97, dated 6th March 1996 (06/03/1996), I can confirm that it is written in a Nurses Care Plan "Pain well controlled, syringe driver renewed at 9.45 AM" (0945). This is not in my writing but the entry bears my name, but not my signature, along with that of Nurse Pat WILKINS . I assume that the entry is in Pat's writing and would have been written at the time or shortly after. It was usual to have two signatures if I was with a qualified nurse and we both had contact with the patient.

Although I cannot recall this patient, I can assume that the pain was controlled by the use of the

RESTRICTED

syringe driver, and if it was not used then the patient would incur further pain.

What I have said in this statement is what I would do now as a qualified nurse, this is not necessarily how I may have thought as a Health Care Support Worker.

Taken by: Code A

Signed: W EDGAR
2004(1)

Signature Witnessed by: Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

LAY/HOSP

Statement of: JOINES, SHEELAGH

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED RGN

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: S A JOINES Date: 12/02/2003

I am the above named person and I live at the address overleaf. I began my training as a nurse in 1955 at the Royal and Queen Alexander Hospital in Portsmouth. I qualified in August 1958 as a State Registered Nurse and went on to qualify as a midwife in 1960 at Beckenham in Kent.

In 1961 I married my husband who was in the RAF. In 1963 we were stationed in RAF Changai where I worked as a civilian sister for about 2½ years. I returned to England in 1966 and I began working at the GWMH as a staff nurse on the female ward. I worked there until 1968 when I adopted a son. I gave up work and had a daughter in July 1969.

In March 1970 we moved to South Africa where I again started work as a nurse at the Vordrekkerhoogte Military Hospital. I was a sister on a general ward leaving in 1971. I then worked in Nedpark Hospital Arcadia as a sister for about a year. In early 1973 we returned to Gosport in the UK.

Having returned to England I began working again at the GWMH, I was a staff nurse on the male ward for about two - three months and then began work at Northcote Annex as a sister for about 18 months. This was a geriatric ward, the first one I had worked on.

I then had a period of 18 months on a children's ward before going back to Northcote Annex where I worked for about a year before returning to the children's ward. I think this would have been about 1977.

In 1979 until 1997 (rough dates) I worked on the male ward at GWMH as a sister, dealing with

RESTRICTED

medical, surgical, geriatric and terminal care patients. During that period the male ward moved to Daedalus Ward in 1993. The male ward at the GWMH came under GP's but Daedalus Ward was under the control of a consultant, Dr LORD . I enjoyed a good working relationship with Dr LORD, who in my opinion was an excellent doctor.

The other doctor who worked on Daedalus Ward was Dr Jane BARTON , who was the clinical assistant. Dr BARTON would make the early morning visits and review the patients. I found Dr BARTON to be one of the best doctors I worked with. She is a very caring lady and someone I would describe as compassionate, she is a fair lady and someone who valued the opinion of her staff. She is still my GP and someone I trust and respect highly. Although we had a first class working relationship we never went out socially.

Although Daedalus Ward was there to cater for rehab patients in my opinion this was not always possible. We would take stroke rehab where it was not always possible to rehabilitate them. We did rehabilitate some patients and got them home or into nursing homes. The rest of the beds in the ward were long stay patients. Many of these patients were at the hospital for respite care. However if it was felt that their relatives were unable to cope with them at home they would then be transferred into a long stay bed. This decision would be made by Dr LORD.

Whilst working I was involved in terminal care of very ill patients. There were people who were so ill they were expected to die. It was always my aim to give these people care, comfort and dignity. I was given instruction in the use of syringe drivers. These provided patients with 24 hour pain relief, normally for patients who were unable to swallow oral analgesics. We could also administer sedation and drugs to dry up secretions.

Only a doctor could authorise the use of a syringe driver, they would be put up by two trained nursing staff and with the consent of the patients family. With regard to the very ill patients for whom there was no further treatment who were in pain or distressed, I would inform the family that the use of the syringe driver would lead to a peaceful, dignified death. The use of the syringe driver did not accelerate the process of dying. In the four years I was at Daedalus only one family declined and asked for treatment by antibiotics. This was done as per their request.

RESTRICTED

Whilst at Daedalus Ward some patients would suffer from pain for a period of time prior to being seen by Dr BARTON. This was because quite rightly the patients were being seen by partners of Dr BARTON who did not know the case history and were therefore unwilling to prescribe analgesic drugs required by the patients.

To that end it was agreed by Dr LORD, Dr BARTON and myself that Dr BARTON would prescribe medication prior to it being required. This was done in case a patient deteriorated and needed the drugs that had been prescribed. The prescriptions were written up as a patients admission in case they were needed, not as a matter of routine. I do not know if this practice was used on other wards.

Once the drug had been prescribed if and only if the patient deteriorated I would inform Dr BARTON and tell her I thought the time had come for the drugs to be given. I would see the relatives and discuss the situation with them in detail, involving the outcome and only if they agreed I would speak to Dr BARTON again informing her the family had given their permission and on her authority commence a syringe driver on minimal dosage given the scale as laid down by Dr BARTON. Any increase in dosage could only be authorised by Dr BARTON.

Dr BARTON would only give her permission to start a syringe driver, a few hours after having seen the patient and was fully aware of their medical condition and the need for a syringe driver. At no time did Dr BARTON and I ever disagree about the use of syringe drivers. I have never had any concern about the use of syringe drivers or the drugs given under the direction of Dr BARTON. Had I been worried I would have questioned Dr BARTON had she failed to answer me in a satisfactory manner I would have spoken with my manager or Dr LORD.

I am not aware of any trained or auxiliary staff voicing concern about the use syringe drivers. I am not aware of any of the families I dealt with making complaints about syringe drivers or Dr BARTON.

In my opinion as a result of the current investigation many people will not get the pain free,

RESTRICTED

dignified deaths they would otherwise have had.

In January 1997 I retired from the GWMH. Since then I have worked as a night nurse co-ordinator which is a clerical post based at Waterlooville.

RESTRICTED

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: JOINES, SHEELAGH ANN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: NIGHT NURSE COORDINATOR

This statement (consisting of 6 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: S A JOINES Date: 13/10/2004

I am Sheelagh Ann JOINES and I live at an address known to the Police.

Further to my previous statement made to the Police on 12th March 2003 (12/03/2003), I would like to add the following; my current role is that of a Night Nurse Coordinator at St Christopher's Hospital in Fareham. I have held this position for some 7 years since my retirement from Nursing.

In 1996 my role at the Gosport War Memorial Hospital was that of Sister in charge of Daedalus Ward. On a day to day basis I was responsible for the running of the ward in general. My responsibilities also included the clerical work, and accompanying the Doctor on the Ward round, usually between 0800 and 0830 hrs.

I am unsure who my line manager was at this time, it could have been Isobel EVANS , Barbara ROBINSON or Sue HUTCHINGS who would have held the position of what we used to call Matron, the person who is charge of the staff is the best way I can describe it.

My weekly hours of work at that time were 371/2. My duties, as far as I can recollect were from 0730 to 1330, 0730 to 1630/1700 and 1215 to 2030.

I was not certified to use IV drugs, and in any event these were not used on the ward at that time.

I have no knowledge of the term Wessex Protocols, but if it means the analgesic ladder, I am of course familiar with that.

Signature Witnessed by: **Code A**

RESTRICTED

I am fully trained in the use of syringe drivers but I am unsure what type of driver was being used at the time in question.

With regards to training for nurses regarding syringe drivers I had been trained in their use, But I can't remember now by whom. It could have been someone from the company that supplied it, a trained nurse, or a Marie Curie or Countess of Mountbatten nurse who would use them far more often that we would. The training would have been for a day at the most but probably less than that. It quite a simple procedure and I have trained it myself. The training consists of how to set up the syringe driver and how to put the required dose into the driver. Trained nurses only would be allowed to use such equipment. Health care and support workers would not.

At this time the there were two teams of nurses, the red and blue teams. The named nurse was the person in overall charge of each of those teams.

The time and date of all entries in the patient notes were usually completed first thing in the morning after handover or done on the day.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I can say that I have no recollection of this patient, but after referring to her medical notes, exhibit reference BJC/30 pages 131,151, 153, 200 to 228 and a letter page 13.

I can confirm that on the 23rd February 1996 (23/02/1996), page 131 I wrote the following on what I believe to be a Diabetes prescription nursing record:

Date	Time	Drug Name and Dose	Reason	Signature
23/2/96 (23/02/1996)	1730	Mixtard Insulin	Blood Sugar 8	S JOINES

With reference to this I can now see that I did not record the actual dose of insulin, which is not like me and I have no explanation as to why. This particular type of insulin is subcutaneously injected just under the skin, usually in the abdomen, upper arm or thigh

RESTRICTED

The blood sugar figure is a sign of whether the diabetes is controlled. The reading 8 is satisfactory.

I must say that I really do not recognise this form, after all this time.

I can confirm that also on the 23rd February 1996 (23/02/1996), page 151 I wrote the following at 1720 hrs on what I believe to be the Kardex admission notes - Pathology phoned- Platelets 36? Too small sample. To be repeated Monday. Dr BARTON informed - will review. This entry is signed by me.

With reference to this entry I believe this to mean that not enough blood was taken, therefore it was not possible to do a full blood count. To repeat and take more blood on Monday, the right amount. Platelets are concerned in the make up of blood. I am not familiar with chemical pathology records so I am unable to comment on any attempt to cross reference the two records.

I can confirm that in a letter from Dr JC TANDY (Consultant Physician in Geriatrics) which reads;

Elsie LAVENDER, DOB **Code A**

I think the most likely problem here is a brain stem stroke leading to her fall. I note she has iron deficient anaemia. Upper GI investigation might be helpful as, in view of the atrial fibrillation, one might want to consider Aspirin here (I would be reluctant to consider Warfarin as I think she's going to be at great risk of falling). Alas, I don't think her brain stem stroke would show up particularly well on a CT and were now 11 days post-ictus.

I'll get her over to Daedalus Ward, Gosport War Memorial Hospital, for rehab as soon as possible. I'd be grateful if her notes and x rays could go with her.

Thank you for asking me to see her.

Yours sincerely

Signed: S A JOINES

Signature Witnessed by: **Code A**

RESTRICTED

Dr JC TANDY
Consultant Physician in Geriatrics
CC Dr EJ PETERS , the Surgery, 149 Forton Road, Gosport, P0123HH
Sister S JOYNES, Daedalus Ward, GWMH.

I am shown as being a recipient of this letter, I believe purely because I was the Sister in Charge of the Ward and for no other reason. As I have said I have no recollection of this patient. I don't know Dr TANDY personally, but I know of her.

On Daedalus Ward at that time there were 8 stroke beds and 14 geriatric long stay beds.

I can confirm that on page 153 of Exhibit BLC/30 dated 25th and 26th February 1996 (26/02/2004), I wrote the following 1900 hrs on 25/2/96 (25/02/1996).

Appears to be in more pain, screaming "My back" when moved but uncomplaining when not. Son would like to see Dr BARTON; this entry was signed by me.

On 26/2/96 (26/02/1996), I wrote the following;

Seen by Dr BARTON MST> 20mgms BD. She will see Mr LAVENDER @ 1400 hrs this afternoon. I did phone him. Blood sugars 20> this entry was signed by me

Insulin dose increased
1430 hrs - Son's wife seen by Dr BARTON- prognosis discussed. Son is happy for us to just make Mrs LAVENDER comfortable and pain free. Syringe driver explained.

1440hrs- All mattress needed changing- 10 MST mgms given prior to moving on to Pegasus mattress.

The meaning of this is almost self explanatory in that the use of the syringe driver was explained to Mr LAVENDER junior's wife in order for the patient to be comfortable and to be

RESTRICTED

free from pain.

MST means Morphine Slow release Tablets were used as Mrs LAVENDER was not responding, it was not controlling the pain.

The Pegasus air mattress was required for release of pressure from bed sores.
I can confirm that on page 151 of Exhibit BJC/30, dated 24/2/96, I wrote the following

Pain not controlled properly by DF 118. Seen by Dr BARTON- boarded for MST 10Mgs BD, this entry was signed by me.

I knew that the pain was not being controlled by observing that the patient was in pain when moved. Another reason would be that the patient informed us of pain.

Because of this I informed Dr BARTON who visited and boarded for MST 10 Mgs twice a day. This was usually at 0600 and 1800

Boarded means, written up or prescribed in treatment sheet
BD means twice a day
DF 118 is a strong Analgesic tablet
Dr BARTON increased the MST to 20Mgs on 26/2/96 (26/02/1996)
This is shown on page 145 of BJC/30, the prescription charts.

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

LAMENDED

Statement of: Code A

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

This statement (consisting of 3 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: 26/10/2004

I am Code A and I live at an address known to the police. Code A

Code A, Gosport War Memorial Hospital.

Code A

Code A

Code A

I have never heard of the term, Wessex Protocols.

Signed: Code A

2004(1)

Signature Witnessed by: Code A

RESTRICTED

Continuation of Statement of: Code A

I am not trained in the use of syringe drivers and have never used them. I have no idea what syringe drivers were being used in 1996.

My understanding of the term named nurse is that they would be responsible for that particular patient and any problems with them if on duty. If not on duty then another would be the named nurse.

Entries in the nurse's notes are usually made at the time of any contact with the patient, but they may be done later if it's in the middle of a busy period, or indeed at the end of the shift.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER. I have no recollection of this patient. Code A

Code A

Code A

Code A This was standard practice when I was with another member of staff.

Although I have no recollection of this patient, one who was in pain might inform us of the fact, we might ask the patient if they were, or the patient might wince when moved.

I have perused the notes and find that my signature is also on the following entries in the notes:

Page 99 dated 23.2.96 (23/02/1996) "Transferred X 2" together with the signature of Pat WILKINS
Page 101 dated 25.2.96 (25/02/1996) "Bed rest maintained" together with the signature of Yvonne ASTRIDGE
Page 105 dated 23.2.96 (23/02/1996) "Bed bathed" together with the signature of Pat WILKINS
Page 105 dated 25.2.96 (25/02/1996) "Blanket bathed"
Page 109 dated 2.3.96 (02/03/1996) dittoed from entry above which says "Dressing remains in place"
Page 113 dated 25.2.96 (25/02/1996) "Catheter draining" together with the signature of Judith

RESTRICTED

Continuation of Statement of: Code A

COOK

Page 113 dated 2.3.96 (02/03/1996) "Catheter draining satisfactorily"

Page 115 dated 25/2/96 (25/02/1996) "Sacral area weak and blistered Beterdene spray applied"

together with the signature of Judith COOK.

Taken by: Code A

Signed: Code A

2004(1)

Signature Witnessed by: Code A

RESTRICTED

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: QUADE, GEOFFREY JAMES

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

This statement (consisting of 1 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: G Quade Date: 06/04/2005

At 0917 hours on Thursday 24th March 2005 (24/03/2005) in company with Detective Constable YATES we conducted a tape recorded interview of Dr Jane BARTON in an office within the Fraud Squad at Support HQ, Netley . Also present was Doctor BARTON's solicitor Mr Ian BARKER .

The interview was concluded at 0939 hours that morning. During the interview Doctor BARTON made a prepared statement which she read out and then signed and dated. This prepared statement is available with an identification reference of JB/PS/4.

The interview was conducted in accordance with the Codes of Practice for tape recorded interviews and the sealed master tape is available with an identification reference of CSY/JAB/5.

Signature Witnessed by: