Field Fisher Waterhouse

FFW/91/03

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

DR BARTON'S STATEMENTS

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General

4-11-04

STATEMENT OF DR JANE BARTON

I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport Hampshire.

I am a Registered Medical Practitioner and qualified in 1972 at Oxford University with the degrees MA, BM BCh. I joined my present GP practice in January 1980, initially as an assistant for three months and then as a minimum full time partner.

As a General Practitioner I had a minimum full time commitment. I had approximately 1500 patients on my list. I worked eight general practice surgery sessions weekly and carried out house calls on my own patients and I conducted half of the out of hours on call responsibilities of my partners with one night in ten and one weekend quarterly on duty for the whole practice.

In addition to my general practice duties, I took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial Hospital in 1988. The GWMH was a cottage hospital. It had 48 long stay beds and was originally on three separate sites, and was resourced, designed and staffed to provide continuing care for long stay elderly patients.

The position of Clinical Assistant is a training post, and for me it was a part-time appointment. Initially the position was for 4 sessions each week, one of which was allocated

to my partners to provide out of hours cover. This was later increased, so that by 1998 the Health Care Trust had allocated me 5 clinical assistant sessions, of which 1½ were now given to my partners in the GP practice for the out of hours aspects of the post. I was therefore expected to carry out my day to day responsibilities in this post in effect within 3½ sessions each week. This was of course in additionto my GP responsibilities.

By 1998, I was working on two of the wards at the Hospital, Daedalus, and Dryad Wards. The two wards had a total of 48 beds. About 8 of the beds on Daedalus Ward were for 'slow stream' stroke patients. The remaining beds were otherwise designated to provide continuing care for elderly patients.

Two Consultants in elderly medicine were responsible for each of the wards. Dr Althea Lord was responsible for Daedalus Ward and Dr Jane Tandy for Dryad Ward. Both Consultants, however, had considerable responsibilities elsewhere and thus their actual time at the 'osport War Memorial Hospital was significantly limited. Dr Lord for example was responsible for an acute ward and a continuing care ward at the Queen Alexandra Hospital in Portsmouth, and had responsibilities at a third site, St Mary's Hospital, also in Portsmouth. As a result, Dr Lord's presence at the hospital was limited to conducting a continuing care ward round on Daedalus Ward every other Monday. She would also be in the hospital, conducting outpatients on Thursday when she would carry out a further ward round in relation to the stroke patients.

Dr Tandy took annual leave towards the end of April 1998 followed immediately thereafter by maternity leave, so that she did not return to work until February 1999. In spite of the considerable workload, the Trust took the decision that her post should not be filled by a locum. Dr Lord kindly volunteered to make herself available to cover, but the reality was that given her own position as a very busy consultant, she could not carry out a ward round on Dryad Ward. For much of 1998 therefore, I had no effective consultant support on one of the two wards for which I had responsibilities, with the consultant role on the other ward already being limited.

At the time of my resignation from the GWMH in April 2000 there were 2 Elderly Medicine consultants covering the wards and providing a weekly ward round. The consultant nominally in charge of Dryad was also Clinical Director for the Trust as well as his other extensive clinical commitments in two other hospitals and was not always available to provide the weekly service.

In carrying out my duties as Clinical Assistant I would arrive at the Hospital each morning when it opened about 7.30am. I would visit both Daedalus and Dryad wards, reviewing patients and liasing with staff, before I then commenced my General Practitioner responsibilities at 9am. I would return to the Hospital virtually every lunchtime. New patients, of whom there were about 5 each week, would usually arrive before lunchtime and I

would admit patients, write up charts and see relatives. Quite often, in particular if I was the duty doctor, I would return to the Hospital after GP surgery hours at about 7pm. I was concerned to make myself available to relatives who were not usually able to see me in the course of their working day. This became a very important time commitment in the job. I would also attend the Daedalus ward round on Mondays with Dr Lord, but was unable to attend the round for stroke patients on Thursdays.

I was also concerned to make myself available even outside those hours when I was in attendance at the hospital. The nursing staff would therefore ring me either at home or at my GP surgery to discuss developments or problems with particular patients. In the event that medication was to be increased, even within a range of medication already prescribed by me, it would be usual for the nursing staff either to inform me of the fact that they considered it necessary to make such a change, or they would inform me shortly thereafter of the fact that the increase had been made.

When I first took up the post, the level of dependency of patients was relatively low. In general the patients did not have major medical needs. An analogy now would be to a nursing home. However, over time that position changed very considerably. Patients who were increasingly dependent would be admitted to the wards, so that in time, and certainly by 1998, many of the patients were profoundly dependent with minimal Bartell scores. There

was in consequence a considerable increase in the medical and nursing input required to care for such patients.

Further, in 1998 as an example, the bed occupancy was about 80%. However, the Trust was concerned to increase that still further and it then rose to approximately 90%. There would therefore be as many as 40 or more patients to be seen and/or reviewed by me when I attended each day. There was no increase in nursing staff, support staff, occupational therapy, and physiotherapy, and no support from social services to assist with the increase in patients, and the increase in dependency and medical needs. On a day by day basis mine was the only medical input.

Part of the list of duties laid down for me, as Clinical Assistant was to be responsible for the day-to-day medical management of patients. My work involved looking after a large number of elderly patients approaching the end of their lives and requiring continuing care from the Health Service. The vast majority had undergone treatment in the acute sector and were transferred to our care for rehabilitation, continuing care or palliative care after their acute management was completed. A major group of these patients were suffering from end stage dementia as well as major organ failure such as renal failure. A lot of my time would be spent attempting for forge a relationship with families and helping them come to terms with the approaching death of a loved one. This aspect of the job was often not helped by unrealistic expectations of the level of rehabilitation available at our cottage hospital or possible in

these individual patients and difficult dynamics within the families. The act of transferring such frail patients also further compromised their condition, sometimes irreversibly.

In carrying out my work I relied on a team of nurses both trained and untrained to support the work I did. Between us all we tried to offer a level of freedom from pain, physical discomfort, unpleasant symptoms and mental distress, which is difficult to offer in an acute setting and is more allied to palliative care.

Over the 12 years in which I was in post, I believe I was able to establish a very good working relationship with the nursing staff at the hospital. I found them to be responsible and caring. They were experienced, as I think I myself became, in caring for elderly dependent patients. I felt able to place a significant measure of trust in the nursing staff.

Over the period in which I was in post there was only a marginal increase in the number of nursing staff. With the significant number of patients and the considerable increase in dependency over the period, the nurses too were faced with an excessive workload.

The picture therefore that was emerging, at least by 1998 at the hospital was one in which there had been a marked increase in the dependency of the patients, and indeed an increase in their numbers. There was limited consultant input, reduced still further by the fact that no locum was appointed to cover Dr Tandy's position. By this time the demands on me were

very considerable given that I was expected to deliver this significant volume of care within a mere 3½ sessions each week. I raised this matter with management, albeit verbally, saying that I could not manage this level of care for the number of patients, but the reality was that there was no one else to do it. In due course I felt unable to continue. I resigned from my post in 2000.

It may be of some significance that my position was then replaced, not with another part-time clinical assistant, but a full-time staff grade. Indeed, my present understanding is that this post may be increased to two full-time positions, and is a clear reflection of the very considerable demands upon me at the relevant time when I was struggling to cope with the care of patients. In addition, the Consultant cover to the two wards was increased to ten sessions per week in 2000.

In 1998, I had tried to raise the issue with Trust management, but there was no one else to o the job. I could have said that I couldn't do the job any more and walked away, resigning my position at that time. However, I felt obliged to remain, to support my colleagues, and more particularly, to care for my patients. I felt that if I left I would be letting down the nursing staff with whom I had worked for 12 years, and letting down the patients, many of whom were in my practice and part of my own community. In reality I was trying to do my best in the most trying of circumstances. I continued to express my concern to Trust management, but to no avail, and eventually I felt compelled to resign in April 2000.

In caring for patients on a day by day basis therefore I was 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 others. In the circumstances, I attended to my patients and I readily accept that my note keeping suffered in consequence. The medical records therefore do not set out each and every review with a full assessment of a condition of a patient at any given point. Of necessity they were sparse. The constraints on the caring experienced nursing staff meant that they too had the same problem - to tend to the patients, keeping them clean, feeding them, and attending to their other nursing needs, or to write detailed notes.

Similarly, in relation to prescribing I felt obliged to adopt a policy of pro-active prescribing, giving nurses a degree of discretion and administering within a range of medication. As a result, if the patient's condition deteriorated such that they required further medication to ease pain and suffering, that medication could be given even though the staffing arrangements at the hospital were such that no medical staff could attend to see the patient. This was of assistance in particular out of hours. It was a practice adopted out of necessity, but one in which I had trust and confidence in the nurses who would be acting on my prescripts, and indeed in which the nurses would routinely liase with me as and when increases in medication were made even within the authority of the prescription. I accept that this would not be necessary in a teaching hospital or even big district general hospital

where a professor or consultant in geriatrics will have a plethora of junior staff. Somebody will either be on the end of a bleep or be available on the ward to write up/review a prescription for opiates.

It may also be of some significance that prescriptions of this nature by me were inevitably reviewed on a regular basis by consultants when carrying out their ward rounds. At no time was I ever informed that my practice in this regard was inappropriate.

Lest this observation, and indeed others, in relation to the degree of consultant support appear in any way to be critical of Dr Lord, I am very anxious to emphasise that Dr Lord was caring, thoughtful and considerate. The reality is that Dr Lord too had a considerable workload, and she did what she could, given the constraints upon her.

A

STATEMENT OF DR JANE BARTON - RE: LESLIE PITTOCK

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

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Leslie Pittock. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mr Pittock.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal 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.

4. Whilst the demands on my time were probably slightly less in 1996 than the position which then pertained in 1998 and beyond, certainly even by 1996 there had been a significant increase in dependency, increase in bed

occupancy, and consequent decrease in the ability to make notes of each and every assessment and review of a patient. These difficulties clearly applied both to me and the nursing staff at the time of our care of Mr Pittock. Similarly I had by this stage felt obliged to adopt the policy of pro-active prescribing to which I have made reference in my previous statement to you, given the constraints and demands on time.

5. In any event, it is apparent from Mr Pittock's medical records that he was 83 years of age and had been suffering from depression since his 50's. Mr Pittock had been living in a residential home, Hazeldene and also had been an in-patient at the Knowle Hospital where he had received Electro Convulsive Therapy as treatment for severe depression. Having returned to Hazeldene, early in 1995 it is recorded that by September that year Mr Pittock had taken to his bed and was no longer eating and drinking properly. In view of his general condition and depression, he then appears to have been admitted to Mulberry Ward at the G W M H having been seen at Hazeldene by a Community Psychiatric Nurse in September 1995.

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

7. From Mr Pittock's records it appears then that he was admitted to Mulberry Ward on the 14th September 1995 under the care of Consultant in Old Age Psychiatry, Dr Vicki Banks. Mulberry Ward is the long stay

elderly mental health ward at the Gosport War Memorial Hospital. On admission it was recorded that there had been a deterioration of Mr Pittock's mood and physical capabilities over recent months. Whilst on Mulberry Ward, Mr Pittock's depression was treated with Lithium, Sertraline, and he also received Diazepam and Thioridazine.

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

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

10. With his condition remaining poor, Dr Bayly wrote a note on 2nd January 1996 requesting Dr Althea Lord, Consultant Geriatrician, to see Mr Pittock. In her note Dr Bayly said that on admission Mr Pittock's mobility had initially deteriorated rapidly and that he had developed a chest infection. She reported that his chest was now clearing, but he remained bed bound, expressing the wish to die. The following day, Mr Pittock was said to be deteriorating.

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

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

13. Accordingly, Mr Pittock was admitted to Dryad ward the following day, 5th January, though under the care of Consultant Geriatrician Dr Jane Tandy, and I undertook his assessment. Unfortunately, given the very considerable interval of time I now have no real recollection of Mr Pittock, but my admission note in his records reads as follows:

"5-1-96 Transfer to Dryad Ward from Mulberry
Present problem
Immobility depression
broken sacrum. Small superficial areas

ankle dry lesion L ankle
both heels suspect

Catheterised
transfers with hoist
may help to feed himself

Long standing depression on Lithium and
Sertraline"

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

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

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

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

17. The nursing note for 9th January documents that Mr Pittock had taken a small amount of diet. He was noted to be very sweaty that morning, but

apyrexial. He stated that he had generalised pain and it was noted that he would be seen by me that morning.

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

19. The notes show that Dr Tandy and I then saw Mr Pittock the following day, 10th January. Dr Tandy noted his dementia, that he was catheterised, had superficial ulcers, his Barthel score remained zero, and he would eat and drink. She wrote that Mr Pittock was "for TLC" (tender loving care). This indicated that Dr Tandy effectively agreed with Dr Lord's assessment and felt Mr Pittock was not appropriate for attempts at rehabilitation but was for all appropriate nursing care and treatment only. She noted that she had had discussion with Mr Pittock's wife who had agreed that in view of his very poor condition this was appropriate.

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

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

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

23. I anticipate that I would have seen Mr Pittock again the following day. Although I did not make a clinical entry in Mr Pittock's records, I wrote up a further prescription chart for the various medications Mr Pittock was then receiving. In addition I increased the Oramorph available for Mr Pittock's pain, anxiety and distress, by adding an evening dose of 5mls to the four daily doses, to tide Mr Pittock overnight. I also provided a further prescription for Hyoscine, Diamorphine, and Midazolam, with the latter two drugs being at a slightly greater level than I had written the previous day, at 80 - 120 mgs and 40 - 80 mgs respectively. I would have been concerned that although it was not necessary to administer the medication at that stage, Mr Pittock's pain, anxiety and distress might

develop significantly and that appropriate medication should be available to relieve this if necessary. The Sertraline and Lithium were discontinued from this point, given Mr Pittock's poor condition.

24. I anticipate that I would have seen Mr Pittock on the Friday morning, but would then have been away from the hospital over the weekend. I returned on the morning of Monday 15th January, and would have reviewed all of the patients on both Dryad and Daedalus wards in the usual way, including Mr Pittock. I believe I may have been told that his condition had deteriorated considerably over the weekend and he appeared to be experiencing marked agitation and restlessness and to be in significant pain and distress, through his mental and physical condition. Unfortunately, I did not have an opportunity to make a clinical entry in Mr Pittock's notes, I anticipate due to lack of time, but the nursing note indicates that I saw Mr Pittock and that 80mgs of Diamorphine, 60mgs of Midazolam, and 400mcgs of Hyoscine over 24 hours were commenced subcutaneously via syringe driver at 08.25 that morning.

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

26. I tried to judge the medication, including the increase in the level of opiates to ensure that there was the appropriate and necessary relief of his condition, whilst not administering an excessive level, and to ensure that this relief was established rapidly and maintained through the syringe driver. This had to take into account the fact that the Lithium and Sertraline with their additional sedative effects had previously been discontinued and that he would have developed some tolerance to the oral regime.

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

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

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

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

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

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

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

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

"18-1-96 Further deterioration
sc analgesia continues
difficulty controlling symptoms
try nozinan."

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

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

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

38. I would not have been on duty over the weekend, and it appears that one of my GP partners, Dr Michael Briggs, was available. The records show that on Saturday 20th January, he was consulted about Mr Pittock, and he advised that the Nozinam should be increased to 100mgs and the Haloperidol discontinued. My expectation is that Dr Briggs would have been advised of Mr Pittock's condition and the drug regime. The only modification being in the antipsychotic medication, it would seem that Dr

Briggs did not consider the general regime to be inappropriate in view of Mr Pittock's condition.

39. Dr Briggs specifically recorded in the notes that Mr Pittock had been unsettled on Haloperidol, that it should be discontinued and changed to a higher dose of Nozinan.

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

41. I would have seen Mr Pittock again on the Monday morning, 22nd January. I have not made a note, but the nursing records indicate that Mr Pittock was poorly but peaceful.

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

43. Sadly, in the early hours of 24th January, Mr Pittock deteriorated suddenly, and he died at 01.45.

Signed Code A

dated 3-3-05

Handed to D.C. Yates Code A

B

STATEMENT OF DR JANE BARTON - RE: ELSIE LAVENDER

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

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mrs Elsie Lavender. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mrs Lavender.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal 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.

Code A

4. 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.

5. Mrs Lavender aged 83 was transferred to Daedalus Ward at GWMH on 22nd February 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 her husband and had a son living in Warsash 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 ward A4 at Haslar and dictated a letter to Surgeon Commander Taylor on 16th February 1996.

6. Dr Tandy had recorded that she had examined Mrs Lavender. She felt 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, 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 heart no murmurs. She had Code A 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.

7. 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 in tact 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 GWMH.

8. 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 Mrs Lavender, but my entry in her records for the assessment on her admission reads as follows:

> "22-2-96 Transferred to Daedalus Wd GWMH
> PMH fall at home top to bottom of stairs
> laceration on head
> leg ulcers
> severe incontinence needs a catheter
> IDDM needs Mixtard Insulin bd

regular series B.S.
transfers with 2
incontinent of urine
help to feed and dress. Barthel 2
Assess general mobility
? suitable rest home if home found for cat"

9. 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.

10. 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, Becomethasone as an asthma preventer, and Salbutamol as an asthma reliever.

11. 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.

12. 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 & protein Trimethoprim"

13. 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.

14. 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.

15. 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 GWMH 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.

16. 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, though 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 sore and broken areas.

17. 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 GWMH at 2pm for that purpose.

18. 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.

19. 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.

20. 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 then 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.

21. 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.

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

> "26-2-96 not so well over w/e
> family seen and well aware of prognosis
> and treatment plan
> bottom very sore - needs Pegasus mattress
> institute sc analgesia if necessary"

23. 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 Diamorphine 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.

24. 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.

25. 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 - were covered 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.

26. 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.

27. Unfortunately, Mrs Lavender was again suffering in pain by 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.

28. 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.

29. The syringe driver was then set up at 9.30am that morning, with the Diamorphine and the Midazolam at the lower end of the range, 100mgs 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 now 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.

30. 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 ∴ start sc analgesia
> Let family know"

31. 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.

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

> "6-3-96 Further deterioration
> sc analgesia commenced
> comfortable and peaceful
> I am happy for nursing staff to confirm death"

33. 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.

34. 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 9.30pm.

Signed Code A 24-3-05

handed to Dr Yates.

Code A

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POLICE STATEMENT OF DR JANE BARTON

1. I, am Dr Jane Barton of the Surgery, 148 Forton Road, Gosport Hampshire.

2. I am a Registered Medical Practitioner and qualified in 1972 at Oxford University with the degrees MA, BM BCh. I joined my present GP practice initially as an assistant and then as a partner. In 1988 I took up the additional post of Clinical Assistant in Elderly Medicine on a part time sessional basis. This post originally covered three sites but in due course was centred at Gosport War Memorial Hospital (GWMH). I retired from that position this year.

3. As a General Practitioner, I have a minimum full time position. I have approximately 1500 patients on my list. I conduct half of the on call responsibilities of my partners, with one night each fortnight on call and one weekend every quarter. I carry out one morning surgery every day and evening surgeries on a pro rata basis.

4. The GWMH has 48 long stay beds and is designed to provide continuing care for elderly patients. In each week I would carry out 5 Clinical Assistant sessions. When in this post I would attend the hospital every week day morning at an early hour to review patients and would conduct two formal ward rounds each week with the consultant geriatrician. At the time of my retirement from the post there were two consultants attending the wards. Dr Lord was the consultant responsible for Daedalus Ward. In August 1998, however only one consultant was in post; Dr Lord who was thus covering both wards. The other consultant was on maternity leave.

5. The consultant would ordinarily carry out two ward rounds each week; one continuing care and a Stroke round on Daedalus on a Thursday afternoon. Her other clinical commitments were on two other hospital sites, but she was usually available by telephone for advice and assistance

6. As Clinical Assistant, I was responsible for care of patients in both wards at the hospital. My work involved seeing a large number of elderly patients approaching the end of their lives and requiring continuing care from the Health Service. Many patients had undergone orthopaedic procedures following falls, whether in their own home, sheltered accommodation or

in residential care. They were transferred to our care once their acute management was completed. Many of the patients were also demented. I spent time attempting to forge a relationship with families and helping them to come to terms with the approaching death of a loved one. One of the strengths of our unit is that patients can be offered a level of freedom from pain, discomfort, unpleasant symptoms and mental distress which is much more difficult to deliver in an Acute Unit. One complication for our patients is that the act of transferring someone from one unit to another for whatever reason causes a marked deterioration in their condition, which may last for several days and is frequently irreversible.

7. In carrying out my work I relied on a team of nurses, both trained and untrained, to support the work that I did. Their attitude towards relatives and handing of the patients is crucial to the way the unit works. My work also involved providing support and guidance to my staff.

8. Mrs Gladys Richards was 91 and was admitted to the GWMH on 11.8.98. She had previously been a resident in the Glenheathers Nursing Home in Lee-on-the-Solent where she had fallen and fractured the neck of her right femur. She had been admitted to the Royal Hospital Haslar (RHH) and undergone a right hemi arthroplasty, a major orthopaedic procedure involving replacing the head of her femur with a metal prosthesis. The operation is performed to relieve pain and to give a patient a chance of walking again.

9. Following surgery she was assessed at RHH by Dr Ian Reid, Consultant Physician in Elderly Medicine at the Queen Alexandra Hospital, Portsmouth. Dr Reid provided an opinion to the Orthopaedic Consultant Surgeon at RHH, which gave some of the background information to Mrs Richards' condition. He reported that Mrs Richards had apparently been confused for some years, but was mobile in her nursing home until around Christmas 1997 when she had sustained a fall. She started to become increasingly noisy. She had been seen by Dr Banks a consultant Psycho geriatrician who appeared to have felt that she was depressed as well as suffering from a dementing illness. She had therefore been treated with haloperidol, a major tranquilliser and Trazodone, a sedating antidepressant.

10. Dr Reid reported that according to Mrs Richards' daughters she had been "knocked off" by this medication for months and had not spoken to them for some six to seven months. Her mobility had also deteriorated in that time and when unsupervised she had a tendency to get up and fall. Dr Reid understood that she was usually continent of urine but had occasional episodes of faecal incontinence. Dr Reid noted that following admission, Haloperidol and Trazodone had been stopped. According to the daughters, following the discontinuance of the Haloperidol and

Trazodone she appeared much brighter mentally and had been speaking to them at times. Dr Reid went on to say that when he had seen Mrs. Richards in hospital on 3rd August she had clearly been confused and was unable to give any coherent history. She was, however, pleasant and co-operative. She was able to move her left leg quite freely and, although not able actively to lift her extended right leg from the bed, she appeared to have little discomfort on passive movement of the right hip. Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to re-mobilise and it was his intention therefore to arrange transfer to the GWMH on Daedalus Ward under the care of his colleague Dr Lord in order to give her this opportunity.

11. The admission then took place to the GWMH on 11th August. The RHH would not have been able to keep Mrs Richards as an in patient, as her condition was not appropriate for an acute bed. Dr Reid had also recorded that Mrs Richards' daughters were unhappy with the care she had been receiving at the Nursing Home and that they did not wish her to return there. Her admission was therefore also a holding manoeuvre while it was seen whether she would recover and mobilise after the surgery. In this case she could be transferred back to a nursing home. If, as was more likely, she would deteriorate due to her age, her dementia, her frail condition and the shock of the fall followed by the major surgery, then she was to be nursed in a calm environment away from the stresses of an acute ward.

12. I assessed Mrs. Richard on admission. My admission note made on 11th August reads as follows:-

11.8.98 *Transferred to Daedalus Ward Continuing Care*
HPC Ⓡ # neck of femur 30.7.98
PMH) Hysterectomy 1955
Cataract operations
deaf
Altzheimers
0/E Impression frail hemi arthroplasty.
Not obviously in pain.
Please make comfortable.
transfers with hoist
usually continent
needs help with ADL
Barthel 2

I am happy for nursing staff to confirm death

13. In my view Mrs Richards was probably near to death, in terms of weeks and months from her dementia before the hip fracture supervened. Given her transfer from nursing home to acute hospital and then to continuing care and the fact that she had recently undergone major surgery; in addition to her general frailty and dementia, I appreciated that there was a possibility that she might die sooner rather than later. This explains my reference at that time to the confirmation of death, if necessary by the nursing staff.

14. The Barthel score is an assessment of general physical and life skill capability. The maximum score available would be 20, but Mrs Richards was so dependant that she scored only 2. She needed total care with washing and dressing, eating and drinking and was only mobile with 2 people and hoist for transfers to bed from chair etc..

15. When I assessed Mrs Richards on her arrival she was clearly confused and unable to give any history. She was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including Oramorph and Diamorphine. This allowed nursing staff to respond to their clinical assessment of her needs, rather than wait until my next visit the following day. This is an integral part of team management. It was not in fact necessary to give Diamorphine over the first few days following her admission but a limited number of small doses of Oramorph were given totaling 20mg over the first 24 hours and 10 mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure.

16. On the afternoon of 13th August Mrs Richards was found by nursing staff to have slipped out of her chair at approximately 1.30pm. I was not at the hospital or on duty at that time, and I was not made aware that day that she had injured herself. The duty doctor, Dr M. Brigg was contacted during the evening by nursing staff. He advised analgesia through the night and an X-Ray the following morning. The X-Ray Department at GWMH closes at 5.00pm and he felt that it was not appropriate to transfer and X-Ray the patient at RHH that evening. A transfer that evening would not have altered clinical management and it was left that I would review the patient in the morning. I arrived as usual early on the following morning 14th August and assessed Mrs. Richards. The report I received from the trained staff on duty that Friday morning

stated that she had slipped out of her chair the previous day. I arranged an X-Ray and discussed the position with the ward manager Philip Bede. The plan was that if the X-ray confirmed a dislocation of her prosthesis then Mrs Richards should be transferred to Haslar after confirmation with Dr Lord. The X-ray revealed that she had indeed dislocated her prosthesis. Surgeon Commander Spalding at the RHH was contacted and Mrs Richards was duly transferred back to the Haslar hospital. Although I was concerned, given Mrs Richard's overall condition and her frailty, that she might not be well enough for another surgical procedure; I felt that this clearly would be a matter for assessment by the clinicians at Haslar.

17. My notes on that occasion read as follows:-

"*14.8.98* *Sedation/pain relief has been a problem*
screaming not controlled by haloperidol
but very sensitive to Oramorph.
Fell out of chair last night
(R) hip shortened and internally rotated
Daughter aware and not happy
Plan X-Ray
Is this lady well enough for another surgical procedure?"

18. I later made a further entry in Mrs Richards' records as follows:-

"*14.8.98* *Dear S. Cdr Spalding*
Further to our telephone conversation
thank you for seeing this unfortunate
lady who slipped from her chair at
1.30 p.m. yesterday- and appears to have
dislocated her R hip
hemi arthroplasty was done on 30.7.98
I am sending X-Rays across
she has had 7.5 mls of !0 mg/ in 5 ml oramorph
at midday
Many thanks"

19.. This is a copy of the courtesy referral letter I prepared to advise Surgeon Commander Spalding of the position after telephoning him. Once at RHH. Mrs Richards had a closed

reduction of the prosthesis under intravenous anaesthesia. She remained unconscious and unresponsive for approximately 24 hours during which time she was catheterised. Normally a healthy patient would wake up within minutes of the end of an Intra-venous anaesthetic (a short acting agent is used). This worrying response to the anaesthetic may well have been an indication of how ill and frail she was.

20. On 17th August it was considered appropriate to transfer her back to the Daedalus Ward at GWMH. The discharge letter from RHH to the nurse in charge gave advice as to how she was to be nursed using a canvas knee immobilising splint to prevent crossing of the legs and further dislocation of the hip as this was a strong possibility. This splint was to remain in situ for four weeks. When in bed it was advised that the hips be kept apart using pillows or a wedge, again to reduce the chances of dislocation. Despite these instructions while she was in bed, she could be stood with 2 nurses and fully weight bear. This instruction was given because when possible it is important to keep elderly patients moving. The surgeon was making it clear that if her general condition did improve then standing her out of bed would pose no dangers for the stability of her prosthesis.

21. I saw Mrs Richards when she was readmitted on the 17th August and my note reads as follows:-

17.8.98 *readmission to Daedalus from RHH*
closed reduction under iv sedation
remained unresponsive for some hours
now appears peaceful
Plan continue haloperidol
only give oramorph if in severe pain
see daughter again"

22. At the time of her arrival back on the ward Mrs Richards appeared peaceful and not in severe pain. This was however an initial judgement made on an assessment shortly after her arrival on the ward. I was concerned that she should have opiates only if her pain became a problem, and I altered her drug chart accordingly. I was not aware at that time that she had been having intravenous morphine at RHH until shortly before her transfer. This would have explained why at this time she appeared to be peaceful and not in pain. Her general condition had deteriorated as a result of the further operative procedure and subsequent transfer. For a frail, elderly and demented person, this can have a profound effect on their chances of survival. My

note "see daughters again" indicated that I should explain the position to Mrs Richards' daughters and prepare them for what I believed was to come. In my experience, transfer of an elderly frail patient in such circumstances frequently causes a set back in their condition with a marked deterioration. It can be something from which the patient does not recover.

23. I believe Mrs Richards later experienced further pain as it was necessary for the nursing staff to give Oramorph on four occasions between 1300 on the 17th and 0500 on the 18th August. During that time I was telephoned by the nursing staff out of my contracted hours and informed that Mrs Richards was very uncomfortable and might have suffered a further dislocation. I asked for another X- Ray to be arranged. It transpired that it was not possible for the X-Ray to be carried out simply on the basis of a verbal order; accordingly another GP signed the relevant form and the duty Doctor from my practice viewed an X-Ray with the consultant reporting the film. As far as I am aware he did not see the patient or write in her notes. The X-Ray did not show any dislocation.

24. I then reviewed Mrs Richard early the following morning. My entry for the 18th August reads as follows:-

18.8.98 *Still in great pain*
nursing a problem
I suggest sc diamorphine/Haloperidol/
Midazolam
I will see daughters today
Please make comfortable"

25. To my mind having seen Mrs Richard originally when she had been admitted on the 11th August there was by this stage a marked deterioration. My assessment of Mrs Richards on this occasion confirmed my view reached on readmission the previous day that she was dying. She was barely responsive and was in a lot of pain. By this time she was not eating or drinking. When I examined Mrs Richards there was a lot of swelling and tenderness around the area of the prosthesis. There was no evidence of infection at that time, and it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated. This was in all probability the cause of Mrs Richards' significant pain and unfortunately a not uncommon sequel to a further manipulation required to reduce the dislocation. This complication would not have been amenable to any surgical

intervention and again further transfer of such a frail and unwell elderly lady was not in her best interests and was inappropriate.

26. After I had seen Mrs Richards that morning and following morning GP surgery, I then spoke with her daughters in the presence of Philip Bede the Ward Manager. I explained my concern to administer appropriate and effective pain relief and that without this nursing their mother was a significant problem. They understood, but did not like the idea that diamorphine was to be given. However I explained that it was the most appropriate drug. As their mother was not eating or drinking or able to swallow, subcutaneous infusion (a tiny needle implanted under the skin) of pain killers was the best way to control her pain and by titrating the dose over 24 hours frequent injections could be avoided. Both daughters reluctantly agreed to the use of a syringe driver. This drug, the dose used and this mode of administration are standard procedures for patients who are in great pain but who cannot safely take medicines by mouth.

27. I believe I would have mentioned fluids and explained that in my view they were not appropriate. I was aware that Mrs Richards was not taking food or water by mouth. It would have been dangerous to try to give her food or water by mouth as her poor conscious state meant that she might have choked. Mrs Richards would have had mouth care and sips of water to aid her comfort. In view of this the only alternative for further nutrition would have been to administer fluids intravenously or subcutaneously. We did not have the facilities to administer iv fluids, and accordingly to do that it would have been necessary to transfer her back to an acute unit. I did not feel that this was appropriate medically. She might well not have survived the journey let alone the process. Given my assessment that she was terminally ill and that the actual administration of fluid would not affect that outcome, it would not have been in her best interests and could have caused her further pain and distress.

28. I believe I would have explained to the daughters that subcutaneous fluids were not appropriate. Their use would not have altered the outcome and there are several clinical studies showing this in terminally ill patients. Administration of subcutaneous fluids can cause significant tissuing of fluid and discomfort for the patient. There is a risk of oedema and infection and even tissue necrosis. If the kidneys are failing the additional fluids can overload the heart and precipitate heart failure. This would cause clinical distress and require unpleasant treatment. Given these potential complications and the fact that subcutaneous fluids would not have affected the outcome, again I did not consider it would be in Mrs Richards' best interests that subcutaneous fluids be given.

29. I also included in my discussion the opinion that Mrs Richards was likely to develop a chest infection due in part to her immobility despite regular turning by the nurses and partly due to the inadequate clearing of secretions. Antibiotics would not have been appropriate or indeed effective.

30. I said to the daughters that the prognosis was very poor and that she was not well enough for a further transfer to an acute unit. I was concerned in all the circumstances to provide an honest view.

31. When Mrs Richard was admitted to Daedalus Ward for the first time, I think it was suggested by her daughters and reported to me by nursing staff, that she might be sensitive to morphine, hence my mention of it in the clinical notes of 14.8.98. However I had seen no evidence of that when she had been given Oramorph earlier in her admission. In the first 18 hours following her transfer back from RHH she was not responding to a total of 45 mg of morphine orally in less than 24 hours. Therefore to ensure pain relief this would have to be increased. Diamorphine is a more potent analgesic than Morphine. In view of the need to increase the amount of pain relief (45mgs of Morphine in less than 24 hours having been clearly insufficient) and that Morphine (into which Diamorphine is broken down) has a relatively short half life, I consider that 40mgs of Diamorphine was appropriate for her pain relief. Mrs Richards would also have developed a tolerance to opiates through the previous administrations of Oramorph.

32. My use of Midazolam in the dose of 20 mg over 24 hours was as a muscle relaxant, to assist movement of Mrs Richards for nursing procedures in the hope that she could be as comfortable as possible. I felt it appropriate to prescribe an equivalence of Haloperidol to that which she had been having orally since her first admission.

33. I reviewed Mrs Richards' condition with the senior trained staff again on the morning of 19th August. From my assessment it was apparent that she had a 'rattly' chest and had developed bronchopneumonia. This would have been as a result of her frail condition and despite the fact that she was being turned regularly she was vulnerable to an infection developing. I did not make a note of this assessment but did prescribe hyoscine in the dose of 400 mcg and this was duly added to the syringe driver. Hyoscine is an antimuscarinic drug which is given to dry the bronchial secretions produced by the infection. This drug as with the others was reviewed and discussed daily as I visited the ward and assessed her overall condition. I am clear in my mind that there was no apparent depression of Mrs Richard's respiration. Had

there been any such depression, I would have reviewed the drug regime. As it was, Mrs Richards was apparently now out of pain and accordingly I considered the drug regime and the dose used to have been appropriate. In such circumstances, as I was not in position to attend continuously, it was necessary to have reliance on the nursing staff for reports on any problems arising. No further problems were related to me during this period. I saw Mrs Richards again on the morning of 20th August. There was no significant change in her overall condition.

34. I saw Mrs Richards again on the morning of 21st August. My note of that attendance reads as follows:-

21.8.98 *I think more peaceful*
needs hyoscine for rattly chest"

35. In my clinical opinion, by the 19th August Mrs Richards had developed bronchopneumonia. I do not believe that the dose of 40 mg of diamorphine administered over 24 hours had contributed to the development of the bronchopneumonia. It was an appropriate amount required to relieve her of her pain.

36. Sadly Mrs Richards died on 21st August, being pronounced dead at 9.20pm by one of the nursing staff. I gather that her daughters were with her when she died.

37. On the next working day, Monday , 24th of August, I discussed the case with the Coroner's Officer, a police officer at Cosham Police Station. I informed him that Mrs Richards had sustained a fractured neck of femur on the ~~13th August~~ 30th July and was subsequently operated on at RHH. I would have told him of the dislocation and the fact that she had returned to RHH and back to our care and had died on 21st August; in my view of bronchopneumonia. The Coroners Officer was happy that no further investigation was required and I signed the death certificate putting bronchopneumonia as the cause of death. I believe that this was the cause of death in all the circumstances.

38. At no time was any active treatment of Mrs Richards conducted with the aim of hastening her demise. My primary and only purpose in administering the Diamorphine was to relieve the pain which Mrs Richards was suffering. Diamorphine can in some circumstances have an incidental effect of hastening a demise but in this case I do not believe that it was causing respiratory depression and was given throughout at a relatively moderate dose.

39. Similarly it was not my intention to hasten Mrs Richard's death by omitting to provide treatment for example in the form of intravenous or subcutaneous fluids. By the 18th August it was clear to me that Mrs Richards was likely to die shortly. I believed that transfer to another hospital where she would be in a position to receive intravenous fluids was not in her best interests as it would have been too much of a strain and brought about a premature demise. There is clear evidence that the administration of intravenous or subcutaneous fluids would not have prolonged her life and faced with the complications which could arise such intervention was not in her best interests.

40. I explained the position to Mrs Richard's daughters, they did not appear to demur at the time and indeed at no time requested a second opinion.

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STATEMENT OF DR JANE BARTON - RE: RUBY LAKE

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

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mrs Ruby Lake. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mrs Lake.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. I confirm that these comments are indeed a fair and accurate summary of the position in 1998 when I was involved in the care of Mrs Lake.

4. Ruby Lake was admitted to the Gosport War Memorial Hospital on 18th August 1998. She had previously been admitted to the Royal Hospital Haslar on the 5th August 1998 via Accident and Emergency after falling at home. She had fractured left neck of femur and had undergone left semi hemiarthroplasty.

5. Mrs Lake had been diagnosed as suffering with mild hypertension as early as 1980 and had gone on to develop arthritis and gout. In 1988 a chest x-ray had revealed cardiomegaly, an enlarged heart. She had also suffered with leg ulceration and liposclerosis with soft tissue calcification.

6. In September 1993 she was then admitted to the Queen Alexandra Hospital as an emergency suffering with chest pain, and it appears that those caring for her considered that she had left ventricular failure of the heart and that she had previously had a myocardial infarction.

7. Mrs Lake was then discharged from Hospital towards the end of September 1993, and after discharge was seen on 30th September by Consultant Geriatrician Dr Althea Lord. Dr Lord wrote to Mrs Lake's GP on the 30th September noting the diagnosis as left ventricular failure, controlled atrial fibrillation, aortic sclerosis, improving renal failure, and osteoarthrosis. She said that Mrs Lake had done well since discharge.

8. Mrs Lake returned to Dr Lord's clinic on the 4th November 1993. Dr Lord's senior registrar felt that on examination she was reasonably well but noted elevated blood pressure and that she remained in atrial fibrillation which was said to be controlled.

9. In August 1997 Mrs Lake was then referred by her General Practitioner to Dr Barrett, Consultant Dermatologist at the GWMH. The GP noted that Mrs Lake had had terrible ulcers on her legs in the past. She now had a recurrent lesion on her lower leg which the Practice Nurse had been trying to heal but without success. This had been getting bigger and her GP Dr North was concerned to see Dr Barrett's assessment and advice.

10. It seems that in due course Mrs Lake's condition improved. She was reviewed by Dr Barrett at his Dermatology Clinic on the 3rd January 1998, and he wrote to Mrs Lake's GP several days later indicating that her right leg was looking very much better, but said there was so much soft tissue calcification on the leg that there was likely to be further ulceration in the future.

Code A

11. In March 1998 Mrs Lake was referred by her GP once more, to Consultant Rheumatologist Dr McCrae with further difficulties associated with her osteoarthritis. Dr McCrae's senior registrar reported to the GP that Mrs Lake had had joint pains affecting her shoulder and her knees intermittently for 20 years. These apparently continued to trouble her with difficulty standing and walking. Her main complaint at that point was apparently of lower left lumbar pain which had been worse since a fall at Christmas.

12. Following x-rays, Dr McCrae then saw Mrs Lake again on the 27th April 1998 on noting that there were quite marked degenerative changes in the lower lumbar facet joints. She planned to arrange physiotherapy.

13. In June 1988 Mrs Lake was then admitted to Sultan Ward at the GWMH with infected leg ulcers. It is not immediately clear to me when

she was then discharged, but her records show that on the 5th August she was then admitted to the Royal Hospital Haslar having fallen. A fractured left neck of femur was diagnosed, and as I have indicated an operation - a cemented hemiarthroplasty was then performed the same day. It appears that at some stage shortly after admission to hospital, Mrs Lake was given 2.5mgs of Diamorphine intravenously for pain relief.

14. Mrs Lake had something of a stormy post-operative course, in developing chest pain and pulmonary oedema, shortness of breath, diarrhoea and vomiting. By the 10th August she was suspected to have a chest infection and it was thought she might have suffered a myocardial infarction. She was also dehydrated.

15. On the 12th August the Registrar seems to have thought that Mrs Lake was much improved but she was developing sacral bed sores. The following day Dr Lord was asked to review her by Surgeon Captain Farquharson-Robert. His House Officer recorded in a note to Dr Lord in Mrs Lake's records that post-operative recovery had been slow with periods of confusion and pulmonary oedema, though she had been alert and well over the last two days. Dr Lord duly saw Mrs Lake the same day, noting in her records that she had a left bundle branch block and left ventricular failure, which was improving. The left bundle branch block would have resulted in the electrical pulses to the left side of the heart being interrupted. In addition, Dr Lord noted that Mrs Lake had sick sinus syndrome with atrial fibrillation. This meant that the heart was not transmitting electrical impulses properly and so was not beating efficiently - hence the reference to atrial fibrillation. Mrs Lake was said to be dehydrated but improving. She had bilateral buttock and leg ulcers and hypokalaemia - a low potassium level, together with

normochromic anaemia. Mrs Lake had been suffering with vomiting and diarrhoea.

16. Dr Lord suggested that Mrs Lake should have a potassium supplement in the form of slow K, given that she was on Digoxin, a cardiac glycoside which was being administered to reduce oedema in view of the left ventricular failure. Dr Lord also noted that Mrs Lake should be hydrated orally, and that stools should be sent for culture and sensitivity. She concluded her note by stating that it was difficult to know how much Mrs Lake would improve but that she would take her to an NHS continuing care bed at the GWMH the following week.

17. It was apparent from Dr Lord's note that she recognised that Mrs Lake might very well not recover, and I anticipate from those circumstances given her underlying condition, including heart failure, Mrs Lake might die.

18. Dr Lord then wrote to Surgeon Captain Farquharson-Roberts the following day recording her history and that the ECG showed atrial fibrillation and a variable interval indicating the sick sinus syndrome, with ischaemic heart disease and left ventricular failure also having been problems. She noted that Mrs Lake's appetite was poor and that she was eating and drinking small amounts. Dr Lord confirmed to Surgeon Captain Farquharson-Roberts that she was happy to arrange the transfer to the GWMH, uncertain as to whether there would be a significant improvement. She said that overall Mrs Lake was frail and quite unwell at present.

19. A Barthel assessment was conducted on the 15th August, giving a score of 9.

20. Following on from Dr Lord's assessment, Mrs Lake was then duly admitted to the GWMH on the 18th August 1998. It is apparent from her records that I admitted her, though I am unable now at this remove of time to recall anything about her. In any event, my note in her records on this occasion reads as follows:-

> "18-8-98 Transfer to Dryad Ward continuing care
> HPC # n o femur L 5-8-98
> PMH Angina
> CCF
> Catheterised
> transfers with 2
> needs some help c ADL
> Barthel 6
> Get to know
> gentle rehabilitation
> I am happy for nursing staff to confirm death"

21. As is apparent from my note the history of present complaint was the fracture of the neck of femur which had occurred on the 5th August. I also recorded the past medical history of angina and congestive cardiac failure, noting at this stage that Mrs Lake was catheterised, that she transferred with the assistance of two people, and needed help with activities of daily living. I noted a Barthel assessment of 6, though I anticipate that would have been related by others rather than being a reflection of my own assessment at that stage. Clearly Mrs Lake had a significant degree of dependence.

22. My note also indicates I hoped that gentle rehabilitation could take place, but I would have been aware that Mrs Lake was in a frail condition and quite unwell, as of course previously noted by Dr Lord. I was conscious that Mrs Lake might not recover hence my note that I was happy for nursing staff to confirm death. Mrs Lake had had the

trauma of a fractured neck of femur with a significant operation in consequence, she had heart failure, and had possibly experienced another myocardial infarction. She had also just undergone the stress of a hospital transfer at the advanced age of 84. My note was designed to ensure that the nursing staff were aware that it was not necessary to call a doctor to attend to certify if death occurred out of hours, as I indicated previously.

23. Having assessed Mrs Lake, I then prescribed various medications for her, specifically Digoxin administered to improve her cardiac output in view of the left ventricular failure, Slow K to maintain Potassium in view of her previous dehydration, Butemetamide a diuretic, again for her congestive cardiac failure, and Allopurinol for her gout. I also prescribed Temazepam as required to assist sleeping. All of these medications previously had been prescribed at the Royal Hospital Haslar.

24. In addition, I prescribed Oramorph for pain relief. I was concerned that Mrs Lake might very well require pain relief in view of the recent fracture and operation, and in consequence of the sacral and leg ulcers. The Oramorph was in a 10mg in 5 mls solution, and at a dose range of 2.5 to 5mls four hourly.

25. The records show that 5mgs of Oramorph was given at 2.15pm, and the nursing entry for that afternoon indicates that Mrs Lake seemed to have settled quite well and was fairly cheerful.

26. Mrs Lake was then noted to have settled and slept well from 10pm through to midnight, but she apparently awoke very distressed and anxious, saying that she needed someone with her. A further 10mgs of

Oramorph was given at 12.15am, but apparently with little effect, and Mrs Lake remained very anxious during the night and was confused at times. Temazepam was available for the nursing staff to administer, but they probably did not consider that appropriate, and preferred the Oramorph in view of the fact that she was suffering from anxiety and distress, for which the Oramorph would be appropriate.

27. Oramorph was also appropriate in view of Mrs Lake's history of congestive cardiac failure. Temazepam might have made Mrs Lake's heart failure worse, and it is conceivable at this stage Mrs Lake was experiencing further heart failure.

28. I would have reviewed Mrs Lake again the following morning, 19th August. I believe that I was chairing a Primary Care Group Steering group meeting at the GWMH starting at about 12.30pm, so I would have seen Mrs Lake, and all the other patients on the Dryad and Daedalus wards in advance of that.

29. I have not made a specific entry of this in Mrs Lake's medical records, and anticipate that I simply did not have an opportunity through excessive pressure of work, for the reasons previously stated. I anticipate I was concerned that Mrs Lake's condition had deteriorated from her already frail and poorly state in view of the transfer and the difficulty she had overnight. I believe I would have been concerned she might now be likely to die shortly, and was anxious that she should have appropriate relief from the pain of her fractured hip and sacral ulcers, and from her anxiety and distress which had been apparent overnight. Opiates provided for that purpose would also assist in relieving the pulmonary oedema from congestive cardiac failure.

30. Accordingly, I prescribed Diamorphine, 20 to 200mgs, Hyoscine 200 to 800mcgs and Midazolam 20 to 80mgs, all to be administered subcutaneously. It was of course my intention that these medications, if necessary, should be started at the bottom end of the dose range, but increase was available within this prescription if that proved necessary.

31. The nursing record shows that at 11.50am on 19th August Mrs Lake complained of chest pains. The nurse specifically noted that this was not radiating down the arm and was no worse on exertion. Mrs Lake's pulse was measured at 96 and she was noted to be grey around the mouth. Quite properly a further 10mgs of Oramorph were given. The nursing record also indicates that the doctor was notified, and my expectation is that I would have been informed of Mrs Lake's condition at about this time, and I would have been quite content that Oramorph should be given for the pain, though I have no recollection of events at this remove of time. There is no ECG available at the hospital, and it would have been difficult to say if Mrs Lake had experienced another myocardial infarction but I anticipate there was increasing cardiac failure.

32. Unfortunately, it seems that the Oramorph was not successful in relieving the pain over any prolonged period. A further nursing entry indicates that the pain was only relieved for a short period and Mrs Lake was said to be very anxious. Accordingly, the syringe driver was commenced with 20mgs of Diamorphine and 20mgs of Midazolam at 4pm that afternoon.

33. I do not know if I was informed of this at the time, but given the fact that Mrs Lake was still suffering with pain and was very anxious,

institution of the Diamorphine and Midazolam at these levels was in my view entirely appropriate. By this stage of course Mrs Lake had received quantities of Oramorph which sadly had not been sufficient.

34. It appears that in consequence, Mrs Lake had a comfortable night and did not suffer with distress and anxiety as she had the previous evening. The nursing entry records that she settled well, had a comfortable night and was drowsy but rousable the following morning.

35. Unfortunately it seems that Mrs Lake's condition was perceived to be deteriorating. The syringe driver was re-charged at 10.10am, on 20th August - and in addition to the 20mgs of Diamorphine and Midazolam, 400mcgs of Hyoscine was added. The Hyoscine would have assisted in reducing the pulmonary oedema and secretions consequent on Mrs Lake's heart failure. The nursing record also indicates that Mrs Lake's family were informed of her condition, with her daughter being present. Again, I anticipate I would have reviewed Mrs Lake that morning, but did not have an opportunity to note this in her records.

36. Over the course of the next night, Mrs Lake's condition apparently continued to deteriorate. The nurses recorded that she remained very bubbly, with suction being attempted, and it is likely that the Hyoscine had previously been administered in consequence of those secretions. Mrs Lake was apparently distressed when turned, and clearly in spite of the fact that Diamorphine and Midazolam were administered, they were not entirely successful in relieving Mrs Lake's distress.

37. In view of the continuing distress, it appears that the driver was re-charged at 7.35 - the following morning, this time with 60mgs of Diamorphine, 60mgs of Midazolam and 800mcgs of Hyoscine.

38. I believe I would have reviewed Mrs Lake's condition again that morning, though whether this was before or after the re-charging of the syringe driver I cannot say. It is possible that I was not informed of the increase at that point, but would have arrived very shortly afterwards and reviewed Mrs Lake, and would have been content that it was appropriate. Again I was probably unable to make an entry in her records for the reasons previously stated.

39. Unfortunately, as evidence by the nursing notes, Mrs Lake's condition continued to deteriorate. It is recorded that all care continued, and that her family were present all afternoon. Sadly she passed away at 6.25pm.

40. The Diamorphine, Midazolam and Hyoscine were prescribed, and in my view administered solely with the intention of relieving the pain, anxiety and stress which Mrs Lake was suffering, in conjunction with her congestive cardiac failure. At no time was any medication provided with the intention of hastening Mrs Lake's demise.

Signed in the presence of Dr Yates

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STATEMENT OF DR JANE BARTON - RE ARTHUR CUNNINGHAM

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

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Arthur Cunningham. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mr Cunningham.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. I confirm that these comments are indeed a fair and accurate summary of the position in 1998 when I was involved in the care of Mr Cunningham.

4. Arthur Cunningham was a retired gentleman of 79 who had been under the care both of Elderly Medicine and of Elderly Mental Health for some time. He suffered from Parkinson's disease, and features of this degenerative disease had apparently been present since the mid 1980's. In addition, Mr Cunningham had an old spinal injury from a plane crash during the second world war - with associated chronic back pain, and diet controlled type 2 diabetes mellitus.

5. Mr Cunningham was referred to Dr Lord by his GP in early 1998 with complaints of breathlessness. Dr Lord saw him in March and considered that he might have problems with intermittent left ventricular failure. She also gave advice about the level of his medication for his Parkinson's disease.

6. At that time Mr Cunningham was living in sheltered accommodation, where he had been for a number of years. It appears that he was then admitted to the Merlin Park rest home shortly after he saw Dr Lord. It appears that Mr Cunningham attended at the Dolphin Day Hospital on a number of occasions before being referred once more to Dr Lord by his GP in June 1998. Mr Cunningham had apparently developed quite marked dystonic movements involving his face trunk and arms, and he had been experiencing hallucinations which the GP thought might be due to the amount of medication for his Parkinson's.

7. Dr Lord saw Mr Cunningham at a domiciliary visit on 19th June. When she wrote back to his GP several days later she said that she was most struck at the amount of weight Mr Cunningham seemed to have lost since she had last seen him. She felt he was indeed taking too much Levopoda for

his Parkinson's, and that he was depressed at the move to the rest home. Mr Cunningham apparently agreed to attend at the day hospital.

8. However, even before that arrangement could be put into effect, on 22nd June, Mr Cunningham was then brought by a social worker to the Phoenix Day Hospital, which was located in the same building as GWMH. Mr Cunningham had apparently stayed the previous night with friends and was refusing to return to the Merlin Park rest home. In addition to Parkinson's disease, he was felt to be suffering with dementia, hallucinations from his medication, and from depression.

9. The medical records suggest that a place was then found at Alverstoke nursing home. He was reviewed at the Dolphin Day Hospital on 6th July, when his Barthel score was 9 (having been 17 the previous year), and he was then seen the following day at Alverstoke at a domiciliary visit by staff grade psychiatrist Dr Mary Scott-Brown. Dr Scott-Brown felt that Mr Cunningham was clinically depressed and prescribed Sertraline, an anti-depressant.

10. Mr Cunningham was then seen again at the Dolphin Day Hospital, where concern was raised about him having problems with a myeloproliferative disorder and it appears that the Sertraline may have been discontinued in consequence. It seems that Mr Cunningham continued to be depressed and arrangements were then made for him to be admitted to the Mulberry Ward at the GWMH on 21st July. He was assessed on admission when his problems were considered to include dementia, Parkinson's disease, depression, and myelodysplasia. The latter was demonstrated by thrombocytopaenia - a low platelet count, and neutropaenia - a low white cell count. It was felt that this had been a chronic problem since February the previous year, and that he was more susceptible to

infection. At the time of admission he was considered to be "quite physically frail".

11. Mr Cunningham was seen by Dr Lord on 27th July when she noted that he had low albumin and white cell counts. By this stage he was receiving Mirtrazapine as an alternative anti depressant to the Sertraline.

12. Mr Cunningham remained on Mulberry Ward for a period slightly in excess of a month. His notes show that he was reviewed by Dr Lord on the 27th August. Dr Lord noted that Mr Cunningham had been catheterised as he had been retaining urine, and 1900 mls were produced on catheterisation. A nursing note the same day indicates that granuflex dressing continued to be applied to the sacral area, and indeed 6 days previously there had been a note indicating that the area was sore and cream had been applied. Dr Lord felt that the Parkinson's disease had deteriorated and Mr Cunningham was now not really mobile. Dr Lord decided to continue with the same dose of L-Dopa for his Parkinson's disease as increasing this might worsen Mr Cunningham's mental state. She felt Mr Cunningham should be transferred to the Thalassa Nursing Home the following day, and follow-up was to be arranged at the Dolphin Day Hospital, with Mr Cunningham to be seen there on the 14th September. The Waterlow pressure score at that time was measured at 20, constituting a very high risk.

13. Mr Cunningham was actually discharged two days later, on the 29th August. A placement had by that stage been found at the Thalassa Nursing Home. The discharge note records that Mr Cunningham's myelodysplasia was stable, and that his creatinine following the urinary retention was abnormally high at 301.

14. Mr Cunningham was then duly seen at the Dolphin Day Hospital on the 14th September, and by this stage the area on the sacrum had deteriorated. The nursing assessment indicates that pressure areas were broken on the sacrum and that Mr Cunningham required pressure relieving cushions. It seems from the subsequent nursing note that a swab would have been taken from the sacral sore at the attendance on the 14th September.

15. He was seen at the Day Hospital by Dr Ross, and his current medication was noted to be Amlodipine 5mg Code A hypertension, Magnesium Hydroxide 10mls bd for constipation, Codanthrusate 2 capsules nocte for severe constipation, Sinamet 110 I qds and Sinamet CR I nocte both for Parkinson's disease, Co-proxamol 2 qds for pain relief, Mirtazapine 30 mgs nocte as an anti-depressant, Senna 2 nocte for constipation, Triclofos 20 mls nocte as sedation to assist sleep, Risperidone 0.5 mgs at 6pm also for sedation, and Carbamazepine 100 mgs nocte as sedation and pain relief from neuralgia.

Code A

16. Mr Cunningham attended again at the Day Hospital 3 days later on the 17th September, when the swab was noted to have had a positive result, and an anti-biotic, Metronidazole was commenced. The nursing notes record that Dr Lord saw Mr Cunningham that day and there was a possibility he would be admitted the following Monday. Mr Cunningham was also noted as having expressed a wish to die.

17. Dr Lord duly reviewed Mr Cunningham again at the Dolphin Day Hospital on the Monday 21st September. She noted that he was now very frail with an offensive large necrotic sacral ulcer with a thick black scar. She noted his medical problems to be the sacral sore, Parkinson's disease, his old back injury, depression with an element of dementia,

diabetes, and that he had been catheterised for retention of urine. The decision was made to admit Mr Cunningham to Dryad Ward at the GWMH. A note written by a member of the nursing staff on the 24th September, but seemingly relating to about this time recorded that there had been a physical decline and the pressure sore had developed. Mr Cunningham was said to be 'terminally ill and not expected to live past the weekend according to the sister on the ward'.

18. Dr Lord wrote to Mr Cunningham's General Practitioner the same day, reporting that he had been reviewed at the Dolphin Day Hospital, and that he had a "large necrotic sacral ulcer which was extremely offensive. There was some grazing of the skin around the necrotic area, and also a reddened area with a black centre on the left lateral malleolus." Dr Lord said that she was admitting him to the Dryad Ward with a view to more aggressive treatment on the sacral ulcer as she felt that this would now need Aserbine. This is a medication which Dr Lord probably hoped would dissolve the black scab area of the pressure sore, to help with healing. In Dr Lord's entry in the medical records, she noted the plan to administer Aserbine, recorded that Mr Cunningham should be nursed on his side, should have a high protein diet, and that Oramorph should be given if required for the pain. In concluding her note, she recorded that the prognosis was poor. By that, Dr Lord would have felt that Mr Cunningham was probably dying.

19. I recall that prior to Mr Cunningham being moved to Dryad Ward, I went to see him at the Day Hospital together with Sister Hamblin. He was clearly upset, distressed and in pain when we then took him down to Dryad Ward. Once at Dryad Ward I examined him. A photograph was taken of the pressure sore which was very extensive. As Dr Lord had previously produced a detailed note by way of review at the Day

Hospital, and as we had a photographic record of the pressure sore, my note on this occasion was more limited. Given Mr Cunningham's very frail condition and Dr Lord's assessment of the prognosis, I included within my note the entry that I was happy for the nursing staff to confirm death. That would have the effect of ensuring that it was not necessary for a duty doctor to be asked to attend specifically for that purpose if Mr Cunningham were then to die.

20. I assessed Mr Cunningham the same day, and my note reads as follows:

> "21-9-98 Transfer to Dryad Ward
> Make comfortable
> give adequate analgesia
> I am happy for nursing staff to confirm death."

21. The drug chart which had been available at the Dolphin Day Hospital was brought to the ward, and the medication continued - as per the drugs which had been set out by Dr Ross in her record of the 14th September. Dr Lord added the prescription for Oramorph, 2.5 - 10 mls to be available four hourly as required. I also later prescribed Actrapid for Mr Cunningham's diabetes, at 10 units if the blood sugar was in excess of 15, and 5 units if it was in excess of 10.

22. Having assessed Mr Cunningham personally, I was concerned that although the Oramorph would assist in providing pain relief, this might become inadequate. The sacral sore was very significant, being the size of a fist, and the second largest I have ever seen. It was clearly causing Mr Cunningham significant pain and distress at the time when I assessed him. Accordingly, I decided to write up Diamorphine on a proactive basis and a dose range of 20 to 200 mgs. This was a wide

range, but I was conscious that inevitably the medication would be commenced at the bottom end of this range, if given at all. Any increase would then ordinarily be with reference to me or another practitioner.

23. In addition to the Diamorphine I prescribed 200 - 800 mcgs of Hyoscine and Midazolam, 20 - 80 mgs. These medications were prescribed by me purely with the aim of alleviating Mr Cunningham's significant pain, distress and agitation. It was also apparent to me that Mr Cunningham might have a problem with swallowing - Dr Lord's note for earlier that day indicated that tablets had been found in his mouth, and this gave rise to a concern that Mr Cunningham would not be able to take tablets, including the Carbamazepine, Mirtazapine, Risperidone, and Triclofos, the lack or reduction in which would cause corresponding increase in his agitation.

24. The nursing records for the 21st September record the admission and that I saw Mr Cunningham. The nursing record and the drug chart also indicate that at 2.50pm Mr Cunningham was given 5 mgs of Oramorph prior to the dressing of his wound. It appears that a further 10 mgs of Oramorph was given later in the day.

25. A further nursing record indicates that Mr Cunningham was said to very agitated at 5.30pm. A dressing was applied to the buttock at 6.30pm, with Asberine cream to the necrotic area, together with Zinc and Caster Oil to the surrounding skin. Further Oramorph, 10 mgs, was given later at around 8.15 - 8.20pm. A further nursing entry indicates that Mr Cunningham remained agitated until approximately 8.30pm. It seems then that Mr Cunningham pulled off the dressing to the sacral area.

26. Later that evening at about 11pm the syringe driver was established, with 20 mgs of Diamorphine and 20 mgs of Midazolam. I have no specific recollection, but I anticipate that the second dose of Oramorph had been insufficient in relieving the pain and anxiety, and in the circumstances, to ensure that Mr Cunningham was free from pain and anxiety, and had a settled and an uninterrupted night, the Diamorphine was then commenced, providing continuous pain relief for what was clearly a most unpleasant ulcerated wound. A subsequent entry in the nursing notes suggest that Mr Cunningham had been distressed and anxious at about this time; and no doubt he would also have been in pain.

27. I cannot now say if I was specifically contacted about the institution of the Diamorphine. Ordinarily I would have been contacted, but the administration was at the lowest end of the dose range, and its provision had been agreed with me and the nursing staff earlier, so it is possible that specific reference was not made. In any event, the nurses noted that Mr Cunningham was peaceful following the institution of the Diamorphine and Midazolam, and slept soundly. He was said to have had two glasses of milk, taken when he was awake, and in the morning was much calmer. A further nursing entry the following morning records that he had had a very settled night.

28. Although I made no record of it, I would have seen Mr Cunningham again the following morning and reviewed his condition. A Barthel assessment was carried out the same day, Mr Cunningham's Barthel score being nil, in other words he was totally dependent by this time. Again, my ability to complete notes at this stage would have been significantly hampered by my workload, with the large number of patients to be reviewed.

29. The nursing records indicate that Mr Cunningham's step-son telephoned in the course of the day, and it was explained to him that a syringe driver with Diamorphine and Midazolam had been commenced the previous evening for pain relief and to allay his anxiety following an episode when Mr Cunningham had tried to wipe sputum on a nurse saying that he had HIV and he was going to give it to her. This is the episode of distress and anxiety to which I made reference above. He had apparently also tried to remove his catheter and empty the bag, and remove his sacral dressing, throwing it across the room.

30. The syringe driver was noted to have been charged at 8.20pm on 22nd September with a further 20 mgs of Diamorphine and Midazolam, Mr Cunningham noted to appear less agitated that evening. It seems therefore that the Diamorphine and Midazolam had had the appropriate affect, though the agitation was only 'less', and had not apparently resolved completely.

31. I saw Mr Cunningham again the following morning, 23rd September, which is recorded in the nursing record. Again I was unable to make a note in Mr Cunningham's records. The nurses indicated that Mr Cunningham had become chesty overnight and was now to have Hyoscine added to the syringe driver. That would have been a decision made by me following my assessment of him. Mr Cunningham's step-son, Mr Farthing, was contacted and informed of Mr Cunningham's deterioration. The step-son asked if this was due to the commencement of the syringe driver, and was apparently told by the nursing staff that Mr Cunningham was on a small dose which he needed. I would agree that the dose involved was both small and necessary.

32. Later that day Mr and Mrs Farthing came to the hospital and were seen by Sister Gill Hamblin, together with staff nurse Freda Shaw. They were apparently very angry that the driver had been commenced, but Sister Hamblin noted that she explained again the contents of the syringe driver were to control Mr Cunningham's pain, and if discontinued we would need an alternative method of giving pain relief. Sister Hamblin noted that Mr Farthing was now fully aware Mr Cunningham was dying and needed to be made comfortable. It would appear from her note and from the nature of the explanation given to Mr Farthing, that Sister Hamblin agreed this medication was necessary to relieve Mr Cunningham's pain and distress.

33. The driver was then renewed at 8pm with 20 mgs of Diamorphine, but with an increase in the level of Midazolam to 60 mgs, together with 400 mcgs of Hyoscine. I anticipate that Mr Cunningham's agitation might have been increasing, hence the increase in the level of Midazolam, and indeed in spite of that, the notes go on to record that Mr Cunningham became a little agitated at 11pm with the syringe driver being boosted with effect. The nursing staff recorded that Mr Cunningham seemed to be in some discomfort when moved, and the driver was boosted prior to changing position.

34. Again, I anticipate that I would have been contacted about the increase in the medication and agreed with it, though I have got no recollection of this.

35. I anticipate, though I have made no specific note of it, that I would have again seen Mr Cunningham the following morning, 24th September in order to review his condition.

36. On the 24th September, Sister Hamblin recorded a report from the night staff that Mr Cunningham was in pain when being attended to, and was also in pain with the day staff, though it was suggested that this was especially in his knees. In any event, the syringe driver was increased to 40 mgs of Diamorphine, and the Midazolam to 80 mgs, together with 800 mcgs of Hyoscine. The dressing was reviewed in the afternoon, and Sister Hamblin went on to record that Mr Farthing had been seen by me that afternoon and was fully aware of Mr Cunningham's condition.

37. I have no recollection of meeting Mr Farthing, but clearly I did so and indeed that is recorded in my own note in Mr Cunningham's records which reads as follows:-

> "24-9-98 Remains unwell
> Son has visited again today and
> is aware of how unwell he is
> sc analgesia is controlling the pain - just
> I am happy for nursing staff to confirm death"

38. I anticipate that I would have explained Mr Cunningham's condition to his step-son, that we were endeavouring to keep him free of pain distress and agitation, and that sadly he was dying. My note indicates that although the subcutaneous analgesia was controlling the pain, this was "just", and clearly I envisaged that Mr Cunningham's condition was such that it might become necessary to increase the medication.

39. The nursing records indicate for the night of the 24th September Mr Cunningham was aware of being moved - it being necessary periodically to

alternate the position in which he was lying, but he was felt to have had a peaceful night sleep though sounding chesty in the morning.

40. I anticipate that in the usual way I would have seen Mr Cunningham again that morning, 25th September. I wrote a further prescription for the Diamorphine, Hyoscine and Midazolam, this time with the ranges being 40 - 200 mgs, 800 mcgs - 2 grammes, and 20 - 200 mgs respectively.

41. It appears then that the Diamorphine was increased to 60 mgs, with 80 mgs of Midazolam and 1200 mcgs of Hyoscine at 10.15 that morning. My expectation is that this increase was necessary to relieve Mr Cunningham's pain and distress. It is likely that by this time Mr Cunningham would have been becoming tolerant to opiates, and that might have added to the need to increase the doses of medication. It appears from the previous drug chart that an error was made by the nurse on the 25th September, where she started to record the 60 mgs as if for the previous day 24th September, but she has gone on then to complete the entry on the new chart, and it seems clear from the nursing notes that this increase in the dose of medication was indeed instituted on the morning of 25th September.

42. It appears that my partner, Dr Sarah Brook, was on duty over the course of the weekend, and so would have been on call from the evening of Friday 25th September. I anticipate that I might have informed her of Mr Cunningham's condition, and the fact that he was likely to die soon. It is possible that in consequence of this Dr Brook decided to review Mr Cunningham and it is clear she attended to see him, noting in the record that he remained very poorly, that he was on a syringe driver and was for "TLC", meaning tender loving care. Dr Brook would have appreciated that he was likely to die soon and that keeping him free

from pain and distress was all that could be reasonable achieved in the circumstances.

43. Sadly and inevitably, Mr Cunningham continued to deteriorate. It appears that he had a peaceful night, but the nursing records record specifically that his condition was deteriorating slowly, with all care being given.

44. The following morning, at about 11.50am, the medication was increased again, with Diamorphine at 80 mgs, Midazolam at 100 mgs, and the Hyoscine maintained at 1200 mcgs. I anticipate that Mr Cunningham was experiencing further pain and distress, necessitating the increase, and that Dr Brook would have agreed with it, though it is also possible that I might have been contacted prior to the increase by the nursing staff instead. In view of Mr Cunningham's condition, with the significant pain from the large sacral sore, and the fact that he would have been becoming inured to the medication, that increase would have been necessary.

45. Sadly, Mr Cunningham continued to deteriorate. There is no record that Mr Cunningham was experiencing pain in the course of the day, and it appears therefore that the medication was successful in relieving pain, distress and anxiety at that time. Mr Cunningham died that evening at 11.15pm, death being confirmed by nurses Beverley Turnbull and Anita Tubbritt.

46. At all times the medication given to Mr Cunningham and as authorised by me was provided solely with the aim of relieving his pain, distress and anxiety in accordance with my duty of care to Mr Cunningham.

Signed and Handed to DC Yates

Code A 21-4-05 Code A

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STATEMENT OF DR JANE BARTON - RE: ROBERT WILSON

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

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Robert Wilson. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mr Wilson.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. I confirm that these comments are indeed a fair and accurate summary of the position in 1998 when I was involved in the care of Mr Wilson.

4. Unfortunately, at this remove of time I have no recollection of Mr Wilson. With the benefit of the notes however, it is apparent that Mr Wilson was a 74 year old gentleman who was admitted to the Queen Alexandra Hospital on the 21st September 1998 following a fall at home during which he had sustained a fractured greater tuberosity of the left humerus. Mr Wilson had been admitted the previous year with epigastric pain which was diagnosed as left lobar pneumonia and alcoholic gastritis with grossly abnormal liver enzymes. He was found to have a small bright liver compatible with alcohol liver disease, and indeed it seemed that he had been consuming excessive alcohol for a number of years. In the course of this admission in 1997 Mr Wilson was treated with antibiotics and diuretics but was unco-operative about diet. He was discharged after three weeks with a planned follow up in out-patients.

5. It appears that Mr Wilson spent the night of the 21st September 1998 on the A & E ward. He complained of pain, and the relevant A & E record shows that he received 10mgs of morphine intravenously at 9pm that evening.

6. Mr Wilson was then assessed in the fracture clinic the following day. He was reported as not being keen to undergo surgical intervention, and following this he was admitted to Dickens Ward in the Elderly Medicine Department of the Queen Alexandra Hospital. It appears that on admission Mr Wilson's analgesia was not sufficient, and intravenous Morphine, 2 - 5mgs was prescribed, together with 30mgs of Codeine Phosphate 6 hourly as required.

7. Although not seemingly recorded on the prescription chart, a nursing entry records that the medication was subsequently altered so that the Morphine was given by a subcutaneous injection, with the addition of the Codeine Phosphate.

8. A Barthel score assessment was made on the 22nd September following his admission, a score of 5 being recorded.

9. Although there appears to be no entry in the prescription charts, the medical notes record that on 24th September Mr Wilson was given 5mgs of Diamorphine, though an examination following that administration the area from the shoulder to the elbow was said to be very painful. Indeed, the nursing records show that an initial 2.5mgs of Diamorphine was given with little effect, seemingly requiring a further 2.5mgs about half an hour later.

10. It seems that Mr Wilson may have had oedema, and on 24th September diuretics in the form of Frusemide and Spironolactone were prescribed. On 25th September Mr Wilson was recorded as still being in pain, and indeed he appears to have continued to have been throughout much of his stay on Dickens Ward in pain in spite of the administration of Morphine and Codeine Phosphate from time to time. On 1st October for example his left arm was said to be "painful +++ on movement", though he had no apparent pain at rest, and that continued generally. On the 4th October he was said to be still in great pain, and the humerus was elevated slightly on the pillow to help reduce the swelling.

11. On the 11th October the pain was said to remain "quite bad in his L arm", and then again on the 12th the nursing notes record that he remained "in a lot of pain when being cared for".

12. It appears on the 29th September Mr Wilson had become very dehydrated and his renal function had deteriorated. His diuretics were stopped and he was commenced on IV fluids. A medical entry that day records that Mr Wilson had impaired renal function, that his liver function was abnormal and he had alcoholic hepatitis. It was also recorded that Mr Wilson was "not for resuscitation in view of poor quality of life and poor prognosis". I do not know who made this entry in the records, but clearly one of the medical team considered that Mr Wilson was significantly unwell with a poor prognosis, to the extent that resuscitation would not be appropriate.

13. Mr Wilson's arm became swollen through oedema. Consultant Surgeon, Mr Hand appears to have reviewed Mr Wilson at a clinic on the 6th October and reported to Dr Durrant the GP that the left arm was grossly swollen, Mr Hand suspecting that this was secondary to immobilisation as well as fluid retention. On the 8th October it is also recorded that his ankles were very oedematous. On 9th October diuretics were recommended in view of the gross oedema, with Bendrofluazide being added.

14. A Barthel score was recorded as only 3 on the 2nd October, by 6th October this had risen to 5.

15. It appears that Mr Wilson had become depressed in consequence of stopping alcohol, and on the 2nd October referral was made to Dr Lusznat, Consultant in Old Age Psychiatry. The note of referral in the medical records stated specifically that he was "very withdrawn and depressed".

16. Dr Lusznat carried out an assessment on the 8th October and recorded her impression that Mr Wilson was suffering with early dementia, possibly alcohol related, together with depression. She prescribed Trazodone as an anti-depressant. In a subsequent letter to Dr Grunstein, Consultant in Elderly Medicine, Dr Lusznat stated that physically Mr Wilson was obese with his left arm in a sling and his left hand still grossly swollen and bruised. She also noted that there was also marked oedema of both legs. In relation to his mental state she recorded that he was subjectively low in mood and objectively easily tearful. Although he had no active suicidal ideas or plans, he had said that there was no point in living. Dr Lusznat confirmed her impression that Mr Wilson had developed an early dementia which could well be alcohol related although alternatively this might be an early Alzheimer's disease or vascular type dementia. Further, on her assessment record Dr Lusznat noted that Mr Wilson had a lot of pain in his left arm, and admitted feeling low and wishing to die. He wanted to go home.

17. Unfortunately, it seems that Mr Wilson had an unrealistic expectation of his position. The records show that an assessment was carried out the following day, 9th October and it was felt Mr Wilson required help with all the activities of daily living, generally by two people. Specifically his "conception of discharge" home was said to be "totally unrealistic", and he was felt to be too much at risk at that time to be managed at home.

18. On the 11th October a further Barthel assessment was carried out, producing a Barthel score of 7.

19. It appears that Mr Wilson's condition remained essentially unchanged. Attempts were made without success for him to have a convalescent

bed, and arrangements were then made for him to be transferred to the GWMH. Mr Wilson was seen on a ward round on the 13th October and it was agreed that he still needed both nursing and medical care. It was felt that a short spell in a long-term NHS bed would be appropriate. He was still very oedematous and his albumin was very low. Frusemide was added to his diuretics and renal function was to be reviewed. The nursing notes also record that he continued to require special medical/nursing care given his oedematous limbs were at high risk of breakdown, and indeed his right foot was apparently already having started to breakdown.

20. A referral form was completed on the 13th October with Mr Wilson recorded as continuing to be in a lot of pain, and indeed the prescription chart shows he had been receiving Codeine Phosphate over the previous days. The referral form also confirmed that Mr Wilson's legs were very oedematous with high risk of breakdown, and secondary to cardiac failure and low protein.

21. Mr Wilson was then transferred to Dryad Ward at the GWMH the following day, 14th October. I believe I assessed Mr Wilson on his admission, and my note in his records reads as follows:-

"14-10-98 Transfer to Dryad Ward continuing care 75
HPC # humerus L 27-8-98
PMH Alcohol problems
Recurrent oedema
CCF
needs help c ADL
hoisting
continent
Barthel 7
Lives c wife Code A
plan gentle immobilisation"

22. As will be apparent I inadvertently recorded the date of the fracture as the 27th rather than the 21st September. Although I also recorded the Barthel score as 7, assessment done the same by the nursing staff in fact gave a score of only 4. My notation "CCF" meant that I understood Mr Wilson to have congestive cardiac failure, apparent from his significant oedema, and indeed confirmed by the referral form which had specifically recorded cardiac failure. I do not know what records would have been available to me at the time, but I anticipate some form of records would have came with the patient on transfer.

23. Following my assessment I wrote up prescriptions on Mr Wilson's drug chart, mirroring the medication which had been recorded on the referral form. Specifically, I prescribed Thiamine 100mgs once a day - a vitamin given for nutrition due to alcoholism, multi vitamins once a day for the same purpose, Senna and Magnesium Hydroxide for constipation probably brought on by the opiate medication given for pain relief Frusemide 80mgs in the morning and Bendrofluazide 25mgs once a day both as diuretics to reduce the oedema, together with Spiranolactone 50mgs twice a day as a diuretic which increases the efficacy of the Frusemide. I also prescribed Trazodone 50mgs once a day for Mr Wilson's depression, and Paracetamol as recorded on the referral letter.

24. Although the referral letter made no mention of the codeine phosphate which had clearly been given to Mr Wilson over the previous days, I had felt it appropriate to provide further pain relief of medication beyond the Paracetamol in circumstances in which the referral letter made clear that Mr Wilson continued to have a lot of pain in his arm. Accordingly I prescribed Oramorph, 10mgs in 5mls at a dose of 2.5mgs - 5mls as needed, 4 hourly.

Code A

25. The nursing notes confirm Mr Wilson's admission, with a history of the fractured humerus, the long history of heavy drinking and left ventricular failure, with chronic oedematous legs. The nursing notes also record that following my assessment Mr Wilson was given 10mgs of Oramorph for pain control.

26. The prescription charts also contain prescriptions for Diamorphine in a dose range of 20 to 200mgs subcutaneously, together with Hyoscine 200/800mcgs and Midazolam 20 to 80mgs via the same route. I do not know when I wrote this up but I anticipate it may have been at the time of my assessment on Mr Wilson's admission. I anticipate I would have been concerned to ensure that there was a pro-active regime of pain relief and medication available in case of deterioration and with the potential for Mr Wilson to become inured to the opiate pain relief which was clearly necessary at that stage. It would have been my expectation in the usual way that the nursing staff would endeavour to make contact with me or the duty doctor before commencement of that medication - if Mr Wilson's medical condition warranted it and indeed it would be commenced at the bottom end of the dose range.

27. I anticipate that I would have seen Mr Wilson again the following day, 15th October, though clearly I have no recollection of this. I have not made an entry in his clinical notes but did I record a further prescription for Oramorph, with 10mgs to be given 4 hourly at 6am, 10am, 2pm and 6pm and a further 20mgs at 10pm in the hope of ensuring that Mr Wilson did not experience pain and distress in the course of the night.

28. The nursing note for the 15th October confirmed that Oramorph was commenced 4 hourly for pain in Mr Wilson's left arm. Mrs Wilson was then seen by Sister Hamblin who apparently explained that her husband's condition was poor. 20mgs of Oramorph was apparently given at midnight with good effect but it appears that Mr Wilson then deteriorated over night becoming 'very chesty' with difficulty in swallowing medications.

29. I believe I was absent from the Hospital on Friday 16th October. I think I attended at a meeting in Portsmouth at the Health Authority in the morning and would not have been contactable. It is clear though from the records that one of my partners, Dr Knapman, came to see Mr Wilson on 16th October in my absence. Dr Knapman has recorded that Mr Wilson had declined overnight with shortness of breath and that on examination he was 'bubbling' and had a weak pulse. He was said to be unresponsive to spoken orders. Dr Knapman recorded oedema in the arms and legs and suspected that Mr Wilson had suffered a silent myocardial infarction. He increased the dose of Frusemide in an attempt to reduce the oedema.

30. From the nursing records it appears that Mrs Wilson was informed of her husband's deterioration, and later that day Mr Wilson was said to have a very bubbly chest. A syringe driver was then commenced with 20mgs of Diamorphine and 400mgs of Hyoscine. It is not clear if the diamorphine was commenced following discussion with Dr Knapman or any other doctor then on duty, or indeed if it might have been discussed with me. It is possible that nursing staff might have made contact with me if I had been available later on 16th October, but equally Dr Knapman or one of my other partners would have been available on duty.

31. The 20mgs of Diamorphine was in effect broadly commensurate with the Oramorph which had been administered, 50mgs of Oramorph having been given the previous day. In view of the reported difficulty Mr Wilson had in swallowing medications, a switch to the equivalent subcutaneous medication appears to have been sensible, together with the Hyoscine to help reduce or 'dry' the chest secretions.

32. A nursing note later on the 16th October records the commencement of the Diamorphine and that the reason for the driver was explained to the family, with Mrs Wilson being informed of her husband's continued deterioration. Later that evening, at approximately 10.30pm, Mr Wilson was recorded as being a little "bubbly" with more secretions during the night, but it was also said that Mr Wilson had not been distressed and appeared to be comfortable.

33. It appears that the following morning, 17th October, the Hyoscine was increased to 600mcgs as pharyngeal secretions had been increasing overnight. The Diamorphine was maintained at 20mgs. It appears that my partner Dr Peters then saw Mr Wilson in the course of the day, recording in the notes that he was comfortable but there was a rapid deterioration. Dr Peters was probably on duty that weekend. Dr Peters also noted that the nursing staff could verify death if that proved necessary. Clearly Dr Peters' expectation was that Mr Wilson might die shortly. It appears that in the course of the day the Diamorphine was then increased to 40mgs, and Hyoscine to 800mcgs, with the addition of 20mgs of Midazolam. I do not know if that increase might have been with reference to Dr Peters either when Dr Peters visited or otherwise, or indeed separately with reference to me.

34. The effect of secretions which were reported to be increasing, can be very unpleasant for a patient, producing a sensation of inability to breath, and the administration of a drug such as Diamorphine can assist in relieving the significant agitation and distress which can be experienced from such a sensation, and indeed reduce oedema from cardiac failure. This may have been a factor in the decision to increase the Diamorphine. The nursing note immediately preceding the reference to the increase in Diamorphine refers to suction being required very regularly to remove copious amounts of secretions. Further, there may well have been a concern that Mr Wilson might become tolerant of the opiates and that increase might be required accordingly.

35. Fortunately, although noisy secretions continued at night, it seems then the medication was indeed successful in relieving any distress. Specifically the secretions were said not to be disturbing him, and he appeared comfortable.

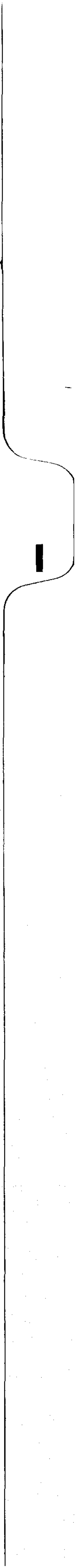
36. Although Dr Peters has not made a separate entry in the medical records the following day, 18th October, it seems that Dr Peters attended again at the hospital, there being a ~~significant~~ specific Code A entry in the nursing records that Mrs Wilson had remained overnight and that Dr Peters spoke with her. There was said to have been a further deterioration in Mr Wilson's already poor condition. The syringe driver was apparently renewed at 2.50pm with an increase in the Diamorphine to 60mgs, Midazolam to 40mgs, and Hyoscine at 1200mcgs. That latter prescription was in excess of the dose range I had previously authorised, and Dr Peters made a further specific prescription as a verbal order to enable that to be given.

37. Sadly, it appears that Mr Wilson's condition continued to deteriorate and the nurses later recorded that he died peacefully at 11.40pm in the presence of members of his family.

19-5-05

Signed **Code A** and handed to DC Yates.

Code A



STATEMENT OF DR JANE BARTON

RE: ENID SPURGIN

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

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mrs Enid Spurgin. Unfortunately, at this remove of time I have no recollection at all of Mrs Spurgin. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mrs Spurgin.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998.

I confirm that these comments are indeed a fair and accurate summary of the position then, though if anything, it had become even more difficult by 1999 when I was involved in the care of Mrs Spurgin.

4. Mrs Enid Spurgin was 92 years of age and lived alone in a bungalow, together with her greyhound. I am unable to relate anything of significance in relation to her medical history, being unable to recall Mrs Spurgin at this remove of time, and only very limited previous medical records have been made available to me. From the documentation which has been produced, it appears that in November 1997 she was referred to a Consultant in Elderly Mental Health, seemingly suffering with depression. The Consultant, Dr Mears, carried out a domiciliary visit and reported that Mrs Spurgin had lost interest in the things she previously enjoyed. She had fleeting suicidal ideas, and she described Mrs Spurgin's mood as depressed and hopeless. Dr Mears diagnosed that Mrs Spurgin was suffering from a depressive illness relating to failing physical health and her loss of independence. Mrs Spurgin had been taking Domperidone, and prior to that Prothiaden, but Dr Mears decided that she should try a very small dose of Citalopram. She planned to arrange for the Community Psychiatric Nurse to call to offer support and counselling.

5. Consequent on that assessment Dr Mears then wrote to the Community Psychiatric Nurse on 12th November 1997 asking her to call in to see Mrs Spurgin saying that she had become depressed over the last couple of months, that her physical health was failing and she was losing her independence. The Community Psychiatric Nurse (CPN) duly saw Mrs Spurgin and reported to Dr Mears the following January that poor short-term memory appeared to be her primary problem, and her main concern was poor eyesight and her consequent loss of independence.

6. It appears that she reported a number of falls in the course of 1998 due to her dog pulling her over.

7. Mrs Spurgin was also referred in turn by the CPN to Occupational Therapy for help aids to daily living. A number of suggestions were made to her including a bubble bath which Mrs Spurgin compared to "having a bath with a cobra". Other modifications were, apparently more helpful, including grab rails and a Bath Knight. She was discharged from CPN follow-up, apparently in good spirits, in January 1999.

8. On 19th March 1999 Mrs Spurgin fell and fractured her right leg femur. She was admitted to the Royal Hospital at Haslar, and the following day had a dynamic hip screw inserted. By 26th March it appears that she was considered well enough to be transferred to Dryad Ward at the GWM Hospital for rehabilitation, although I do not know anything of the circumstances in which she came to be admitted, in the absence of medical records in that regard.

9. The nursing note accompanying Mrs Spurgin on her transfer to the GWMH suggested that she was mobile from bed to chair with the assistance of 2 people and could walk short distances with a Zimmer frame. She was said to have no urinary symptoms, but despite being continent during the day she was sometimes incontinent at night. Her skin was described as "paper thin" and so no TED stockings had been given to her following the operation. Her right lower leg was very swollen and had a small break on the posterior aspect. She apparently needed encouragement with eating and drinking but could manage independently. Her only medication at that time was Paracetamol as required.

10. I admitted Mrs Spurgin to Dryad Ward, and my note in this regard in her record reads as follows :-

"26-3-99 Transfer to Dryad Ward

HPC # no femur ® 19-3-99

PMH - nil of significance

Barthel xxxxx

not weight bearing

tissue paper skin

not continent

Plan sort out analgesia"

11. Mrs Spurgin had been discharged from the Royal Hospital Haslar, relatively shortly after her fracture and operation and I believe we were concerned to reassess her wound and ensure that she should have adequate analgesia, anticipating that she would be in pain. A Nursing Care Plan for 26th March 1999 records that swabs were to be taken, with MRSA screening, and steps taken by the nursing staff to prevent infection. Resulting reports confirm that swabs were taken that day from the nose, throat, groin and wound, all being negative for MRSA. I also authorised blood tests.

12. A nursing entry for 26th March recorded that Mrs Spurgin was experiencing a lot of pain on movement. Her named nurse, Lyn Barrett, also noted that Mrs Spurgin was experiencing a lot of pain on movement. She advised giving prescribed analgesia and monitoring the effect. Concerned to ensure that she had adequate pain relief, I prescribed Oramorph in a 10 mg/5ml solution, 2.5mls 4 hourly, with a further 5mls at night. I also wrote up a further PRN prescription for Oramorph to

be given as necessary - representing a further 2.5/5 mls 4 hourly as required. As Oramorph might bring about constipation, I prescribed Lactulose, 10mls twice a day.

13. The nursing records for 26th March record that Mrs Spurgin was admitted for rehabilitation and gentle mobilisation, and that in Haslar she was mobile with a Zimmer frame and two nurses for short distances, the transfer apparently being satisfactory. It was noted, however, that transfer had been difficult since admission, and that she was complaining of a lot of pain for which she was receiving Oramorph regularly with effect.

14. The nursing staff confirmed that Mrs Spurgin's skin was very fragile and a Waterlow pressure sore score produced a figure of 32, a figure of 20 or more indicating very high risk. In consequence, Mrs Spurgin had a Pegasus B-wave mattress in an attempt to prevent the development of pressure sores.

15. Following my prescription, Mrs Spurgin did indeed receive Oramorph on 26th March, 2 doses of 5mgs followed by a further 10mgs that night. The nursing entry for the night of 26th March records that she required much assistance with mobility due to pain/discomfort. A further 5mgs Oramorph was then given early the following morning.

16. The following day, 27th March was a Saturday, but I believe that I was on duty that weekend and would have visited the ward on the Saturday morning, and would therefore have assessed Mrs Spurgin's condition although I did not have an opportunity to make an entry in her records. Her nursing entry record for 27th March noted that Mrs Spurgin was having regular Oramorph but was still in pain. I anticipate that when I

assessed her on the morning of 27th I was concerned that the Oramorph previously administered had not been adequate in relieving pain, and the drug chart shows that I increased the prescription accordingly, prescribing 10mls of Oramorph to be given 4 times a day, with a further 20mls at night. With 5mgs having been given at about 6.00 am, a further 20 mgs were given in the course of the day. It was not considered necessary to administer Oramorph at 6.00 pm, but the 20mg dose was then given at 10.00 pm, representing a total of 45mgs that day.

17. Further Oramorph was then given the following day, 28th March, with 2 lots of 10mgs being administered in the morning as prescribed, but thereafter it was discontinued. The nursing entry records that Mrs Spurgin had been vomiting with the Oramorph and that I advised that it should be stopped. I anticipate that I was contacted by the nursing staff, being on duty that weekend, and I advised that in view of the vomiting the Oramorph should be discontinued. I asked that Mrs Spurgin should be given 2 tablets of Co-Dydramol 4 times a day, together with Metoclopramide 10mgs, to be given as required. Both drugs are written up on the drug chart as having been authorised by me, and I subsequently endorsed the prescriptions with my signature.

18. I would then have reviewed Mrs Spurgin again the following morning, Monday 29th March and I anticipate I hoped that the Co-Dydramol might be successful in relieving the pain at that time. The nursing records show that Mrs Spurgin's wounds were re-dressed, and further swabs were taken from the wound site and from the axilla to test once more for MRSA and other infection. There is an entry in the Nursing Care Plan signed by Lyn Barrett requesting further swabs in this regard. The swabs were subsequently reported as being negative for infection.

19. I also prescribed Senna tablets on 29th March for constipation.

20. Dr Ian Reid, Consultant Geriatrician, under whose care Mrs Spurgin had been admitted, would generally carry out a weekly ward round, but there is no entry recorded for the week commencing 29th March and I am unable now to say if he saw Mrs Spurgin in the course of that week. I would, however, have reviewed Mrs Spurgin again the following day, 30th March. The nursing staff noted that her wounds were re-dressed, Mrs Spurgin having a wound on her calf in addition to the wound on her hip at the site of operation. One wound was said to be oozing slightly.

21. Unfortunately, the Co-Dydramol appears to have been inadequate in relieving Mrs Spurgin's pain. I believe I would have reviewed Mrs Spurgin again on 31st March, and there is an entry on the drug chart recording a prescription by me for 10mgs of Morphine Sulphate to be given twice a day. The first dose was administered at 9.30 am that morning, and I anticipate this would have been in consequence of inadequate pain relief from the Co-Dydramol, although again I did not have an opportunity to make a specific entry in Mrs Spurgin's records. The nursing notes, however, record the fact that she was commenced on 10mgs of Morphine Sulphate twice a day, and that when she walked with the Physiotherapist she was in a lot of pain. It appears that in addition to the Morphine Sulphate given that day, 5mg Oramorph was given at 1.15 pm for pain, that being available through my original PRN prescription, but apparently with not much effect.

22. A further 10mgs of Morphine was given at 8.00 pm in accordance with my prescription.

23. On 31st March her wounds were re-dressed once more, and there is reference in the nursing notes to a wound on her ankle, reflecting the fact that her skin was indeed very fragile.

24. Unfortunately, the Morphine Sulphate appears to have been unsuccessful in alleviating Mrs Spurgin's pain entirely. The nursing record indicates that she was still having pain on movement the following day, 1st April.

25. The following day, 2nd April Mrs Spurgin was now noted as having a small wound on her arm. She continued to have Morphine Sulphate, 10mgs twice a day, but on 3rd April it was again noted that she still continued to have pain on movement even with the Morphine Sulphate.

26. I would not have seen Mrs Spurgin over the course of the weekend 3rd/ 4th April, but anticipate that I would have reviewed her condition again on the following Monday, 5th April.

27. I saw Mrs Spurgin again the following morning, 6th April, and although I would not have had an opportunity to make a specific note in her records, I believe that as she was experiencing pain which was still not adequately controlled by the Morphine Sulphate, I was concerned to increase the dose of Morphine Sulphate to 20mgs twice a day. 10mgs had been administered at 8.00 am, but 20mgs were then given at 8.00 pm that evening.

28. I believe I was also concerned at the possibility that Mrs Spurgin was now developing an infection from her wounds. On 6th April the nursing staff noted that the wound in her right hip was oozing large amounts of serous fluid and some blood. Swabs were taken from the wound on her

calf, and staphylococcus infections were subsequently reported to us several days later.

29. On 7th April the nursing staff recorded that the fracture site was red and inflamed, and Mrs Spurgin was seen by me, with my indicating that she should be commenced on Metronidazole and Ciprofloxacin, and I anticipate that I was concerned Mrs Spurgin was developing an infection and should commence these antibiotics even in advance of the results of the swabs.

30. Dr Reid saw Mrs Spurgin the same day in the course of what I anticipate was a ward round, and noted specifically that she was still in a lot of pain and was very apprehensive. He also recorded the fact that the Morphine Sulphate had been increased to 20mgs twice a day the previous day. He advised that Flupenthixol, a minor antidepressant should be given and he wrote up a prescription for the Flupenthixol on her drug chart accordingly. He also asked that an x-ray of Mrs Spurgin's hip should be undertaken as movement was still quite painful and there appeared to be a 2 inch shortening of her right leg. I am unable now to say what the x-ray demonstrated as there is no report available in the medical records provided to me.

31. The nursing record confirms that x-ray was arranged for the following day at 3.00 pm.

32. I anticipate that I would have seen Mrs Spurgin again on 8th and 9th April, and noted that her condition remained essentially unchanged - that she was in a lot of pain as recorded by Dr Reid on 7th April in spite of the fact that she was now taking 40mgs of Morphine Sulphate a day. On 8th April it was reported by the nurses that the wound on her hip

was oozing slightly overnight and the redness of the edges of the wound was subsiding. A nursing entry on 9th April records that she was to remain in bed and rest until Dr Reid had seen the x-ray of her hip, suggesting that the x-ray was in fact undertaken.

33. On 9th April Mrs Spurgin was catheterised as she had become incontinent and was in great pain when toileted. Her urine was very concentrated, as she was not drinking. The catheter drained 500mls urine over night.

34. Unfortunately, it appears that Mrs Spurgin's condition deteriorated over the weekend of 10th/11th April. The nursing entry on 10th April records that she had a very poor night. She was said to be leaning to the left, did not appear to be as well, and was experiencing difficulty in swallowing. The reference to her leaning to the left raised the possibility that Mrs Spurgin might have had a cerebro vascular accident. The stitch line from the site of the operation was said to be inflamed and hard, with a complaint of pain from Mrs Spurgin. It appears in consequence of the pain my original PRN prescription for Oramorph was utilised, 5mgs of Oramorph being given at 7.15 am on 11th April by Night Nurse Sue Nelson.

35. An assessment of the wound the same day, 11th April, by the nursing staff indicated that the wound was not leaking, but the hip felt hot and Mrs Spurgin was complaining of tenderness all around the site. She was said to be very drowsy and irritable.

36. Unfortunately, it appears that Mrs Spurgin deteriorated in the course of the afternoon. A further nursing entry that evening records that her nephew was telephoned at about 7.10 pm as her condition had

deteriorated. She was now said to be very drowsy and unrousable at times, was refusing food and drink, and was asking to be left alone. The site around the wound in the right hip still looked red and inflamed and she felt hot. She apparently did not have pain when left alone but complained when she was moved at all. It appears that a discussion took place between Mrs Spurgin's nephew and the nursing staff, with the nephew recorded as having been anxious that she should be kept as comfortable as possible.

37. The next entry in the nursing records indicates that Mrs Spurgin was seen by me, and that she was to be commenced on a syringe driver. Although there is no date by the side of that entry, suggesting that I would have seen Mrs Spurgin on the night of Sunday 11th April, I think in fact this represents a nursing entry made the following morning, 12th April. That accords with the date of the prescription for Diamorphine and Midazolam to be administered by syringe driver which I have written up on the drugs chart for 12th April.

38. I anticipate that in the usual way I would have reviewed Mrs Spurgin on the morning of Monday 12th April, and in view of her condition and deterioration, I was concerned that Diamorphine and Midazolam should now be available to provide relief from pain and distress. I wrote up a prescription on her drugs chart for Diamorphine to be administered subcutaneously by syringe driver at a dose range of 20-200mgs, Hyoscine to be available PRN - as required - 200-800 mcgs and Midazolam to be administered at a dose range of 20-80mgs. In case of nausea I also prescribed Cyclizine, 50-100mgs to be given as required subcutaneously, together with a further prescription of Lactulose and Senna tablets in case of constipation.

39. Administration of Diamorphine and Midazolam are then recorded as having commenced by syringe driver at 9.00 am on 12th April, the Diamorphine at a dose of 80mgs, and the Midazolam at 20mgs. I anticipate that the dose of both the Diamorphine and the Midazolam would have been discussed with me. I believe I would have considered 80mgs to be appropriate at that time given the fact that the Oramorph was clearly inadequate in alleviating Mrs Spurgin's pain and distress. She had by that time been receiving 40mgs of Morphine Sulphate per day, with a further 5mgs of Oramorph Code A day previously, and I considered this increase in medication to be a reasonable one in view of her condition at that time.

40. Dr Reid then appears to have carried out a ward round that afternoon, recording that Mrs Spurgin was now very drowsy since the Diamorphine infusion had been established - though of course there were nursing entries for 11th April, preceding the administration of the Diamorphine, which indicated that she had been very drowsy at that time, which I anticipate was in consequence of her infection. In any event, Dr Reid felt it advisable to reduce the Diamorphine infusion to 40mgs, but noted that if the pain recurred, it should be increased to 60mgs. He recorded that it was now possible to move Mrs Spurgin's hip without pain and that she was not rousable at that time.

41. The corresponding entry in the nursing records indicates that the Diamorphine was to be reduced to 40mgs, but if the pain recurred, the dose could be gradually increased as and when necessary. It was noted that Mrs Spurgin's nephew had been spoken to and was aware of the situation. I anticipate that the nursing staff were well aware by this stage that Mrs Spurgin was probably dying and would have been concerned to make her nephew aware of the position.

42. In consequence of Dr Reid's review, the nursing records show that the dose of Diamorphine in the syringe driver was discarded, with 40mgs over 24 hours being commenced at 4.40 pm. Accordingly, from the time when the Diamorphine was instituted at 9.00 am only approximately 25mgs of Diamorphine would have been administered in accordance with my initial prescription by the time of the change in dose at 4.40pm.

43. The nursing night staff recorded that on the night of 12th April Mrs Spurgin's condition "remained ill". Her urine was said to be very concentrated. The syringe driver was apparently satisfactory, though she appeared to be in some discomfort when attended to, so that even the 40mgs of Diamorphine was not seemingly successful in relieving her pain and distress entirely. Her breathing was reported as very shallow.

44. Sadly, Mrs Spurgin is recorded as having died peacefully at 1.15 am on 13th April.

45. The Diamorphine and Midazolam, and indeed the Oramorph and Morphine Sulphate which preceded them were prescribed by me and in my view administered solely with the intention of relieving the pain and distress which Mrs Spurgin was suffering. At no time was the medication provided with the intention of hastening Mrs Spurgin's demise.

Signed and dated Code A
15-3-05 handed to
DC Yates 9.43am
Code A

J

Copy JB/PS/11

STATEMENT OF DR JANE BARTON

RE: GEOFFREY PACKMAN

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

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Geoffrey Packman. Unfortunately, at this remove of time I have no recollection at all of Mr Packman. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mr Packman.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998.

I confirm that these comments are indeed a fair and accurate summary of the position then, though if anything, it had become even more difficult by 1999 when I was involved in the care of Mr Packman.

4. Mr Geoffrey Packman was a 67 year old man who lived at home with his wife and daughter in Emsworth. It appears that he was visited regularly at home by the District Nurse who in February of 1999 noted that he had a large red weeping area on the shin of his right leg. A Doppler's test was performed, being an ultrasound measurement of the pressure in the veins of the legs. Mr Packman's GP appears to have referred him to Consultant Urologist Mr Chiverton at some point after April 1999. The GP referred in his letter to symptoms of prostatism and a raised PSA. He said that Mr Packman had had a negative mid-stream urine test, but rectal examination, presumably to assess the size of the prostate, had been virtually impossible because of Mr Packman's huge size and inability to lie properly on his side. The GP noted that Mr Packman was grossly obese, and indeed a subsequent measurement of his weight was recorded at 146 kg - in excess of 23 stone.

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

6. At the end of June his GP then made a further referral, this time to Consultant Dermatologist Dr Keohane in relation to Mr Packman's leg ulceration. Mr Packman had apparently been attending the District Nurse's leg ulcer clinic for many months, and had hugely oedematous legs. The District Nurse had drawn the GP's attention to a large granulomatous raised area on the back of his right calf, and Dr Keohane's advice was requested. At this stage it seems that Mr Packman was being visited by the District Nurse 3 times a week in order

to dress the leg ulceration, that he had recently become immobile and his condition had worsened. Mr Packman was seen in the dermatology clinic on 30th June 1999, the Senior House Officer reporting back that Mr Packman had bi-lateral severe oedema with some leg ulceration secondary to venous hypertension. Mr Packman was to be brought in for further Doppler's testing.

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

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

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

10. Following assessment his problems were recorded as cellulitis of the left leg, chronic leg oedema, poor mobility, morbid obesity, raised blood pressure and possible atrial fibrillation. In relation to the latter, and prior to the performance of the ECG, anticoagulants were suggested if atrial fibrillation was confirmed, and the possibility of left ventricular dysfunction was also raised. Shortly thereafter Mr Packman was commenced on Clexane 40mgs twice daily.

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

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

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

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

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

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

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

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

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

20. Mr Packman was then admitted to the GWMH on 23rd August 1999. There is a clerking-in noted contained within his records, but I do not recognise the handwriting or signature of the doctor who assessed him on this occasion. His problems were noted to be obesity, arthritis, immobility and pressure sores. The episode of melaena on 13th August was noted, with his haemoglobin being stable. At that stage he was said to be in no pain. Cardiovascular and respiratory systems were thought to be normal. The clinician admitting Mr Packman also prescribed medication in the form of Doxazosin 4 mgs daily for hypertension, Frusemide 80 mgs once a day as a diuretic for Mr Packman's oedema, Clexane 40 mgs twice a day for DVT prophylaxis and atrial fibrillation. Paracetamol 1gm 4 times daily for pain relief, Magnesium Hydroxide 10 mls twice daily for constipation, together with Gaviscon for indigestion and cream for his pressure sores.

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

22. I anticipate that I would have reviewed Mr Packman the following day as part of my assessment of all the patients on the ward, though it appears that I did not have an opportunity to make any entry in his medical

records on this occasion. The prescription chart shows that I prescribed Temazepam for Mr Packman on a PRN basis - as required - at a dose range of 10-20 mgs. 10 mgs of Temazepam was then given on the night of 24th August, with a night nursing record then indicating that he slept for long periods.

23. I anticipate that I would have reviewed Mr Packman the following day, 25th August, though again I did not have an opportunity to make an entry in his records. It appears that Mr Packman then was noted to have passed blood per rectum, and Dr Beasley was contacted, Dr Beasley presumably being on duty out-of-hours. He advised that the Clexane should be discontinued. Dr Beasley also appears to have prescribed Metoclopramide by way of verbal order, which I later endorsed, together with Loperamide. The Metoclopromide was apparently given at 5.55 pm with good effect. The dressings on the pressure sores were removed on 25th August and were noted to be contaminated with faeces.

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

"26-8-99 Called to see pale clammy unwell
suggest ? MI. treat stat diamorph

and oramorph overnight
Alternative possibility GI bleed but no
haematemisis
not well enough to transfer to acute unit
keep comfortable
I am happy for nursing staff to confirm death."

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

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

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

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

28. It appears that I re-attended to see Mr Packman at 7.00 pm on 26th August. Concerned that he should have further appropriate medication to relieve his pain and distress, I prescribed Oramorph 10-20 mgs 4 times a day together with 20 mgs at night. 20 mgs of Oramorph was later given at 10.00 pm.

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

30. I would have reviewed Mr Packman again the following morning, and indeed the nursing record confirms that I attended to see him then. Sister Hamblin has recorded that there had been some marked improvement since the previous day and that the Oramorph was tolerated well and should continue to be given, though Mr Packman apparently still had some discomfort later that afternoon especially when the dressings were being changed. In spite of the earlier improvement, Mr Packman was said to remain poorly. 10 mgs of Oramorph were administered 4 hourly, together with a further 20 mgs

at night as prescribed, so that Mr Packman received a total of 60 mgs that day, though this was seemingly not enough to remove his pain and discomfort when his dressings were being changed. The nursing records indicate that he appeared to have a comfortable night.

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

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

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

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

34. I do not know if I would have seen Mr Packman again the following morning, Monday 30th August, that being a Bank Holiday. I have no way of knowing now if I was on duty then. If I did see him as part of my review of all the patients on the two wards, I did not have an opportunity to make a specific entry in his records on this occasion. A Barthel score was recorded as 4. The nursing record indicates that Mr Packman's condition remained poor, and later that day - at 2.45 pm the syringe driver was set up to deliver 40 mgs of Diamorphine and 20 mgs Midazalam subcutaneously. I anticipate that Mr Packman would have continued to experience pain, and clearly in view of the significant sacral

sores, it was highly likely that he would have been experiencing further significant discomfort.

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

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

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

38. I believe I would have seen Mr Packman again that morning, though again I did not have an opportunity to make an entry in his records. I anticipate his condition would have been essentially unaltered, and that he would have remained comfortable. Similarly, I would probably have seen Mr Packman again on the morning of 1st September but would have been unable to record this. I anticipate that his condition was again

unchanged. 5 separate pressure sore areas were noted by the nurses. A Barthel score of only 1 was recorded.

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

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

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

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

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

44. Sadly, Mr Packman passed away on 3rd September 1999 at 1.50 pm. My belief was that death would have been consequent on the myocardial infarction.

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

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STATEMENT OF DR JANE BARTON - Re ELSIE DEVINE

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

I understand you are concerned to interview me in relation to a patient at the GWMH, Mrs Elsie Devine. Elsie was 88 when she was transferred from the Queen Alexandra Hospital to Dryad Ward at GWMH on 21st October 1999. The circumstances of her transfer to us were slightly unusual for a number of reasons. She had been under the care of Dr Robert Logan consultant in elderly Medicine and incidentally consultant in charge of Saint Christopher's hospital and Dr Tanya Cranfield Consultant Haematologist. She had a series of diagnoses including Multiple Myeloma, Chronic renal failure secondary to nephrotic syndrome, and vascular dementia. Elsie had also seen consultant renal physician Dr Judith Stevens in relation to her renal failure, who felt this was *"likely to be long-standing glumerulonephritis."* She had been admitted under the physicians to an acute ward in QAH on 9th October 1999 with confusion aggression and wandering, possibly caused by a urinary tract infection superimposed on her chronic renal failure. She had initially responded well to intravenous fluids and an appropriate antimicrobial for her UTI although her behaviour remained aggressive. A referral was made on 13th October to psychiatrist, Dr Lusznat, and a member

of the Elderly Mental Health team saw her the following day, recording in her notes as follows:

> "Thank you. This lady has settled a little in her behaviour. She has been deteriorating at home and unable to cook etc since Jan 99. It is likely that she has dementia and had an acute episode 2° to UTI. Her daughter is no longer able to cope because of her husband's illness and I would suggest that she is referred to Social Services for placement. She will need Residential Care with experience in dealing with confused patients. If her behaviour does deteriorate again we will need to transfer her for further assessment. MMSE 9/30. Severe dementia".

The family had apparently indicated that Elsie would be unable to return to live with her daughter who that time was with her husband at the Brompton Hospital in London while he underwent a bone marrow transplant, and the family circumstances of the son who lived in Gosport were such that he was willing but unable to have his mother with him.

By 16th October 1999 Mrs Elsie had a Bartel score of 12 and a referral was made to Social Services for eventual rest home placement. In the meantime the original plan was for her to go for convalescence at St Christopher's Hospital in Fareham close to the family. The family, having complained about the care given to Elsie in QAH, objected to this, as there had been a

family bereavement there previously, and despite initial reservations by the family a transfer was arranged to Dryad Ward. Elsie had a CT scan performed under sedation on 18th October 1999, which confirmed the diagnosis of dementia and was reported as showing involutional and ischaemic changes.

Elsie was duly transferred to Dryad Ward at GWMH on 21st October 1999 under the care of consultant Dr Ian Reid. I clerked her in the same day. I recorded previous diagnoses of dementia, myeloma and hypothyroidism. I was also aware of the fact that she had chronic renal failure. I assessed her Bartel as 8 and a mini-mental test score of 9/20. The plan was to get to know her, assess her rehabilitation potential, with the probability of transfer to a rest home in due course. I was aware that her creatinine at this time was 206 (the normal range would be up to 90). My entry in her records on this occasion reads as follows:

"Transfer to Dryad Ward continuing care
HPC Acute confusion. Admitted to Mulberry
→ QA → Dryad

PMH Dementia
Myeloma
Hypothyroidism

Bartel Transferred with one
so far continent
needs some help ĉ ADL
MMSE 9/30
Bartel 8

Plan Get to know
Assess rehab potential
Probably for rest home in due course"

I prescribed Thyroxine, 100mcg once a day, for Elsie's hypothyroidism, and Frusemide, 40mgs once a day, which was to reduce the oedema from the renal failure. In addition I prescribed Temazepam, 10mgs as required, to help Elsie to sleep. All three drugs were a continuation of the medication Elsie had had available at QAH. I also prescribed Oramorph, 10mgs in 5mls at a dose of 2.5-5mls, to be given as required. I was concerned that a low dose of pain reliving medication should be available for Elsie in case she experienced distress and discomfort and a doctor was not available to write up a prescription for her.

Following my initial assessment on 21st October, I would have seen Elsie every morning, when reviewing patients on the wards, in the way I have described above. The fact I have not made a specific entry on each occasion is a reflection of the fact that I had only a limited time available to me, again as I have explained above. On the majority of occasions there would have been no essential change in Elsie's condition. On others, the change in condition might be demonstrated with reference to a change in medication recorded on the drug chart. I believe that at an early stage I spoke with Elsie's son, and established that Elsie was unable to continue living with her daughter as she had become too demented and frail, and because her daughter's husband would be returning from hospital. She was therefore to remain at Dryad Ward until a nursing home could be found.

Initially Elsie's mobility and her renal function appeared to improve, with her creatinine reducing to 187 on 22nd October. She was seen on a Ward Round by the consultant Dr Ian Reid on 25th October. He assessed her as:

> "Mobile unaided
> Washes ĉ supervision
> Dresses self.
> Continent.
> Mildly confused
> BP 110/70
> Normochromic anaemia - chronic renal failure.
> Was living with daughter and son-in-law.
> - ? son-in-law awaiting bone marrow transplant.
> Need to find out more re son-in-law etc.".

By the 27th October her general improvement was sustained and her renal function improving, with her creatinine down to 172, though this was still clearly abnormal.

Dr Reid's next visit was on 1.11.99 when he recorded:

> "Physically independent but needs supervision ĉ W + D, help ĉ bathing
> Continent.
> Quite confused + disorientated Eg wandering during the day
> - is unlikely to get much social support at home.
> - ∴ try home visit to See if functions better in own home."

An entry in the nursing summary records that Dr Reid also indicated Elsie should be started on Amiloride, 5mgs once a day. Amiloride is a diruretic and would have been designed to enhance the effect of the Frusemide in reducing the oedema, and to improve Elsie's mobility. Accordingly I wrote up a prescription for the Amiloride in her notes the following day, 2nd November.

On the 9th November we had the first indications of biochemical deterioration parallel with her behaviour changes with a creatinine of 200. The following day, 10th November, there is an entry in the nursing care plan that Elsie had been confused during the night, had been wandering around the ward, and had refused night sedation.

As Elsie's behaviour and general condition were deteriorating we commenced Thioridazine on 11th November, at a dose of 10mg three times a day if required. I also wrote a prescription for Trimethoprine on 11th November. This is an antibiotic which is used specifically for the treatment of urinary tract infections. At the time we were concerned that Elsie might have such an infection. A mid stream urine test was arranged, and I wrote the prescription so that the antibiotics could be commenced as soon as possible in the event of a positive test. In fact the result was reported as negative the following day and it was never necessary to commence the antibiotic.

The deterioration in Elsie's behaviour continued and is confirmed in Dr Reid's note of 15th November when he recorded:

> "Very aggressive at times | has needed
> Very restless | THIORIDAZINE.
>
> On Rx for UTI - MSU sent ∵
> blood + protein in urine.
> O/E P - 100/reg
> Temp 36.4°C
>
> JVP ↓ H xxxxx
> Oedema +++ → Thighs
> HS - nil added
> Chest clear
>
> Bowels regular - PR empty 13.11.99
> xxx good bowel active xxxx
> (* MSU - no growth)
>
> Ask Dr Lusznat to see."

Dr Lusznat was the Consultant in Elderly Mental Health who had seen Elsie during her acute admission in QAH. I believe the seriousness of Elsie's condition was explained to her son by nursing staff following the ward round.

In any event, the following day I made the referral to Dr Lusznat, writing in Elsie's records as follows:

> Dear Rosie
> Thank you so much for seeing Elsie.
> I gather she is well known to you.
> Her confusional state has increased
> in the last few days to the point where we
> are using thioridazine. Her renal function is ↓.
> Her MSU showed no growth.

Can you help?
Many thanks

Jane Barton".

On 16th November Elsie's son visited and we attempted to make him aware of the marked deterioration in his mother's general condition. My understanding was that Elsie's son was the desired point of contact for the family and that we should not contact Elsie's daughter given her husband's condition, so that he had effectively taken over as next of kin.

Following Dr Reid's referral, a locum staff grade psychiatrist from Elderly Mental Health attended on 18th November, recording:

> "Elderly Mental Health
> Thank you. This lady has deteriorated
> and has become more restless and
> aggressive again. She is refusing medication
> and not coping well.
> She doesn't seem to be depressed and
> Her physical condition is stable. I will
> arrange for her to go on to the waiting
> list for Mulberry Ward."

As the psychiatrist recorded, Elsie was deteriorating, becoming more restless and aggressive, and was refusing her medication. He suggested that Elsie should go on the waiting list for the psychiatric ward, though beds on that ward would only be available infrequently. He noted that Elsie's physical condition was stable, but in fact there had been a significant deterioration in Elsie's renal function. A blood test had been taken on 16th November, and I believe the results were available later on 18th November, showing her creatinine had

increased to 360. Having received the blood test results, it became apparent that transfer would not be appropriate, even if a bed did become available, and that her medical condition was deteriorating significantly, accompanied by marked restlessness and agitation. After discussion amongst the team who were concerned about her obvious discomfort, and given the fact she was refusing to take medication, I decided to commence a Fentanyl 25 mcg patch on the skin. This was in an attempt to calm her, to make her more comfortable, and to enable nursing care. Elsie was not eating or drinking well by this stage. I did not feel that a subcutaneous infusion would be helpful at that point as she was likely simply to remove it.

Unfortunately, on arrival on the ward on the morning of 19th November I found Elsie in an extremely aggressive state, hanging onto the bars in the main corridor of the ward. She was clearly very agitated, anxious, and distressed. She would not allow anyone to approach her or administer any of her usual medication. In due course we were able to administer 50mg of Chlorpromazine intramuscularly. This took some time to be effective, but in due course we were able to get her back into her own bed. This major tranquiliser had made her quite drowsy and we made the decision to discontinue the transdermal Fentanyl which I knew would take have taken about 22 hours to reach steady state drug levels, and to opt instead for subcutaneous analgesia.

As Elsie had already received opiates in the form of the Fentanyl, and had been resistant to this to a degree, I prescribed 40mgs of Diamorphine, to be administered via syringe driver

over 24 hours, together with 40mgs of Midazolam. This medication was prescribed at 9.25am and was administered with the sole intention of relieving Elsie's significant distress, anxiety and agitation, which were clearly very upsetting for her. I also prescribed Hyoscine to be given when required, to dry any chest secretions, but in fact it did not prove necessary to administer this. At this point it was clear that Elsie's renal function had deteriorated markedly, superimposed on her dementia, and she was now dying. The Fentanyl patch was removed a little later.

I asked the ward staff to contact Mr Devine and arranged to meet him at lunchtime when I finished morning surgery to discuss the further deterioration in his mother. I told him of the diagnosis of end stage renal failure, that the dementia had become much worse, and that his mother was terminally ill. I explained that we had had to use medication to make his mother more comfortable. I asked him to make contact with his sister. Mr Devine said he would notify her. He also said that he had been visiting his mother daily over the preceding four days and was aware of her deterioration. I recall he also expressed concern for the level of stress being suffered by his sister up in London.

Later that day I made an entry in Elsie's notes, recording the position at that time, as follows:

> "Marked deterioration overnight.
> Confused aggressive. Creatinine 360.
> Fentanyl patch commenced yesterday
> Today further deterioration in general condition

needs sc analgesia ĉ midazolam.
Son seen and aware of condition and
diagnosis.
Please make comfortable.
I am happy for nursing staff to confirm death."

During the interval between her arrival on the ward and this entry in the notes I had seen Elsie on every weekday morning and had met the son on at least 2 occasions. As I have stated, I was not in a position to make an entry in my clinical notes every day and relied greatly on daily reports from the nurse in charge and their nursing note entries.

As I have indicated, I was under the impression that Mr Devine was effectively acting as next of kin for his mother as his sister was staying up at the Hammersmith hospital with her husband, and also that she was happy for him to relay information to her as necessary. It appeared later that feedback had not occurred.

In any event, I was phoned by the ward during evening surgery and asked to return to discuss the situation with the rest of the family. Over the years I had become aware of how important it is to keep relatives informed, especially towards the end. I fully appreciate how anxious and upset they would feel at the condition of their mother, so after a day on duty and a busy evening surgery, I was happy to see the family, returning to the ward when I was informed that Elsie's daughter had arrived.

I discussed Elsie's condition with the family group. I attempted to explain the current situation and the medications that we were using under the particular circumstances to ensure that Elsie's safety and comfort were paramount.

Elsie was noted by the nursing staff to have had a peaceful night. The following day, 20th November, her condition was recorded as remaining poor. The family apparently visited and ...re recorded as being aware of her poorly condition. Elsie had another peaceful night on 20th November, but sadly, she continued to deteriorate slowly and she died peacefully the following day, 21st November, at 20.30.

Following death I prepared a death certificate recording 'renal failure' as the cause of death, unaware that the Registrar would feel that this was not sufficiently specific. Accordingly, when this was drawn to my attention later, I added 'chronic glumerulonephritis'. Long-standing glumerulonephritis had of course previously been mentioned as Elsie's likely ...nderlying diagnosis by consultant renal physician Dr Judith Stevens when she had seen Elsie back in June 1999.

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