Field Fisher Waterhouse

AFW/95/05.

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

HEALTHCARE COMMISSION
FILE 4

Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

HEALTHCARE COMMISSION

4

1

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2. National Sentinel Clinical Audit, Evidence-Based Prescribing for Older People, Report of National and Local Results, Portsmouth Healthcare NHS Trust

3. Junior Doctors Accreditation Information, 2 April 2001

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5. Memo from Code A, District Audit re Review of Rehabilitation, 23 January 2001; Data Pack for Audit 1999-2000

6. District Audit, Clinical Governance, Portsmouth Healthcare NHS Trust Audit 1998/99, Summary Report

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2. Community Hospitals, Clinical Governance Development Plan – 2001/02.

3. Community Hospitals Third Quarter Quality Report January 2001

4. General Rehabilitation Clinical Governance Group, minutes of meeting 6 September 2001.

5. Day Hospital Clinical Governance meeting, 9 October 2001.

6. Stroke Service Clinical Governance meeting, minutes of meeting 12 October 2001.

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8. Portsmouth Healthcare National Health Service Trust, Community Hospitals Clinical Leadership Programme Update, 19 November 2001.

9. Portsmouth Healthcare National Health Service Trust, Practice Development Programme, March 1999.

10. Portsmouth Healthcare National Health Service Trust, Third Quarter quality/clinical governance report, Community Hospitals Service Lead Group, January 2000.

11. Community Hospitals Clinical Governance Baseline Assessment Action Plan, September 1999.

12. Portsmouth Healthcare National Health Service Trust, Community Hospitals CLG Quality Action Plan 1999/2000

13. Portsmouth Healthcare National Health Service Trust, Notes of a Community Hospital Service Lead Group Meeting, 26 May 2000.

14. Mandatory training by contract group, November 2000.

15. Portsmouth Healthcare National Health Service Trust, Risk Event forms and Instructions.

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17. District Audit, Clinical Governance Portsmouth Healthcare National Health Service Trust, Audit1998/1999.

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21. Portsmouth Healthcare National Health Service Trust, Risk Management Strategy, 1999/2002.

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11. Portsmouth Healthcare National Health Service Trust, Gosport War Memorial Hospital, Patients survey information and action plan, October 2001.

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20. Isle of Wight, Portsmouth & South East Hampshire Health Authority, A local Procedure for the Identification and Support of Primary Care Medical Practitioners whose Performance is Giving Cause for Concern
21. Health Service Circular, 27 August 1999, The Public Interest Disclosure Act 1998, Whistleblowing in the NHS
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	PHCT Administration of Medicines, Community Hospitals – Programme for updating qualified staff, 13 March 1997
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	Trust Medicines Management Structure, 16 October 2000
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	Policy Statement – Training and Education, April 2001
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	PHCT Clinical Governance – Annual Report – 2000/2001
	PHCT Risk Management Strategy 2000-2003

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1. Portsmouth Healthcare National Health Service Trust, from 1923 to 1995, 3 October 2001.

2. Portsmouth Healthcare National Health Service Trust, Information Leaflet, Gosport War Memorial, 3 October 2001.

3. Gosport War Memorial Hospital Outpatients Clinics, 3 October 2001.

4. Portsmouth Healthcare National Health Service Trust, Trust Board Agendas and Strategic Briefing Documents 2001– Trust Board Strategic Briefing 9 January 2001, Public Meeting of the Trust Board 15 February 2001, Agenda for Part Two of Meeting of Trust Board 15 February 2001, Public Meeting of the Trust Board 17 May 2001, Agenda for Part Two of Meeting of Trust Board 17 May 2001, Trust Board Strategic Briefing 21 June 2001, Trust Board Strategic Briefing 19 July 2001, Public Meeting of the Trust Board 20 September 2001, Agenda for Part Two of Meeting of Trust Board 20 September 2001, Trust Board Strategic Briefing 18 October 2001.

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6. Portsmouth Healthcare National Health Service Trust, Trust Board Agendas and Strategic Briefing Documents 1999– Trust Board Strategic Briefing 21 January 1999, Public Meeting of the Trust Board 18 February 1999, Agenda for Part Two of Meeting of Trust Board 18 February 1999, Trust Board Strategic Briefing 15 April 1999, Public Meeting of the Trust Board 20 May 1999, Trust Board Strategic Briefing 17 June 1999, Trust Board Strategic Briefing 15 July 1999, Public Meeting of the Trust Board 16 September 1999, Agenda for Part Two of Meeting of Trust Board 16 September 1999, Trust Board Strategic Briefing 21 October 1999, Public Meeting of the Trust Board 18 November 1999, Agenda for Part Two of Meeting of Trust Board 20 May 1999, Agenda for Part Two of Meeting of Trust Board 18 November 1999.

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(A) Trust Strategic - Volume I

1. Our work, our values – a guide to Portsmouth Healthcare National Health Service Trust.

2. Portsmouth Healthcare National Health Service Trust, Annual Plan 2001:2002. Business Plan and Local Objectives 2001 – 2002.

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6. Portsmouth Healthcare National Health Service Trust, Business Plan 2000/2001. Local Objectives, 21 November 2001.

7. Portsmouth Healthcare National Health Service Trust, Business Plan 1999/2000. Local Objectives, 21 November 2001.

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10. Isle of Wight, Portsmouth and South East Hampshire, Health Improvement Programme 2000 – 2003, Portsmouth and South East Hampshire, April 2000.

11. Fareham and Gosport, Primary Care Group, Fareham Health Improvement Programme 2000 – 2002, 22 October 2001.

12. Portsmouth Healthcare National Health Service Trust, 2001/02 SAFF Cost and Service Pressures, January 2001.

13. Portsmouth Healthcare National Health Service Trust, Patient Involvement Strategy, November 2001.

14. Portsmouth Healthcare Trust, A Report on a Future PALS Service for Fareham and Gosport Primary Care Trust, November 2001

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- Lyn Barrat
- Code A
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- Shirley Hallman
- Katie Mann
- Code A

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- Code A
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- Code A

CHI INVESTIGATION INTO GOSPORT WAR MEMORIAL HOSPITAL
Winmax File

A. Trust Strategic
A1 Leadership: Approach and role of chief executive; culture of trust
A2 Accountabilities: Role of trust board; accountability to regional office
A3 Direction & Planning: broad strategic planning including Service & Financial Framewoks (SaFFs); key priorities during investigation period
A4 Health Economy Partnerships: eg policy on, and work with, acute trust, health authority, social services, primary care, nursing homes
A5 Patient and Public Partnership: eg consultation with public about trust planning; use of patient surveys; involvement of community health council

B Service Strategic
B1 Leadership: Include under this code any information you may receive about direction of elderly peoples' care at the trust. Is leadership solely from the consultant or is it shared with senior nurses and/or managers?
B2 Accountabilities: What systems are used to report internally and externally about the care of older people at the trust?
B3 Direction & Planning: Any information about planning for the care of older people should be included under this code. Who does it? How is it done?
B4 Service performance management: How is it managed, against which targets and by whom? What is the system for recording and reporting adverse incidents internally and externally? Is it understood by key staff?

C Quality
C1 Staff attitude: eg staff morale ; view of trust leadership; attitude toward patients
C2 Effectiveness & Outcomes: eg examples of ensuring appropriate rehabilitation for patients
C3 Access to Services: eg access to occupational, physiotherapy
C4 Organisation of Care: access to X-Ray, pathology and other diagnostic services; handover arrangements
C5 Humanity of Care: eg kindness and compassion; policy and practice in making patients and relatives comfortable (tea for relatives, reading material for patients, TV and radio); privacy and dignity of patients and their relatives; ensuring that patients given their own clothes; help with basic activities

like feeding, using the lavatory; responding to patient requests for help
C6 Environment: ie cleanliness, attractiveness and comfort of wards and lounges; regular cleaning and maintenance
C7 Positive patient experience: Include under this code any examples you may be given of good treatment of patients, particularly those that may have been acknowledged in writing.
C8 Negative patient experience: Examples of unsafe, uncaring or negligent treatment of patients.

D <u>Staffing and Accountability</u>
D1 Workforce and Service Planning: How has the staffing of the older people's wards been planned and managed? What criteria or guidelines have been used in this planning?
D2 Medical Accountability: accessibility of consultants and clinical assistants; attendance of doctors on wards and involvement in care of patients
D3 Nursing Accountability: nurse cover on wards: how many and roles of different nurses; handover arrangements
D4 Allied Health Professionals Accountability: role of AHPs on three wards; involvement in planning for individual patient care and rehabilitation programmes
D5 Other Staff Accountability: middle management involvement in three wards; porters; reception and catering staff; chaplain
D6 Out of hours arrangements: How do they work in practice? Experience with Healthcall doctors; are arrangements known and understood by staff, patients and relatives
D7 Team Working (within teams): Nursing team work arrangements: how do they work; what is the level of co-operation? How is conflict/disagreement within the team managed?
D8 Team Working (between teams): How do the allied health professionals work with the nursing staff on the wards (regular meetings, consultation about procedure?); medical team working relationship with the nursing staff/AHPs
D9 Staff Welfare: eg staff counselling services, support from union; trust support for staff through ensuring humane working hours (compliance with European Working Time Directive); family-friendly work arrangements
D10 Recruitment & Retention: any problems in recruiting skilled staff locally? sickness and turnover; exit interviews

D11 Performance Management: Appraisal of staff; anything about the IPR process; work targets and objective setting; management of poor performance; grievances

E Guidelines

E1 Patient transfer: eg policy between GWM and other hospitals about transfer of patients; management of patients during transfer

E2 Do Not Resuscitate policy: is it recorded, and known to ward staff? Is it discussed with patients and their relatives?

E3 Palliative care: ***For E3,4 & 5,note down any information about the guidelines and procedures for care of the dying patient, and for the rehabilitation and continuing care of patients on the three wards.***

E4 Rehabilitation: See E3

E5 Continuing care: See E3

E6 Nutrition: any matter relating to the provision of food and drink to patients, orally or by IV drip; also include anything about mouth swabbing

E7 Patient records

E8 Continence: eg catheterisation of patients; use of commode/bedpan; assistance in using the toilet

E9 Trust performance management: CHI needs to be aware of any guidelines against which the performance of this trust is managed either through the health authority or regional office.

E10 Consent: trust policy on consent & practice in seeking it from patients and relatives

E11 Control of infection: eg segregation of patients when infection identified; ward or trust procedures on management of MRSA

F Drugs

F1 Prescribing: trust procedures for ensuring appropriate prescription; system for taking prescription instructions from doctors by telephone, fax or email; adherence to prescribed protocols and guidelines

F2 Administration: Responsibility for giving drugs (who can do it and to whom are they accountable?); adherence to trust/health authority/national guidelines and protocols; management of errors in administration of drugs

F3 Review: eg doctors checking that drug prescription was right or if any nurse concerns re effect of drugs; is checking of prescriptions done routinely?

F4 Recording: eg note of doctor's telephone instructions for prescription recorded by nurse; instructions or information about prescriptions from

sending hospital, GP or nursing home; maintenance of drug Codexes

G Communication

G1 Patients: eg oral and written communication with patients; consultation with patients about their care; informing patients about their treatment and care

G2 Relatives & Carers: eg oral and written communication with relatives/carers; consultation with them about their care; informing patients about treatment and care of their sick relatives

G3 Primary Care: eg systems for keeping GPs informed the admission, care and discharge of their patients; systems for keeping LMC and PCG abreast of changes in procedure, key matters affecting care of the elderly at GWM, particularly concerns about issues like out of hours cover, transfer from acute trusts and discharge

G4 Acute: Any information about liaison between GWM and the main acute trusts in the area (ie Queen Alexandra, Haslar and St Mary's). How do staff in charge of older peoples' care at GWM learn about bed pressures in the acute sector and about intended transfer of patients?

G5 Health Authority: liaison between trust and health authority through meetings or other means

G6 Haslar: regular meetings/other exchange of information; agreed policies and procedures

G7 Social services: informing them about admission, transfer and discharge of patients

G8 Nursing homes: How does GWM keep informed about bed availability in local homes? Any visiting of ward by nursing home staff?

G9 Staff: Examples of how staff are kept informed of trust policy and wider developments in the health economy; consultation with staff about changes in trust policy

H End of Life

H1 Patient Care: How is the dying patient cared for?
H2 Relatives & Carers: Breaking the news to relatives (practical examples of how this has been done at GWM); supporting relatives sensitively and compassionately
H3 Staff: Support for staff caring for dying patients
H4 Cultural & spiritual needs: Role of the chaplain; catering for patients and relatives of different faiths

I Supervision and training

11 Medical: Include under this code any evidence about supervision of the consultant (eg by medical director) appraisal of consultants (ie for revalidation or by medical director); also include information about any CME/CPD in gerontology for medical staff. What arrangements are made for supervising clinical assistants, new staff grade doctor and locums? What are the reporting arrangements?
12 Nursing: How are nurses supervised on the wards? How are their training needs determined? Is their training linked to complaints or untoward incidents on the wards?
13 Allied Health Professionals: Include here any evidence about training for occupational and physiotherapists and about their reporting arrangements.
14 Other Staff: Include here any information about training for managers that may be relevant to the care of patients on the 3 wards as well as staff in portering, catering and administration. Who do A&C, catering and portering staff report to?
15 Induction: Include here any information about induction for all categories of staff including sessional and temporary staff.
16 Mandatory training: Include here training which must be undertaken to meet the requirements of professional bodies (royal colleges etc) and courses which the trust requires staff to attend.
17 Joint training: Include here evidence about multi-disciplinary courses or those which a range of staff were required or encouraged to attend as part of, for eg, complying with an action plan.

J Complaints

J1 Trust management: Systems for responding to complaints from patients and relatives; reporting to board

J2 Ward management: How do ward staff respond to complaints from patients or relatives? How are they reported to senior clinicians and management? Are there written guidelines? Also include anything here about post-complaint action plans and their implementation.

J3 Trust Lessons: How does the trust ensure that key lessons from complaints are translated into changes in the care of patients or in dealing with relatives?

J4 Ward Lessons: Is there a process for informing ward staff about complaints and for ensuring that there are appropriate changes in practice following complaint?

J5 Training: What training is provided on dealing with complaints and to whom?

K Clinical Governance

K1 Trust arrangements

K2 Ward arrangements

K3 PCT arrangements

OBS Observations

NC No Code

Stakeholders - All codes

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2	Assessment and pain Management Policy	May 2001	
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4	Handling Patient Related Complaints	Jan 2000	
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5	Fareham and Gosport Locality Division	Sept 2001	
6	Ward breakdown and medical staff	Dec 2001	
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7	History leaflet	Undated	
8	Introduction Leaflet	Undated	
	Background (service)		
13	Gosport and Fareham Divisional review (inc patient incident and critical event info)	Jan-Mar 2001	
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2	Rehabilitation of Older People: Evidence of effectiveness to assist purchasing of general rehabilitation, and specific packages for Rehabilitation of stroke and fractured neck of femur.	Compendium Document D1(1997)	British Geriatrics Society
3	Prescribing for the older person. Vol 11 No10	2000	MeReC Bulletin National Prescribing Centre
4	Standards for Health and Social Care Services for Older people.	2000	The Health Advisory Service
5	The NHS Plan : A Summary & Chpt 15 Dignity, security and independence in old age.	July 2000	The NHS
6	National Service Framework for Older People: Executive Summary.	2001	Department for Health
7	Medicines and Older People: Implementing medicines-related aspects of the NSF for Older people.	2001	Department for Health
8	NSF for Older People: A Short Summary.	2001	Department for Health
9	Caring for Older People: A Nursing Priority. Integrating knowledge, practice and values.	March 2001	Report by the Nursing and Midwifery Advisory Committee.

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3	Prescribing for the older person. Vol 11 No10	2000	MeReC Bulletin National Prescribing Centre
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Letter from Code A, to Code A re: Draft CHI Investigation Report- Factual Checking.

Document 4: 08 May 2002
Copy of factual accuracy document sent to Code A.

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Document 7: Email dated 30 September 2002 from Code A Nursing Director, CHI to Code A n, Medical Director, CHI regarding the Draft Terms of Reference – Gosport

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Document 1: Letter dated 29 January 2003 from Code A Solicitors to the General Medical Council (Field Fisher Waterhouse - The European Legal Alliance) to Code A Investigations Manager, CHI regarding General Medical Council – Dr Code A Code A

Document 2: Letter dated 9 January 2003 from Code A Solicitors to the General Medical Council (Field Fisher Waterhouse - The European Legal Alliance) to Code A Investigations Manager, CHI regarding General Medical Council – Code A Code A

Document 3: Fax dated 28 November 2002 from Code A Solicitors to the General Medical Council (Field Fisher Waterhouse - The European Legal Alliance) to Code A er, CHI regarding General Medical Council – Code A Code A and request to see relevant documents and evidence amassed during the CHI investigation

Document 4: Letter dated 4 October 2002 from Code A, Conduct Case Presentation Section, General Medical Council to Code A, Investigations Manager, CHI regarding Dr J A Barton and making available background documentation gathered.

Document 5: Letter dated 16 September 2002 from Code A Conduct Case Presentation Section, General Medical Council to Code A, Investigations Manager, CHI regarding the Council's Preliminary Proceedings Committee and information provided by Hampshire Constabulary

Document 6: Letter dated 4 October 2002 from Code A, Conduct Case Presentation Section, General Medical Council to Code A Investigations Manager, CHI regarding Dr J A Barton

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Document 1: Email dated 3 December 2002 from Code A, Code A, Investigations Manager, CHI regarding Gosport and legal advice from Code A Capsticks solicitors about GMC's investigation of Dr Barton

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Document 1: Letter dated 6 December 2002 from Code A, Investigations Manager, CHI to Code A, Fareham & Gosport PCT regarding GMC request for CHI Investigations Information

Document 2: Letter dated 30 August 2002 from Code A, Investigation Coordinator to Code A regarding information requested on Hampshire Ambulance Service NHS Trust and CHI's whistle blowing policy

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Document 2: Email dated 5 August 2002 from Code A Investigations Manager, CHI regarding Gosport Action Planning

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Document 2: Press cutting dated 19 November 2002 taken from Nursing Times "Inquiry into patient deaths undermines staff morale"

Document 3: Press cutting dated 8 November 2002 taken from Daily Telegraph "Hospital deaths investigation"

Document 4: Press cutting dated 7 November 2002 taken from The Times "Shipman-style inquiry into 50 deaths at hospital"

Document 5: Press cutting dated 6 November 2002 taken from Portsmouth Times, Hampshire "More families speak over mystery deaths"

Document 6: Press cutting dated 5 November 2002 taken from Birmingham Post "Families concerned at hospital deaths"

Document 7: Press cutting dated 5 November 2002 taken from Southern Daily Echo, Southampton "Police are criticised over hospital probe"

Document 8: Press cutting dated 5 November 2002 taken from The Independent "Fifty families complain of hospital in death inquiry"

Document 9: Press cutting dated 5 November 2002 taken from The Times "Police investigate deaths of 30 elderly patients"

Document 10: Press cutting dated 5 November 2002 taken from The Times Online "Police investigate deaths of 30 elderly patients"

Document 11: Press cutting dated 4 November 2002 taken from Portsmouth News, Hampshire "Hospital families vow to call for public probe: Inquiry call: Authorities given last chance to investigate deaths"

Document 12: Press cutting dated 22 October 2002 taken from Portsmouth News, Hampshire "Families call for new ward deaths probe"

Document 13: Press cutting dated 21 September 2002 taken from Portsmouth News, Hampshire "Why did my mother die?"

Document 14: Press cutting dated 21 September 2002 taken from British Medical Journal "Clinical audit ordered for Gosport War Memorial Hospital"

Document 15: Press cutting dated 18 September 2002 taken from Portsmouth News "Hospital inquiry leads to misconduct charge"

Document 16: Press cutting taken from General Practitioner "Baker leads hospital's death inquiry" and press cutting taken from Southern Daily Echo "Doctor could face charges over deaths"

Document 17: Press cutting to include cutting "families welcome department's statement"

Document 18: Press cutting dated 16 September 2002 taken from The Times Online "Families prompt hospital deaths inquiry"

Document 19: Press cutting dated 16 September 2002 taken from The Daily Mail Code A expert to head hospital deaths inquiry"

Document 20: Press cutting dated 16 September 2002 taken from The Daily Mirror "Probe at 13 death hospital"

Document 21: Press cutting dated 16 September 2002 taken from The Times "Families prompt hospital deaths inquiry"

Document 22: Press cutting dated 15 September 2002 taken from The Sunday Times

Document 23: Press cutting dated 15 September 2002 taken from The Sunday Times "Police probe 13 hospital deaths"

Document 24: Press cutting dated 14 September 2002 taken from The Daily Telegraph "CPS to look at hospital deaths"

Document 25: Press cutting dated 14 September 2002 taken from The Guardian "Inquiry launched into 'suspicious deaths' at hospital"

Document 26: Press cutting dated 14 September 2002 taken from The Guardian "Inquiry into deaths at hospital"

Document 27: Press cutting dated 14 September 2002 taken from Portsmouth News "Time to end the doubt over deaths"

Document 28: Press cutting dated 14 September 2002 taken from PA News "members of the federation of small businesses, BUPA care homes and Barclays"

Document 29: Press cutting dated 14 September 2002 taken from PA News "1Health Audit"

Document 30: Press cutting dated 14 September 2002 taken from Portsmouth News "Third Inquiry"

Document 31: Press cutting dated 12 July 2002 taken from Public Finance "Gosport patients 'put at risk', says chi"

Document 32: Press cutting dated 12 September 2002 taken from Portsmouth News "Relatives blast police over hospital death probe" and article taken from West Lancashire Evening Gazette "Report sparks death probe"

Document 33: Press cutting dated 8 September 2002 taken from Luton on Sunday "Top-level probe into failing trust"

Document 34: Press cutting dated 23 August 2002 taken from Southern Daily Echo "Hospital deaths files being sent to CPS"

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WHY ARE WE INVESTIGATION GOSPORT WAR MEMORIAL HOSPITAL

Document 1: Letter dated 14 December 2001 from Gary A Ford, Professor of Pharmacology of Old Age to Detective Superintendent J James, Hampshire Constabulary regarding a copy of report on five patients who died at the Gosport War Memorial Hospital

Document 2: Letter dated 22 November 2001 from Dr K I Mundy, Consultant Physician and Geriatrician to Detective Superintendent J James, Hampshire Constabulary regarding Confidential Medical Report regarding medical management of patients at Gosport War Memorial Hospital

Document 3: Letter dated 3 July 2001 from Code A Chief Executive Isle of Wight, Portsmouth and South East Hampshire Health Authority t Code A Chief Executive CHI regarding assistant by CHI with a local inquiry

Document 4: File note: Telephone call dated 4 July 2001 from Professor Gary Ford and written by Code A

Document 5: File note: Telephone call dated 8 August 2001 between Code A and Code A

Document 6: File note: Telephone call dated 10 July 2001 with Deputy Chief Executive, Code A from Portsmouth Healthcare NHS Trust regarding Gosport War Memorial Hospital

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Document 8: Press Cutting dated 23 October 2001 taken from The News "Watchdog looks at Hospital Care"

Document 9: News article dated 30 October 2001 taken from a website called ThisisHampshire.net "Hospital Safety Inquiry"

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Document 13: Press cutting dated 25 October 2001 taken from Health Service Journal "Investigation launched after elderly deaths"

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Document 15: Press cutting dated 24 October 2001 "Hospital investigation may bring NHS change"

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Document 17: Letter dated 23 November 2001 from Jane Barton to Code A Investigation Coordinator regarding specific points that have direct bearing on the investigation

Document 18: dated 21 June 2001 from Code A w Larter regarding SUI: Suspicious deaths at Gosport War Memorial Hospital

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Document 21: dated 16 October 2001 Briefing for Prime Minister's Questions: CHI investigation of Gosport War Memorial Hospital

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Captsicks comments on draft Gosport report.

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Doc number	Document title	Date	Produced by
1	Seamless Care- Obstacles and Solutions	Compendium Document D1(1997)	British Geriatrics Society
2	Rehabilitation of Older People: Evidence of effectiveness to assist purchasing of general rehabilitation, and specific packages for Rehabilitation of stroke and fractured neck of femur.	Compendium Document D1(1997)	British Geriatrics Society
3	Prescribing for the older person. Vol 11 No10	2000	MeReC Bulletin National Prescribing Centre
4	Standards for Health and Social Care Services for Older people.	2000	The Health Advisory Service
5	The NHS Plan : A Summary & Chpt 15 Dignity, security and independence in old age.	July 2000	The NHS
6	National Service Framework for Older People: Executive Summary.	2001	Department for Health
7	Medicines and Older People: Implementing medicines-related aspects of the NSF for Older people.	2001	Department for Health
8	NSF for Older People: A Short Summary.	2001	Department for Health
9	Caring for Older People: A Nursing Priority. Integrating knowledge, practice and values.	March 2001	Report by the Nursing and Midwifery Advisory Committee.

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Portsmouth HealthCare NHS
NHS Trust

Gosport War Memorial Hospital Information

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Portsmouth HealthCare NHS
NHS Trust

Gosport War Memorial Hospital

Gosport War Memorial Hospital is managed by Portsmouth HealthCare NHS Trust (PHCT). Services provided from Gosport War Memorial Hospital include GP beds, Elderly Medicine and Elderly Mental Health with assessment / rehabilitation and continuing care beds and day hospitals.

The Hospital also has Physiotherapy, Occupational Therapy and Podiatry departments. Speech and Language Therapy and Community Dental Services can also be found on site.

A full range of outpatient services are also provided, although the majority of these relate to Portsmouth Hospitals NHS Trust.

The three wards under review are described below:

Ward Name	Ward Type	Number of Beds	Medical Staff
Daedalus Ward	Elderly Medicine including Stroke Care	24	Consultant - Dr Lord Staff Grade - Code A
Dryad Ward	Elderly Medicine Continuing Care	20	Consultant - Code A Staff Grade
Sultan Ward	GP Beds	24	All GPs on Gosport Bed Fund

These three wards comprise the Elderly Inpatient component of Gosport War Memorial Hospital. However, Sultan ward is distinct from Dryad and Daedalus as it is a GP Bed Fund ward, admissions to which are controlled by the local GPs. In addition the local GPs are contracted to consult to these beds.

Medical cover to both Dryad and Daedalus wards is provided by the Department of Elderly Medicine and out of hours cover from a local GP practice with access to the 'on call' Medical Consultant. During 1998/1999 there were difficulties recruiting appropriate locum medical support to cover maternity leave. At this time both Dryad and Daedalus wards had a Continuing Care function which, in the case of Daedalus gradually altered to accept a different case mix. These patients were largely slow stream rehabilitation and the change a reflection of changing referrals to the local Consultants. Daedalus also had a Slow Stream Stroke care function. Management of these patients is subject to the Trust Stroke Guidelines (these are nationally recognised guidelines and a copy is available on request). Daedalus has also been included in the

National Annual Sentinel Audit of Stroke Care which demonstrated that the care provided was in the upper percentile of all Trusts audited. (The Trust's process and organisation scores for the 1999 audit are included along with a summary letter from Code A Lead Consultant for Elderly Medicine.) The full document is available on request.

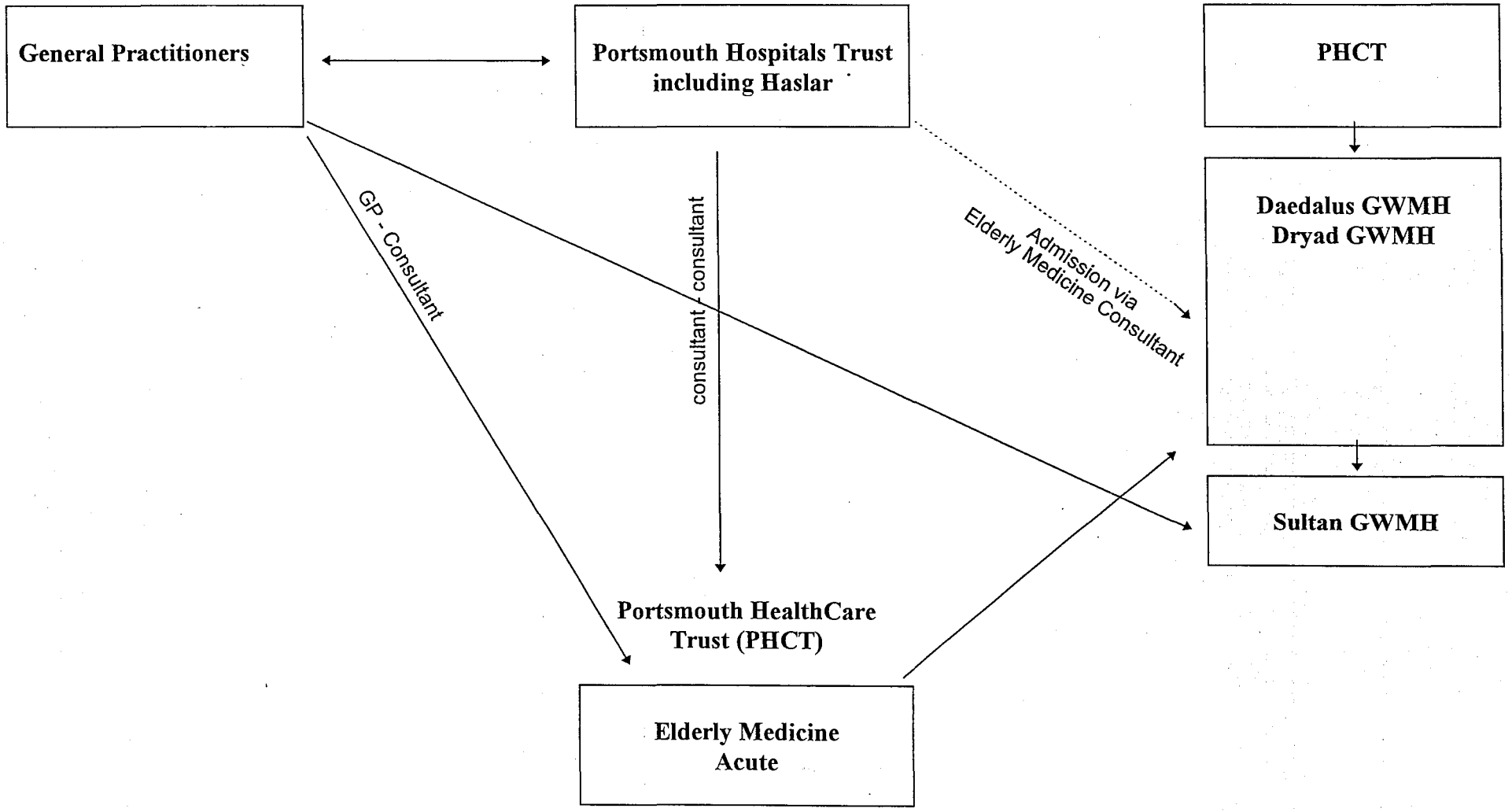
In late 1999, in response to a recognised shortage of Doctors, and in response to a patient complaint, it became clear that the medical cover at that time (Clinical Assistant time from a local GP Practice and Consultant ward rounds) was insufficient to provide the level of service to both patients and their families. A full time Staff Grade Doctor was subsequently funded. The immediate benefit of this being the presence of a Doctor during working hours as opposed to a daily ward visit from the Clinical Assistant.

By the middle of 2000, the Intermediate Care agenda was in process and one million pounds worth of development money was invested in Fareham and Gosport. A proportion of this enabled the change of use of Daedalus ward from Continuing Care/Stroke Care to Elderly Medicine, rehabilitation/Stroke Care with additional Consultant support. The appointment of an H Grade Nurse in a Practice Development role and enhanced therapy input and training and development for staff in managing less stable patients was also funded at this time.

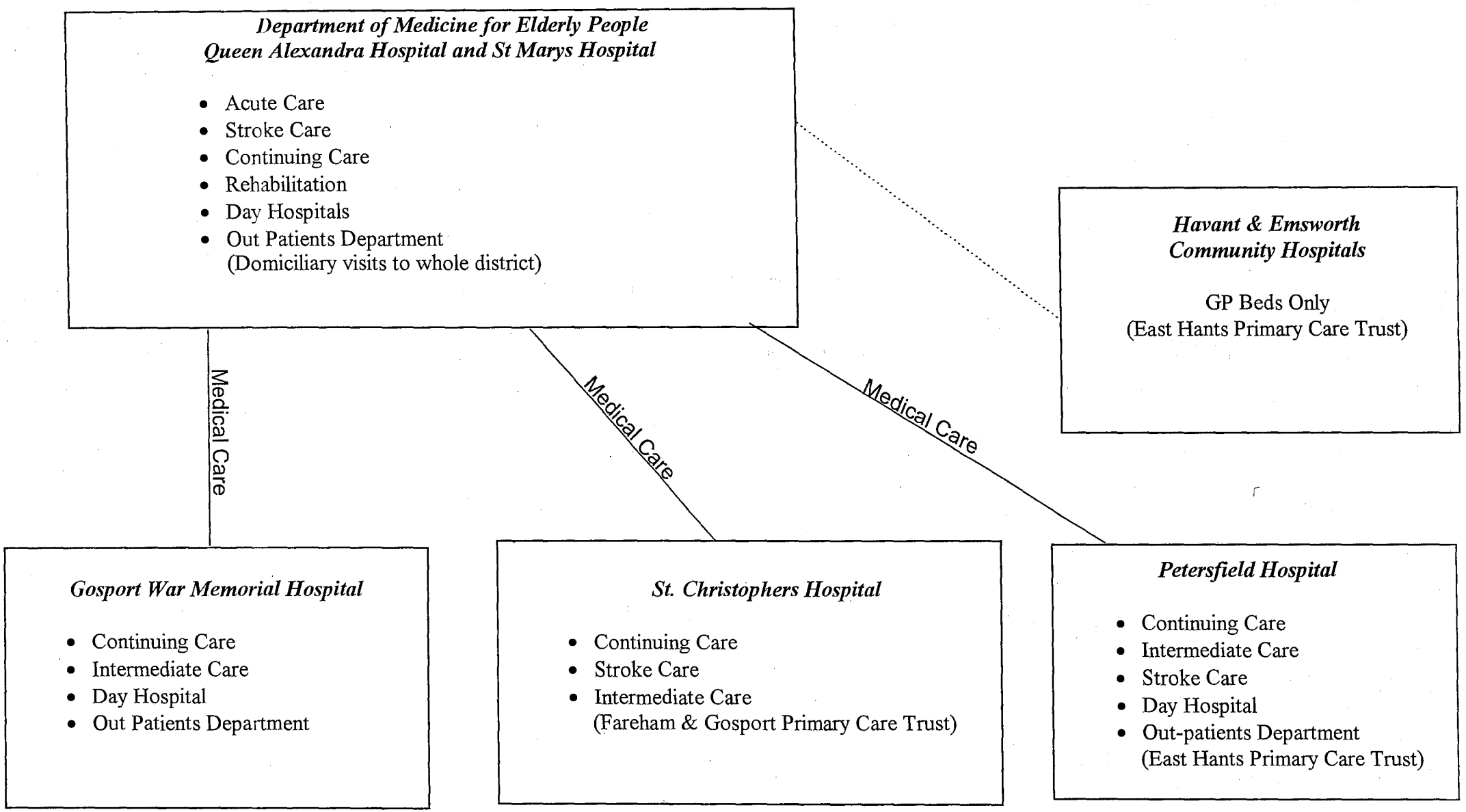
Specifically in relation to nursing, a nursing review was conducted in the Trust in 1998 which led to the creation of a Clinical Leadership Programme, this resulted in the appointment of a Clinical Practice Facilitator in all Trust areas. The Facilitators were supported by a Clinical Supervisor programme and by a training initiative which was led by the Trust Nursing Director. This programme achieved national commendation.

In January 2000 new General Management and Clinical Governance structures were introduced so that the accountability pathway for nurses led from Service Managers to General Managers and ultimately to the Trust's Nursing Director.

Patient Flows



THE DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE
Services Provided



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	Fareham and Gosport Primary Care Groups Intermediate Care and Rehabilitation Services, May 2000
	PHCT User involvement in service development: a framework, 16 November 2001
	Letter re Gosport Health Improvement Programme (HImP) 2002-2003 and attached HImP 2000-2002, 22 October 2001
	Fareham and Gosport Primary Care Groups, Proposal to establish a Primary Care Trust for Fareham and Gosport, July 2001
Section B	Service Strategic
	The department of medicine for elderly people, Service provided
	PHCT Fareham and Gosport Locality Division (Organisational chart), 25 October 2001
	March 2001 Final Monitoring Report Intermediate Care, 14 May 2001
	IOW, Portsmouth and SE Hampshire Health Authority, NSF Older People Steering Group (District-wide Implementation Team), Terms of Reference, Draft 3
	IOW, Portsmouth and SE Hampshire Health Authority, Fareham and Gosport Perimary Care Groups, Fareham and Gosport Older Persons Locality Implementation Group Progress Report
	PHCT Development of intermediate care and rehabilitation services within the Gosport locality
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	PHCT Gosport War Memorial Hospital Feedback from patient Survey – July 2001
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	Quarterly report – Governance indicators, Quarter ending 30 June 2001
	Infection Control Services, Nursing Practice Audit, 9 May 2001
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	PHCT Specification of medical service provided by retained medical officer (RMO)
	PHCT Department of Medicine for Elderly People, Essential Information for Medical Staff
	Comparison of the % who agree to the % who disagree per question (Staff survey results), 19 October 2001

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	Sickness absence statistics for Daedalus, Dryad and Sultan Wards, Gosport War Memorial Hospital, 2000/2001
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	PHCT Night Skill Mix Review Gosport War Memorial Hospital, 28 march 2001
	PHCT Development of intermediate care and rehabilitation services within the Gosport locality
	PHCT Operational policy, Bank/Overtime/Agency, Fareham and Gosport Community Hospitals and Elderly Mental Health
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	PHCT Urgent notice for all Medical and Nursing staff, Daedalus and Dryad Wards, 19 November 2001
	PHCT Discharge Summary Form, 21 November 2001
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	Audit of Patient Records, December 1997 – July 1998
	Audit of Nutritional Standards, October 1997 – April 1998
	PHCT Falls Policy Development
	Stepping Stones – Daedalus Ward
	PHCT Programme of Training events 2000-2001
	PHCT Procedure for the Initial Management of Medical Emergencies in GWMH, 15 January 2001
	BGS Compendium of Guidelines, Policy Statements and Statements of Good Practice, Contents
	Policy for psychiatric involvement, November 2001

	PHCT Trust Corporate Policies, Guidance for Staff, Revised August 2000
	PHCT Policy for Client Records and Record Keeping, December 2000
	PHCT Policy for prevention and management of malnutrition within trust residential and hospital services, November 2000
	PHCT Policy for the prevention and management of pressure ulcers, May 2001
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	PHCT Audit of Neuroleptic Prescribing in Elderly Medicine, November 1998 – July 1999
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	PHCT Policy for Assessment and Management of Pain, May 2001
	PHCT Administration of Controlled Drugs – The Checking Role for Support Workers
	A Spoonful of Sugar, Medicines Management in NHS Hospitals, 27 December 2001
	PHCT Administration of Medicines, Community Hospitals – Programme for updating qualified staff, 13 March 1997
	Scoresheet – Medicines management standard (controls assurance)
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	IPR Audit 2000
	Introduction to Gosport War Memorial Hospital
	PHCT Induction Training, October 1999
	PHCT Clinical Nursing Development, January 1998
	Royal College of Nursing, Gerontological Nursing Programme, Community Hospitals Version 2.0 2001

	Training and Development for Nursing Staff in PHCT Community Hospitals relating to Intermediate Care, 12 February 2001
	PHCT An Evaluation of Clinical Supervision Activity in Nursing throughout Portsmouth HealthCare NHS Trust, December 1999
	Policy Statement – Training and Education, April 2001
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	PHCT Handling Patient Related Complaints, January 2000
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	PHCT Clinical Governance – Annual Report – 1999/2000
	PHCT Clinical Governance: Minimum expectations of NHS Trusts and Primary Care Trusts from April 2000, Action Plan review March 2001
	PHCT Clinical Governance – Annual Report – 2000/2001
	PHCT Risk Management Strategy 2000-2003

PORTSMOUTH HealthCare NHS TRUST

DEVELOPMENT OF INTERMEDIATE CARE AND REHABILITATION SERVICES WITHIN THE GOSPORT LOCALITY

RESOURCE REQUIREMENTS ASSOCIATED WITH THE DEVELOPMENT OF COMMUNITY REHABILITATION AND POST ACUTE BEDS WITHIN GWMH

1. Planning Assumptions

- There will be a change of use of beds within Daedalus ward at GWMH (24 beds) to provide 24 community rehabilitation and post acute beds. Dryad ward (20 beds) will continue to provide continuing care and these will be the only CC beds at GWMH. It is however assumed that all beds will be used flexibly to meet patient need and demand.

- Given that the change of use of Daedalus is only a small part of a drive to improve bed management across the district there is likely to be an impact on both Sultan ward (24 beds) and Dolphin Day Hospital. This impact is not known but will evolve with both the intermediate care and Community Enabling service proposals.

- In addition there is scope within Sultan to improve occupancy and a willingness expressed by the GP's to support this. It is also possible, providing remuneration arrangements were satisfactory, that a number of GP's would support the idea of consulting to patients in their beds from practices outwith the bed fund.

- Daedalus - likely split of beds

Slow stream stroke care	8
fast stream stroke care	8
post acute	8
TOTAL	24

NB - specific numbers for planning purposes only, to be flexibly used.

2. Resource Implications/Costs

The following costs for therapies are 'notional' in that costing for these services were worked up in an inclusive way to take account of the community enabling service, St Christopher change of bed use and GWMH change of bed use. As a result costs only are tabled as it is likely that therapy staff will input across the entirety of this service. It is possible to attribute WTE's to the costs but caution would need to be exercised.

Physiotherapy	£ 15,000
Occup therapy	£ 3,000
S&LT	£ 10,000
Nursing	£ 92,500 (H-1 E-1.06 D-1.68A-0.48 A&C2-1)
Medicine	£ 40,000 (1.5 sessions cons, 4 sessions staff grade & locum 7 wks)
TOTAL	**£160,500**

3. Disaggregation

This is a complex issue comprising two main elements.

(i) Therapy input to acute and acute medicine wards currently.

With the exception of OT it is felt that, as the purpose of this exercise is to free up acute beds and increase admissions to them, both physio and S&LT will be likely to be required as previously. OT is different as whilst OT involvement occurs when discharge planning begins, significant involvement is close to the discharge date and after discharge.
As a consequence there is a view that physio and S&LT will require to increase their establishments across the board to cover both acute and intermediate care. Occupational therapy might not require new resources, however this would be dependant on early disaggregation.

(ii) Current inequity of provision in the localities.

Whilst inequity exists to varying degrees it is relatively small and would generate critical mass issues and split posts.

4. Risk Issues

The following list is not exhaustive but thought to represent the issues where management plans will be required prior to implementation.

(i) Consultant cover - given the time scales to recruit it is unlikely that a suitable individual could be appointed prior to Jan 2001. The impact of this is significant given the difficulties finding locum cover and the associated cost of this. Needs further discussion with PCG and Code A

(ii) Medical risk - the change in client group will mean that more patients are likely to have conditions which if they deteriorated, would require specialist intervention. The introduction of automated defibrillators to community hospitals may to some extent resolve part of the issue. However clear protocols will be required for the urgent transfer of individuals as well as timescales within which medical cover can be obtained out of hours. Needs further discussion between PCG/PHCT.

(iii) Preparatory Training - This relates in the main to qualified nursing staff. A course has been identified 'ALERT', and a bid made against consortia monies to fund sufficient places. This particular course would address the need for qualified nursing staff to develop their skills in relation to assessment of changes/deterioration in patients conditions. However there is an additional need which relates to rehabilitation work and discussion need to take place to clarify the components of this.
It might be possible to appoint in relation to the H grade someone with the requisite skills and provide this 'in house'.

5. Other Issues

- potential impact on loans store
- enabling works St X only
- potential accommodation issues
- requirement for increases in visits from community pharmacist
- potential increase in the use of borderline substances
- potential increase in orthotics
- admin and clerical support

Rehab/Intermediate Care

Based on 24 beds   8 Fast Stream Stroke
8 Rehab/Intermediate Care
8 Slow Stream Stroke

Nursing

		WTE	No.	Variation
Day	Clinical Manager (G)	1	1	0
	Senior Staff Nurse (F)	1	1	0
	Staff Nurse E	4.93	5	1.85
	Staff Nurse D	2.76	4	1
	HCSW A	9.36	12-16	0.85
		19.05		
Nights	Senior Staff Nurse (F)	0	0	-0.67
	Staff Nurse E	2.93	4	~~1.73~~ —
	Staff Nurse D	0 .83	0	~~1.06~~ 1.83
	HCSW A	4.39	0	0
Other	Ward Clerk	0.85 1.0	1	1.0 (0.58)
	Activity Co-ordinator	? 0.53	1	0

Multidisciplinary Team

OT/Physio   Holiday & Sick cover
Prompt filling of vacancies
W/end cover from physio &/or OT assistants (e.g. 2 hrs Sat & Sun am)

Social worker – Code A ↑ 0.85 = 32 hrs. – need cover for AL

Training Needs:

ECG Recording
Orthopaedic rehab
Canulation
Blood transfusion monitoring
Fast Stream Stroke Rehab (update)
Accessing results on PC terminal

} Night & Day → Staff

ongoing manual handling

7 – 8 a.m
4/5 p.m.

General

Ward terminal for access to results **(essential)** = some wiring local distance.
Review of resus policy and procedures **(essential)** -
Review of medical supplies & faster ordering and delivery system - Material management system.
Improved daily drug ordering (2nd delivery and weekend delivery) - delays in treatment.
- Additional wheelchairs 6 - different.
Oxygen saturation monitor
ECG machine
Digital sphygmomanometer
Notes Trolley
Reading Enlargement of ward office/nursing station +
Drip stands - 4

Air beds ↑ 21 beds
Pressure Relieving cushions ↑ 18
Armchairs whabs.
Ambulatory BP machine.
Suction machine x1
+ infusion pumps.

Budget

Additional funding needed for:

Pharmacy - Review of medication supplies -- + increase Pharmacy.
Medical supplies -
Border line substances -
+ increase beverages.

General Ideas

Take slow progress patients from FSSR for second half of rehab. All discharge planning to be initiated following transfer to Daedalus.

+ v. small - drop one bed.

upgrade old equip. room to office - needs window + telephone.

PORTSMOUTH HealthCare NHS TRUST

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

FULL TIME STAFF GRADE PHYSICIAN
GOSPORT WAR MEMORIAL HOSPITAL

INTRODUCTION

Portsmouth and South East Hampshire Health Authority is the largest in the South West Region and serves a population of 544,000. It borders the Solent and English Channel and includes the City of Portsmouth and the Boroughs of Gosport, Fareham, Havant and Petersfield. The District extends from Warsash in the west to Emsworth on the Sussex border and its northern boundaries encompass Code A and Code A With the exception of the northern rural areas it is essentially urban.

Portsmouth is a University city on the South coast with ready access to London (one and a half hours by train). There are ferries to France and the continent. Sailing and watersports are very popular and sandy beaches are within easy reach. The area offers the advantages of city life with close proximity to the beautiful South Downs with pleasant villages and seaside towns. Hampshire is an ideal location for families with many good schools.

GOSPORT WAR MEMORIAL HOSPITAL

This Community hospital has been recently re-built and now has a busy Outpatients Department and onsite Physiotherapy and Occupational Therapy Departments, Radiology and Phlebotomy services. From the 1st October 2000 Daedalus Ward will have 24 patients for general, fast and slow stream stroke rehabilitation and Dryad Ward 20 patients for NHS Continuing Care. The Department of Old Age Psychiatry has 2 wards for acute admissions, Phoenix Day Hospital and Redclyffe Annexe for Continuing Care for the Elderly Mentally Infirm. Sultan Ward has beds for GP admissions, and Blake Ward provides post-natal care.

Dolphin Day Hospital has been open now for more than 7 years and caters to patients with a variety of complex medical and rehabilitation needs. The Day Hospital Staff run a Parkinson's Disease Group for patients and carers twice a year and also offer a COPD Service. A Falls' Service is to be implemented later this year. Code A and Dr. Code A are the 2 Consultants in Elderly Medicine with responsibility for patients on Daedalus and Dryad Wards and Dolphin Day Hospital.

At present Haslar Hospital provides an acute inpatient and diagnostic service to service personnel and civilians in Portsmouth. Provision of general and elderly medical services in Portsmouth are under active review at present and there could be changes in the near future. There is tremendous potential to further develop services in Gosport

with a view to providing more post-acute care, rehabilitation and rapid assessment of elderly patients.

THE DEPARTMENT

The Department aims to provide a comprehensive service, including acute admission facilities, rehabilitation, continuing care (longstay), shared care, holiday relief, day hospitals, palliative care, liason with other departments (specially Orthopaedics and Old Age Psychiatry) and domiciliary visits.

The Department is based at Queen Alexandra Hospital with facilities at St Mary's Hospital (DGH) and in community based hospitals at Fareham, Gosport and Petersfield. NHS Continuing Care is also provided in Jubilee House in Cosham. This was previously an NHS Nursing Home.

The Elderly Medicine Department's acute admission centre is based at Queen Alexandra Hospital (131 beds on 7 wards). These beds include six acute stroke beds on Mary Ward.

The Department operates an unselected acute admissions policy of patients aged 65 and over. There is a stroke service for patients aged 75 and over, involving acute admissions and appropriate rehabilitation. The Department also takes younger strokes over the age of 65. Current figures show we take 84% of all strokes in the area. There is an active rehabilitation service for over 65's, taking patients from all specialties.

There are general rehabilitation beds on Kingsclere Ward at Saint Mary's Hospital. Outpatient clinics are also provided at the District General Hospital sites and at Gosport War Memorial and Petersfield Hospitals.

There are four Day Hospitals - Amulree Day Hospital at Saint Mary's Hospital, Trevor Howell Day Hospital at Queen Alexandra Hospital, the Laurel Day Unit at Petersfield Community Hospital and Dolphin Day Hospital at Gosport War Memorial Hospital.

Modern library facilities exist at both district general hospital sites and bench libraries at most of the smaller sites. Ample opportunity exists for Continuing Medical Education (CME) both internally and externally. The Trust is committed to CME and Continuing Professional Development (CPD).

Department Statistics

District population 1998	544,174
Aged over 65 years	87,612

Available Beds

Acute	
Queen Alexandra Hospital	125
Stroke Unit - Mary Ward	6

Rehabilitation				
Fast stream stroke	-	Guernsey Ward	20	(SMH)
Slow stream stroke	-	Queen Alexandra	18	
	-	St Christopher's	9	(Fareham)
	-	Petersfield Hospital	4	
General	-	Kingsclere Rehab	37	(SMH)
General & Stroke	-	Daedalus	24	
Palliative Care	-	Charles Ward	8	(QAH)
Continuing Care	-	George Ward	18	
	-	Jersey Ward	18	(SMH)
	-	Petersfield	20	
	-	St Christopher's	62	(Fareham)
	-	Gosport War Mem.	20	
	-	Jubilee House	25	(Cosham)
Day Hospital Places	-	St Mary's Hospital	25	
	-	Queen Alexandra	25	
	-	Petersfield	10	
	-	Gosport War Mem.	15	

Medical Statistics

Total admissions (1998/1999) 5,181
(4,087 acute)

Outpatients (Queen Alexandra and St Mary's Hospital only)

New attendances	830
Follow-ups	2,640
Total attendances	3,470

Departmental Staffing

Consultants	Special Interest	NHS Sessions
Dr Code A	Medical Director (Trust)	6 clinical, 5 Trust
Prof Code A	School of Postgraduate Medicine	2
Code A	Drugs & Therapeutics	10
	Community Clinical Tutor & Lead Consultant	11
Code A	Clinical Audit	11
	Day Hospitals	11
	Stroke Service	5.75
	Ortho-geriatrics & falls	11

Associate Specialist

Dr Code A	Palliative Care, Continuing Care and Slow Stream Stroke Care (Petersfield)	7

Staff Grades

Code A	Stroke/General Rehab	10
	Stroke/General Rehab	10

Junior Staff

4 Specialist Registrars
6 Senior House Officers - 4 on internal rotation with general medicine
- 2 vocational training scheme
2 Pre-registration House Officers
41 Clinical Assistant sessions
3 Hospital Practitioner sessions

THE POST

The postholder will be based at Gosport War Memorial Hospital and will look after 20 Continuing Care/Slow Stream General Rehabilitation patients on Dryad (Consultant - Dr. Ian Reid). Daedalus Ward (Consultant – Dr. Althea Lord) will provide general and stroke rehabilitation for 24 patients. Duties will involve admitting patients transferred from other wards, the day to day medical care of these patients, communicating with relatives and patients, functioning as a member of an interdiscliplinary team, and liason with Elderly Medicine and other Departments. It will be essential to participate in Discharge planning and the relevant documentation and communication with General Practitioners. There is a need to work flexibly with community services and colleagues in the acute setting. Two sessions a week are being currently arranged at Dolphin Day Hospital although this may vary depending on the workload in the other areas.

Out of hours and weekend cover to both wards is currently provided by Dr.A.Knapman and partners who are from a local General Practice.

There are active Education Centres at both Saint Mary's Hospital and Queen Alexandra Hospital with ample opportunity for using library facilities and attending local educational events. Staff Grade Physicians are encouraged to participate in the departmental education programmes. There have been a number of audits within the rehabilitation services and staff grade doctors are encouraged to develop audit ideas in conjunction with consultant staff and the clinical audit department. There are also opportunities for research and input to service development.

The Department has the following weekly sessions at Queen Alexandra Hospital:
Wednesday 8.45 am – Radiology
Wednesday 1 pm – Topic Teaching
Friday 1 pm – Journal Club
Facilities are available at Gosport War Memorial Hospital to access databases and electronic journals via the internet.

The current timetable is shown below but it is anticipated that there may be changes in the future as the Department is undergoing re-organisation.

Day	AM	PM
Monday	Ward Work	Daedalus – Consultant Ward Round
Tuesday	Ward Work	Dryad – Consultant Ward Round
Wednesday	Dolphin Day Hospital/ Ward Work	1pm – QAH – Educational Meeting Audit & Admin
Thursday	Dolphin Day Hospital	Daedalus Stroke Rehabilitation
Friday	Ward Work	Ward Visits

CONDITIONS OF SERVICE

The post is covered by Terms and Conditions of Service of Hospital Medicine and Dental Staff (England and Wales) and the General Whitley Council Conditions of Service.

The basic salary for the post is in accordance with Whitley Council rates on a scale £25,320 - £33,600 for a full-time post, with a further four optional points in accordance with AL(MD) 4/97.

Because of the nature of the work for which you are applying, this post is exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975. Applicants are therefore not entitled to withhold information about convictions and, in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action by the Authority. Any information will be completely confidential and will be considered only in relation to an application for positions to which the order has been applied.

Applicants must be fully registered with the General Medical Council.

Completion of a health questionnaire is required which may result in a medical examination.

The postholder must normally have a current driving license and his/her private residence must be maintained in contact with the public telephone service.

COMMENCEMENT OF DUTIES

The appointee will be required to take up the post no longer than three months from the date of offer of employment, unless a special agreement has been made between the appointee and the Authority. If you consider it unlikely that you will be able to take up the appointment within such a period, you are advised to point this out at the time of your application.

Interested candidates can arrange to visit the Hospital and can speak to Dr Althea Lord (T:023 92286915).

NOTIFICATION OF ANNUAL LEAVE AND STUDY LEAVE

When planning leave, the postholder must first liaise with the Medical Staffing Co-ordination in Elderly Medicine (Code A). As much notice as possible should be given to enable cover arrangements to be made; there is no guarantee that requests can be granted if minimal notice is given (i.e. less than six weeks). The Medical Director must give educational approval to study leave applications. The appropriate application form can be obtained from Medical Personnel Department.

PERSON SPECIFICATION

STAFF GRADE PHYSICIAN
DEPRATMENT OF MEDICINE FOR ELDERLY PEOPLE
GOSPORT WAR MEMORIAL HOSPITAL

ESSENTIAL	DESIRABLE
Full recognised medical qualification	MRCP
Experience of rehabilitation at SHO/Registrar level	Broad general medical experience
Ability to work with other professionals in a constructive way	Interest in teaching - particularly in a multi-professional setting
Good communication skills at all levels. Ability to discuss complex problems with patients, their family/carer and staff.	Interest in research
Flexible working practice and a desire to innovate and move the Service forward in a changing medical world	Current driving licence
Ability to assist in department audits	

SG Job Desc/5.7.00.

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Index – Gosport War Memorial Hospital Investigation: Team Folder (Introduction: First papers, Briefing, Site Visit, Report Briefing...)

AGENDA

Document 1: Agenda for the Gosport Investigation Team Briefing Day on Monday 17 December 2001 at the Commission for Health Improvement

TEAM INFORMATION

Document 1: Document regarding Biographies of team members for the investigation

Document 2: Document titled "What makes a good CHI interview?" and dated November 2001

GENERAL INFORMATION

Document 1: Document titled "How to find the Commission for Health Improvement"

WHY ARE WE INVESTIGATION GOSPORT WAR MEMORIAL HOSPITAL

Document 1: Letter dated 14 December 2001 from Gary A Ford, Professor of Pharmacology of Old Age to Detective Superintendent J James, Hampshire Constabulary regarding a copy of report on five patients who died at the Gosport War Memorial Hospital

Document 2: Letter dated 22 November 2001 from Dr K I Mundy, Consultant Physician and Geriatrician to Detective Superintendent J James, Hampshire Constabulary regarding Confidential Medical Report regarding medical management of patients at Gosport War Memorial Hospital

Document 3: Letter dated 3 July 2001 from Code A Chief Executive Isle of Wight, Portsmouth and South East Hampshire Health Authority to Peter Homa, Chief Executive CHI regarding assistant by CHI with a local inquiry

Document 4: File note: Telephone call dated 4 July 2001 from Professor Gary Ford and written by Code A Medical Director, CHI

Document 5: File note: Telephone call dated 8 August 2001 between Code A and Code A

Document 6: File note: Telephone call dated 10 July 2001 with Deputy Chief Executive, Code A from Portsmouth Healthcare NHS Trust regarding Gosport War Memorial Hospital

Document 7: File note: Telephone call dated 11 July 2001 with Code A from Portsmouth Healthcare Trust

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Document 8: Press Cutting dated 23 October 2001 taken from The News "Watchdog looks at Hospital Care"

Document 9: News article dated 30 October 2001 taken from a website called ThisisHampshire.net "Hospital Safety Inquiry"

Document 10: Letter dated 15 August 2001 from Max Millet, Chief Executive Portsmouth Healthcare NHS Trust to Code A Investigation Manager, CHI regarding Police Investigation into the death of Gladys Richards

Enclosure: Document: GWMH Police Investigation – Chronological Sequence of Events

Document 11: File note: Meeting to discuss concerns relating to Gosport War Memorial Hospital dated 3 September 2001

Document 12: Report for the Investigations and Fast Track Clinical Governance Review Programme Board meeting on 18 September 2001

Document 13: Press cutting dated 25 October 2001 taken from Health Service Journal "Investigation launched after elderly deaths"

Document 14: Press cutting dated 25 October 2001 "Hospital failed relatives"

Document 15: Press cutting dated 24 October 2001 "Hospital investigation may bring NHS change"

Document 16: Press cutting dated 23 October 2001 taken from Southern Daily Echo "Hospital Safety Inquiry"

Document 17: Letter dated 23 November 2001 from Jane Barton to Code A Investigation Coordinator regarding specific points that have direct bearing on the investigation

Document 18: dated 21 June 2001 from Code A SERO Briefing Unit to Code A Larter regarding SUI: Suspicious deaths at Gosport War Memorial Hospital

Document 19: dated 5 April 2001 from Code A Briefing unit to Code A regarding SUI: Suspicious deaths at Gosport War Memorial Hospital

Document 20: dated 30 July 2001 from Code A, Briefing Unit to Code A regarding suspicious deaths of patients

Document 21: dated 16 October 2001 Briefing for Prime Minister's Questions: CHI investigation of Gosport War Memorial Hospital

Document 22: document titled Additional Information: Isle of Wight, Portsmouth & South East Hampshire Heath Authority Joint Investment Plan for Older People 2001 – 2002

Section: MEETING

Document 1: Notes: Briefing dated 17 December 2001 – Code A

Document 2: Gosport Timetable dated Monday 7 January 2001 and Tuesday 8 January 2001

Document 3: Portsmouth Healthcare NHS Trust: OTHER STAFF dated 23 November 2001

Document 4: Document titled A Trust Strategic

Document 5: Interview Notes

Document 6: Presentation: Gosport War Memorial Hospital Investigation Team Briefing – Code A, Investigation Manager

Document 7: Final Terms of Reference dated 18 October 2001

Document 8: Presentation: Investigation at Gosport War Memorial Hospital – Nan Newberry et al, Senior Analyst

Document 9: Information regarding stakeholders

Document 10: Gosport Stakeholder meetings Key Themes

Document 11: Portsmouth Healthcare NHS Trust: OTHER STAFF dated 23 November 2001

Document 12: Commission for Health Improvement: Weekly Staff Time Recording Sheet

Document 13: Commission for Health Improvement Investigation/Review Expenses Claim form

Document 14: Finance Information Pack for Investigation/Review Team Members

Document 15: Commission for Health Improvement: Conditions of Suitability for Appointment

Section: FOLLOW-UP TEAM BRIEFING

Document 1: Letter dated 21 December 2001 from Code A Code A Hl regarding the briefing meeting and enclosure of documents

Document 2: Document titled Gosport War Memorial Hospital (Portsmouth Healthcare NHS Trust) Briefing Paper: Investigation 2001/2002 (document dated 20 December 2001)

Document 3: Document titled College of Health: Consumer Audit Guidelines

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Section: SITE VISIT

Document 1: Timetable of interviews

Document 2: Questions for Executive Team/Pharmacist

Document 3: Observation sheet

Document 4: Annual Plan 2001:2002

Document 5: Various leaflets

Document 6: Leaflet titled "Your views matter: making comments or complaints about our services..."

Document 7: Document concerning ward round

Document 8: Occupational Therapy Supervision contract and record sheet

Document 9: Mulberry Assessor/Acute Unit, Collingwood/Ark Royal Redclyffe House/Summervale House - transfer form

(4)

FILE NOTE – Telephone call 4 July 2001 from Professor Gary Ford.

Professor Ford is a Professor of Pharmacology and Geriatric Medicine at Newcastle University. He has been called in to be an expert witness on a case from Portsmouth, Gosport Hospital. He had concerns and so wished to report them to CHI.

There was a police investigation into a possible unlawful killing of a 91year old woman in the Geriatric Rehabilitation Ward. There was one expert report (from Professor Brian Livesley) which was very dogmatic that the patient should not have received the treatment she had. They have therefore asked for a further expert witness report.

The particular case concerns a lady who lived in residential/nursing home, was ambulant and fell. She had a fractured neck of femur, surgery and was referred through a geriatrician for rehabilitation for her mobility. She was on co-codomal at that time. The hospital ward for rehabilitation is overseen by a consultant but has a GP assistant who calls in. She was written up diamorphine and oromorph, she fell and dislocated her hip again. This was operated on and she was taken back to the rehabilitation ward after a few days. She was transferred in a private ambulance and the story is that she was not on a stretcher but in a sheet – she was very distressed. She was apparently in pain and they were worried that she may have dislocated her hip again, but the x-ray showed that it was not dislocated.

As she was "distressed and in pain" she was given hyoscine, haloperidol and diamorphine infusion written up by the GP assistant and then died. There is now concern as to whether that medicine was appropriate and to whether she had been given too much diamorphine.

On the ward, apparently it is the male charge nurse who seems to decide who goes on diamorphine.

There is a poor relationship between the public and the local hospital and there have been reports of ten other complaints and of patients being "killed" by the hospital.

The concern raised by Professor Ford was, are their other patients being given too much diamorphine?

We discussed the options for this. He thought that the police would contact us and may contact the Department of Health. I undertook to feed this into our investigation process to decide if there were any grounds for us undertaking an investigation. I thought we were due to do a clinical governance review at Portsmouth by the end of 2001, but on further checking, this is the community and mental health Trust and they are not listed for review.

On the 6 July 2001 when Code A was out of the office, Superintendent John James from the Hampshire Police, telephone number Code A rang. He is

(11)
31.8.01

RESTRICTED – IN CONFIDENCE

File note.

Meeting to discuss concerns relating to Gosport War Memorial Hospital.

Present: Detective Superintendent John James (JJ), Major Incident Complex, Portsmouth

Code A

Pre-meeting brief

- Police investigation(s) following death of a patient in 1998
- Concerns had been raised with CHI about the patient with Code A Code A had also had discussions with Code A
- Patient's family had complained, remained dissatisfied and took concerns to police
- GMC and UKCC also aware
- CE of Health Authority had asked for CHI review
- Report being prepared by MT: possible investigation or fast track clinical governance review

Meeting

Superintendent John James had asked to meet CHI to discuss specific concerns and outlined background information to police involvement.

- Daughters (one of whom is a nurse) concerned about care of mother who was frail and suffered from dementia. Nonetheless considered fit enough for hip replacement.

- Daughters dissatisfied with outcome of complaint and reported to the police.

- "Superficial" first police investigation and daughters complained again. Second police investigation more rigorous.

- Expert report raised a number of concerns:
  - GP contracted to provide cover and pre-prescribed diamorphine as a routine
  - Staff at liberty to administer
  - Delivered continuously with no record to suggest/support review
  - Although apparently no record to indicate patient dying, staff interviewed felt treatment appropriate because they thought she was dying

- Because of strong view of expert report, police referred to CPS and 2 case conferences. However view was that not enough evidence to proceed to prosecution on basis of 1 case, although no one disputes core elements of report.

- Export report took rigid view and disputed cause of death as broncho pneumonia, analysis of law flawed.

- Subsequently the case was reported in the press and between 8-10 other people came forward about the hospital. Code A s explained that staff at the hospital had been in jeopardy of criminal proceedings for some time thus there was a need, if police were to pursue, to take rapid action. Thus 4 patients were selected which appeared broadly similar to the first complaint, i.e.

  - Conditions apparently not terminal
  - All pre prescribed diamorphine
  - All had diamorphine administered continuously
  - Quantities administered sufficient to keep patient sedated

Two experts (one of whom is a clinician in geriatric medicine) were asked to look at these 4 cases, specifically to consider:

- How patients managed
- Clinical practice
- Roles/responsibilities for case – issues of duty of care
- Diagnosis/prognosis for each patient
- Evaluation of drug regime
- Adequacy of records
- Justification for decisions

The families concerned are not aware of this review but will need to be notified of the outcome. While a detailed report is awaited (late September/early October) the immediate concerns of the two experts are:

- quantity of drug
- continuous administration
- no recorded review of quantity and administration

Superintendent James explained that the only offence for which police can prosecute is that of manslaughter/gross negligence. As such they:

- must establish there is a duty of care
- prove a breach of duty of care
- must establish that the breach led to death
- that the clinician(s) involved were so grossly negligent as to be criminal, i.e. at such an extreme it is criminal.

The situation is problematic because it involved a doctor and a nurse, and although the report is not completed, the initial view of one of the experts is that the threshold of the extreme of "grossly negligent" has not been reached. Nonetheless,

Supt. James believes that whatever the outcome, there remains a residual anxiety about the quality of care and talked about a culture that may have evolved on the ward over a period of time:

- colloquially known as "dead loss ward"
- "Patient in danger of talking himself into a syringe driver"

He also raised a concern that over a period of 5 years one doctor had been responsible for certifying the death of 600 patients, over two thirds of which were broncho pneumonia. He acknowledged that in a palliative case centre there are bound to be a large number of deaths, and the numbers quoted would require a more detailed examination to draw a paper conclusion. Nonetheless Supt. James had no access to other information, which would enable him to draw an appropriate/reasonable conclusion.

Supt. James felt that the fact so many organisations aware eminated from his discussion with one individual who had then felt a duty to report to professional body and CHI.

The press are maintaining a keen interest in the issues.

Next steps

- Code A will write and thank Supt. James for providing information and maintain contact with him
- Code A to include information provided in report to investigations and fast track clinical governance review board
- Code A o attend programme board meeting (as Code A and Code A on leave)
- Code A to inform Supt. James of outcome of programme board meeting on return from leave
- Code A iscuss in confidence with Review Manager undertaking cgr of the acute hospitals in Portsmouth, particularly the way in which information about cgr targeted
- Code A discuss availability of Code A or Code A for stakeholder events with review manager (Portsmouth)
- Code A to circulate notes of meeting to:
  - on
  - Code A
  -
  -
  -

Code A

(13)

Investigation launched after elderly deaths

An investigation into the care of elderly people at Gosport War Memorial Hospital has been launched by the Commission for Health Improvement following the deaths of two patients in 1998.

Concerns were raised three years ago by the members of the public over the administration of drugs at the hospital. A police investigation was launched into the first death, but the case was dropped in July.

The second death resulted in a complaint to the health service ombudsman – though Portsmouth Healthcare trust, which runs the hospital, said it was 'exonerated'.

With police and ombudsman enquiries completed, CHI decided to conduct an investigation, and a CHI team will spend a week at the hospital carrying out interviews and visiting clinical areas. The public will also be invited to give accounts of their experience of care for older people. The investigation will centre on arrangements for administering drugs, the clarity of responsibility for patient care and the transfer arrangements with other local hospitals.

Trust chief executive Max Millett said he hoped CHI could reassure people about the care provided at Gosport and progress in developing services made over the past three years, as well as providing opportunities for improving care.

'The trust has full confidence in the staff who work at Gosport War Memorial Hospital and in the excellent services they provide. We will be anxious to support them during the review process to ensure they can contribute to it fully,' he said.

CHI chief executive Peter Homa said the patients at the hospital were 'elderly and particularly vulnerable'.

Meanwhile, CHI has agreed to a request from junior health minister Lord Hunt to fast-track its review of St Helens and Knowsley trust following an inquiry into the care of former patient Michael Abram, who was acquitted of attempted murder after an attack on former Beatle George Harrison. The report identified failings with communication and with integration of mental health services.

Set in stone: Ashford and St Peter's Hospital trust director Mark Jennings joins artist Susan Goldblatt to inspect her new mosaic which adorns the main entrance to Ashford Hospital. It was officially unveiled at an open day marking staff long service and educational achievement, which also coincided with the publication of the report on the trust by the Commission for Health Improvement (see story below).

CHI highlights star-ra

By Maura Thompson

Stark contradictions between the new star-ratings measure of a trust's performance and the Commission for Health Improvement's evaluation were highlighted last week with the report of a favourable clinical governance review of no-star Ashford and St Peter's Hospital trust.

As the report was published, health secretary Alan Milburn confirmed that he wants to see the work of CHI and the star-ratings system quickly integrated into a single performance measure. He told the Commons health select committee: 'I want to get to a position where – and I hope we will get this next year – what we do and what CHI does gives one set of reporting in the NHS. We need to rationalise it so we are producing one set of information.'

CHI's overwhelming concerns at Ashford and St Peter's centred on problems with delayed discharge and lack of staff – both persistent and severe throughout west Surrey and reinforced in the commission's report on adjacent Royal Surrey County Hospital trust a week earlier.

The trust, which was given three months to turn things round when awarded no stars last month, was commended by CHI for its 'excellent' risk-management procedures, 'its friendly and caring' staff and its 'effective and well-respected leadership'.

Discrepancies between the two systems were most significant on clinical effectiveness indicators. On the star rating's balanced scorecard the trust 'significantly underachieved' on the two clinical focus measures, which managers attributed to incomplete data. CHI concluded that on clinical outcomes, 'the trust performs well in comparison to England and comparable trusts'.

Like Royal Surrey trust, patients are spending up to four days in the accident and emergency department, with 40 patients staying overnight in A&E d CHI visit. The report a A&E department is fre busy. There are often tw to a cubicle, making it in to maintain the patient' and dignity.'

CHI highlighted the tr ous staffing problems, c ing to bed closures and c trust £6m a year on age The trust's poor financial was a further reason for star rating.

Despite cohesive and leadership, CHI also shortage of middle man managers at directora found themselves 'fire and 'overly embroiled in tional issues'.

And it concluded: 'The team recognise the sig pressures facing the However, there is also a tion that these issues wer their control, with the re bility for solving these iss with the regional office.'

HEALTH: NHS Trust accepts it caused unnecessary distress to families of terminally ill patients

Hospital failed relatives

HEALTH chiefs today admitted failing the relatives of terminally ill patients by not keeping them informed over the pain relief drugs their loved ones receive.

They accepted they caused unnecessary distress to relatives by not involving them in decisions to give drugs to dying patients.

The announcement followed an independent inquiry into the death of an elderly woman at Gosport War Memorial Hospital.

An action plan was drawn up last month by health bosses as a result of the findings of the review called by the dead woman's family.

Portsmouth HealthCare NHS Trust, which runs the community hospital in Gosport, said action had already been taken including a policy to keep patients and relatives informed when pain-relieving drugs were first given.

by Rebecca Ellinor
Health reporter

Max Millett, chief executive of the trust, said the existing procedure was insufficient and had not be followed closely enough by staff.

'We realise we can't rely on individual staff and we now have written guidelines to prevent distress being caused to family when they were not being kept informed how their relatives were treated.

'Issues include communication between doctors and nurses when patients continue to deteriorate and pain relieving drugs need to be given.'

Relatives will be informed when terminally ill patients are first given pain relief drugs. They will also be given the chance to question the doctors' decision throughout the patients' stay.

The hospital has been adapted and workshops have been held to better train staff how to communicate with relatives.

'We reviewed the written policy and guidelines for management of pain to build in more contact with relatives and to make sure staff are quite clear how to communicate that,' Mr Millett said.

'We revised bits of paper that lay out how pain should be managed, when used and how next of kin and relatives are informed.'

Relatives can object to the administering of pain relief but it is still ultimately up to the doctor responsible for the patient to decide whether drugs are given.

Watchdog to investigate care of elderly patients

THE NEWS comes as it was announced that an independent health watchdog is set to investigate care of elderly patients at the Gosport community hospital.

Officials from the Commission for Health Improvement (CHI) have launched a probe at the hospital which could result in sweeping national changes in the way drugs are given to elderly patients.

Elizabeth Fradd, director of nursing at the commission, will lead a team of six or more who will hold the inquiry over 24 weeks.

As a result of their findings, which will be made public, recommendations could be made that may lead to national changes in the NHS.

In particular, it will look at arrangements for the administering of drugs, responsibility of patient care and the transfer of patients between the war memorial hospital and other hospitals.

THURSDAY 25TH OCTOBER 2001

(14)

(15)

WEDNESDAY 24TH OCTOBER 2001

Hospital investigation may bring NHS change

AN investigation by a health watchdog of a Gosport hospital could result in sweeping national changes with the way drugs are given to elderly patients.

As reported in *The News* yesterday, officials from the Commission for Health Improvement (CHI) have launched a probe at Gosport War Memorial Hospital in the wake of a six-month police investigation into the deaths of elderly patients.

Elizabeth Fradd, director of nursing at the commission, will lead a six-or-more strong team who will hold the inquiry over 24 weeks.

As a result of their findings, which will be made public, recommendations could be made that end in national changes in the NHS.

by Rebecca Ellinor
Health reporter

In particular, it will look at arrangements for the administering of drugs, responsibility of patient care and the transfer of patients between the war memorial hospital and other hospitals.

The inquiry at the Gosport community hospital, is the seventh special investigation the CHI has been involved with in its 18-month history.

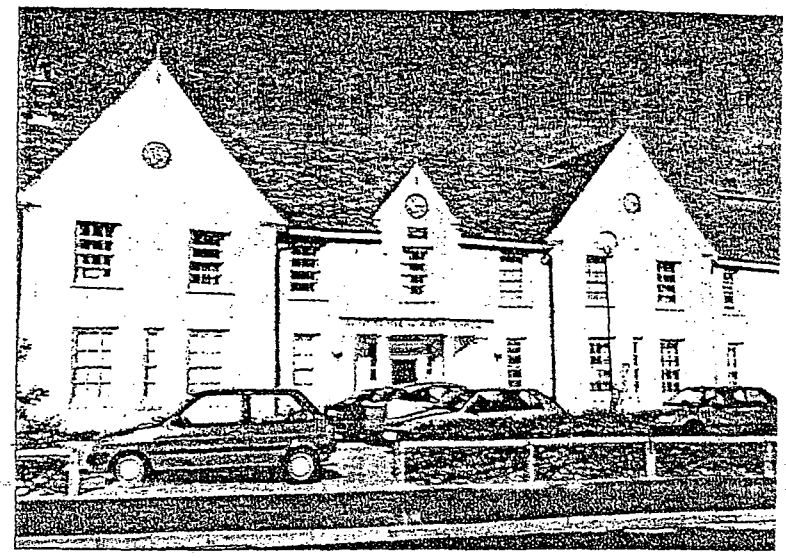
Mrs Fradd said the commission only chooses to press ahead with those inquiries where they believe the National Health Service has lessons to learn.

She said: 'Given all the information, we are led to believe there are things worth looking at and exploring at the Gosport War Memorial Hospital.'

(16)

SOUTHERN DAILY ECHO
TUESDAY 23RD OCTOBER 2001

Hospital safety inquiry



INQUIRY: Gosport War Memorial Hospital.

A PROBE has been launched at Gosport War Memorial Hospital by a government health watchdog into patient safety following concerns over the quality of care for elderly patients.

By **Siân Davies**
sian.davies@soton-echo.co.uk

The 24-week investigation by the Commission for Health Improvement was launched after concerns were raised over the level of care older people have received at the hospital.

Concerns have been raised by families of nine people who died at the hospital.

Local organisations and members of the public are being urged to talk to investigators about their experiences of care for older people at the hospital in a bid to determine whether standards at the hospital are being met.

CHI chief executive Peter Homa said: "CHI is undertaking this investigation to look into concerns over the quality and culture of care that patients, who are elderly and particularly vulnerable, have received at Gosport War Memorial Hospital.

"The trust, which runs the hospital, is keen to work closely with us to address these concerns and work to improve the quality of care provided."

The investigation will start a week-long visit by inspectors at the hospital in January where they will visit wards and theatres and interview staff and former patients.

Mr Homa said: "The findings of our investigation will result in lessons for the whole of the NHS and this is especially important at a time when community and primary care services are undergoing major change."

The CHI investigation will centre on the administration of drugs at the hospital, transfer arrangements for patients between Gosport War Memorial Hospital and other local hospitals and the clarity of responsibility for patient care.

Today, officials at Portsmouth NHS Trust, who run the hospital, welcomed the investigation.

Chief executive Max Millett said: "We welcome the commission's visit and its review of the service we provide for older people at Gosport War Memorial Hospital.

"We hope the CHI visit will help reassure people about the care provided today and allow us to demonstrate the progress we have made in service provision over the past two or three years."

The latest probe follows an inquiry by detectives into allegations of unlawful killing at the Bury Road hospital.

In April prosecutors examined files concerning the death of 91-year-old Gladys Code A whose daughter Code A Mc-Kenzie claimed she died as a result of mistreatment at the hospital.

However, prosecutors found insufficient evidence to press charges against the hospital and despite a public meeting with Portsmouth NHS Healthcare chiefs Mrs MacKenzie insisted her mother's death could have been avoided.

Mrs Richards had been admitted to the hospital in August 1998 for rehabilitation following surgery on a damaged hip at neighbouring Royal Haslar Hospital.

Code A, 67, of Eastbourne, East Sussex, told the *Daily Echo*: "I am not satisfied that my mother was treated correctly."

A new investigation was launched in September by Hampshire Police Major Crime Unit into Mrs Richard's death along with claims from eight other families over the death of relatives at Gosport War Memorial Hospital.

A report into the findings of the CHI investigation will be published in a year.

From: Commodore T J BARTON Royal Navy

(17)

Naval Assistant to Naval Secretary
2SL/CNH Headquarters
Rm 165 Victory Building
PP72
HM Naval Base Portsmouth
Hants PO1 3LS

Tel: (
Mil: (
Fax: Code A

Code A
Commission for Health Improvement
FREEPOST
LON 15399
LONDON
EC1B 1QW

23 November 2001

Dear Code A

As a member of the public, who is not part of the NHS, but someone who has been closely associated with it and the Gosport War Memorial Hospital (GWMH) for many years, I would like to make a few general observations about the NHS and raise some specific points which I believe have a direct bearing on your investigation at the GWMH.

The ethos of a Health service that is free at the point of delivery is morally very laudable, however it shifts the rigor of establishing affordability from the individual and passes it to the Government. As the expectations from such a service will always exceed the money we are prepared to pay for it, these expectations must be curbed to the point where there is broad parity to the resources available. While the present policy of appeasing the public opinion by blaming the deliverers of healthcare for the shortfall may be a short term expedient, it does not address the underlying issue. In fact, it is inflicting deep seated and long lasting damage by eroding morale of the people that we rely on to deliver the care. I have never known morale to be at such a low ebb and regrettably it continues to drop. I cannot see this trend changing as long as the present blame culture persists. The emerging evidence that output continues to decline, despite all the additional resources being pumped into the NHS, is in my opinion, a clear indication of just how significant morale is to the delivery of healthcare. The deliverers of healthcare, who contrary to Public perception, are, with very few exceptions, caring competent people working extremely hard, in very stressful conditions who feel unsupported and vulnerable.

My wife, a very competent General Practitioner, who until April 2000 worked as a Clinical Assistant in Elderly Care at the GWMH in addition to being a minimum full time GP, has been through hell and back as a result the "Blame" culture that is being inculcated throughout the NHS and indifferent management by the Portsmouth Healthcare Trust. In this instance the Staff at the GWMH have been made the scapegoats for a decision by the Healthcare Trust to change the role of the GWMH without providing adequate facilities (Enclosures 1 & 2). To date, she has been subject to two separate Police Investigations, appeared before the disciplinary board of the GMC and has been subjected inappropriately (Enclosure 3) to the scrutiny of the "Failing Doctors Scheme" all for the same allegation over a period lasting a staggering 3 years. In addition she was

A1

A3

INVESTOR IN PEOPLE

subjected to trial by the media that included attempts by the local press to interview me outside my home at 7 am in the morning. Each of these protracted and extremely stressful and deeply humiliating procedures concluded that there was no case to answer and all were characterised by a complete lack of support from her employers. Indeed she was suspended from her position, as Chair of the PCG by the Health authority after the finding of the various investigations had found there was no case to answer pending the outcome of undisclosed ongoing investigations, which presumably include CHI (Enclosure 4). As there appears to be no end to this process she has felt obliged to resign.

D8

While there should be no let up in the drive to root out the tiny number of criminal and negligent healthcare professionals the current emphasis is disproportional to the size of the problem. Unless there is a more equitable balance between protecting the interests of patients and supporting the deliverers of healthcare, the decline in morale will continue, and could ultimately lead to the collapse of the current system.

What are the solutions? The allocation of adequate resources is essential but there is a danger that these additional resources disappear into the black hole caused by the endless rounds of reorganisations and restructuring. This management churning is costly, provides a ready method of obfuscation and does not address the issue of lack of funding. The present blame culture must be replaced with some form of positive underpinning for healthcare providers. Most importantly, patients must be drawn into the cost-containment process to reduce the gap between expectation and affordability.

Sadly the frenzy of adverse publicity that accompanied the announcement of the CHI investigation coupled with the associated literature perpetuates what I can only describe as the institutionalised bullying of healthcare deliverers by an unstoppable bureaucratic juggernaut. If the management and treatment of staff at the Gosport War Memorial Hospital is an indication of Human Resource management in the NHS as a whole I am amazed that we have a service at all.

As an interested outsider can I urge that during your investigations due consideration is given to the staff, who continue to give of their best without support from their management. Some recognition of the devoted care they have provided to hundreds of frail and vulnerable people would be a refreshing change.

Finally I have enclosed copies of four letters to help in your deliberations about the process. You may find it significant that only the letter dated 28 April 2000 was deemed worthy of an acknowledgement.

Yours sincerely.

Code A

Enclosure (1)

Dr Ian Reid
Clinical Director
Elderly Medicine
Portsmouth Healthcare Trust

Dr Jane Barton
Clinical Assistant in Elderly Services
The Surgery
148, Forton Road
Gosport
HANTS PO123HH
Tel 02392583333

28th January 2000

CLINICAL ASSISTANT ELDERLY MEDICINE GOSPORT WAR MEMORIAL HOSPITAL

I feel that this is an opportune moment to examine my post for a number or reasons.

Firstly there is currently a review of the arrangement of Elderly Services and their relationship with future Primary Care Trusts and a future Trust configuration .These will undoubtedly impact on the future use of present continuing care beds throughout the District.

Secondly the Clinical and Managerial Integration between the Hopsitals Trust and DSCA and the possible future implosion of acute work at Haslar will have a major effect upon the types of subacute and post acute care offered at Gosport War Memorial Hospital in reconfigured services on the peninsula in the future.

Thirdly and perhaps more relevantly at the moment, the type and throughput of patients who are currently using our beds is completely different from those I looked after when I took up the post twelve years ago.The types of patients and their medical conditions have changed markedly and perhaps this issue has not been looked at comprehensively within the Trust. . There is no such thing as Continuing Care nowadays, and Palliative care is something that I do perforce without a great deal of specialised back up.
At a clinical level this manifests itself in a number of ways, the most strikingly obvious of which is the expectations of patients and their relatives.
In part I feel that this stems from a mistaken perception that Gosport War Memorial is a Hospital with a capital 'H', ie resident medical staff and full on site resuscitation facilities.
It is also apparent during discussions that relatives take the word rehabilitation literally and expect a much higher level of care and expertise than the current staffing levels and my time allow.

Whereas as recently as three years ago I would expect to spend a specific period of time with a worried relative over and above the normal consultation process once every few weeks, currently I find myself having to do this on a more frequent than weekly basis. In addition the climate of complaint, litigation and actual prosecution fuelled by intense media interest at present in care of the elderly and the issue of dying makes my position as a General Practitioner attempting to provide day to day care extremely difficult.

I am finding the pressures on me to continue to provide what I consider appropriate care for patients, proper consultation with their relatives and support of my hard pressed nursing staff almost intolerable. The current Police investigation into a charge of attempted murder only serves to highlight the almost impossible task faced by a team dedicated to offering seriously ill patients a dignified and peaceful passing.

I would be most grateful if you would give this matter your earliest attention as I feel that the issue is placing considerable stress on the nursing staff and I personally feel extremely vulnerable to litigation for reasons that are outwith my control.

Yours Sincerely

Jane Barton

Copy to Dr A Lord
Max Millett

Enclosure (2)

Code A
Personnel Director
Portsmouth Healthcare trust
St James Hospital
Portsmouth PO48LD

Dr.JA Barton
Clinical Assistant in Elderly Services
148, Forton Road
Gosport
Tel 023 92583333
28th April 2000

References:
a. My letter 28.1.2000 to Clinical Director Elderly Medicine
b. My letter 22.2.2000 to Dr Code A (copies of both letters attached)

Dear Code A

Over recent months I have become increasingly concerned about the clinical cover provided to the continuing care beds at Gosport War Memorial Hospital. I have highlighted these worries on two occasions previously in the enclosed letters.

I returned from my Easter leave this weekend to find that the situation has deteriorated even further. For example on one of the wards I will only be having locum consultant cover until September . In addition an increasing number of higher risk "step down" patients continue to be transferred to the wards where the existing staffing levels do not provide safe and adequate medical cover or appropriate nursing expertise for them.

The situation has now reached the point that, with the agreement of my partners, I have no option but to tender my resignation.

My original contract of employment signed in 1993 indicates I am required to give you two months notice. However, I wish my serious concerns and anxieties to be placed on record during the notice period.

Yours sincerely,

Code A

Copies to:
M Millett

Code A

Enclosure (3)

Code A
Chief Executive Health Authority
Finchdean House
St Marys Hospital
Portsmouth

Dr Jane Barton
Chair Gosport PCG
11,Village Road
Alverstoke
1 July 2001

Following a visit from your Director of Public health at extremely short notice last Friday 28th June I understand that I am being investigated under the

"Local procedure for the identification and support of primary care medical practitioners whose performance is giving cause for concern".

In addition it is fel t by the Health Authority that I should stand down from the Chair of the Primary Care Group.

IS REFERRAL TO THE "FAILING DOCTORS SCHEME" THE APPROPRIATE PROCEDURE?

I was informed that the referral to this procedure, which will investigate all my General Practice activities, is as a direct result of my appearance the previous Thursday in front of the Interim Orders Committee of the GMC.

This appearance concerned an alleged criminal case, which has been ongoing for three years and is known to you. The incident took place while carrying out my duties as a Clinical Assistant working for Portsmouth Health Care Trust in August 1998.

The GMC committee considered all the evidence and determined that it was **not** necessary for protection of members of the Public, in the public interest or in my own interest that a suspension order should be made. In other words in their v iew there was no case to answer.

Notwithstanding the findings of the above, the Health Authority has decided to proceed now , some three years after the event, with the Poor Performance Process whose grounding principles supposedly include a prompt and effective raising of matters, the confidence of all parties involved and protection of doctors against vexatious allegations (Section 2.1)

Under Section 3 of the terms of reference for the Performance procedure it states that that there are two separate parts to the process; the first of which, the **performance screening group** which can be called at short notice, determines the appropriate course of action. I have been informed that this part of the process has been convened and that my case has been referred directly to the second stage **performance reference panel** without any consultation with me or screening group having any knowledge of the details and findings of the GMC enquiry.

In addition, the guidance (section 4.2) states that criminal activity should be directed to the correct process rather than being considered under the Poor Performance Procedure. Does not an appearance in front the GMC constitute the correct procedure?

MY POSITION AS AN EMPLOYEE OF THE HEALTH AUTHORITY

I was asked at the same interview whether I felt it was appropriate for me to continue to represent the Health Authority in public in my role as Chair of the PCG. As I do not consider I have done anything wrong, a view supported by the GMC , I can see no reason to do this. However, if the Health Authority do not feel it appropriate for me to represent them in public then you should suspended me from my position with an unambiguous statement giving the reason for this.

Having worked for you for some years during which time I have always had immense respect for your fairness and balanced views, I am conscious that the tone of this letter is contentious, but I do feel there is a worrying underlying moral principle about the protection of doctors once the

unstoppable momentum of complaint and investigation has begun. This post Code A "yard arm" clearing culture with the associated ritual humiliation, leaves the medical profession unacceptably vulnerable and the long term consequences this will have on recruitment and retention will be devastating.

Dr J A Barton

Enclosures (4)

Fareham and Gosport NHS
Primary Care Groups

Unit 100, Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

Tel: 01329 233447
Fax: 01329 234984

Ref: JB/VB/L1

Code A

IOW Portsmouth and SE Hampshire
Health Authority
Finchdean House
Portsmouth
PO3 6DP

01 November 2001

Dear P Code A

As briefed by Code A a couple of weeks ago, CHI has been called in to investigate the process of patient care at Gosport War Memorial Hospital since the complaints of 1998.

I find it tragic that after 24 weeks of intensive work including further traumatisation of dedicated Clinical staff at the hospital, a report will be produced to coincide with the dissolution of the Healthcare Trust as it becomes part of the PCT. The cynic in me would go so far as to believe this is a deliberate ploy to avoid resolving this sorry episode before the beginning of April next year.

It also leaves open the implication that in addition, any further complaints, which would appear to be inevitable judging by the media frenzy that accompanied the announcement of the CHI investigation could be referred back to the police, GMC or UKCC, further extending the three years of misery which this indifferently handled episode has caused.

For my own part I can not morally justify drawing a salary and adding to the enormous financial cost of this unmanageable bureaucratic process which should be being spent on patients without being able to fully contribute. I feel it may already be being said in certain quarters that I am drawing a salary for doing nothing.

Not withstanding the fact that the original investigation of the criminal case against me and your Local "Failing Doctors" procedure have found that there was no case to answer I can see there being no speedy conclusion to this matter and further, no prospect of my being reinstated as the Chair of the PCG.

I therefore feel forced to tender my resignation.

Yours sincerely

Code A

CHI
COMMISSION FOR HEALTH IMPROVEMENT

PRIVATE & CONFIDENTIAL

3 December 2001

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103-105 Bunhill Row
London EC1Y 8TG
Telephone: 020 7448 9200
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Commodore T J Barton
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Direct Dial: 020 7448 9323
Email: julie.miller@chi.nhs.uk

www.chi.nhs.uk

Dear C[redacted] Code A

Thank you for your letter and enclosures of 23 November 2001, which Code A forwarded to me as the lead manager for the Commission for Health Improvement (CHI) investigation at the Gosport War Memorial Hospital.

I have noted your comments around the need to strike a balance between protecting the interest of patients and supporting those who actually deliver care. CHI is committed to working with the NHS to create an open, blame-free culture in which lessons can be learnt from mistakes.

I would like to reassure you that CHI's approach places the patient at the heart of all our work and does not seek to allocate blame. All of our reports are non-attributable and are made public. CHI has no statutory remit to re-investigate cases involving the care of individual patients. In its investigations CHI seeks above all, to establish whether the systems and processes followed by healthcare organisations support good quality patient care.

CHI does fully appreciate the strain both your wife and other members of staff have been under in recent years. I have already met with the main unions supporting staff at the trust, together with the Local Medical Committee, in order to give staff reassurances about CHI's methods of working and outline how staff can contribute to the investigation process.

For your information, I have enclosed a copy of the investigation term of reference and an information sheet together with some more general information about CHI.

Thank you once again for your contribution to this investigation.

Yours sincerely,

Code A

Code A
Investigations Manager

Restricted - Investigation

(18)

To: Code A
APS, PS(H)

From: Code A
SERO Briefing Unit
Date: 21 June 2001
Copy: See e-mail

SUI: SUSPICIOUS DEATHS AT GOSPORT MEMORIAL HOSPITAL

Issue

1. You asked for an update on my minute of 5th April on this SUI. You will also have seen e-mails from Code A and Code A to Code A copied to Code A about the case of Dr Jane Barton, one of the doctors mentioned in my original note.

2. Dr Code A appeared before the GMC's Interim Orders Committee yesterday.

Background Code A Code A

3. Robin and Paul's e-mails set out the background to the GMC hearing. At the time of Mrs Richards' death Dr Barton, a Gosport GP, was also working as a clinical assistant at the hospital a couple of sessions per week. Code A n resigned from that post last year and now works solely as a GP. Code A is also Chair of the Gosport Primary Care Group.

4. The police felt it appropriate to notify the GMC and UKCC of their investigation. As part of that investigation, Code A ' consultant, Dr Lord, Dr Barton and the relevant nursing staff were interviewed.

5. Code A has not beei Code A a any criminal offence. The case has been referred to the Crown Prosecution Service (CPS).

IOC decision

Code A

6. The IOC decided not to make an order against Dr Barton. The Committee was reluctant to do so in the absence of an expert report.

7. The GMC was aware that asking IOC to consider the case, while the CPS was considering the police report, carried some risk but was of the view that an early reference was required. The GMC will obtain the appropriate expert report and liase further with the police.

Conclusion

8. This decision does not mean that GMC interest in Dr Barton is at an end. The IOC may revisit her case based on the expert report and CPS decision.

Restricted - Investigation

SERO Line to take

The Crown Prosecution Service is still considering the case of Mrs Richards. It would therefore be inappropriate to comment at this time.

Code A
Rm 100 EBT
Ext 32519

19

Code A

From: Code A

Date: 5 April 2001

Copy: Code A

SUI: PORTSMOUTH HEALTHCARE NHS TRUST – SUSPICIOUS DEATHS OF PATIENTS

Issue

1. The purpose of this minute is to inform PS(H) of stories in The Portsmouth News highlighting a police investigation in to the death of a patient at the Gosport War Memorial Hospital in 1998.

2. Subsequent to the initial story, Portsmouth News has identified two further cases that are expected to be referred to the local police.

Background

Richards case

3. The local police carried out an investigation in to the death of Mrs Gladys Richards who died at the hospital in 1998. In August 1998 the Trust received a complaint from Mrs Richard's family about the care she received. The complaint concerned the administration of diamorphine - the family believed Code A was given excessive dosages. As well as receiving treatment at Gosport, Code A also received care at Royal Hospital Haslar. The complaint was fully investigated by the Trust and no evidence of inappropriate care was found.

4. In the Autumn of 1998 one of Mrs Richard's daughters alleged that her mother had been unlawfully killed. A police investigation followed and the papers on the case are currently with the Crown Prosecution Service (CPS). The Trust co-operated fully with the investigation, as have staff at Haslar.

Additional cases

5. Following publicity on this case, Portsmouth News has also been talking to the Trust about allegations from the family of a second patient. This case was also the subject of a complaint to the Trust. The complaint was subsequently referred to the Health Ombudsman and was not upheld.

6. The family in this case is planning to present a dossier to Gosport police today (5th April), asking them to investigate a possible unlawful killing. This information was presented to the Trust on 4th April by Portsmouth News, not the patient's family. It is now expected that the News will publish the follow-up story tomorrow (6th April).

7. Portsmouth News also claims to have identified a third case. This case was not the subject of a complaint to the Trust but, again, it is expected that the police will be approached.

NOT IN THE PUBLIC DOMAIN

8. There are factors common to all three cases. The consultant was the same, as was the clinical assistant who is a local GP. However, all three cases followed a similar route from Haslar to Gosport, which could have influenced which clinical staff were involved. At this time there is no evidence to suggest that this is a factor in any of the cases nor has one clinician has been identified by Portsmouth News.

Local Media interest

9. In the course of the police investigation in the Richards case a number of other deaths were examined but Mrs Richard's is the only case currently under investigation. A Portsmouth News journalist was informed of this by the family, which was unhappy about the length of time the police had taken with the investigation. The journalist erroneously picked up a story that the police were checking 500 other deaths at the hospital. Although the police have told both the Trust and the journalist that this is not the case, it is understood that the News is still likely to run the story before a decision is made by the CPS.

Trust action

Code A

10. In the **Code A** case the Trust has taken the following lines:

- The Trust takes the safety of its patients very seriously.
- The initial complaint regarding Mrs Richard's treatment was investigated and no evidence of inappropriate care was found.

- The Trust is aware of the police investigation at Gosport War Memorial Hospital and has co-operated fully. This is the only case at Gosport War Memorial Hospital being investigated by the police.

- The Trust is awaiting the decision of the Crown Prosecution Service (CPS) and is unable to comment further on the issues whilst the case is with the CPS.

Second allegation

11. On the second allegation the Trust has responded to the Portsmouth News by acknowledging that a complaint had been investigated by the Trust, that the Trust had co-operated fully with the Health Ombudsman's investigation and that the Ombudsman had not upheld the complaint.

12. The Trust has also said that it will fully co-operate with any police investigations in to this or other case.

Conclusion

13. Although there are factors common to the three cases mentioned, there is not sufficient evidence, at this time, to suggest that these deaths are linked or are the result of foulplay.

14. I will ensure you are kept up to date with any developments.

SERO Lines to take

- **The case of Mrs Richards is currently being considered by the Crown Prosecution Service, therefore it would be inappropriate to comment at this time. It would also not be appropriate to comment on any cases that are the subject of a police investigation.**

- **It is understood that the police are not investigating a large number of cases as suggested by The Portsmouth News.**

Code A
Rm C10U EBT
Ext 32519

20

Code A

From: Code A

Date: 30 July 2001

Copy:

ER

Code A

SUI: PORTSMOUTH HEALTHCARE NHS TRUST – SUSPICIOUS DEATHS OF PATIENTS

Issue

1. The purpose of this minute is to inform PS(H) of a story in the Sunday Telegraph on 29th July 2001 highlighting a police investigation in to the death of a patient at the Gosport War Memorial Hospital in 1998.

2. The story was originally run in the Portsmouth News in April 2001 and the Sunday Telegraph story appears to be lifted directly form the original News article.

Background

3. The local police carried out an investigation in to the death of Mrs Gladys Richards who died at the hospital in 1998. Our previous briefing on 5th April 2001 refers.

4. A case against a GP acting as a clinical assistant in the hospital was submitted to the CPS, which recently concluded that there was no case to answer in respect of the death of Mrs Richards.

5. Following publicity about the case a number of other families have approached the police with concerns about treatment of relatives at the hospital. The police are now investigating these claims.

Local Media interest

6. There has been no further local media coverage since the original story in April.

7. In the Code A case the Trust has taken the following lines:

- The Trust takes the safety of its patients very seriously.
- The initial complaint regarding Mrs Richard's treatment was investigated and no evidence of inappropriate care was found. The CPS has also concluded there is no case to answer.
- The Trust will co-operate fully with any police investigations as it has done in the past.

Conclusion

8. The Sunday Telegraph story appears to be based on the local story of four months ago and does not contain new information. It does not reflect the fact that the CPS has now decided not to prosecute in the case of Code A

9. I will ensure you are kept up to date with any developments.

SERO Lines to take

- **The case of Code A is been considered by the Crown Prosecution Service, which has concluded that there is no case to answer. It would also not be appropriate to comment on any other cases that are the subject of a police investigation.**

Code A
[illegible]
Ext 32519

(21)

16 October 2001: Briefing for Prime Minister's Questions

CHI INVESTIGATION OF GOSPORT WAR MEMORIAL HOSPITAL

1 Accusation

The Commission for Health Improvement (CHI) is to investigate allegations into activities at Gosport War Memorial Hospital.

2 Facts

In August 1998 Portsmouth Healthcare NHS Trust received a complaint from the family of Mrs Gladys Richards who died at Gosport War Memorial Hospital. The complaint concerned the administration of diamorphine - the family believed Mrs Richards had been given excessive dosages. As well as receiving treatment at Gosport, Mrs Richards also received care at Royal Hospital Haslar. The complaint was fully investigated by the Trust and no evidence of inappropriate care was found.

In the Autumn of 1998 one of Mrs Richard's daughters alleged that her mother had been unlawfully killed. A police investigation followed and the papers were presented to the Crown Prosecution Service (CPS). The CPS recently decided there was no case to answer.

Following publicity about the case a number of other families approached the police with concerns about treatment of relatives at the hospital (claimed in the local media to be 9 cases in all). The police are now investigating these allegations and a decision on any prosecutions has still to be made by the CPS.

As part of the police case on Mrs Richards, papers on the role of a local GP, Dr Jane Barton, were submitted to the CPS. Dr Barton was acting as a clinical assistant in the hospital for 2 sessions per week and resigned from that post last year. Dr Barton's involvement is still part of the ongoing investigations in the other alleged 9 cases. Dr Barton was, at the time, Chair of Gosport Primary Care Group but stepped down when the investigations began.

Dr Barton also appeared before the GMC's Interim Orders Committee (IOC). The IOC decided not to make an order against her and requested further information.

CHI was informed of concerns, including allegations of unlawful euthanasia by the police and the Health Authority. Other concerns included how patients were managed, lines of clinical responsibility, diagnosis and prognosis for patients and management of drug regimes (reviewed following the Richards case). CHI decided to undertake an investigation. Information was received suggesting that the announcement of this investigation would be made on 18th October. The latest information from CHI indicates terms of reference have not yet been signed off but are expected to be announced on 19th October.

3 Elephant Traps

Initially concerns were raised that this had the potential to be another Harold Shipman case but there is no evidence to support this. Police investigations are continuing into four of the other 9 cases and no decision has yet been made by the CPS on possible prosecutions.

Dr Barton's performance as a GP has been formally assessed under the local procedure for supporting and identifying general practitioners whose performance has given cause for concern. The GMC is awaiting further contact from the police before deciding what action to take next.

4 Lines to take

- Police investigations have concluded that there is no criminal case to answer in the death of Mrs Richards. It would be inappropriate to comment on any other investigations at this time.

- It would be inappropriate to comment on Dr Barton's position while police investigations are underway and enquiries by the General Medial Council are not yet concluded.

- CHI has been made aware of concerns about the treatment regimes for some patients at the hospital and is currently considering what the terms of reference for any investigation should be. This is a matter for the Commission and they will make an announcement once final decisions have been made.

5 Political Context

None. This is a local issue, although potentially high profile.

6 Key quotes

N/A

Contact Official: Code A *t 32715*

(10)

GOSPORT STAKEHOLDER MEETINGS KEY THEMES

1 PATIENTS, RELATIVES. MEMBERS OF THE PUBLIC & REPRESENTATIVES: CHI team met with friends and relatives of 10 people who had been patients in Gosport War Memorial during the investigation period,) and with representatives of the CHC. In addition, we spoke to 5 relatives over the phone and received seven written submissions from relatives.

2 VOLUNTARY STAKEHOLDERS: League of Friends

3 STATUTORY STAKEHOLDERS: HEALTH AUTHORITY, SOCIAL SERVICES: Code A Portsmouth Health Authority), Code A (Portsmouth District Council Social Services), T Code A (HampshireCounty Council Social Services), Code A (Royal College of Nursing), Code A (UNISON)

4 PRIMARY CARE : Code A hief exec, Fareham & Gosport PCG. Code A Code A, Gosport LMC, T Code A Portsmouth LMC

5 MISCELLANEOUS: Local MPs

KEY THEMES FROM STAKEHOLDER CONSULTATION

1 PATIENTS AND RELATIVES

- The majority of families or spouses whom we met in person were critical of the care their relatives had received at the War Memorial. However, all the written submissions, and all but one of the phone calls, from relatives were very complimentary about the standards of care at the hospital
- Relatives who were critical raised serious concerns about the standard of nursing care provided on the Daedulus and Dryad wards, particularly in the feeding of patients and help in using the toilet or commode.
- A small but significant number of patients raised concerns about drug administration, particularly diamorphine and sedatives
- Most of the relatives to whom we spoke had major concerns about nutritional matters, including the lack of assistance in eating and drinking and the failure, in some cases, to provide any nutrition
- A number of families raised concerns about the catheterisation of their relatives, questioning the necessity for it or concerned about the manner in which the procedure was carried out
- Some relatives were concerned about the humanity of care in the wards, suggesting that their loved ones were not treated insensitively
- Some relatives also complained that they had been treated discourteously or insensitively by staff

2 VOLUNTARY STAKEHOLDERS

- CHI spoke to a small number of local voluntary groups including the Alzheimers Society, the Motor-Neurone Association and the GWM League of Friends. They had considerable praise for the hospital and raised no matters of concern about the quality of care provided to older people by the hospital.

3 STATUTORY STAKEHOLDERS

- Union representatives had considerable praise for trust management, particularly their human resources policies. Notable achievements included family-friendly working arrangements and a comprehensive policy on helping staff who had been victims of domestic violence. There was also praise for the accessibility of senior management to unions, the openness of decision-making, the regular briefing of staff about policy changes within the trust and the provision of counselling support.

- Social services officials: Both the district and county council (responsible for Gosport since April 2001) considered that communications with the hospital were good, although there were concerns about lack of social service involvement in patient transfer between hospitals. Main role of county social services, and local area office in Gosport, is to facilitate discharges. Considered to be good multi-disciplinary working in developing discharge plans. Increasing shortage of nursing homes in Gosport area leading to delayed discharge from community hospitals like GWM.

- Health Authority: It was said that during much of the investigation period, communication between health authority and hospital tended to focus on physical facilities and activity figures (eg bed occupancy) rather than on quality of care or patient outcomes. Co-ordination between different parts of the local health economy has greatly improved over the last few years, with many examples of constructive joint working on services for older people. Priority now for health authority is reducing delayed discharges and bed blockages in both acute and community hospitals.

- Primary Care: CHI spoke to the chairmen of both the major local medical committees with a link to the Gosport War Memorial as well as the chief executive of the new Fareham & Gosport primary care trust. Communications between the hospital and GPs in the area were said to be generally good, particularly in arranging admission or discharge. However, there were concerns about failure to liaise with LMCs on strategic planning and complaints about consultation on the PCT. GPs raised concerns were raised about the inappropriate use of beds in Dryad and Daedulus wards. It was claimed by the GPs that acutely ill patients, some requiring intensive care, were being off-loaded by acute hospitals

facing bed shortages. GPs also gave evidence about arrangements for drug prescribing/administration and out-of-hours cover for GWM.

Community Health Council:

3 MISCELLANEOUS

MPs: CHI spoke to two of the local MPs. Neither had any concerns about the GWM. Indeed, both felt that the standard of care provided was excellent.

(11)

Portsmouth HealthCare NHS
NHS Trust

OTHER STAFF

NAME	TITLE
Code A t	Lead Consultant, Dept of Medicine for Elderly People
	Lead Consultant, Fareham & Gosport Elderly Mental Health Services
	Divisional General Manager, Fareham & Gosport (Jan 2000)
	Project Director AMH Reprovision (Divisional General Manager Fareham & Gosport up to Jan 2000)
	Deputy General Manager, Dept of Medicine for Elderly People (Service Manager Community Hospitals Fareham & Gosport up to March 2000)
	PHCT Catering Adviser
	PHCT Domestic Adviser
	Nurse Consultant, Dept of Medicine for Elderly People
	Project Manager Complaints - PHCT
	Chair Community Hospitals Clinical Network (also Service Manager Community Hospitals East Hampshire Primary Care Trust)
	Practice Development Facilitator and GNP Critical Companion (East Hants PCT)
	Senior Personnel Manager, Fareham & Gosport
	Nurse Consultant AMH (previously Practice Development Co-ordinator)

Code A

Code A

FRIDAY ?

Code A

Gosport Investigation Interviews

Deadalus

Philip Beed

Code A

Dryad

Dr Ravindrane
Dr Qureshi

Code A

Anita Tubbitt
Night enrolled nurse

Sultan

Code A

Joint/Others

Patient Affairs Manager

Code A

Dr Barton (Tuesday)
Senior Nurse Mulberry Ward
Senior Nurse Collingwood Ward

bt thing tues 2 sessions

Code A

12/11/01 14:35

To: Code A
cc:
Subject: Document request & core corporate interviewees

Code A

Attached is a composite grid to coordinate our information request and act as a check sheet. We'll be indexing our information along the headings set out in the top left box A - K. If you could do the same, it would make like easier this end and should act as a reference for you.

Code A has kept the left hand column blank for you to add any additional documents you think helpful. If you could forward those, as well as those highlighted, by 23 November I'd be grateful. In order to gain the input of the investigation team, I've asked them to suggest anything we've not covered, their deadline is 16 November. If the team suggest anything further, the deadline for return of that will also be 23 November. That should then be it.

I've also attached a list of corporate people we'd like to interview on the Monday pm & Tuesday. I've ordered them in the sequence we need to see them. We will be able to interview 3 people simultaneously, for a maximum of an hour. I'd rather not get into any more detail in terms of timings etc until we have the staff list from you & we can start to plan the whole week. There is a possibility that we'd like to see some of these people again on the Friday - so they need to be available then too.

Chief Executive
Medical Director
Nurse Director
Risk Manager
Operational Director
Personnel Director
Chief Pharmacist
Complaints Manager
NED Complaints Convener

The service/ward staff will follow these interviews.

Please do give me a call if any of this is unclear.

Thanks

Code A

Code A
Investigations Manager
Commission for Health Improvement
Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Code A

5

SECTIONS A – D = VOLUME 1
E – F = VOLUME 2
G – K = VOLUME 3

Gosport War Memorial Hospital Investigation
Team Folder

Section A	Trust Strategic
	Our work, our values – a guide to Portsmouth HealthCare NHS Trust
	PHCT Background and Organisational Structures
	PHCT Gosport War Memorial Hospital
	Gosport War Memorial Hospital, 3 October 2001
	PHCT Trust Board, May 2001
	Fareham and Gosport Primary Care Groups Intermediate Care and Rehabilitation Services, May 2000
	PHCT User involvement in service development: a framework, 16 November 2001
	Letter re Gosport Health Improvement Programme (HImP) 2002-2003 and attached HImP 2000-2002, 22 October 2001
	Fareham and Gosport Primary Care Groups, Proposal to establish a Primary Care Trust for Fareham and Gosport, July 2001
Section B	Service Strategic
	The department of medicine for elderly people, Service provided
	PHCT Fareham and Gosport Locality Division (Organisational chart), 25 October 2001
	March 2001 Final Monitoring Report Intermediate Care, 14 May 2001
	IOW, Portsmouth and SE Hampshire Health Authority, NSF Older People Steering Group (District-wide Implementation Team), Terms of Reference, Draft 3
	IOW, Portsmouth and SE Hampshire Health Authority, Fareham and Gosport Perimary Care Groups, Fareham and Gosport Older Persons Locality Implementation Group Progress Report
	PHCT Development of intermediate care and rehabilitation services within the Gosport locality
Section C	Quality
	PHCT Gosport War Memorial Hospital Patient Survey Action Plan
	PHCT Gosport War Memorial Hospital Feedback from patient Survey – July 2001
	PHCT Gosport War Memorial Hospital Feedback from patient Survey – October 2001
	Quarterly report – Governance indicators, Quarter ending 30 June 2001
	Infection Control Services, Nursing Practice Audit, 9 May 2001
Section D	Staff and Accountability
	PHCT Specification of medical service provided by retained medical officer (RMO)
	PHCT Department of Medicine for Elderly People, Essential Information for Medical Staff
	Comparison of the % who agree to the % who disagree per question (Staff survey results), 19 October 2001

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	Sickness absence statistics for Daedalus, Dryad and Sultan Wards, Gosport War Memorial Hospital, 2000/2001
	Sickness absence statistics for Daedalus, Dryad and Sultan Wards, Gosport War Memorial Hospital, 1998-2001
	Wastage for qualified nurses
	Vacancy Levels 1998-2001 for Sultan, Daedalus and Dryad Wards
	PHCT One Year On: Aspects of Clinical Nursing Governance in the Department of Elderly Medicine, September 2001
	PHCT Night Skill Mix Review Gosport War Memorial Hospital, 28 march 2001
	PHCT Development of intermediate care and rehabilitation services within the Gosport locality
	PHCT Operational policy, Bank/Overtime/Agency, Fareham and Gosport Community Hospitals and Elderly Mental Health
	PHCT Strategy for Employing Locum Medical Staff
	The Development of Clinical Supervision for Nurses
	Supervision Arrangements
	PHCT Supervision Arrangement Consultant Timetable
	PHCT Fareham and Gosport Locality Division (Organisational chart), 25 October 2001
	Medical Accountability Structure
	Staff Opinion Survey Results, 18 December 1998
	Staff Opinion Survey 2000 (results)
	PHCT Department of Medicine for Elderly People, Full time staff grade physician Gosport War Memorial Hospital (Job description)
Section E	**Guidelines**
	Guidelines for admission to Daedalus Ward, 4 October 2000
	Admission and discharge policy, September 2000
	Patient Flows, 24 October 2001
	PHCT Winter escalation plans elderly medicine and community hospitals
	Protocol for the Transfer of Patients from an Acute Ward to GP Step-down Beds
	PHCT Urgent notice for all Medical and Nursing staff, Daedalus and Dryad Wards, 19 November 2001
	PHCT Discharge Summary Form, 21 November 2001
	PHCT Audit of Detection of Depression in Elderly Rehabilitation Patients, January – November 1998
	Audit of Patient Records, December 1997 – July 1998
	Audit of Nutritional Standards, October 1997 – April 1998
	PHCT Falls Policy Development
	Stepping Stones – Daedalus Ward
	PHCT Programme of Training events 2000-2001
	PHCT Procedure for the Initial Management of Medical Emergencies in GWMH, 15 January 2001
	BGS Compendium of Guidelines, Policy Statements and Statements of Good Practice, Contents
	Policy for psychiatric involvement, November 2001

	PHCT Trust Corporate Policies, Guidance for Staff, Revised August 2000
	PHCT Policy for Client Records and Record Keeping, December 2000
	PHCT Policy for prevention and management of malnutrition within trust residential and hospital services, November 2000
	PHCT Policy for the prevention and management of pressure ulcers, May 2001
	PHCT Resuscitation Status Policy, April 2000
	PHCT Whistleblowing, February 2001
	PHCT Risk Management Policy, January 2001
	PHCT Recording and Reviewing Risk Events, May 2001
Section F	Drugs
	PHCT Control and Administration of Medicines by Nursing Staff, Hanuary 1997
	PHCT Audit of Neuroleptic Prescribing in Elderly Medicine, November 1998 – July 1999
	Prescription Writing Policy, July 2000
	PHCT Policy for Assessment and Management of Pain, May 2001
	PHCT Administration of Controlled Drugs – The Checking Role for Support Workers
	A Spoonful of Sugar, Medicines Management in NHS Hospitals, 27 December 2001
	PHCT Administration of Medicines, Community Hospitals – Programme for updating qualified staff, 13 March 1997
	Scoresheet – Medicines management standard (controls assurance)
	Controls Assurance Baseline score and action plan for 2000/2001
	Trust Medicines Management Structure, 16 October 2000
Section G	Communication
	PHCT Training on Demand, Working in Partnership
	PHCT Programme of Training Events 2001-2002
	PHCT Gosport War Memorial Hospital Patient Survey, 31 October 2001
	PHCT Sultan Ward
	Department of Health, Consent – what you have a right to expect, A guide for relatives and carers
Section H	End of Life
	PHCT Chaplaincy information
	PHCT Because We Care (leaflet)
	Talking with dying patients
	Loss, death and bereavement
Section I	Supervision and Training
	Procedural statement – Individual Performance Review, April 2001
	IPR Audit 2000
	Introduction to Gosport War Memorial Hospital
	PHCT Induction Training, October 1999
	PHCT Clinical Nursing Development, January 1998
	Royal College of Nursing, Gerontological Nursing Programme, Community Hospitals Version 2.0 2001

	Training and Development for Nursing Staff in PHCT Community Hospitals relating to Intermediate Care, 12 February 2001
	PHCT An Evaluation of Clinical Supervision Activity in Nursing throughout Portsmouth HealthCare NHS Trust, December 1999
	Policy Statement – Training and Education, April 2001
Section J	Complaints
	Similar Complaints, 23 December 1999
	CHI Summary of 1998-2001 Dryad, Daedalus and Sultan wards complaints
	Gosport Investigation Complaint – Code A
	Gosport Investigations Ombudsman Investigation – Code A Code A
	Gosport investigation Independent Review Panel – Code A
	PHCT Your Views Matter – making comments of complaints about our services...
	PHCT Handling Patient Related Complaints, January 2000
Section K	Clinical Governance
	PHCT – Clinical Governance Development Plan 2001/2002
	PHCT Clinical Governance – Annual Report – 1999/2000
	PHCT Clinical Governance: Minimum expectations of NHS Trusts and Primary Care Trusts from April 2000, Action Plan review March 2001
	PHCT Clinical Governance – Annual Report – 2000/2001
	PHCT Risk Management Strategy 2000-2003

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Sultan.

INTRODUCTION TO GOSPORT WAR MEMORIAL HOSPITAL

The Hospital was built as a memorial to those who died in the Great War of 1914-1918. Field Marshall Earl Haig laid the Foundation Stone in 1921. The whole project was financed by the local community who made a regular monthly subscriptions, annual voluntary contributions, and public fund raising with organised auctions of household furniture and fittings, and fetes. Building work began in May 1921, and the original plan of forty beds was scaled down to twenty-six.

Gosport War Memorial is a Community Hospital and it was formally opened by Major General Sir Code A MP on April 28th 1923 complete with its own X-ray department. A new extension was added on in 1932 with the money left over from the initial fifty thousand [£50.000] pounds raised for the Hospital. In 1991 the Hospital had a further renovation and extensive building development to arrive at the present broadening facilities that operates from the premises.

Included below are all the other wards and services currently available in the Hospital before giving a fuller exposition of what Sultan Ward can offer the students.

DAEDALUS WARD

This is a twenty-four bedded unit, of which eight is reserved for slow-stream rehabilitation, fifteen for continuing care, and one for shared care.

DRYAD WARD

A twenty-bedded unit that caters for post-acute medical, surgical, and slow-stream orthopaedic rehabilitation.

MULBERRY WARD

A forty-bedded unit for the Elderly Mental Health patients. This unit is currently divided into three sections, serving the functionally and organically ill patients, however, this is been looked into with a view to having two sections only.

BLAKE WARD

A maternity unit with ten beds and two delivery rooms. This ward unlike the rest of the Hospital functions under the auspices of St Mary's Hospital.

DOLPHIN DAYHOSPITAL

This is a Day Hospital provides short courses of medical assessment and/or rehabilitation. The unit is supervised by two Consultant Geriatricians with nurses on site from Monday to Friday. Patients have access to physiotherapist, occupational therapist, speech and language therapist, chiropodist and also the services of a dietician should the need arise. Occasionally some patients attend the day unit just for Ace and L-Dopa trials. It has a capacity for fifteen patients, and they have their lunch in the unit as part of the service.

PHOENIX DAY HOSPITAL

This is an assessment unit for Elderly Mental Health patients. It has its own occupational therapist, physiotherapist, and Community Psychiatric Nurse. Group Therapy forms part of the assessment process in this unit which is open Monday to Friday. ECT is also available as a treatment, and a sensory room has recently been established.

OUT-PATIENT DEPARTMENT

The OPD has several visiting consultants with differing specialities. The clinics are held in the weekday, and the patients are from the local community who have been referred by their own GPs. Some patients however, are in-patients who have been admitted for medical or surgical reviews or urgent assessment or treatment. At present there is also a Minor Injuries department in operation in this unit, but this will be closed on the 31st of July 2000, and the service will be taken over temporarily by Haslar Hospital.

The Hospital also has a well-equipped X-ray, Physiotherapy and Occupational Health Departments. The students who are on placement are welcome to visit these units to see how they work in conjunction with the other services. There may be occasions when the students could take part in the patient's home assessment by the physiotherapist and the occupational therapist.

SULTAN WARD

This is a twenty-four bedded GP medical unit. It comprises of ten separate rooms, six of which are for single occupancy, and three of these are en-suite. There is one six bedded area and the remainder three rooms have four beds each. All the rooms also have their own wash basins.

The patients are from the local community, and are admitted for various medical reasons. Some patients require observation prior to treatment, some needing assessment for pain, some are for rehabilitation following surgical procedures, some are admitted for treatment for acute infection. A percentage of our patients are admitted for palliative and terminal care. There are also patients who come in periodically for medication readjustment and respite care.

We are looking into developing team nursing, and all students are given the opportunity to observe and participate in all aspects of care. There are nine qualified staff on the day shift, and we each have their own expertise [diabetes, stoma care, wound care, tissue viability, nutrition etc] which the students can glean information and knowledge from.

The students are also encouraged to observe the input by the physiotherapist and occupational therapist to gain a better understanding of the processes that go into rehabilitation work. This process provides a greater insight into the on-going support given to the patients that enables them to return to their own homes and live a fairly independent life. Often this process involves the Social Services department and sometimes the District Nurses as well. This cycle of input portrays a vivid account of how a multidisciplinary team works.

STANDARDS OF PRACTICE

The physical environment is well equipped for comfort, dignity and privacy. For the purpose of safe lifting and handling of patients there are three Wessex overhead hoists, and two mobile Dextra and one Sara hoists. We also have an Oxford hoist for patients who weigh over twenty-five stones. Glide sheets are used for moving or turning patients in bed.

All the beds have either Transfoam mattresses, Pegasus Airwave, Biwave plus, or Transair for pressure relieving. There are also pressure-relieving cushions for the armchairs for those patients whose medical condition dictates their physical status.

There is a call-set plugged into a console over each bed, this set enables the patient to call the nurse, on this console is also a detachable earphone for listening to the radio and the television. There is a mobile telephone on the ward for the patients who wish to contact their families and friends.

A large communal lounge at one end of the ward serves as a dinning room and sitting room for the patients and visitors. There are a television and a music centre in this room, however there are also several portable televisions for those who are unable to go to the lounge.

DOCUMENTATION: Admission Pack

Enclosed is an admission pack with an updated Social Services referral and Health Summary for the same service. These documents are regularly reviewed and evaluated. This pack is in current use, and is also used in the community setting, though there has been a recent review, so a change might be in the pipeline.

The student will be supervised and overseen by her assessor during her placement, but in the absence of her assessor, another qualified staff will act on her behalf. All the students will have ample opportunities in assisting in the admission process, and this will form

part of the student's learning and exploration of the importance of observation, accurate documentation, and planning of individualised care.

All the students coming to Sultan Ward are invited to look through the pack closely, and perhaps prepare some questions with regards to the reasoning and ethics underpinning each piece of document.

ADMISSIONS

The Named nurse and her associate nurse, or the student who is helping the admission should introduce themselves to the new patients. The patient and relatives are given some information about the ward, for example, the visiting time, the Hospital telephone number etc. A ward booklet is being revised at present.

Each patient is allocated to a qualified nurse who is then responsible for assessing, planning, evaluating, and implementing the initial care for this particular patient. It is hoped that when team nursing is fully developed in the ward philosophy, the named nurse will also be the co-ordinator of care with other disciplines and agencies for that patient throughout his or her stay.

The patient's blood pressure, temperature, pulse, weight and urinalysis are checked and recorded as soon as the patient is made comfortable. This is followed by a body check for skin integrity, any skin blemishes or discoloration is recorded, all pressure areas assessed and documented in the Waterlow Pressure Sore prevention Chart, and the body chart. This procedure should be done within two hours of admission so that the patient's risk of developing pressure is ascertained, because a high risk factor means the patient needs a pressure-relieving mattress and cushion.

CONCLUSION

This is a very brief description about GWMH and Sultan Ward in particular. We hope this has been useful to you and has stimulated your interest to invest some time to learn more about us. We are happy to answer any queries you may have, and hope that your stay with us will be an enjoyable and fruitful one.

On completion of your placement, we would appreciate any comments, positive and negative, in order that we may adapt the service to serve nursing in the Community Hospital at its best.

PORTSMOUTH
HealthCare
NHS
TRUST

Introduction for Student Nurses

Our ref

Your ref

Date

Ext

Sultan Ward is a 24 bedded GP unit in Gosport War Memorial Hospital, and it is part of the Portsmouth HealthCare Trust.

The ward caters for a wide variety of patients from the local community. Patients are admitted for medical care, assessment, observation, rehabilitation, palliative, and terminal care. We have no age bar, however, the majority of our patients are over the age of sixty.

The nursing staff works closely with other professionals, GPs, physiotherapist, occupational therapist, social workers, pharmacist, and district nurses. We also have access to the X-ray department, outpatient consultant referrals, community dentist, chiropodist, and speech therapist.

We practice primary care nursing, and each patient is assigned a trained staff on admission. The primary carer will assess, plan, implement, and evaluate care and needs of the individual patient in conjunction with the patient, and if appropriate the patient's carer and family are involved in the process.

What can we offer each student?

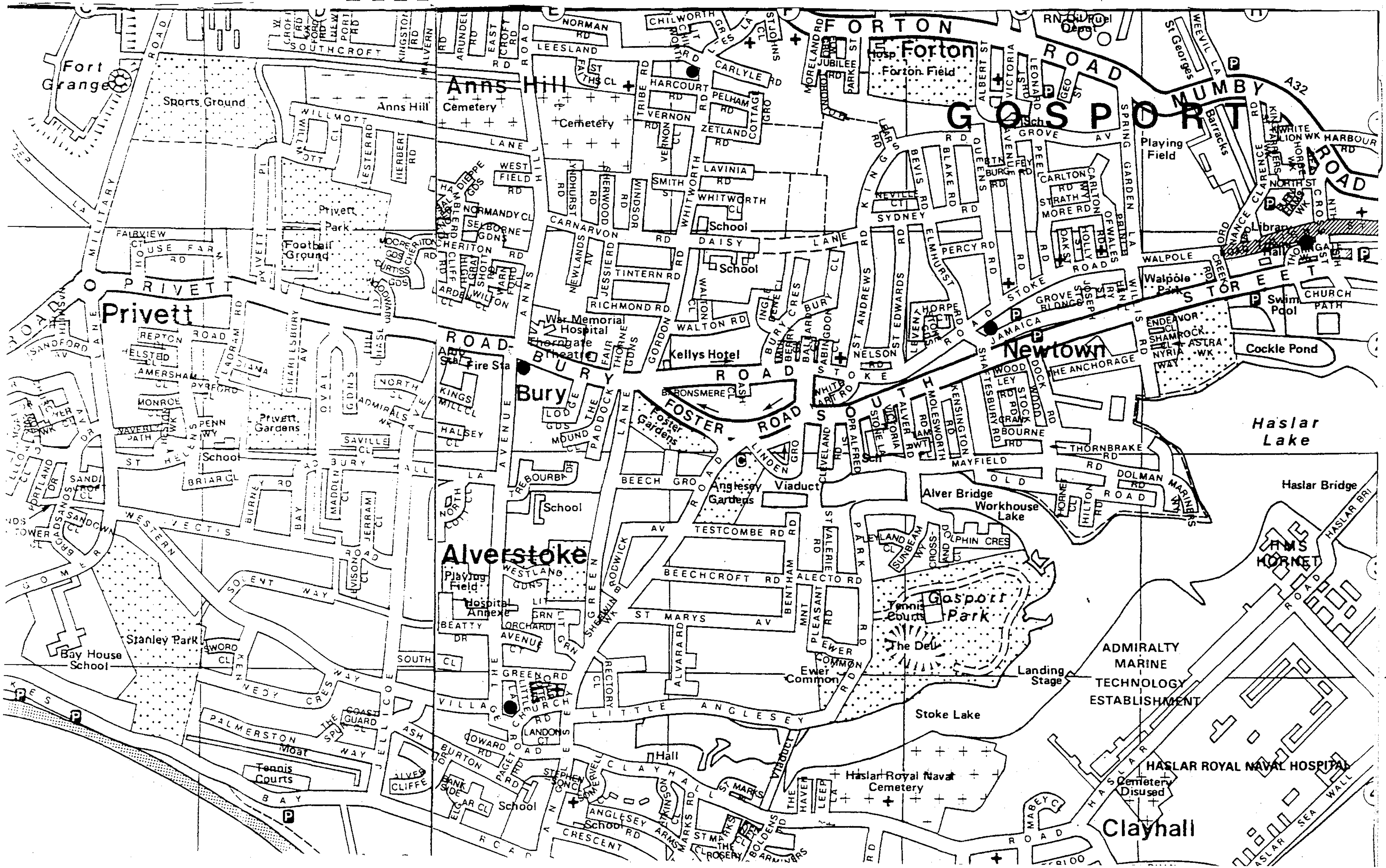
Each student is assigned an assessor as soon as we receive notice of the student's impending placement. The student is welcome to come to meet her assessor to plan her timetable to facilitate her role into the ward. Depending on the time span of the student's placement, and the stage of the individual's development, we can offer a very varied scope of learning, some of which I will list below.

1. The admission process; the complexity and psychology of this process will give the students many objectives for EBLs.
2. The assessment and planning of care.
3. The evaluation of care in each stage of health progress, and documentation.
4. Disease process and its impact on health, particularly in the older patients.
5. Participation in ward and home assessment by the occupational therapist.
6. Involvement in physiotherapist input.
7. Assist trained staff in medication administration.
8. Working in a team for a common cause.
9. Learn about wound care, stoma care, etc.
10. The workings of a Community Hospital

In return we expect the students to be appropriately dressed, be punctual, and adhere to the UKCC code of conduct. We will endeavour to be supportive, and assist you in your clinical application and theoretical exploration.

COMMUNITY HEALTH SERVICES

Gosport War Memorial Hospital
Bury Road, Gosport, Hampshire PO12 3PW
Tel: 01705 524611 Fax: 01705 580360



BEING UPDATED

PORTSMOUTH HealthCare NHS TRUST

DAEDALUS WARD

GOSPORT WAR MEMORIAL HOSPITAL

FOREWORD

Code A

Departments within the Hospital:-

Dryad Ward - Continuing Care/Rehab Ward
Sultan Ward - GP Unit
Dolphin Day Hospital
Mulberry - Ark Royal) EMH Assessment
- Collingwood)
Phoenix Day Hospital - EMH Day Hospital
Redclyffe House - EMH Continuing Care
Blake - Maternity Unit
Outpatients
X-Ray
Pathology
Medical Records
Patient Affairs
Physiotherapy
Speech and Language Therapy
Occupational Therapy

Hospitals you may come into contact with:-

St Christopher's Hospital - Fareham	-	Tel. No. * 3070
Queen Alexandra Hospital - Portsmouth	-	* 3064
St Mary's Hospital - Portsmouth	-	* 3071
Haslar Hospital - Gosport	-	* 3043

Daedalus Ward

Gosport War Memorial Hospital

Daedalus Ward is a 24 bedded intermediate care ward, providing rehabilitation for elderly patients. These are divided into; 8 fast stream stroke rehab; 8 slow stream stroke rehab, and 8 general rehab beds.

Patients are transferred to us from other acute wards, for assessment and rehabilitation, and ultimately discharge home or to another care environment.

Nursing care is delivered in teams, with each team having a specific group of patients to care for. The nursing teams work collaboratively, with all staff having a working knowledge of all the wards patients, and being able to move between teams as and when required.

Nursing teams are in turn part of a larger multidisciplinary team, comprising:

- Consultant
- Staff Grade Physician
- Physiotherapists
- Occupational Therapists
- Speech and Language Therapists
- Dietician
- Social Worker

The team works together with the patient and their family, to assess needs, and agree goals and plans for rehabilitation. The underpinning ethos is that patients should be encouraged, supported, and helped to be as independent as possible.

Learning and development is actively supported on the ward, with formal and informal educational opportunities being available to all grades of staff. We are also constantly looking at ways of building upon and improving the services we provide, in order to try and provide care which meets the needs and expectations of our patients and their families.

As a team we are constantly looking for and exploring new ideas for the way we work and organise care. All staff are encouraged to contribute to this process and fear of failure is not allowed to prevent ideas from being tried out. Some examples of changes which have occurred over the last twelve months include: nursing staff changing to tunic and trousers; repositioning patients mirrors to aid in washing and shaving and the introduction of Stroke Patient Handling Training.

Nurses are supported in their training for stroke rehabilitation by stroke specialist nurse and multidisciplinary therapy team. There is opportunity for in-house training and study.

Nurse development is encouraged through I.P.R's and supported by the team leaders and Clinical Manager. Staff are encouraged to discuss their practice at team meetings and introduce practice that will enhance patient care - underpinned by evidence based practice.

Daedalus Ward is a placement area for Student Nurses.

Visiting Hours

Monday - Friday 1 pm - 8 pm
Saturday/Sunday 10 am - 8 pm

Other times to be arranged with Nurse in Charge. Relatives are asked not to enter bedrooms before midday or when any patient in the room is having their personal needs attended to.

Multi-disciplinary Team Meetings

These are held on a Monday 1.30 pm - 2.30 pm. The nurse doing the Continuing Care round that week will attend prior to doing the ward round.

Ward Round Days

Continuing Care Round	-	every Monday except Bank Holidays.
Stroke Round	-	every Thursday

The nurse doing each CC and SSSR round is by rota. This will share out the ward rounds evenly and ensure a more balanced rota overall. We are endeavouring to have 5 staff on a late shift on all round days, to free up the person doing the round. Therefore it would be preferred if people did not swap their shifts or take annual leave and leave 4 staff on a late shift on Mondays and Thursdays.

Shifts and Breaks

7.30 am - 12.30 pm) - 15 minute coffee break
7.30 am - 1.30 pm)
7.30 am - 4.15 pm - 15 minute coffee break + 1 hour lunch break

12.15 pm - 8.30 pm) - ½ hour tea break
1.15 pm - 8.30 pm)

3.30 pm - 8.30 pm - ¼ hour tea break

8.15 pm - 07.45 am - night shift

Ward Clerk - Code A weekly programme

Monday, Tuesday, Friday - Daedalus Ward
Wednesday, Thursday - Dryad Ward

Code A will also spend 45 minutes each day on the other ward to deal with requests.

Handovers

7.30 am - 1 pm - 8.15 pm

1 pm Handover will be done by teams. This will ensure information is passed on by the person who has been looking after the patients concerned and provide team members with the opportunity of discussing their patients progress with members of the multidisciplinary team.

Application of Named Nurse Principle

In order to enhance the effectiveness and benefits of team nursing, a concerted effort is to be made to care and associated activities being completed by the nurse, or team responsible for each patient.

This needs to be done on a daily basis and includes such aspects of care as referrals, tests and investigations, communication with relatives etc.

Information Folder

This can be found in the office. Please read at least once a week for the latest news and any new issues arising.

Duty Sister Rota

DAY	ALL DAY
SUNDAY	DAEDALUS
MONDAY	SULTAN
TUESDAY	DRYAD
WEDNESDAY	DAEDALUS
THURSDAY	SULTAN
FRIDAY	DRYAD
SATURDAY	SULTAN

Bleep Holders and Nos. to be found at end of Telephone Extension List in Office

Ward Telephones

Being able to use the ward phones is an important part of everyone's job. Please take the time to familiarise yourself with the system and how it is used.

The ward has two phone lines:

The office line is Extension 2218 and has a standard phone and a mobile phone.

This is also our direct line. Dialling Code A from outside the hospital gets directly through to the ward, bypassing the switchboard. This is the number which should be used by yourself or anyone wishing to contact the ward from outside the hospital, as it saves them time and reduces the work of the switchboard (and out of hours the Porters and Duty Nurse).

The nursing station line is Extension 2217 and has a standard phone and the Fax machine.
As this is an internal extension, we cannot receive Fax's but can send them.

For each extension you can swap a call to the second phone simply by picking up the received, as you would on your phone extensions at home. In the case of the mobile you also need to press the green button.

Special features:

Group pick up

Incoming calls on either the office or nursing station phone can be taken on the other line, by picking up the phone and dialling **O

Call transfer

To transfer a call from one line to another you need to use the standard phone. If you have picked up the Fax handset or the mobile, pick up the other phone and put the Fax or mobile handset down.

- Press the button marked *recall*
- Dial the extension you want e.g. 2218 for the office phone
  2259 for Dryad
- If the line is engaged press *recall* again and you will be reconnected to the original caller
- When the phone answers you will be able to talk to the extension without the original caller hearing you
- Advise the person answering that you have a call for them (or anything else you need to say) and replace your handset
- When you replace your handset the caller will be automatically connected to the new extension

Tip - before attempting to transfer a call you may wish to advise the caller of the extension they require. If you then get cut off they can redial direct to the area they require.

Faxing

To send a FAX:

- Place the papers to be sent face down in the FAX machine (note that it is better not to use double sided forms if you intend to fax them)
- Press the button marked *speaker*
- Dial the number you require, remembering that you need to precede with a 9 for outside lines

  You will hear the phone ringing and answering
- Wait until you hear a high pitched warble, then press the *start/copy* button
- Your papers will then be faxed

Note that while we can send Faxes we cannot receive them directly as the Fax machine does not have a dedicated phone line.

Faxes can be received by the General Office on 023 92580360

To Bleep a Porter

Dial 5 - wait for ringing followed by long tone - dial 100 - then number of ward e.g. 2218
e.g. Dial 5 - 100 - 2218

Panic Button

This is situated at the nurses station. It is only used in case of an emergency or if urgent assistance is required.

To Reset Panic Button

Press the red switch at the nurses station and turn the key.

Emergency Line to Switchboard - Dial 4 for Help

An emergency line has been set up to the switchboard. This is **only** to be used in an emergency. For example if you need urgent assistance from the Porters.

To Use this Service

1. From any extension telephone in the hospital Dial 4 and wait for an answer. These calls will be given priority by the Telephonists

2. When answered state the emergency and help required

3. The Telephonist will summon assistance

When switchboard is closed your call will be answered by a Porter or the Duty Person in charge, via their pagers. These calls will take a little longer to be answered as they have to get to a telephone to take the call.

This service should not be used in place of a call to the Emergency Services.

Any queries please contact switchboard.

Admissions - are only accepted to Daedalus Ward after being referred from Dr Code A via Elderly Services at Queen Alexandra Hospital. Brenda (Dr Code A Secretary) normally phones the ward with the following information:-

1. Patient's Name
2. Address
3. Date of Birth
4. Hospital Number
5. Hospital and Ward patient is coming from.
6. Patient's condition and anything that is relevant e.g. any pressure sores, diet etc.

These details are written in the diary on the bottom of the page of the admission date. The new patient's name and date of admission is then written on the board at the front desk.

Notes

On admission the notes usually accompany the patient, unless the hospital is outside the area, then we need to obtain them. If for some reason, the notes have not come with the patient, then June (Ward Clerk) will retrieve them from Medical Records. Haslar have now amalgamated with Portsmouth Trust so whereas in the past Haslar notes were sent back to Haslar they are now combined until the patient is discharged.

All notes are filed in the patient's trolley which is kept in the office.

Patients Admitted for Respite Care

June will ensure the medical notes are on the ward prior to admission.

Letter

Prior to admission a detailed letter is sent to the ward from Elderly Services regarding the new patient to be admitted. This is then filed in the notes. A discharge letter accompanies the patient from the ward/area where patient has been discharged.

Preparation of Room/Bed Area

This is done preferably 1-2 days prior to admission.

1. Ensure the room has been cleaned.
2. Ensure the bed is made.
3. If previous information warrants, cot sides with bumpers.
4. Pressure relieving mattress if condition indicates, High Waterlow Score or any known pressure sores.
5. If patient has MRSA, Clostridium Difficile, ensure there is a yellow bin bag in the room, gloves, wipes, towel, hibiscrub.
6. Ensure there is a trolley outside the room with supplies of gloves, white aprons, yellow, red, blue bags and in a sealed container, water soluble bags.
7. Enter room number by patients name on board at front desk and in the diary.

When a patient is admitted the patient's name, Date of Birth, type of admission is entered on the relevant bed state form i.e. Continuing Care or Stroke and number of patients and available beds entered on board

Inform [Code A]

MRSA Swabs

Patients admitted with MRSA Monday - Friday should be swabbed on admission, by 12 midday. Swabs and forms are then taken to Pathology and placed in the appropriate container by 12.30 pm to ensure that they will be collected in time for the Path run. Full screen = nose, groins, any open wounds, catheters.

Fill in admission pack, include details of past relevant medical history and social history, ensure next of kin/contact number is correct.

Ensure all assessment forms are completed within 24 hours, as well as relevant care plans.

Property form to be filled in for any valuables and sent together with items to hospital safe.

Medication requirements check with 'stock supplies', order from pharmacy if necessary.

Record BP, TPR, urinalysis and weight.

List property, label glasses and ensure clothes are adequately marked with patients name and ward. Send for marking if required.

Laundry

When patients are admitted to the ward all their property is recorded on a property form and filed with the care plans. Family and friends are given the choice of either having their relatives clothes laundered in the hospital or taken home. Whichever is decided clothes must be marked with the patients name, ward and code e.g. [Code A], Daedalus O5. This is to help prevent patients clothes being lost or if sent to the laundry in error they stand a better chance of being sent back to the ward. If any items are lost these must be entered in the lost laundry book and reported to [Code A] in laundry.

On Daedalus ward patients are encouraged to wear their own clothes as this helps in their rehabilitation and well being.

Discharge Procedure

Write discharge date on board.

TTO's requested from Doctor, ordered from Pharmacy at least 7 days before discharge.

Inform GP of discharge, District Nurses, Patient, Next of Kin.

Write Discharge Letter, District Nurse letter if necessary.

Check transport arrangements, order transport if required.

Ensure all patients have a discharge checklist and that this is filled in for all patients.

Send nursing notes with Patient, District Nurses notes home with patient.

Place medical notes and X-Rays in Ward Clerk's tray.

Ensure the Doctor signs Discharge Summary within 24 hours and is sent to patients own GP.

Enter discharge date on bedstate form, alter number of patients and beds available on board on wall.

Day Hospital Referrals

To reduce the problems that occur when discharges are postponed, we need to be referring to Dolphin Day Hospital one or two working days before discharge.

For Monday and Tuesday discharges, referrals need to be on Thursday or Friday. Please ensure they are entered in the diary so they are not overlooked.

Referral to Social Services

When making referrals please complete a 24 hour nursing record of care and send a copy with the Health Summary and Risk Assessment Form.

Ward Policies/Guidelines

These are kept in the Ward Office. However a full set is kept in the office by Ann's Hill Reception.

Information leaflet for Bereaved Relatives to be found in Ward Office.

Drug Ordering - is normally done on a Wednesday afternoon by 1 or 2 trained members of staff. However depending on the workload and staffing levels, it may be done on a Thursday p.m. The box is then collected by the Porters early Friday morning where it is taken to the Pharmacy at Queen Alexandra Hospital. The box is then returned to the ward on Tuesday.

Daily Drug Ordering and Weekends

Drugs can be ordered daily over the phone or faxed to QAH Pharmacy. In order to do this you must ensure that orders are phoned/faxed through before 10 am. This is to make certain that the drugs are on the path run and are received on the ward by approx. 1 pm.

It is up to the trained nurses to ensure that there are enough dressings, stock, non-stock and Controlled Drugs in stock to cover weekends, bank holidays and holiday periods. If a drug is needed urgently, the doctor on call can write out an outside script. The porter will take the script and collect the medication from the chemist across the road at the Bury Road entrance.

Controlled Drug Ordering

This is ordered by a trained member of staff who has previously provided a specimen signature for Pharmacy. The order must be countersigned by either the ward GP or Consultant [Code A] As we are not allowed to give Controlled Drug orders over the phone, the order must be posted via the internal mail system and delivered to Queen Alexandra Hospital Pharmacy. On receipt of receiving the Controlled Drugs phone Queen Alexandra Pharmacy and verify their arrival with their serial number. Post back the Pharmacy Controlled Drug slip which is enclosed with the drugs initialled by the person who received and entered them into the Controlled Drug Book.

[Code A] the Community Pharmacist comes to the ward once a week usually Mondays/Thursdays to order the non stock medication/items

Duty Requests

Our Ward Manager does the ward off duty at least 2 - 4 weeks in advance. If you would like a day off, annual leave, early or late shift or any other request, then you must fill in both parts of a request form and ensure that it is put in the request box in the office before the off duty is done. If the off duty is done and for some reason you need to swap a shift, then it is up to you to do this, ensuring that cover for the ward remains adequate.

Photocopying Facilities

The photocopier is situated in the office next door to reception at the Ann's Hill Road Entrance.
To use the photocopier in association to your work you can either ask [Code A] our Ward Clerk to do this for you, alternatively you can type in the code yourself and use the photocopier. If you want to use the photocopier for non work related reasons, then a fee of 5 pence a copy will be charged.

Specimens

Any specimens e.g. urine, MRSA, sputum, blood are collected from the Pathology Dept. Monday → Friday at 1 pm therefore it is important to ensure that any specimens collected on the ward are taken down to Pathology in good time. There are 2 metal boxes situated inside the Blood Taking Room in which these are placed. Alternatively you can post specimens through a drop-in-slot in the wall outside the Blood Taking Room.

Equipment Room (Code Code A

This room is situated next door to the ward kitchen. All staff are welcome to use the computer, books and other facilities as a resource room.

Out of Hours Procedure for Obtaining Medical Records

If a member of staff require an urgent set of patient medical notes out of office hours and on weekends please following the procedures below:-

If the casenote number is already known then it may be possible to obtain the medical notes by asking the Hospital Porter to open up the Medical Records Dept and find the notes on the racks. This will be only possible if the casenote number starts with a 'G'

All notes starting with a 'G' number (i.e. G56568) are Gosport files and should be found on the main racks. These are in numerical order and the files are labelled at the ends of each rack to help you find your way around.

Notes starting with a 'Q' or 'S' number are files belonging to Queen Alexandra Hospital and St Mary's Hospital. These notes will **not** normally be stored in Gosport Medical Records unless the patient has been in hospital here or seen in Outpatients within the last week or so. All S and Q numbers are sent back to QAH Medical Records soon after discharge. It may be necessary to telephone the main hospitals medical records at QAH to obtain the notes from them direct.

The out of hours bleep number at Queen Alexandra Hospital is BLEEP 834.
There is an all night telephone number in QA Medical Records Department
023 92286359

If a set of notes is found in the files then it will be necessary to find the yellow tracer in the front of the notes and mark down the date and where the notes have been taken to. If a yellow tracer card cannot be found then please make sure that a note of the patient or a label is left for the medical records staff to update where the notes have gone to. **(This is a very important step as there is no other way of keeping track of the movement of patient records).**

If the patient's notes are not in the numerical place on the rack and only a yellow tracer card is left, it will say on the tracer card where the notes are and the date they were removed.

If it is urgent and records are needed - telephone the staff below and they may be able to help you track them down.

Code A

Code A

Please Note if you do not get an answer from the first person on list then telephone the next number do not leave a message on the answerphone this person may be away on leave.

There is a floor plan on the wall (left hand side) in Medical Records to help you find your way around.

New Employee Assistance Programme for the Trust

The company providing the Employee Assistance Programme (EAP) contract for the Trust will be changing as from the 1st May 2000. From this date a company called CORECARE will be providing the staff support, advice and counselling service and not EAR.

CORECARE are an extremely well qualified and experienced company who have been providing quality employee assistance programmes to health service staff and others for several years.

Staff will be provided with the same level of service as EAR have been giving for the last 4 years - i.e. a 24 hour telephone helpline giving unlimited support on a wide range of problems.

- Emotional/Personal
- Work/Career
- Legal
- Financial/Tax
- Marital/Family
- Others

As before it is for us and our families and includes referral on to a specialist counsellor, for up to 6 sessions if needed.

New leaflets and cards will be provided for all staff and there will be presentations about the new company in all areas over the next month. Staff already receiving help and support from EAR will continue to get this during a handover period between EAR and CORECARE.

Staff requiring further information, please telephone the new CORECARE Number 0800 181 392 or ring your Occupational Health or Personnel Department.

Staff ringing the EAR number from the 1st May 2000 will be automatically transferred to CORECARE.

FIRE PROCEDURE

On activation of Fire Alarm

Between 8.30 am and 1700 hrs - Main Reception will call Fire Brigade

Between 1700 hrs and 8.30 am Sultan Ward dial 999 and call the Fire Brigade

The duty person (Fire Co-ordinator) proceeds to Ann's Hill Road Muster Point, dons the yellow jacket and reads main alarm panel.

Each Department/Ward sends 2 staff, if possible, **(not if the fire is in their area)** to the nearest muster point, e.g. Ann's Hill Road or Bury Road

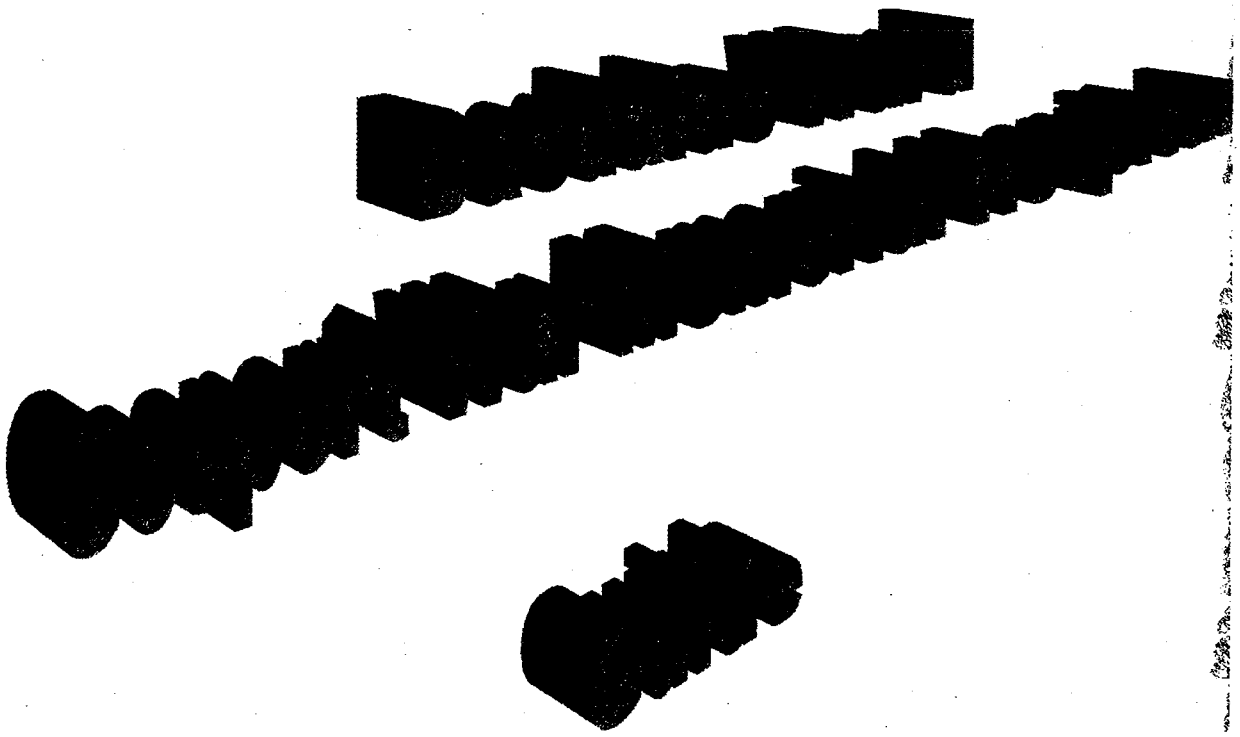
The Fire Co-ordinator **REMAINS AT ANN'S HILL MUSTER POINT** and details 6 Nurses to the scene of the fire

The Nurses report to the Senior Person in Charge of the Ward/Department (Evacuation Team Leader)

One Nurse returns to the Fire Co-ordinator with information. The Fire Co-ordinator details more staff to assist if necessary

Detail runners to meet the Fire Officer and to stand by entrances to stop the general public from entering

NO STAFF PROCEED TO THE SITE OF THE FIRE UNLESS INSTRUCTED TO DO SO BY THE FIRE CO-ORDINATOR



Hospital Bleep Holders Guide (Daedalus Ward)

The Hospital Bleep is held by E Grade staff & above, who have completed a ward based bleep holding training, and are qualified to use the Automated External Defibrillator.

Cover is on a rota basis between Daedalus, Sultan & Dryad Wards.

Currently Daedalus Ward cover Wednesdays and Sundays. This is allowed for in Daedalus Ward Duty Rota allows, and needs to be taken into account by any staff wishing to swap shifts.

In the event of sickness or other absence, it may be possible for another ward to hold the Hospital Bleep, depending on their staffing levels. Likewise we can take the Bleep at any time, if requested by another ward, and our staffing levels are appropriate.

The key Responsibilities of the Hospital Bleep Holder are:

1. Fire Cover
2. Cardiac Arrest Response
3. First Aid Cover*
4. Redirecting Minor Injuries
5. Managing Staffing Requests
6. Medical Records requests
7. Handling valuables
8. Dealing with incidents & problems

The nature of some of these duties varies slightly in & out of normal working hours.

* Following First Aid Training

Answering the Bleep

If you are being paged the Bleep will read TEL followed by the extension to ring:

TEL 2259

When the switchboard is not manned the Bleep will also alert the duty nurse & porter to outside callers. These can be answered by dialing *8 on any extension, and the call

redirected to the appropriate department (refer to "using the telephone system" in Daedalus Ward induction book).

Note that dealing with outside calls can be time consuming if the caller is unsure what department they want.

You can avoid calls for Daedalus Ward going through this system if you use our direct dial number, and give the direct dial number to anyone likely to call the ward:

Daedalus Ward Direct Dial **Code A**

Fire Cover

You will need to be familiar with the hospital fire procedure & will have undertaken bleep holder fire training.

When responding to a fire you will need to access the Anns Hill Reception office. The door code is 2435.

Remember fire doors give 30 minutes protection, and staff local to the situation should handle immediate evacuation and fire procedures. Therefore any fire situation should be dealt with urgently, but without undue haste, which could lead to panic, confusion and injury.

Cardiac Arrest Cover

For full information see the Emergency Response Document

Note that the procedure varies in different situations:

From 8am to 8pm, Mon-Fri 6666 calls go to the switchboard, who activate the response team.

Outside of these hours 6666 calls come to the emergency phone on Daedalus Ward.

The actions required will therefore vary slightly if:

- You are the Bleep Holder, and the arrest is in another area.
- You are the Bleep Holder, and the arrest is on Daedalus.

First Aid Cover

A first aid kit is located in the first aid room (entrance to Dolphin Day Hospital). This can be used for providing first aid to staff and visitors.

An incident from needs to be completed in all instances & a RIDOR form if applicable.

Staff will also need to complete the accident book (located in the duty sister office)

Following administration of first aid, the person can be advised to visit their own GP, minor injuries, or A&E if applicable.

If the injury is serious in nature call an ambulance using (9)999

Redirecting Minor Injuries

Minor injuries will still occasionally turn up at GWMH.

The action to be taken is as follows:

- Ascertain the nature of the problem
- If a real emergency (e.g. chest pain) call an ambulance (9)999
- Administer immediate essential first aid if applicable (e.g. gauze & pressure to lacerations)
- Redirect the person to Minor Injuries Haslar, Own GP, A&E QAH as appropriate

Managing Staffing Requests

Requests for staffing, to cover sickness etc. may be directed to the Duty Bleep Holder

- Ascertain if the department concerned can organise their own cover
- Check requirement e.g. shift & grade
- Mon-Fri 8am-8pm pass request to switchboard, as urgent or routine as applicable*

*Staffing requests will have varying degrees of urgency. It is important not to delay if a request is urgent and getting cover may be difficult. For example qualified cover for the same night may be very difficult to find. Make sure you advise switchboard of the degree of urgency, when you require a response by, and when they should go directly to the agencies. If a short notice request is left to long, you may find no cover is available.

When the switchboard is not manned, you will need to arrange cover, firstly through the bank and if this is not possible through the agencies.

On Daedalus Ward we will normally resolve our own staffing problems, regardless of whether we are holding the bleep or not.

Medical Record Requests

You may be asked to obtain medical records for QAH, St Marys or Haslar.

You will need to call a porter to let you into Medical. An information sheet is available, which tells you how to locate files. You may also find it helpful to visit medical record in working hours, and be shown how the system works (see Code A to arrange this).

When you have located the notes, place them in an envelope, and notify the requesting hospital, who should arrange for them to be collected.

Handling Valuables

The requesting Ward will have completed a property form and placed the valuables in a property envelope.

Place the valuables in the night safe in the Anns Hill Rd reception, and complete the book kept in the safe.

Dealing With Incidents and Problems

Managing other incidents will depend on the nature of the problem. Policy files can be found in the Duty Sisters Office.

Things to remember and general information:

Taxis can be booked through Amber Cars Tel *3003

Complete an incident form if applicable

The duty manager should be contacted for any major incident, and can be contacted at any time if you need advice or need them to come in.

Code A or Code A can be contacted at any time if you need advice or assistance.

Multiple Events

Most of the time you will only have one situation at a time to deal with. However because of the scope of the role, you could find you have different events simultaneously requiring your attention.

How you handle this will again depend on the situation, the time of day, and staffing throughout the hospital:

Non urgent events can either be left until you have time to handle them, or delegated to another member of staff.

If more than one urgent events are occurring, decide which requires your immediate attention. Delegate roles to other staff, and if necessary call in the duty manager and/or contact Code A or Code A

Role of the 2nd Nurse

The nurse not holding the bleep has an important role supporting the Bleep Holder.

As the Bleep Holder may be called away urgently, you will need be prepared to step in & take over anything they were dealing with. For example if a fire or arrest call came whilst relatives were being seen, or a poorly patient being managed, you will need to take over that role and manage the ward generally.

You may also be asked to help if events occur simultaneously. Even if you are not a Bleep Holder you may find it helpful to be familiar with what the role involves, so that you can at least manage a situation until assistance arrives.

INDUCTION TRAINING

Section Main Content Headings

1. *Statement of Policy*

1.1 Purpose

1.2 Scope & Definition

1.3 Responsibility

1.4 Requirements

2. The Starter Pack

3. The Induction Checklist

4. The Local Induction Seminar

5. Mandatory Short Courses

Appendix

1. *Induction Checklist*

INDUCTION TRAINING

1. STATEMENT OF POLICY

1.1 PURPOSE

To ensure an appropriate minimum standard of induction training for all new staff employed by the Trust. The procedure has three main aims :

- to obtain effective performance from the new employee
- to ensure the safety of the new employee
- to ensure a positive image of both the local job environment and the Trust as a whole.

1.2 SCOPE & DEFINITION

Induction is the process of receiving, welcoming and orientating a new employee to the values, procedures and requirements of the Trust and the post. The Policy will apply to all new staff.

1.3 RESPONSIBILITY

The line manager of the new employee is responsible for induction training for all new employees reporting to her/him. Advice and guidance is available from Personnel Departments.

1.4 REQUIREMENTS

A programme will be drawn up for every new employee, using the Induction Checklist as a base. The programme will take account of particular needs of the new employee and of the job to be undertaken. The length and content of the programme will vary according to the job and the individual.

2. THE STARTER PACK

A pack of information leaflets/booklets required by new employees will be assembled and distributed to new employees by local Personnel Departments via managers. Each manager may add relevant documents to this pack as she or he thinks fit.

3. THE INDUCTION CHECKLIST

On the first day of employment the line manager should meet the new employee and explain fully the induction process including the use of the Induction Checklist. The Checklist (see Appendix) should be completed by the manager and the employee. Periodic reviews between the manager and the new employee should be undertaken at appropriate intervals. Upon completion of the induction training, which should be within three months of the starting date, the completed Induction Checklist should be returned to the Personnel Department where it will be retained within the employees personal file.
N.B. Certain information is required from the employee as soon as possible, this includes:

- P45 (or P46) - forwarded to Personnel immediately
- Personal details form - forwarded to Personnel immediately
- Contract of employment - signed and one copy returned to Personnel
- Verification of date of birth - documentary evidence obtained and forwarded to Personnel
- Superannuation forms - forwarded to Personnel

4. THE LOCAL INDUCTION SEMINAR

New employees will attend the local Induction Seminar organised on a regular basis by local Personnel Departments. The content of this local seminar will vary, however, as a general guide will cover the following topics :

1. The Structure of the NHS
2. Portsmouth HealthCare NHS Trust
3. The Structure and Features of the Division
4. The Contracting Environment

5. MANDATORY SHORT COURSES

The new employee may be required to attend certain mandatory courses. These will depend upon the job of the new employee. It is the responsibility of the manager to ensure that the new employee attends the courses necessary for effective and safe performance in her/his job. Courses which may be necessary include :

- Food Hygiene
- Lifting & Handling
- First Aid
- Dealing with aggressive behaviour

Course dates and booking arrangements will be published annually by the course organisers.

Policy produced by: Code A Personnel Director

Produced on: March 1996

Approved by: Trust Board/Operational Management Group

Date: October 1999_

Review date: October 2000

g:\trust_hq\secretar\policies\pers\inductn.doc\26 October, 1999

INDUCTION CHECKLIST

Name :..... Location.....

Job Title..... Date of Commencement ...../...../.....

As each topic is completed, the member of staff and their manager should both sign the relevant boxes. Where a subject is not appropriate, the manager should cross the topic out and initial the deletion. The completed form should be held on the employees personal file.

TOPIC AREA	Date completed	Employee signature	Managers signature
Contract of Employment / Remuneration			
P45			
Verification of D.O.B.			
Contract of employment			
Terms and conditions			
Staff handbook issued			
Salary payment details			
Payroll deductions			
T.U. membership			
Time sheets			
Attendance			
Hours of work			
Annual leave entitlement and procedure			
Special leave			
Health appointments (dentist etc.)			
Absence/sickness : reporting and procedure			
Local Orientation			
Principle Trust locations			
Departmental locations			
Identity,roles and location of other staff			
Travel policy and procedures			
Personal transport options			
Car parking arrangements			
Security of personal belongings etc.			

TOPIC AREA	Date completed	Employee signature	Managers signature
Pension			
Grievance procedure			
Meal facilities			
Changing facilities			
Social/sports opportunities			
EAR Counselling Service			

Local Systems and Procedures

I.T. protocols			
Security procedures			
"Out-of-hours" procedures			
Reimbursement of qualifying expenses			
Internal communications			
Telephone policy and procedures			
Bleep procedures			
Portering			
Maintenance procedures - Estates department			
Acquiring stores/supplies/stationery			

Health & Safety

Employer responsibilities inc. H. & S Committee			
Employee responsibilities			
Introduction to food handling			
Risk assessment notification			
Control of infection			
Waste disposal procedures			
Occupational Health procedures			
Smoking policy			
Alcohol policy			
Manual handling procedures			
Accident procedures (self and others)			
Fire procedures/bomb alerts			
Security of people & premises			

TOPIC AREA	Date completed	Employee signature	Managers signature
Performance			
Nature of duties			
Reporting relationships			
Quality procedures and expectations			
Clinical audit plans			
Personal presentation			
Confidentiality (inc. Data Protection Act & Press)			
Conflicts of interest			
Disciplinary procedure			
Equal opportunity policy			
Harassment policy			
Complaints procedure			
Personal Development			
Training & Development policy			
Access to training & education			
I.P.R.			
Personal development plans			
Research plans			
External Contacts			
Locations, identities and contact procedures for other statutory agencies			
Locations, identities and contact procedures for voluntary agencies			
Locations, identities and contact procedures for educational agencies			
Local professional networks			

Mandatory Courses

COURSE	Date completed	Employee signature	Managers signature
First Aid			

Induction Training Complete Satisfactorily On...../...../19.....

Employee : ..... Manager : .....

6

Gosport War Memorial Hospital Investigation
Medical Audit

Vol 1

Section 1 – Correspondence
A – Trust
B – Team
C – Treasury Solicitor
D – Miscellaneous

Section 2 – Terms of Reference

Section 3 – File Notes/Meetings
A – File Notes
B – Agendas
C – Minutes
D – Schedules

Section 4 – Confidentiality Statements/Disclaimers

Section 5 – Contacts

Section 6 – Administration

Section 7 – Information From Review
i – Information compiled at review

Vol 2

A – Patient checklists (1-41)
B – Patient summaries (1-41 & Dr Walton notes)

Section 8 – Report of Case Note Review

Report of the Gosport Investigation Medical Notes Review Group

Purpose
CHI undertook a review of anonymised medical notes of a random selection of 15 patients who had died between 1st August 2001 and 31st January 2002 on either Daedalus, Dryad or Sultan wards at the Gosport War Memorial Hospital.

CHI's intention for this piece of work was to determine whether the policies and systems put in place by the Portsmouth Healthcare NHS Trust since the events of 1998, to address prescribing practices at the trust are being implemented and are impacting on the quality of care patients are now receiving. CHI's review also considered the nursing notes for each patient and looked at the quality of nursing care as documented in the notes. Finally, the review considered whether the cause of death recorded in the notes was appropriate.

Methodology
The group received 15 sets of anonymised medical notes from the trust which related to the last admission of 15 patients. Five patients were randomly selected from each of the following wards; Daedalus, Dryad and Sultan. A total of 49 patients had died whilst on these wards during the sample timeframe.

Findings

Use of Medicines

Prescription
The group considered that the volume and combination of medicines used was appropriate for this group of patients and was in line with accepted good practice and British National Formulary guidelines. Once only, PRN and syringe driver prescribing was acceptable. There was no evidence of anticipatory prescribing.

The case notes suggested that the use of the "analgesic ladder" to incrementally increase and decrease pain relief in accordance to need was being followed. The group saw no evidence to suggest that patients had been prescribed inappropriately large amounts of pain relief such as diamorphine, following. Cocodamol had been prescribed in a number of cases as an initial analgesic, with progression to alternative medicines as and when more pain relief was needed. The use of the "analgesic ladder" was less evident in Sultan ward.

However, in two cases, the group saw evidence of unacceptable breakthrough pain, with 6 hourly rather than 4 hourly prescriptions, which could have allowed this to happen. There was also some evidence of the simultaneous prescribing of cocodamol and fentanyl, which was not thought by the group to be the most effective combination of medicines.

Administration
Syringe drivers had been used to deliver medication to six of the patients reviewed. Appropriate use of syringe drivers was observed, with discussions with families and patients ? prior to this documented.

Appropriate administration of medicines by nursing staff was evident. Telephone prescriptions issued over the telephone by GPs on Sultan ward were appropriately signed.

Review and recording of medicines
Evidence of consistent review of medication was seen, with evidence to suggest that patients and relatives were involved in helping to determine levels of pain. Nursing staff had appropriately administered medicines in line with medical staff prescriptions. Prescription sheets had been completed adequately on all three wards. Generally, record keeping around prescribing was clear and consistent, though this was not as clear on Sultan ward.

The Use and Application of the Trust's policies on the Assessment & Management of Pain, Prescription Writing and Administration of IV Drugs

The group agreed that these Trust policies were being adhered to, based on the medical notes reviewed.

Quality of Nursing Care Towards the End of Life

The team found a consistently reasonable standard of care given to all patients they reviewed. The quality of nursing notes was adequate, though patchy. There was some evidence to suggest a task orientated approach to care with an over emphasis on the completion of individual tasks, such as the completion of multiple (bowel? Sheets – Code A - was this the form they were endlessly completing?) rather than on the holistic care of the patient. The team saw some very good, detailed care plans and as well as a number of cases were no clear agreed care plan was evident.

The team was concerned that swallowing assessments for patients with dysphagia had been delayed over a weekend because of the lack of availability of a suitably skilled speech and language therapist or trained doctor or nurse (*I think it is inappropriate to suggest SALT hours are the problem, I know of no SALTs who are contracted to work outside usual working hours).* Nurses could be trained to undertake this role in order not to compromise patient nutrition. Despite this, generally the trust's policies regarding fluid and nutrition were being adhered to, though a number of patients had only been weighed once on admission.

There was evidence of therapy input, though this had not always been incorporated into care plans and did not always appear comprehensive.

Some pressure sore prevention issues were identified.. Maureen – could you help here??

There was thorough, documented evidence to suggest that comprehensive discussions were held with relatives and patients towards the end of the patient's life. The discussions with families regarding DNR and view of family members were clearly stated in the medical record.*Families do not make DNR decisions (this is a very IMPORTANT point and CHI should not suggest is is the decision of the family). DNAR (attempt is an important part of DNR description)decisions whould be made in discussion with relative. Doctors need on occasions to make a DNAR decision which is not in agreement with family because such a decision is in the patients best interest.*

Recorded Cause of Death

The group found no cause for concerns regarding any of the stated causes of death.

General Comments

Admission Criteria
The team considered that the admission criteria for both Daedalus and Dryad wards was being adhered to. However there were examples of patients admitted to Sultan ward who were more dependent than the admission criteria stipulates. There is also an issue regarding patients who initially meet the admission criteria for Sultan ward who then develop complications and become more acutely sick. The admission criteria for all three wards should be reviewed

Elderly Medicine Consultant Input and Access to Specialist Advice
Patients on Dadalus and Dryad wards received regular, documented review by consultant staff. There was clear evidence of specialist input, from mental health physicians and medical staff from the acute sector.

Out of Hours
There was little evidence of out of hours input into the care of patients reviewed by CHI, though the team formed the view that this had been appropriate and would indicate that the general management of patients during regular hours was therefore of a good standard.

Code A

Code A
n1.demon.co.uk>

02/06/02 10:44

To: Code A
Subject: Re: Gosport - final report

Code A

I have perused the material from Dr Reid about the development of policy for prescribing diamorphine by subcutaneous infusion during 1999 through 2001. The documents describe the evolving policy and include Minutes of the Medicines and Prescribing Committee.

The documents do provide evidence of interdisciplinary consultation and meetings and incorporate discussions with the Consultant in Palliative Medicine at Portsmouth Healthcare Trust. These activities have borne fruit as evidenced by our audit of case notes although we did find some evidence of occasional timidity which may be a natural reaction to all the other events and investigations, or just to the inexperience of the Staff Grade doctor.

During our audit meeting at CHI Dr Munday expressed concerns about the syringe driver prescription sheet. I confess I did not grasp what he said, it was something to do with the sheet allowing the use of up to three drugs in the same syringe, and a problem with subsequent adjustments in the doses; box 1 obliges the prescriber to state the volume in which that drug is to be diluted and drugs 2 and 3 in the other boxes are diluted in that same volume because there is only the one syringe running per 24 hours.

Later increases in drugs 2 or 3 might require a larger volume in the syringe (else they would not dissolve). If the intended dose of drug 1 over the 24 hours is to stay the same then it will be dissolved in a larger volume, if the prescriber tries to maintain the previous concentration of drug 1 then he will prescribe a larger amount. So there is some ambiguity I think.

Suppose box 1 says 50 mg diamorphine to be diluted in 50 ml saline, and box 2 says 25 mg cyclizine. The prescriber later doubles the dose of cyclizine to 50 mg and it needs 100 ml of saline in which to dissolve. The volume in the syringe becomes 100 ml. Now if the prescription of diamorphine remains the same and still says 50 mg in 50 ml saline what happens? Are two lots put in or does someone say that what is really meant is that 50 mg of diamorphine is now to be dissolved in 100 ml to preserve the same amount of diamorphine going into the patient per 24 hours?

This is my guess as to what Dr Munday was driving at but as I said earlier I am not at all sure.

It may be that our nurse colleagues understood it, if not, then perhaps you could ask Dr Munday to describe his concerns in writing, then that concern can be fed into the report.

Best wishes,

Code A

7

Gosport War Memorial Hospital Investigation
Draft Reports and New Evidence
Volume 2 Part 1

1. Isle of Wight, Portsmouth & South East Hampshire Health Authority Joint Investment Plan for Older People 2001-2002
2. Schedule of times for ward rounds, meals and handovers
3. Letter from Code A re bed crisis at Queen Alexandra hospital, 16 February 2000
4. Letter from District Audit re Rehabilitation Services for Older People, 5 March 2001
5. Hampshire Ambulance Service NHS Trust, Emergency Incidents Originating at Gosport War Memorial Hospital, 1/4/00 – 28/2/02
6. Portsmouth Hospital& Healthcare NHS Trust, Non-emergency Patient Transport Request Form, undated
7. PHCT Patient Transport – Standards of Service, 27 march 2001
8. Portsmouth Hospitals NHS Trust, PHCT & Hampshire Ambulance NHS Trust, Booking Criteria and Standards of Service
9. Letter to Dr Code A from Code A Healthcall Medical Services re new contract for 2002, 15 March 2002
10. Admissions to Sultan Ward, Jan 01 to Jan 02
11. Letter from Julie Miller, CHI to Dr Code A 26 February 2002 re his letter of 22 January 2002, attached
12. Symposium on Older People, Measuring disability: a critical analysis of the Barthel Index, April 2000
13. Copies of Correspondence from Dr J Barton & Commodore Code A April 2000 – December 2001
14. Letter to Code A from Dr Beasley 18 April 2002
15. Printout from Healthcall 11 April 2002
16. Personal Details Form Code A
17. Letter from Code A PHCT to Jo Code A CHI re HR/Personnel Strategy, 15 January 2002
18. PHCT, Strategy for Human Resource Management and Important Human Resource Issues, October 1996
19. Portsmouth and South East Hampshire Health Authority, Community Health Care Services, Human Resource Management, 18 November 1991
20. Isle of Wight, Portsmouth & South East Hampshire Health Authority, A local Procedure for the Identification and Support of Primary Care Medical Practitioners whose Performance is Giving Cause for Concern
21. Health Service Circular, 27 August 1999, The Public Interest Disclosure Act 1998, Whistleblowing in the NHS
22. Stepping Stones
23. Fax from Fareham & Gosport PCT, 24 June 2002 to Code A re Pharmacy audit results
24. Royal College of Physicians, Principles of Pain Control in Palliative Care for Adults, 5 October 2000
25. Reaudit of Neuroleptic Prescribing in Elderly Medicine, September – December 2001
26. Letter to CEO PHCT from Dr Code A Southampton General Hospital, 16 September 1999
27. Memorandum to CEO PHCT from Barbara Robinson re Learning Points from Code A Complaint, 27 October 1999
28. Email from Quality Manager to Medical Director re Prescribing Opiates in Community Hospitals, 29 October 1999

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29. Memorandum from Medical Director (PHCT) re the Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion, 15 December 1999
30. Medicines and Prescribing Committee Meeting Agenda & Minutes, 3 February 2000
31. Letters (and attached protocol) from Medical Director PHCT to Dr H Jones & Dr Code A Vardon re Protocol for Prescription Administration of Diamorphine by Subcutaneous Infusion, 7 February 2000
32. Letter from Dr Code A to Medical Director PHCT re Diamorphine Guidelines, 21 February 2000
33. Letter from Dr Code A to Medical Director PHCT re Syringe Driver Control, 21 February 2000
34. Medicines and Prescribing Committee Meeting Agenda & Minutes, 6 April 2000
35. Medicines and Prescribing Committee Meeting Agenda & Minutes, 6 July 2000
36. Medicines and Prescribing Committee Meeting Agenda & Minutes, 3 November 2000
37. Medicines and Prescribing Committee Meeting Minutes, 5 January 2001
38. Medicines and Prescribing Committee Meeting Agenda & Minutes, 4 May 2001
39. Fax from Code A to Code A 17 April 2002 re FCEs
40. Table of FCEs, 17 April 2002
41. Fax to Code A from Code A Fareham & Gosport PCT, 9 April 2002 re Summary Medicines Use 1997/1998 – 2000/2001
42. Email to Code A from Nan Newberry re drug data, 2 April 2002
43. Drug Charts for Daedalus, Dryad & Sultan Wards, 3 April 2002
44. UKCC Guidelines for the administration of medicines
45. Portsmouth Hospitals NHS Trust, Pharmacy Service, Summary Medicines Use 1999-2001
46. The Palliative Care Handbook, Guidelines on clinical management
47. Clinical Supervision
48. AHP Accountability and supervision
49. Interview notes for Code A Chief Pharmacist, 7 January 2002
50. Interview notes for Code A Pharmacist
51. Interview notes for Code A 8 January 2002
52. Lifespan Healthcare NHS Trust Cambridge, Job Description Hospital Practitioner
53. Improving Working Lives, Publications, Department of Health website

(13)

Scotts New evidence

PORTSMOUTH HealthCare NHS TRUST

Private & Confidential

Dr J Barton
The Surgery
148 Forton Road
GOSPORT
PO12 3HH

Our ref
FC/LD
Your ref

Date
19 May 2000
Ext
214

Dear Jane,

I have been passed a copy of your letter of 28th April 2000 tendering your resignation from the post of Clinical Assistant in Elderly Services at Gosport War memorial, to which I believe Code A has formally responded.

I am writing to offer my thanks for your commitment and support to Gosport War Memorial Hospital over the last seven years. There is little doubt that over this period, both the client group and workload have changed and I fully acknowledge your contribution to the service whilst working under considerable pressure.

Acceptance of the above pressures coupled with your resignation has led to a review paper being produced which outlines the current service at Gosport War Memorial Hospital for Elderly Medicine patients, the medical support to this and the issues and pressures arising. The paper proposes enhanced medical input and rationale for that, which is in keeping with current intermediate care discussions.

I hope that you will be able to give your support to this proposal, given your knowledge of the current situation, when the paper is presented to the PCG.

My thanks for your contribution to Gosport War Memorial Hospital and my good wishes for continued success in your other roles.

Yours sincerely

Code A

Code A
Divisional General Manager

FAREHAM AND GOSPORT DIVISIONAL OFFICE

'The Potteries'
St. Christopher's Hospital, Wickham Road, Fareham, Hants, PO16 7JD

handed to JM - 11.01.02 by Code A New Evidence

Notes of the meeting between Dr Jane Barton and Code A Investigating Officer, on Friday 7th April.

This meeting was convened as part of the investigation of a complaint of harassment brought by Shirley Hallman against Dr Jane Barton and Gill Hamblin.

Dr Barton stated that she had worked on Dryad Ward for 12 years, giving 5 sessions a week, and that she felt she knew Gill Hamblin and the team well. As a visitor to the ward she stated that she did not feel it was appropriate for her to be involved with management issues.

In describing Shirley ~~Hall~~ Hallmann's manner Dr Barton felt that she could be aggressive in manner and would also have periods of apparent sulking. It was often easier not to disagree with Shirley's opinion rather than upset her. In consequence changes to treatment routines particularly relating to opiate administration would happen on shifts that Shirley was not working. She described Shirley as 'working to her own agenda' and not really a 'team player.'

When asked how Shirley had managed when she acted up for Gill Hamblin during an extended period of sick leave, Dr Barton felt she had managed tolerably well, but the ward had not been busy as at that time the Consultant had not been admitting. Dr Barton observed that she felt Shirley appeared to enjoy 'paper work' in preference to a more clinical role.

Dr Barton described how she had only wanted to give advice and support to Shirley Hallman and had never 'put her down or been beastly to her'. She described how Shirley had asked for her advice before applying for the G grade post at QAH and how she had photo-copied some articles for her.

Dr Barton described a discussion between herself and Shirley, initiated by Shirley following her return to Dryad. Shirley had asked if there was a problem between them, to which she had replied 'no'. Dr Barton then asked Shirley how she was getting on with the job opportunities at QAH, assuming Shirley was still wanting to do acute work. 'If I had known she did not want to work there I never would have inquired .... I bitterly regret offering support'.

She described how the work on the ward had changed. There had been limited consultant cover. Families were increasingly demanding, with unrealistic expectations and one or two had been particularly difficult.

When asked how she viewed Gill Hamblin's professional role, Dr Barton described her as the 'Clinical Boss' and with a competent control of the ward. She was consistent in her approach to all staff.

Code A

Code A

Dr Jane Barton noted.

17.3.00

SPOKE TO DR BARTON IN THE TREATMENT ROOM AND SAID COULD I HAVE A WORD. I SAID THAT IF I HAD OFFENDED HER IN ANY WAY THAT I WAS VERY SORRY AND I APOLOGISED.

She also said I was not the only one.

SHE REPLIED THAT IT WAS NOT THAT BUT THE FACT THAT I HAD DIFFICULTY IN "ACCEPTING WHAT WE DO HERE".SHE SAID SHE WAS ANNOYED THAT Code A HAD SPOKEN TO ME ABOUT IT AND THAT SHE HAD IN FACT CALLED HER THAT DAY TO SAY THAT.

DR BARTON CONTINUED WITH THE FACT THAT SHE THOUGHT I HAD DIFFICULTY "KEEPING ALL THE BALLS IN THE AIR AT THE SAME TIME" AND WOULD THERE BE MUCH DIFFERENCE IN PAY BETWEEN TOP E AND MY PAY WITH THE NEW PAY RISES COMING INTO EFFECT.

I SAID "NO" AND SHE ASKED ME IF I WOULD NOT PREFER TO GO TO QAH AS A TOP E AND NOT HAVE ALL "THE STRESS" OF MY PRESENT ROLE.

I SAID I WOULD ACTUALLY HAVE MORE WORKLOAD AT QAH AS AN E THAN I HAVE IN MY PRESENT POST AS AN F.AND THAT I HAD NO INTENTION TO WORK AT QAH IN THE NEAR FUTURE.

* Syringe Divers – **Code A**.
Not all staff happy with decisions – trained + untrained.

Will – very defensive.

#TEXT0901ACShirleyHallmanNurse
#CODENC
Conflict between Ward Sister (Gill Hamblin) and Dr Barton and othe r nurses - mainly Shirley. Evidence of Gill and Dr Barton control ling things.
#ENDCODE
#CODENC
Shirley expressed concerns re. prescribing and administration of c ontrolled drugs - does not appear to have reported this outside of ward - will send details of her grievance.
#ENDCODE
#CODENC
Some protocols and guidelines bad on Jubilee ward but interpretati on different.
#ENDCODE
#CODENC
Felt Trust took appropriate action re. her grievance.
#ENDCODE
#CODENC
Came into Trust in 1998 (Jan) came from Rehab (Moorgreen) to Dryad . F grade post. Left 1 year ago. Works nights in Jubilee House (part of Trust still).
#ENDCODE
#CODED8
On days Dryad Ward FT for nearly 3 years. Was team-leader. Manag er was Gill Hamblin - she was off sick for some time so Shirley be came Acting Manager for some time. Had bad experience with Gill H amblin. Heard rumour that Gill did not want Senior Staff Nurse po st and did not see need for role, so uphill struggle from start (f or Shirley).
#ENDCODE
#CODED8
All other staff were aware of tension. Shirley was unable to deve lop her own role. Situation became worse after Shirley had acted up. She implemented number of changes inc. helping hospital get I IP. When Sister Hamblin came back Shirley was frustrated at havin g to pull back on a number of other initiatives. Trust management was very good - offered mediation and tried to improve working re lationships. Had investigation. SR Hamblin cleared and mediation offered by trust to resolve conflict between 2 of them. However, even with these attempts to improve the working relationships - S hirley felt unable to stay so applied for other job. NB. Shirley took out grievance.
#ENDCODE
#CODED9
All other staff were aware of tension. Shirley was unable to deve lop her own role. Situation became worse after Shirley had acted up. She implemented number of changes inc. helping hospital get I IP. When Sister Hamblin came back Shirley was frustrated at havin g to pull back on a number of other initiatives. Trust management was very good - offered mediation and tried to improve working re lationships. Had investigation. SR Hamblin cleared and mediation

offered by trust to resolve conflict between 2 of them. However, even with these attempts to improve the working relationships - S hirley felt unable to stay so applied for other job. NB. Shirley took out grievance.
#ENDCODE
#CODEB3
Mix of patients changed during Shirley time on Dryad. Continuity Care to rehab. Funding not in place to provide sufficient support staff and AHPs to meet PR need.
#ENDCODE
#CODEC3
Also facilities for number NOF patients not in place.
#ENDCODE
#CODEC4
Had away day to discuss issues. Ward ended up as a bit of a mix o f continuity care patients and rehab. Had change of consultant - this prompted the change from continuity care to rehab.
#ENDCODE
#CODEC4
Other staff were willing to help rehab (ie. the Physios and OTs) b ut did not have time.
#ENDCODE
#CODEG1
Efforts were made to liaise with relatives and understand their go als for the patient. Not so much focus on what patient wanted - s ometimes relatives assured they knew best and could override wishe s of patients.
#ENDCODE
#CODEG2
Efforts were made to liaise with relatives and understand their go als for the patient. Not so much focus on what patient wanted - s ometimes relatives assured they knew best and could override wishe s of patients.
#ENDCODE
#CODEC5
Patients arriving on ward - greeted by nurses and procedures expla ined.
#ENDCODE
#CODEG1
Sometimes patients were cold after their journey and had to be mad e comfortable. Dr Barton informed. Made sure relatives knew wher e patients were when moved from other hospitals.
#ENDCODE
#CODEG2
Sometimes patients were cold after their journey and had to be mad e comfortable. Dr Barton informed. Made sure relatives knew wher e patients were when moved from other hospitals.
#ENDCODE
#CODEG2
Tried to talk to relatives over phone letting them know patients w ere in and would meet up with their relatives. Dr Barton would ta lk to relatives as well and explain what was possible.

#ENDCODE
#CODEG1
Tried to talk to relatives over phone letting them know patients w ere in and would meet up with their relatives. Dr Barton would ta lk to relatives as well and explain what was possible.
#ENDCODE
#CODED7
MDT meetings took place regularly.
#ENDCODE
#CODEF1
Pain Control. If patients came in on inadequate medications, Dr B arton informed, to increase medication. Nurses would use judgemen ts concerning patients pain status and this was conveyed to Dr B o n her arrival at ward.
#ENDCODE
#CODEF2
Pain Control. If patients came in on inadequate medications, Dr B arton informed, to increase medication. Nurses would use judgemen ts concerning patients pain status and this was conveyed to Dr B o n her arrival at ward.
#ENDCODE
#CODEF1
There were several occasions when nurses on wards felt patients we re given too much medications ie. prescribed too much. This was v oiced to Sister Gill Hamblin who said nurses did not understand pa in control and specialist advice was sought from Countess Mountbat ten.
#ENDCODE
#CODEH1
Shirley raised concerns on several occasions about amount of morph ine given to patients via syringe driver. Her concerns were dismi ssed by ward sister. On one occasion sister said that Shirley had upset Dr Barton. Shirley asked Dr Barton if this was so and Code A arton said she was not upset but thought that Shirley didn't appre ciate what was being done on the ward.
#ENDCODE
#CODEF1
Shirley raised concerns on several occasions about amount of morph ine given to patients via syringe driver. Her concerns were dismi ssed by ward sister. On one occasion sister said that Shirley had upset Dr Barton. Shirley asked Dr Barton if this was so and Dr B arton said she was not upset but thought that Shirley didn't appre ciate what was being done on the ward.
#ENDCODE
#CODEF2
Shirley raised concerns on several occasions about amount of morph ine given to patients via syringe driver. Her concerns were dismi ssed by ward sister. On one occasion sister said that Shirley had upset Dr Barton. Shirley asked Dr Barton if this was so and Dr B arton said she was not upset but thought that Shirley didn't appre ciate what was being done on the ward.
#ENDCODE

#CODEF1
Shirley highlighted differences between practice then on Dryad ward and what was happening on Jubilee ward. On Jubilee ward syringe -drivers were in use, but in much more "controlled" way. Also mix of drugs not the same. Feels mix was an issue - thinks diamorphine appropriate often.
#ENDCODE
#CODEF2
Shirley highlighted differences between practice then on Dryad ward and what was happening on Jubilee ward. On Jubilee ward syringe -drivers were in use, but in much more "controlled" way. Also mix of drugs not the same. Feels mix was an issue - thinks diamorphine appropriate often.
#ENDCODE
#CODEG2
Gave example of patient who came for rehab and this was son's expectation but patient was in a much more poorly condition. Felt son had been given unrealistic expectations from previous hospital.
#ENDCODE
#CODEF2
Pain control for patients was increased according to nurses assessment of adequate pain control - usually doubled - Dr Barton would be informed.
#ENDCODE
#CODEF1
Things changed with arrival of new consultant. Example of patient on morphine and rehab doctor wanted her up and walking so morphine was discontinued and patient was rehabilitated and went home.
#ENDCODE
#CODEF1
Nurses concern re. wide parameters of drug dosage, mix of drugs and need for syringe drivers in first place.
#ENDCODE
#CODEF2
Nurses concern re. wide parameters of drug dosage, mix of drugs and need for syringe drivers in first place.
#ENDCODE
#CODEF1
Sometimes Shirley would go off at night and patient was comfortable - next day patient on syringe driver and when challenged was told patients condition had changed.
#ENDCODE
#CODEF2
Sometimes Shirley would go off at night and patient was comfortable - next day patient on syringe driver and when challenged was told patients condition had changed.
#ENDCODE
#CODED3
Nurses did question regime but were told they did not understand pain control. Nothing changed. Difficult for staff to challenge Dr Barton and Ward Sister - Gill Hamblyn.
#ENDCODE

#CODED7
Did put in grievance, one written - about Dr Barton and Sister Ham blyn. Letter to Barbara Robinson (early 2000) about feeling of be ing victimised. Not about syringe driver issue.
#ENDCODE
#CODED9
Did put in grievance, one written - about Dr Barton and Sister Ham blyn. Letter to Barbara Robinson (early 2000) about feeling of be ing victimised. Not about syringe driver issue.
#ENDCODE
#CODED7
Dr Barton had asked Shirley if she would be better at QA. Shirley assumed this was because she had challenged Dr Barton.
#ENDCODE
#CODED3
Sister Hamblyn liked total control!
#ENDCODE
#CODED3
During period Shirley acted up use of syringe-drivers and triple m edication was better controlled.
#ENDCODE
#CODEF1
Things improved with new rehab. Consultant who has far more optimi stic view of patient's potential for rehab. Use of morphine dimin ished.
#ENDCODE
#CODEF2
Things improved with new rehab. Consultant who has far more optimi stic view of patient's potential for rehab. Use of morphine dimin ished.
#ENDCODE

CHI
COMMISSION FOR HEALTH IMPROVEMENT

PRIVATE & CONFIDENTIAL

3 December 2001

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Code A
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PP72
HM Naval Base Portsmouth
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Direct: Code A
Email: Code A

www.chi.nhs.uk

Dear Commodore Barton

Thank you for your letter and enclosures of 23 November 2001, which Code A forwarded to me as the lead manager for the Commission for Health Improvement (CHI) investigation at the Gosport War Memorial Hospital.

I have noted your comments around the need to strike a balance between protecting the interest of patients and supporting those who actually deliver care. CHI is committed to working with the NHS to create an open, blame-free culture in which lessons can be learnt from mistakes.

I would like to reassure you that CHI's approach places the patient at the heart of all our work and does not seek to allocate blame. All of our reports are non-attributable and are made public. CHI has no statutory remit to re-investigate cases involving the care of individual patients. In its investigations CHI seeks above all, to establish whether the systems and processes followed by healthcare organisations support good quality patient care.

CHI does fully appreciate the strain both your wife and other members of staff have been under in recent years. I have already met with the main unions supporting staff at the trust, together with the Local Medical Committee, in order to give staff reassurances about CHI's methods of working and outline how staff can contribute to the investigation process.

For your information, I have enclosed a copy of the investigation term of reference and an information sheet together with some more general information about CHI.

Thank you once again for your contribution to this investigation.

Yours sincerely,

Code A

Investigations Manager

From: Commodore Code A Royal Navy

Naval Assistant to Naval Secretary
2SL/CNH Headquarters
Rm 165 Victory Building
PP72
HM Naval Base Portsmouth
Hants PO1 3LS

Tel:
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Code A
Commission for Health Improvement
FREEPOST
LON 15399
LONDON
EC1B 1QW

23 November 2001

Code A

As a member of the public, who is not part of the NHS, but someone who has been closely associated with it and the Gosport War Memorial Hospital (GWMH) for many years, I would like to make a few general observations about the NHS and raise some specific points which I believe have a direct bearing on your investigation at the GWMH.

The ethos of a Health service that is free at the point of delivery is morally very laudable, however it shifts the rigor of establishing affordability from the individual and passes it to the Government. As the expectations from such a service will always exceed the money we are prepared to pay for it, these expectations must be curbed to the point where there is broad parity to the resources available. While the present policy of appeasing the public opinion by blaming the deliverers of healthcare for the shortfall may be a short term expedient, it does not address the underlying issue. In fact, it is inflicting deep seated and long lasting damage by eroding morale of the people that we rely on to deliver the care. I have never known morale to be at such a low ebb and regrettably it continues to drop. I cannot see this trend changing as long as the present blame culture persists. The emerging evidence that output continues to decline, despite all the additional resources being pumped into the NHS, is in my opinion, a clear indication of just how significant morale is to the delivery of healthcare. The deliverers of healthcare, who contrary to Public perception, are, with very few exceptions, caring competent people working extremely hard, in very stressful conditions who feel unsupported and vulnerable.

My wife, a very competent General Practitioner, who until April 2000 worked as a Clinical Assistant in Elderly Care at the GWMH in addition to being a minimum full time GP, has been through hell and back as a result the "Blame" culture that is being inculcated throughout the NHS and indifferent management by the Portsmouth Healthcare Trust. In this instance the Staff at the GWMH have been made the scapegoats for a decision by the Healthcare Trust to change the role of the GWMH without providing adequate facilities (Enclosures 1 & 2). To date, she has been subject to two separate Police Investigations, appeared before the disciplinary board of the GMC and has been subjected inappropriately (Enclosure 3) to the scrutiny of the "Failing Doctors Scheme" all for the same allegation over a period lasting a staggering 3 years. In addition she was

A1 A3

subjected to trial by the media that included attempts by the local press to interview me outside my home at 7 am in the morning. Each of these protracted and extremely stressful and deeply humiliating procedures concluded that there was no case to answer and all were characterised by a complete lack of support from her employers. Indeed she was suspended from her position, as Chair of the PCG by the Health authority after the finding of the various investigations had found there was no case to answer pending the outcome of undisclosed ongoing investigations, which presumably include CHI (Enclosure 4). As there appears to be no end to this process she has felt obliged to resign.

While there should be no let up in the drive to root out the tiny number of criminal and negligent healthcare professionals the current emphasis is disproportional to the size of the problem. Unless there is a more equitable balance between protecting the interests of patients and supporting the deliverers of healthcare, the decline in morale will continue, and could ultimately lead to the collapse of the current system.

What are the solutions? The allocation of adequate resources is essential but there is a danger that these additional resources disappear into the black hole caused by the endless rounds of reorganisations and restructuring. This management churning is costly, provides a ready method of obfuscation and does not address the issue of lack of funding. The present blame culture must be replaced with some form of positive underpinning for healthcare providers. Most importantly, patients must be drawn into the cost-containment process to reduce the gap between expectation and affordability.

Sadly the frenzy of adverse publicity that accompanied the announcement of the CHI investigation coupled with the associated literature perpetuates what I can only describe as the institutionalised bullying of healthcare deliverers by an unstoppable bureaucratic juggernaut. If the management and treatment of staff at the Gosport War Memorial Hospital is an indication of Human Resource management in the NHS as a whole I am amazed that we have a service at all.

As an interested outsider can I urge that during your investigations due consideration is given to the staff, who continue to give of their best without support from their management. Some recognition of the devoted care they have provided to hundreds of frail and vulnerable people would be a refreshing change.

Finally I have enclosed copies of four letters to help in your deliberations about the process. You may find it significant that only the letter dated 28 April 2000 was deemed worthy of an acknowledgement.

Yours sincerely.

Code A

Enclosure (1)

Dr Ian Reid

Code A

ist

RECEIVED 26 NOV 2001

Dr Jane Barton
Clinical Assistant in Elderly Services
The Surgery
148, Forton Road
Gosport
HANTS PO123HH
Tel 02392583333
28th January 2000

CLINICAL ASSISTANT ELDERLY MEDICINE GOSPORT WAR MEMORIAL HOSPITAL

I feel that this is an opportune moment to examine my post for a number or reasons.

Firstly there is currently a review of the arrangement of Elderly Services and their relationship with future Primary Care Trusts and a future Trust configuration .These will undoubtedly impact on the future use of present continuing care beds throughout the District.

Secondly the Clinical and Managerial Integration between the Hopsitals Trust and DSCA and the possible future implosion of acute work at Haslar will have a major effect upon the types of subacute and post acute care offered at Gosport War Memorial Hospital in reconfigured services on the peninsula in the future.

Thirdly and perhaps more relevantly at the moment, the type and throughput of patients who are currently using our beds is completely different from those I looked after when I took up the post twelve years ago.The types of patients and their medical conditions have changed markedly and perhaps this issue has not been looked at comprehensively within the Trust. . There is no such thing as Continuing Care nowadays, and Palliative care is something that I do perforce without a great deal of specialised back up.
At a clinical level this manifests itself in a number of ways, the most strikingly obvious of which is the expectations of patients and their relatives.
In part I feel that this stems from a mistaken perception that Gosport War Memorial is a Hospital with a capital 'H', ie resident medical staff and full on site resuscitation facilities. It is also apparent during discussions that relatives take the word rehabilitation literally and expect a much higher level of care and expertise than the current staffing levels and my time allow.

Whereas as recently as three years ago I would expect to spend a specific period of time with a worried relative over and above the normal consultation process once every few weeks, currently I find myself having to do this on a more frequent than weekly basis. In addition the climate of complaint, litigation and actual prosecution fuelled by intense media interest at present in care of the elderly and the issue of dying makes my position as a General Practitioner attempting to provide day to day care extremely difficult.

I am finding the pressures on me to continue to provide what I consider appropriate care for patients, proper consultation with their relatives and support of my hard pressed nursing staff almost intolerable. The current Police investigation into a charge of attempted murder only serves to highlight the almost impossible task faced by a team dedicated to offering seriously ill patients a dignified and peaceful passing.

I would be most grateful if you would give this matter your earliest attention as I feel that the issue is placing considerable stress on the nursing staff and I personally feel extremely vulnerable to litigation for reasons that are outwith my control.

Yours Sincerely

Jane Barton

Copy to Dr A Lord
Max Millett

Enclosure (2)

Code A
Personnel Director
Portsmouth Healthcare trust
St James Hospital
Portsmouth PO48LD

Dr.JA Barton
Clinical Assistant in Elderly Services
148, Forton Road
Gosport
Tel 023 92583333
28th April 2000

References:
a. My letter 28.1.2000 to Clinical Director Elderly Medicine
b. My letter 22.2.2000 to Code A (copies of both letters attached)

Code A

Over recent months I have become increasingly concerned about the clinical cover provided to the continuing care beds at Gosport War Memorial Hospital. I have highlighted these worries on two occasions previously in the enclosed letters.

I returned from my Easter leave this weekend to find that the situation has deteriorated even further. For example on one of the wards I will only be having locum consultant cover until September . In addition an increasing number of higher risk "step down" patients continue to be transferred to the wards where the existing staffing levels do not provide safe and adequate medical cover or appropriate nursing expertise for them.

The situation has now reached the point that, with the agreement of my partners, I have no option but to tender my resignation.

My original contract of employment signed in 1993 indicates I am required to give you two months notice. However, I wish my serious concerns and anxieties to be placed on record during the notice period.

Yours sincerely,

Jane Barton
Copies to:
M Millett
Dr I Reid
Dr A Lord

Enclosure (3)

Code A

Chief Executive Health Authority
Finchdean House
St Marys Hospital
Portsmouth

Code A

Chair Gosport PCG

Code A

1 July 2001

Following a visit from your Director of Public health at extremely short notice last Friday 28th June I understand that I am being investigated under the

"Local procedure for the identification and support of primary care medical practitioners whose performance is giving cause for concern".

In addition it is fel t by the Health Authority that I should stand down from the Chair of the Primary Care Group.

IS REFERRAL TO THE "FAILING DOCTORS SCHEME" THE APPROPRIATE PROCEDURE?

I was informed that the referral to this procedure, which will investigate all my General Practice activities, is as a direct result of my appearance the previous Thursday in front of the Interim Orders Committee of the GMC.

This appearance concerned an alleged criminal case, which has been ongoing for three years and is known to you. The incident took place while carrying out my duties as a Clinical Assistant working for Portsmouth Health Care Trust in August 1998.

The GMC committee considered all the evidence and determined that it was **not** necessary for protection of members of the Public, in the public interest or in my own interest that a suspension order should be made. In other words in their v iew there was no case to answer.

Notwithstanding the findings of the above, the Health Authority has decided to proceed now , some three years after the event, with the Poor Performance Process whose grounding principles supposedly include a prompt and effective raising of matters, the confidence of all parties involved and protection of doctors against vexatious allegations (Section 2.1)

Under Section 3 of the terms of reference for the Performance procedure it states that that there are two separate parts to the process; the first of which, the **performance screening group** which can be called at short notice, determines the appropriate course of action. I have been informed that this part of the process has been convened and that my case has been referred directly to the second stage **performance reference panel** without any consultation with me or screening group having any knowledge of the details and findings of the GMC enquiry.

In addition, the guidance (section 4.2) states that criminal activity should be directed to the correct process rather than being considered under the Poor Performance Procedure. Does not an appearance in front the GMC constitute the correct procedure?

MY POSITION AS AN EMPLOYEE OF THE HEALTH AUTHORITY

I was asked at the same interview whether I felt it was appropriate for me to continue to represent the Health Authority in public in my role as Chair of the PCG. As I do not consider I have done anything wrong, a view supported by the GMC , I can see no reason to do this. However, if the Health Authority do not feel it appropriate for me to represent them in public then you should suspended me from my position with an unambiguous statement giving the reason for this.

Having worked for you for some years during which time I have always had immense respect for your fairness and balanced views, I am conscious that the tone of this letter is contentious, but I do feel there is a worrying underlying moral principle about the protection of doctors once the

unstoppable momentum of complaint and investigation has begun. This post Shipman "yard arm" clearing culture with the associated ritual humiliation, leaves the medical profession unacceptably vulnerable and the long term consequences this will have on recruitment and retention will be devastating.

Dr J A Barton

Enclosures (4)

Fareham and Gosport NHS
Primary Care Groups

Unit 100, Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

Tel: 01329 233447
Fax: 01329 234984

Ref: JB/VB/L1

Code A
Chief Executive
IOW Portsmouth and SE Hampshire
Health Authority
Finchdean House
Portsmouth
PO3 6DP

01 November 2001

Dear Code A

As briefed by Code A a couple of weeks ago, CHI has been called in to investigate the process of patient care at Gosport War Memorial Hospital since the complaints of 1998.

I find it tragic that after 24 weeks of intensive work including further traumatisation of dedicated Clinical staff at the hospital, a report will be produced to coincide with the dissolution of the Healthcare Trust as it becomes part of the PCT. The cynic in me would go so far as to believe this is a deliberate ploy to avoid resolving this sorry episode before the beginning of April next year.

It also leaves open the implication that in addition, any further complaints, which would appear to be inevitable judging by the media frenzy that accompanied the announcement of the CHI investigation could be referred back to the police, GMC or UKCC, further extending the three years of misery which this indifferently handled episode has caused.

For my own part I can not morally justify drawing a salary and adding to the enormous financial cost of this unmanageable bureaucratic process which should be being spent on patients without being able to fully contribute. I feel it may already be being said in certain quarters that I am drawing a salary for doing nothing.

Not withstanding the fact that the original investigation of the criminal case against me and your Local "Failing Doctors" procedure have found that there was no case to answer I can see there being no speedy conclusion to this matter and further, no prospect of my being reinstated as the Chair of the PCG.

I therefore feel forced to tender my resignation.

Yours sincerely

Dr Jane Barton

NOT SENT Drugs enclosed TO MLR.

Southampton University Hospitals NHS Trust

Code A

Southampton General Hospital
Tremona Road
Southampton SO16 6YD

Telephone 01703 777222

26

Ref: GFT/SMP

Code A

16 September 1999

Code A
Chief Executive
Portsmouth Healthcare NHS Trust
St James Hospital
Portsmouth
PO4 8LD

Dear Mr Millett

Further to your recent request for my comments about the complaint concerning Code A care, made by her son Mr Wilson, I am please to enclose a letter addressing the specific comments about which you have asked my opinion. There were several other comments I wished to make which were not pertinent to the issues you had specifically raised on behalf of Code A These comments contained herein, are meant to be helpful and of course you are completely free to ignore them but I simply felt they may be of use.

Firstly, of course, the issue of the notes themselves which having been sent for microfilming are extremely difficult to get through. It is interesting however that the microfilming process does not seem to have captured the fluid charts which is I think unusual and may be an issue worth noting. I am not sure whether this is policy or simply that they were not sent to me, in which case I apologise.

Secondly I wanted to make a comment about the nursing care plans. They were sent to me apparently quite separated and it is very difficult to work out which progress chart actually applies to which problems care plan. Whilst I recognise that in the way of things in the notes this would not normally be problem since things would be filed together, notes do become disentangled and I am sure it could cause a problem and I wonder if they should be numbered. I also think that the careplans are a little limited and whilst there is an issue about the encouragement of fluids with regard to the care plan specifically orientated towards her urinary incontinence, I believe that once it became obvious that fluid intake was poor, a specific care plan might well have been started at that time outlining possible manoeuvres for encouraging fluids. I also think that the absence of a night care plan with the nurses simply signing in the progress sheet each morning is not really helpful in terms of recording care on a 24 hour basis.

The third issue about which I would like to express some concern really relates to Code A comments in her reply to the original complaint. She apparently was providing consultant cover on two wards due to maternity leave, which permitted only one ward round every fortnight. Given the difficult nature of a rehabilition unit, it seems to me inconceivable that a fortnightly ward round by a consultant is adequate consultant cover and I would strongly recommend that attention is paid to the provision of maternity leave cover. I do not think that had Dr Code A been able to be present more frequently on the ward it would necessarily have altered the outcome in this particular case, but I feel sure that it would have relieved a lot of anxiety all round.

The fourth comment really relates to the dosage of Morphine. Whilst recognising that in some of the peripheral units the medical staff providing daily cover are often from outside the hospital, I feel that writing Morphine up for a subcutaneous pump with doses ranging from between 20 and 200 mgs a day is poor practice and could indeed lead to a serious problem. As it happens the nurses stuck to using 20 mgs a day of Morphine in the subcutaneous pump and then increased it up to 40mg but they could of course have increased it up to 200 mgs given the way the chart is written. I think it unlikely that the jump from 20 to 40 mgs made any real contribution to Mrs Purnell's management, but I think it is still a large jump and steps need to be taken to consider limiting the flexibility of dosage regime.

I hope that you will accept these comments are meant to be helpful. I fully recognise that I am not a professional nurse and therefore slightly stepping outside my boundaries by commenting on nursing issues, however as Clinical Director I frequently have to consider how we might make our notes better in order to handle specific issues.

Please let me know if I can give you any more information.

With best wishes

Code A

ine

C → I. Reid
B. Robertson
A. Lord

1/10/99

NOT SENT TO MR WILSON

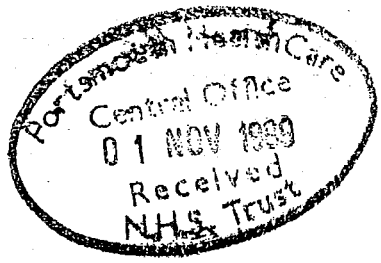
27

Portsmouth HealthCare NHS Trust
MEMORANDUM

Non evidence?

From
Barbara Robinson

Ref
BFR/svn



To
Max Millett

cc

27 October 1999

Max

Learning Points from the Wilson Complaint

Thank you for your memo and the copy of Code A 's letter.

1a) Microfilming/Fluid Chart

It was an unfortunate error that these particular notes were microfilmed so quickly. Notes are not usually filmed until at least one year after the patient has died or 3 years after discharge.

The company have assured us that everything is filmed except blank sheets and address labels.

2b) Nursing Care Plans

This has been picked up as part of the Clinical Governance Action Plan for Community Hospitals. It was also part of an action plan from a workshop on May 20 '99 for Clinical Managers and Clinical Practice Development facilitators. This action plan was evaluated on 20 October '99 and showed that work with Nursing Care Plans has taken place across all areas in the community Hospitals.

I will raise it at NAC to ensure it is being picked up Trust wide.

3d) Good Practice in writing up medication.

It is an agreed protocol that Jane Barton, Clinical Assistant, writes up diamorphine for a syringe driver with doses ranging between 20 and 200 mgs a day. The nurses are trained to gradually increase the dose until the optimum level has been reached for the patient's pain relief. If the prescription is not written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient.

Ian may wish to raise this at the Medicine and Prescribing Committee

I hope this covers all the points

Code A

28

Code A - Project Mgr.

From:
To:
Cc: Code A Max Millett -

Subject: Prescribing opiates in community hosps
Date: 29 October 1999 09:57

Code A I've had a long conversation with Jane Barton today, in response to the comment made by Code A er (review of Code A complaint) - the practice of writing up s/c pump morphine with dosages ranging from 20-200 mgs per day - ? poor practice, ? lead to serious problems.

Code A feels very vulnerable and that the nurses are also vulnerable - but that the system of medical cover makes it difficult to prescribe otherwise. If we say she can't prescribe like this, does she refuse to prescribe opiates, as she can't be expected to attend the wards at the drop of a hat?

She feels very unsupported on clinical risk matters such as this, to the extent of wondering if the job is worth it. She wasn't directly threatening to leave, but was making a plea from the heart about how it feels just now. I told her of our concerns about the harassment clinicians seem to be facing from some complainants.

She asked if we could take a Trust stance on the prescribing of opiates in community hosps. My comment was that I thought this was an important clinical governance issue, a real issue to be recognised and tackled; far more important than sterile tick box risk assessment.

This is our first opportunity to link a complaint into clinical governance - for positive action!

* Where do we take this? Obviously MAC, I guess, but perhaps also to the CGP? and/or RMG?

Code A

29

Agenda for Med / Prescrib Comm.

Portsmouth HealthCare NHS Trust
MEMORANDUM

From: Code A

Ref: g:/memo/diamorph.doc

To: See Distribution

cc: [redacted]

15 December 1999

RE : Memorandum for the Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion,

I enclose a draft protocol along with a blank infusion and pain control chart and a 'completed' Diamorphine infusion and pain control chart.

I should be very grateful for your comments.

Yours sincerely

Code A

DISTRIBUTION:
Dr Jane Barton - Clinical Assistant - Gosport War Memorial
Sister J[redacted] Hamblin - Dryad Ward - Gosport War Memorial
Dr Althea Lord - Consultant Geriatrician - QAH

PROTOCOL FOR PRESCRIPTION AND ADMINISTRATION OF DIAMORPHINE BY SUBCUTANEOUS INFUSION

INTRODUCTION

In community hospitals, particularly at weekends and bank holidays, medical cover is provided on an emergency call out basis.

This can lead to a situation whereby patients who are experiencing increasing pain may not be able to have their pain control needs immediately met. To overcome this and also to give guidance to nurses who may be unsure as to how much analgesia (diamorphine) to administer within a variable dose prescription.

DOSAGE

Guidance from the palliative care service indicates that if pain has not been controlled in the previous 24 hours by 'Xmg' of diamorphine, then up to double the dose should be administered the following day, i.e. up to 2x 'Xmg' should be given.

PAIN CONTROL CHART

It is suggested that a pain control chart (see appendix) should be completed on a four hourly basis for all patients receiving a diamorphine infusion.

PRESCRIPTION

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 20-80 mg, 60-240 mg or similar. The reason for prescribing should be recorded in the medical notes.

ADMINISTRATION

If pain has been adequately controlled within the previous 24 hours, the nurse should administer a similar dose of diamorphine over the next 24 hours.

If the previous 24 hour dose has made the patient unduly drowsy etc., the nurse should use his/her discretion as to whether the dose to be administered for the next 24 hours can/should be reduced, within the prescribed dosage regime. If the minimum dose appears to have made the patient too drowsy, the on-call doctor should be contacted.

If the patient's pain has not been controlled, the nurse should use his/her discretion as to the dose to be given within the next 24 hours, i.e. he or she may administer up to double the previous 24 hours dose.

INFORMATION TO PATIENTS and RELATIVES

Where patients are mentally capable of receiving such information, they must be told that an infusion of a painkiller (diamorphine) is being started and that the dose will be adjusted if necessary to allow them to be as comfortable as possible without being unduly sedated.

When patients are unable to understand such information, by reason of either their physical or mental status, the decision that diamorphine is being, or about to be, administered, should be communicated to their next-of-kin/relatives, again indicating that the aim is to make the patient as comfortable as possible and that the dose will be adjusted to keep the patient as comfortable as possible without being unduly sedated. If relatives express concern about the administration of diamorphine, despite the above discussion, the medical staff should be informed and the medical staff should make every effort to discuss the administration of diamorphine with the patient's next-of-kin/family. A resume of the discussion should be recorded in the patient's notes.

DIAMORPHINE INFUSION AND PAIN CONTROL CHART

DATE		29/9	30/9	1/10	2/10	3/10
DOSE		10 mg	20 mg	40 mg	80 mg	80 mg
TIME INFUSION STARTED	0 hours	1400	1400	1400	1400	1400
PAIN CONTROLLED YES/NO	+4 hours (1800)	Y	Y	N	Y	
	+8 hours (2200)	Y	Y	N	Y	
	+12 hours (0200)	N	Y	Y	Y	
	+16 hours (0600)	N	N	Y	Y	
	+20 hours (1000)	N	Y	N	Y	
	+24 hours (1400)	N	Y	Y	Y	
NO. OF TOP UP DOSES OF DIAMORPHINE		3	1	3	0	
TOTAL DOSE 'TOP UPS' IN 24 HOURS		10 mg	5 mg	20 mg	0 mg	
COMMENTS						

DIAMORPHINE INFUSION AND PAIN CONTROL CHART

DATE						
DOSE						
TIME INFUSION STARTED	0 hours					
PAIN CONTROLLED YES/NO	+4 hours					
	+8 hours					
	+12 hours					
	+16 hours					
	+20 hours					
	+24 hours					
NO. OF TOP UP DOSES OF DIAMORPHINE						
TOTAL DOSE 'TOP UPS' IN 24 HOURS						
COMMENTS						

41

Fareham and Gosport NHS
Primary Care Groups

RECEIVED 10 APR 2002

Unit 100, Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

Tel: 01329 233447
Fax: 01329 234984

FACSIMILE

DATE:	9/4/02
TO FAX NUMBER:	Code A
FOR THE ATTENTION OF:	Code A
ORGANISATION:	CHI
FROM:	Code A
NUMBER OF PAGES:	3 (including this one)

If you do not receive all of the pages please telephone the above number immediately.

MESSAGE

Forwarded
As discussed.

Portsmouth Hospitals NHS Trust
Pharmacy Service

SUMMARY MEDICINES USE 1997/1998 to 2000/2001

Drug		Dose	Pack	1997/1998	1998/1999	1999/2000	2000/2001
Diamorphine Injection	Daedelus	5mg	5	0	5	0	3
	Dryad	5mg	5	0	0	0	6
	Sultan	5mg	5	6	5	0	10
	Total	**5mg**	**5**	**6**	**10**	**0**	**19**
Diamorphine Syringe	Sultan	5mg	1	0	10	0	0
	Total	**5mg**	**1**	**0**	**10**	**0**	**0**
Diamorphine Injection	Daedelus	10mg	5	21	34	27	19
	Dryad	10mg	5	40	57	56	20
	Sultan	10mg	5	67	36	24	35
	Total	**10mg**	**5**	**128**	**127**	**107**	**74**
Diamorphine Syringe	Dryad	10mg	1	0	17	0	0
	Sultan	10mg	1	0	20	0	0
	Total	**10mg**	**1**	**0**	**37**	**0**	**0**
Diamorphine Injection	Daedelus	30mg	5	18	27	15	7
	Dryad	30mg	5	34	51	40	4
	Sultan	30mg	5	67	43	14	31
	Total	**30mg**	**5**	**117**	**121**	**69**	**42**
Diamorphine Syringe	Dryad	30mg	1	0	5	0	0
	Total	30mg	1	0	5	0	0
Diamorphine Injection	Daedelus	100mg	5	2	11	1	2
	Dryad	100mg	5	12	13	2	0
	Sultan	100mg	5	20	27	0	31
	Total	**100mg**	**5**	**34**	**51**	**3**	**33**
Diamorphine Injection	Daedelus	500mg	5	0	1	0	0
	Dryad	500mg	5	0	2	0	0
	Sultan	500mg	5	1	1	0	4
	Total	**500mg**	**5**	**1**	**4**	**0**	**4**
Fentanyl Patch	Daedelus	100mcg/hr	5	0	1	0	0
	Dryad	100mcg/hr	5	0	1	0	0
	Sultan	100mcg/hr	5	0	0	0	0
	Total	**100mcg/hr**	**5**	**0**	**2**	**0**	**0**
Fentanyl Patch	Daedelus	25mcg/hr	5	3	7	2	0
	Dryad	25mcg/hr	5	8	9	18	8
	Sultan	25mcg/hr	5	0	1	0	1
	Total	**25mcg/hr**	**5**	**9**	**17**	**20**	**9**
Fentanyl Patch	Daedelus	50mcg/hr	5	1	3	0	0
	Dryad	50mcg/hr	5	1	3	8	0
	Sultan	50mcg/hr	5	0	0	1	1
	Total	**50mcg/hr**	**5**	**2**	**6**	**10**	**1**
Fentanyl Patch	Daedelus	75mcg/hr	5	3	0	0	0

Portsmouth Hospitals NHS Trust
Pharmacy Service

SUMMARY MEDICINES USE 1997/1998 to 2000/2001

	Dryad	75mcg/hr	5	3	2	2	0
	Sultan	75mcg/hr	5	0	0	0	0
	Total	**75mcg/hr**	**5**	**6**	**2**	**2**	**0**
Haloperidol Injection	Daedelus	5mg/5ml	10	0	3	0	0
	Dryad	5mg/5ml	10	1	1	0	0
	Sultan	5mg/5ml	10	43	15	6	0
	Total	**5mg/5ml**	**10**	**44**	**19**	**6**	**0**
Haloperidol Injection	Daedelus	5mg/5ml	5	0	0	0	4
	Dryad	5mg/5ml	5	0	0	0	1
	Sultan	5mg/5ml	5	0	0	0	16
	Total	**5mg/5ml**	**5**	**0**	**0**	**0**	**21**
Midazolam	Daedelus	10mg/2ml	10	37	51	39	17
	Dryad	10mg/2ml	10	75	108	75	19
	Sultan	10mg/2ml	10	21	9	2	11
	Total	**10mg/2ml**	**10**	**133**	**168**	**116**	**47**

Figures indicate packs of product used

USEFUL TELEPHONE NUMBERS

The Rowans (Portsmouth Area Hospice)			
Inpatient unit and out of hours advice		01705 250001	ext 209
Portsmouth HealthCare NHS Trust			
at The Rowans (9 am - 5 pm)		01705 250001	ext 203
Consultant in Palliative Medicine			ext 203
Palliative Care Nurses (Community)		(Answerphone)	ext 326
Consultant Clinical Psychologist			ext 216
Charles Ward (Elderly Medicine)	QAH	01705 286059	
Portsmouth Hospitals NHS Trust			
Hospital Macmillan Nurses	SMH	01705 286000	ext 2408
			or bleep 419
	QAH	01705 286904	bleep 409
Macmillan Radiographer	SMH	01705 286000	ext 3425
			or bleep 288
Macmillan Centre	SMH	01705 788700	
Pain Clinic	QAH	01705 286312	
Pharmacy	QAH	01705 286117	
Drug Information	SMH	01705 866771	bleep 468
Countess Mountbatten House		01703 477414	
Macmillan Service, Midhurst		01730 812341	
St Wilfrid's Hospice, Chichester		01243 775302	
Haslar Oncology/Palliative Care Nurses		01705 584255	ext 2695

THE PALLIATIVE CARE HANDBOOK

Guidelines on clinical management

FOURTH EDITION

PORTSMOUTH HEALTHCARE NHS TRUST
PORTSMOUTH HOSPITALS NHS TRUST
THE ROWANS (PORTSMOUTH AREA HOSPICE)

in association with all the Wessex Specialist Palliative Care Units

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INTRODUCTION

Palliative care:

- is the active total care of patients and their families, usually when their disease is no longer responsive to potentially curative treatment, although it may be applicable earlier in the illness;
- provides relief from pain and other symptoms;
- aims to achieve the highest possible quality of life for patients and families;
- responds to physical, psychological, social and spiritual needs;
- extends as necessary to support in bereavement.

This handbook contains guidelines to help GPs, community nurses and hospital staff as well as specialist palliative care teams. It aims to provide a checklist for the management of common problems in palliative care, with some information on drug treatment. It is **not** a comprehensive textbook.

Further advice can be sought from the specialist staff identified on the back cover; more detailed drug information may be found in the British National Formulary.

The former term 'radiotherapist' is used in place of 'clinical oncologist', for reasons of clarity and brevity.

Cautionary note: some of the drug usage recommended is outside product licence, either by way of indication, dose, or route of administration. However, the approaches described are recognised as reasonable practice within palliative medicine in the UK.

Abbreviations

csci = continuous subcutaneous infusion (via a syringe driver)
sl = sublingual
sc = subcutaneous injection

*** indicates that these drugs or conditions are best managed by specialist staff**

GENERAL PRINCIPLES OF SYMPTOM MANAGEMENT

- Accurate and full assessment is essential for both diagnosis and treatment
- Be aware of the importance of non-physical factors in symptomatology - emotional, psychological, social and spiritual problems are often mixed together with physical symptoms
- When symptoms are difficult to control there may be more than one cause, or there may be hidden emotional, psychological, social and spiritual factors
- Use appropriate therapies to maintain best possible quality of life and independence, and to allow patient and carers to focus on other important issues
- Be careful that drug side effects do not become worse than the original problem
- Sensitive explanation and inclusion of patient and carers in decision making are essential parts of symptom management
- A multiprofessional approach is essential, and may be facilitated by the use of a drug card and/or a shared information card
- Consider referral for a specialist palliative care opinion:
  - if there is a problem which does not respond as expected
  - in complex situations which may benefit from specialist expertise
  - for support for the hospital or primary health care team
- **Continually reassess**

PAIN

Pain is a common, although not inevitable symptom in cancer and successful treatment requires **an accurate diagnosis of the cause and a rational approach to therapy.** There are many components to cancer pain and all relevant physical and psycho-social factors need to be taken into account. Pain in the cancer patient need not be caused by the **cancer**, and can be due to **previous treatment** or to an **unrelated cause**.

Most pains arise by stimulation of nociceptive nerve endings; the characteristics may depend on the organ involved. The analgesic ladder approach (see over) is the basis for prescribing but careful choice of appropriate adjuvant drugs such as anticholinergics for colic, NSAIDs for bone pain and benzodiazepines for muscle spasm, will greatly increase the chance of effective palliation.

A burning or shooting component to the pain is likely to be due to nerve entrapment or infiltration resulting from compression or erosion respectively.

Diagnosis

There is no easy way of measuring pain in a clinical situation; as such, it is generally held that **pain is what the patient says it is.**

Causes / Risk Factors

1 Physical	Nociceptive pain caused by somatic, visceral or bone injury
	Neuropathic pain caused by nerve injury
2 Non-physical	Anger, anxieties, fears, sadness, helplessness
	Spiritual, social and family distress

If pain is difficult to control, remember:

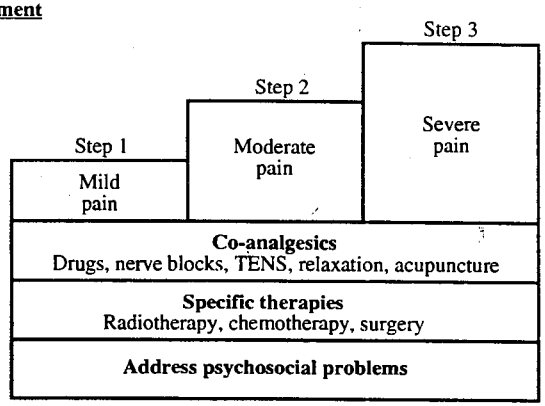
> All pains have a significant psychological component, and fear, anxiety and depression will all lower the pain threshold. Remember also the likely effects of life changes associated with terminal disease including loss of financial security, loss of body image and compromised sexual function. Together with more existential and religious uncertainties, these factors can have a major impact on the way a person perceives and copes with pain.

Assessment

1 Identify the site (with any radiation), severity, duration, timing and aggravating and relieving factors

2 Use a body diagram with the patient's own words

Management



The WHO analgesic ladder

The WHO analgesic ladder has been adopted to emphasize that it is essential to use an analgesic which is appropriate to the severity of the pain; patients whose pains do not respond to weak opioids warrant and deserve to be managed with strong opioids. However, alternative methods of pain control as indicated in the boxes at the base of the diagram **must** be considered in all patients, whatever the severity of their pain.

Step 1 **Non opioids**

Paracetamol	oral or rectal 500mg - 1g qds (maximum 4g / day)
NSAIDs	diclofenac (tabs SR 75mg bd)
	naproxen (tabs/susp/suppos 500mg bd)
	ibuprofen (maximum 2.4g per day)

Step 2 **Weak opioids**

Dextropropoxyphene 32.5mg with paracetamol 325mg (coproxamol)
Codeine 30mg with paracetamol 500mg (cocodamol 30/500)

Several other drugs are available in this category including dihydrocodeine and tramadol (avoid in epilepsy or if on antidepressives) although none has any particular advantage over the two preparations listed above

Step 3 **Strong opioids**

See following pages

Strong opioids

1 **Morphine** is the strong opioid of choice for oral use

Several preparations are available including:

Immediate release oral morphine
a) Oramorph liquid 10mg/5ml, 100mg/5ml (4 hourly)
b) Oramorph unit dose vials 10mg/5ml, 30mg/5ml, 100mg/5ml (4 hourly)
c) Sevredol tablet 10mg, 20mg, 50mg (4 hourly)

Sustained release oral morphine tablets and capsules
a) MST Continus 5mg, 10mg, 15mg, 30mg, 60mg, 100mg, 200mg (12 hourly)
b) Oramorph SR 10mg, 30mg, 60mg, 100mg (12 hourly)
c) MXL 30mg, 60mg, 90mg, 120mg, 150mg, 200mg (24 hourly)
d) Morcap SR 20mg, 50mg, 100mg (12 or 24 hourly)

Sustained release oral suspensions
a) MST Continus 20mg, 30mg, 60mg, 100mg, 200mg (12 hourly)

Morphine suppositories are available if the rectal route is preferred - consult local pharmacy for availability

2 **Diamorphine** is the strong opioid of choice for parenteral use because of its greater solubility - maximum recommended concentration 250mg/ml

3 **Phenazocine*** is useful if there is genuine morphine intolerance. One 5mg tablet is equipotent with 25mg morphine but has a longer duration of action
a) Narphen 5mg (6 - 8 hourly)

4 **Fentanyl TTS patch.** Useful especially when there is difficulty swallowing, vomiting or intractable constipation; dose titration is more difficult and expensive. Possibility of withdrawal symptoms when converting from morphine - responds to small doses of immediate release oral morphine
a) Durogesic 25mcg/hr, 50mcg/hr, 75mcg/hr, 100mcg/hr (72 hourly)

Conversion from oral morphine to transdermal fentanyl

Morphine (mg/day)	<135	135 -224	225 -314	315 -404	405 -494	495 -584	585 -674	675 -764	765 -854
Fentanyl (mcg/hour)	25	50	75	100	125	150	175	200	225

5 **Hydromorphone*** has recently become available in this country; it may be useful if there is genuine morphine intolerance
a) Palladone capsules 1.3mg, 2.6mg (4 hourly)
b) Palladone SR capsules 2mg, 4mg, 8mg, 16mg, 24mg (12 hourly)

6 **Dextromoramide** (Palfium) and **pethidine** have a short duration of action. They are useful for painful procedures but should **not** be used regularly for chronic cancer pain

Use of morphine

1 Instructions to the patient
- Emphasise the need for regular administration and explain about breakthrough medication
- Warn about possible side effects
- Reassure that when used for pain relief, morphine is not addictive and that there is a very wide range of doses available so that they are not prejudicing future pain relief by starting treatment now

2 Start by using an immediate release morphine (liquid or tablet) for dose titration giving it every 4 hours. The eventual effective dose may range from 2.5mg to more than 200mg but only a minority of patients will need more than 30mg 4 hourly. Give a double dose at bedtime to avoid waking at 2 - 3 am but ensure that at least 5 doses are given per 24 hours

3 Start with a low dose and increase by 30 - 50% increments each day until pain controlled or side effects prevent further increase. Doses can be rounded up or down according to individual need. A common dose sequence is:
5 - 10 - 15 - 20 - 30 - 40 - 60 - 90 - 120 - 150 - 200mg
Avoid unwieldy doses such as 22.75mg which will lead to confusion and error

4 Prescribe the same dose as the 4 hourly dose for prn use to be repeated as often as necessary (hourly if necessary) for breakthrough pain while still continuing with the regular dose and review every 24 hours

5 Use continuing pain as an indication to increase the dose and persisting side-effects, eg drowsiness, vomiting, confusion, particularly in association with constricted pupils, as an indication to reduce the dose. If both pain and side-effects are present, consider other approaches

6 Once pain is controlled, consider converting to 12 or 24 hourly sustained release preparation for convenience using the same total daily dose. Always make available immediate release morphine for breakthrough pain (see 4)

7 When oral administration is not possible because of dysphagia, vomiting or weakness, consider changing to diamorphine by subcutaneous infusion using a syringe driver. The conversion from oral morphine to subcutaneous diamorphine (total daily dose) varies between 1/3 - 1/2 allowing some flexibility depending on the requirement for increased or decreased opioid effect

Unwanted effects of morphine

1 **Constipation** is virtually inevitable - use prophylactic laxatives (see p22)

2 **Nausea** normally clears within a week; more common at higher doses. May need antiemetic, eg haloperidol 1.5mg nocte, metoclopramide 10mg tds, prochlorperazine 5 - 10mg tds

3 **Drowsiness** normally clears within 5 days; otherwise suggests overdosage. If persistent reduce dose, consider other forms of analgesia or other opioid

Changing from one opioid to another

There are theoretical proposals in the literature for **opioid rotation***, that is changing from one strong opioid to another if pain does not come under good control without unacceptable side effects. Research evidence is lacking, and most problems can be solved by improving the titration or by using adjuvant drugs

Opioid equivalents

This table provides only an **approximate** guide to opioid equivalents, because comprehensive data are lacking. Doses always need to be re-titrated after a change of opioid. The total daily doses shown are broadly equivalent to oral morphine 30mg

Drug	**Total daily dose**
Coproxamol	8 tablets
Codeine	360mg
Dihydrocodeine	300mg
Tramadol	120mg
Buprenorphine#	0.6mg
Pethidine (intramuscular)#	200mg
Morphine	**30mg**
Diamorphine (subcutaneous)	10mg
Phenazocine*	7.5mg
Hydromorphone*	4mg
Oxycodone (only available in UK as suppositories)	20mg
Methadone*	10mg
Dextromoramide#	15mg

Notes

\# We do not recommend for regular use in chronic cancer pain

* Best used by specialist staff

Management of specific pains

A Bone pain

1 Consider early referral for palliative radiotherapy - usually single fraction

2 **NSAIDS** are effective for pain on movement but beware side effects especially when used with corticosteroids; discontinue if not helping

3 Regular iv infusions of **bisphosphonates*** of proven benefit in bone metastases from breast or prostate cancer and myeloma: **pamidronate** 60 - 90mg, **sodium clodronate** 1500mg every 3 - 4 weeks

4 Consider orthopaedic surgery for painful lytic metastases at risk of fracture

B Abdominal pain

1 Constipation is a common cause; avoid assuming pain must be due to cancer

2 For colic use an anticholinergic such as oral **propantheline** or subcutaneous **hyoscine butylbromide** (Buscopan) 30 - 90mg/24hrs usually by syringe driver

3 For liver capsule pain consider **dexamethasone** 4 - 8mg/day +/- NSAID

4 For pain arising from upper GI tumour consider coeliac plexus block (see **H**)

5 NSAIDs are a common cause of iatrogenic abdominal pain

C Neuropathic pain*

Often burning or shooting, and may not respond in a predictable way to pain relieving medication. May presage cord compression. Specialist palliative care team will be pleased to advise but the following approach is suggested

1 Titrate to maximum tolerated dose of opioid

2 **Amitriptyline** 10 - 75mg or **dothiepin** 25mg - 75mg nocte; increase dose to maximum tolerated and stop if no benefit after 7 days at that dose

3 According to response either add or substitute anticonvulsant eg **sodium valproate** 400 - 800mg/day, **clonazepam** 500mcg nocte or up to tds, **carbamazepine** 200 - 1200mg/day (usefulness is often limited by side effects); discontinue if no benefit after 5 days on highest dose tolerated

4 **Dexamethasone** 8mg daily - stop if no improvement after 5 days

5 To consider: TENS, acupuncture, **clonidine***, **ketamine***, **midazolam***, **mexilitine***, neural blockade

D Rectal pain

1 Rectal drugs: **steroids, diazepam, nifedipine*, baclofen***

2 Local radiotherapy

3 **Tricyclic antidepressives** (amitriptyline, dothiepin - see **C**)

4 If anal spasms, try **glyceryl trinitrate** ointment 0.1 - 0.2% bd

E Muscle pain

1 **Paracetamol, NSAIDs**

2 Muscle relaxants: **diazepam, baclofen, dantrolene**

3 Physiotherapy, aromatherapy, relaxation, heat pad

F Bladder spasm

1 **Oxybutinin** 5mg tds

2 **Amitriptyline** 10 - 75mg nocte

3 If catheterized, intravesical **bupivacaine** 0.25%, 20 mls for 15 mins tds

G Acute pain of short duration

For example pain on moving a fractured limb or changing a painful dressing

1 **Dextromoramide** given sublingually 20 mins prior to procedure

2 **Entonox**

H Pains amenable to nerve blocks

Some techniques are easily learned by the non-specialist whilst others should be performed only by pain management specialist anaesthetist. Neural blockade can be temporary with local anaesthetic or semi-permanent with neurolytic agents such as phenol. By reducing local inflammation, injected steroids are particularly useful when pain is due to compression of the nerve

1 Intrathecal opioid and local anaesthetic infusions may help in difficult pains

2 Back pain due to metastases often responds to epidural injection of high dose steroid and local anaesthetic. Caudal injections are easily performed and are useful for sacral pain. Thoracic and cervical epidurals are much more difficult

3 Chest wall pain eg due to mesothelioma - can be very difficult to control; intercostal and paravertebral blocks are easy to perform; success claimed for cervical cordotomy or thoracic epidurals in very specialized hands

4 Upper abdominal pain especially due to pancreatic tumour - 80% success claimed for coeliac plexus block

5 Lower abdominal and pelvic pain - lumbar plexus block worthwhile benefit but less successful

6 Hip pain - psoas compartment block

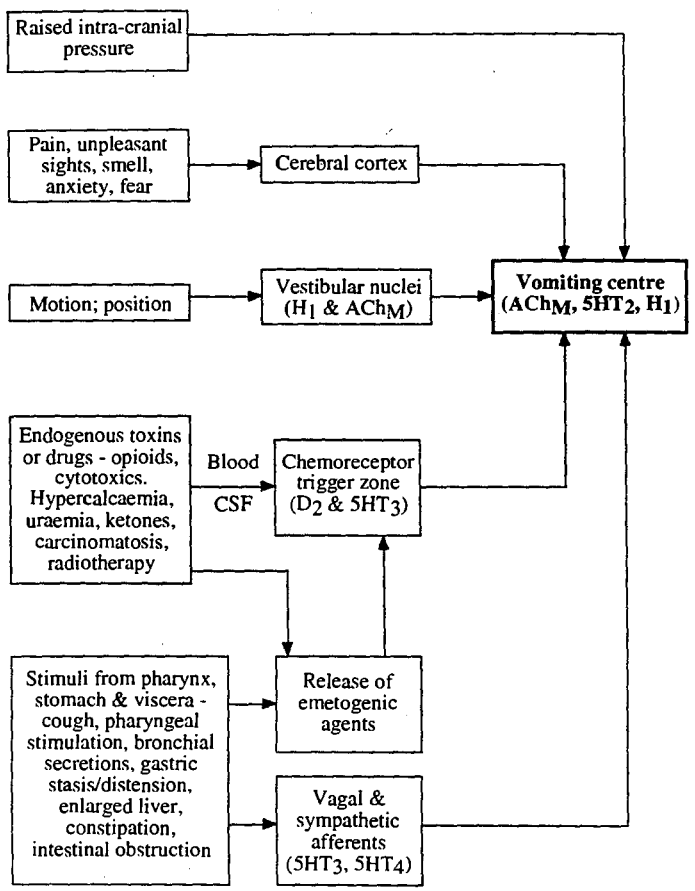
7 Perineal pain - saddle anaesthesia using intrathecal phenol. Like all neurolytic techniques this is the province of the specialist

8 Rib pain - temporarily abolished by intercostal injection of local anaesthetic proximal to lesion. Longer term benefit from infiltration with depot steroid. Care needed but technique well within capability of trained non-specialist

9 Pancoast tumour and similar - brachial plexus block

NAUSEA AND VOMITING

Causes / Risk factors



Management

There are many causes of nausea and vomiting and more than one cause may often be identified in any particular patient. Mechanisms are outlined opposite. See next page for profiles of antiemetics and standard dose regimes

Cause	Therapy
Raised intracranial pressure	1 **Dexamethasone** (see p32) 2 **Cyclizine**
Anxiety etc	1 Benzodiazepines - **diazepam** 2 - 15mg daily 2 **Midazolam** 10 - 30mg/day via syringe driver
Motion, positional	1 **Cyclizine** 2 **Hyoscine**
Endogenous toxins, drugs	1 **Haloperidol** 2 **Prochlorperazine** 3 **Methotrimeprazine** 4 **Metoclopramide**
Chemotherapy (short term)	1 Consult oncology colleagues 2 **Lorazepam** for anticipatory vomiting 3 **Dexamethasone** in reducing doses over 5 days 4 **$5HT_3$ antagonists** only effective in early emesis
Gastric stasis	1 **Domperidone** 2 **Metoclopramide** 3 **Cisapride**
Gastric irritation	1 **Antacids** 2 **Proton pump inhibitors** 3 **Misoprostol** 200mcg bd if caused by NSAIDs
Indeterminate	1 **Cyclizine** 2 **Prochlorperazine** 3 **Methotrimeprazine** 4 **Dexamethasone** 4 - 8mg daily
Constipation	See separate section on p20
Intestinal obstruction	See separate section on p16

Mechanisms of action of antiemetics

Receptor Sites	Type of Receptor
Vomiting centre	Muscarinic (ACh_M) Histamine (H_1) $5HT_2$
Vestibular nuclei	Muscarinic (ACh_M) Histamine (H_1)
Chemoreceptor trigger zone (CTZ)	Dopamine (D_2) $5HT_3$
Upper gastrointestinal tract	$5HT_3$ $5HT_4$ Dopamine (D_2) prokinetic

Antiemetic therapy

In established nausea/vomiting gastric stasis interferes with oral absorption: use other routes. Use oral route for prophylaxis of nausea

Use appropriate non-drug measures and treat basic causes if possible. If nausea/vomiting are caused by other medication consider stopping, reducing dose, changing drug, formulation or route of administration

Caution: most antiemetics have sedative effects

A Anticholinergic/antimuscarinic (ACh_M)

Hyoscine hydrobromide 0.3 - 0.6mg 6 - 8 hourly sl or sc
0.8 - 2.4mg per day by csci
500 - 1500mcg/72 hrs by transdermal patch

B H_1 antihistamines

Cyclizine 50mg three times daily orally or by im or sc injection
100 - 150mg in 24hrs by csci
Also has anticholinergic action

C Dopamine (D2) antagonists

Haloperidol Antiemetic of choice for opioid induced vomiting
1.5 - 5mg at night, oral or sc
2.5 - 5mg over 24 hours by csci

Methotrimeprazine Some activity at several sites (ACh_M, D_2, H_1, $5HT_2$)
Sedative at higher doses (25 - 100mg in 24 hours)
Antiemetic activity at low doses (6.25 - 25mg in 24 hours)
Use at lowest effective dose unless sedation required
Dose varies from 6.25 daily to 25mg tds orally or sc
May be given as csci

Prochlorperazine 5 - 10mg tds orally
25mg suppository tds rectally
12.5mg tds by deep im injection
3 - 6mg bd as buccal tablets
Do not give sc

Metoclopramide Also prokinetic
10 - 20mg three times daily orally or im
In high doses (more than 100mg daily) acts as 5HT3 antagonist and possibly as 5HT4 agonist

Domperidone Also prokinetic
Less likely to cause sedation or extrapyramidal problems
10 - 20mg tds orally
30 - 60mg suppository tds rectally

D 5HT3 antagonists

Mainly used in early emesis caused by chemotherapy/radiotherapy; no good evidence of efficacy in other situations

Ondansetron 8mg bd - tds orally; may also be used sc, im or iv

E 5HT4 agonists

Cisapride 10mg tds orally
Metoclopramide See above
Domperidone See above

Note: **csci = continuous subcutaneous infusion**
See section on syringe drivers, p25

INTESTINAL OBSTRUCTION*

Intestinal obstruction in the patient with advanced cancer is often a difficult and complex situation and early discussion with the specialist palliative care team is recommended. It is usually a result of multiple incomplete obstructions within a bowel which is tethered and infiltrated by cancer. There are thus both mechanical and functional elements

Diagnosis

1 Vomiting often with little preceding nausea
2 Constipation - some flatus may still be passed
3 Abdominal distension and discomfort
4 Bowel sounds may be hyperactive or scanty
5 Colic may not be prominent, but tends to indicate a single site of obstruction
6 Previous operation notes or abdominal x-ray may indicate site(s)
7 Rectal examination to exclude simple constipation

Causes / Risk factors

1 Most common with primary tumours of ovary and colon but may occur with almost any primary tumour, including carcinoma of breast
2 Tumour mass within the intestinal lumen
3 Tumour outside the intestine causing compression or adhesions
4 Infiltration within the muscular coats, preventing normal peristalsis (pseudo-obstruction)
5 Interference with intestinal motility by tumour infiltration of the mesentery
6 Pancreatic carcinomas may cause gastric stasis by an unknown mechanism
7 Other causes including adhesions, post radiation fibrosis, constipation, metabolic disturbances, septicaemia

Management

1 Consider surgery (or occasionally radiotherapy) if **both**
a) single site, large bowel or marked gaseous distension **and**
b) appropriate depending on patient's condition and wishes - reassess often
2 If inoperable, avoid 'drip and suck' - NG tube increases nausea
3 Treat dry mouth (see p20)

4 **Drug therapy**

Shrinkage of tumour masses

Cytotoxic chemotherapy may occasionally be helpful if the patient's overall condition is good, especially in primary carcinomas of the ovary or colon

Dexamethasone 4 - 8mg daily may help to relieve peri-tumour oedema and thus relieve obstruction; particularly helpful with gastric outlet obstruction. May need to be given im or sc in first instance

Colic

Avoid/stop stimulant and bulking laxatives and prokinetic antiemetics (metoclopramide, domperidone, cisapride)

Hyoscine hydrobromide 0.3mg qds sl

Hyoscine butylbromide 20mg qds orally or 40 - 80mg daily by csci

Mebeverine 135mg tds orally

Loperamide may help

Constant aching abdominal pain

Strong opioids - Diamorphine by csci

Nausea and vomiting

Aim to abolish nausea and to reduce vomiting to a minimum

Cyclizine (see p14)

Haloperidol (see p15)

Methotrimeprazine (see p15)

Prokinetic agents ($5HT_4$ agonists) may help where there is gastric stasis, ileus or pseudo-obstruction but are contra-indicated in the presence of colic or if there has been a gastro-jejunostomy

Laxatives

Use pure faecal softeners to coax stool through narrowed loops of bowel

Docusate sodium up to 200mg tds

Magnesium hydroxide mixture 20 - 30ml od - bd

Anti-secretory agents

H_2 blockers (ranitidine, nizatidine) may be useful in high obstructions to reduce the volume of gastric secretions

Hyoscine butylbromide is a relatively mild anti-secretory agent

Octreotide* (see p18) has powerful anti-secretory properties

OCTREOTIDE*

Octreotide* (Sandostatin) is the longer acting synthetic analogue of the naturally occurring hormone somatostatin. Somatostatin's normal physiological function is to help to regulate pituitary and gastrointestinal endocrine and exocrine secretions, gastrointestinal motility and mesenteric blood flow. Note that experience is limited, efficacy variable, and that octreotide is expensive

Uses in palliative care*

NB These uses are outside the product licence - see cautionary note, p3

1 **Intestinal obstruction**
Octreotide decreases the volume of intestinal secretions, and thus reduces intestinal distension, itself a potent stimulus of secretion. It does this by reducing fluid and electrolyte secretion. It also reduces gastrointestinal motility. Both actions may reduce nausea, vomiting and abdominal distension

2 **Fistulae**
Octreotide decreases the output from a variety of fistulae, occasionally leading to closure of the fistula. It has been used in tracheo-oesophageal, pancreatic, entero-cutaneous, entero-vesical and entero-vaginal fistulae

3 **Diarrhoea**
Octreotide has been used in the management of diarrhoea caused by subacute intestinal obstruction (spurious diarrhoea) or entero-enteric fistulae, as well as in severe secretory diarrhoea and carcinoid syndrome

Dose

1 The effective dose ranges from 200 - 600 mcg per day (carcinoid: 100mcg od)

2 Several days may pass before full effect is seen

3 It may be possible to reduce the dose if control is achieved

Administration

1 Warm drug to room temperature to avoid stinging on injection

2 Octreotide is said to be **compatible** with diamorphine, metoclopramide, haloperidol, midazolam and hyoscine. It is **incompatible** with dexamethasone and cyclizine

Cautions

1 Risk of gallstone formation after prolonged use

2 Insulin requirements in diabetic patients may fall; glucose intolerance in others

3 Side-effects uncommon - steatorrhoea, hepatic and thyroid dysfunction

MOUTH PROBLEMS

Good mouth care is essential to the well being of debilitated patients

Diagnosis

1 Assess oral cavity daily using a pen torch and spatula. Note the state of the lips, teeth/dentures, mucous membranes and tongue, also the type/volume of saliva

2 Assess nutritional status - quality of diet and adequacy of fluid intake

3 Assess mental state - will determine the patients' ability and willingness to participate in their care

Causes / Risk factors

1 Poor oral hygiene

2 Poor nutritional state, dehydration, drowsiness, anaemia

3 Oral thrush and other infections

4 Oral tumour

5 Drugs - opioids, tricyclic antidepressives and hyoscine cause dry mouth; some cytotoxics can cause ulceration

6 Local radiotherapy can cause decreased saliva production and oral ulcers

Management

1 Review medications causing dry mouth/ulceration

2 Treat oral infections

3 **Drug therapy**
Frequency of care depends on the patient's condition

General care

Corsodyl mouthwash - antiseptic and inhibits plaque formation. Use regularly after meals and brushing

Betadine and **Oraldene** are antibacterial and antifungal but have little antiplaque activity

Glycerine thymol has mainly mechanical cleansing properties but is transiently refreshing

Ascorbic acid 1g effervescent tablet - allow a quarter or a half of one tablet to effervesce on coated tongue

Specific care

Lack of Saliva

Sips of iced water
Salivary stimulants - lime juice, fresh melon, pineapple, sugar-free gum
Saliva substitutes - Glandosane spray, Saliva-Orthana
Pilocarpine tablets 5 - 10mg tds for radiotherapy induced dryness

Oral Thrush

Nystatin oral suspension - patients must be instructed on correct usage
Fluconazole - 50mg daily for 7 days
Sodium hypochlorite (Milton) - for soaking dentures overnight

Painful Mouth

Difflam mouthwash - anaesthetic action
Adcortyl in Orobase - apply topically (without rubbing in)
NSAID - Piroxicam melt daily for oral cancer pain
Sucralfate suspension - for chemotherapy induced ulcers
Xylocaine spray

Excessive Salivation

Amitriptyline 10mg at night
Hyoscine by patch, syringe driver, orally or sublingually (see p14)
Glycopyrronium by syringe driver - if hyoscine causes confusion or over-sedation

ANOREXIA

Diagnosis

1 A reduced interest in food, which at its most severe may manifest as nausea
2 Often associated with taste changes
3 May increase (appetite diminishes) as the day goes on
4 Distinguish from mouth problems, dysphagia, early satiety due to gastric stasis

Causes / Risk factors

1 Extensive malignancy (but occasionally occurs as a presenting symptom)
2 Uncontrolled symptoms
3 Psychological, emotional and spiritual distress, especially depression
4 Drugs, especially cytotoxics, digoxin

Management

1 Treat nausea, pain and other symptoms
2 Reduce psychological distress with support and counselling
3 Treat depression
4 Review drugs
5 Aim to provide frequent, small, attractive portions within pleasant and social surroundings
6 **Drug therapy** - if drugs are needed and there are no contra-indications
Alcohol before meals
Megestrol acetate 160 - 320mg daily
Medroxyprogesterone 100mg tds
Dexamethasone 2 - 4mg each morning or **prednisolone** 10mg daily to tds
Steroids should always be used with caution, and the dose reduced to the minimum effective at any time, because of the risks of muscle wasting, skin thinning and (rarely) osteoporosis; may also precipitate diabetes. Patients with a history of tuberculosis who have not been treated with triple chemotherapy should receive prophylactic isoniazid

CONSTIPATION

It is extremely important to relieve constipation in patients with advanced disease. Even anorexic patients will need bowel movements to remove faeces formed from gut secretions/cells/bacteria. It is better to anticipate and prevent constipation than to wait until treatment is needed

Diagnosis

1 Passing harder stools, or passing stools less frequently

2 Rectal examination - empty or impacted?

3 Exclude intestinal obstruction (see p16)

Causes / Risk factors

1 Drugs - especially opioids, tricyclic antidepressives, iron, antispasmodics

2 Immobility and lack of privacy

3 Dehydration, due to poor fluid intake, vomiting, polyuria, sweating

4 Diet lacking in fibre

5 Hypercalcaemia

6 Concurrent disease - painful anal conditions, hypothyroidism

Management

1 As far as possible, alleviate cause - encourage fibre intake, keep mobile

2 **Drug therapy:** use softeners if stool is hard, stimulants if unable to expel stool

Patients taking opioids need to be prescribed laxatives as a routine

Combination preparations (stimulant & softener)

Bisacodyl 10 - 20mg nocte with **docusate sodium** 200mg od - tds
Codanthramer (two strengths) susp or capsules 5 - 15ml, 2 - 4 capsules od/bd
Codanthrusate is an alternative

Stimulants

Bisacodyl 10 - 20mg nocte
Senna 2 - 4 tablets nocte
Sodium picosulphate elixir 10 - 20ml bd

Softener

Docusate sodium 200mg nocte or up to 600mg daily

Osmotics

Lactulose 10 - 15ml bd
Magnesium hydroxide mixture 20 - 30ml od - bd

3 Rectal measures are often needed in established constipation - use suppositories, micro-enemas, phosphate or arachis oil enemas

DIARRHOEA

Diagnosis

The patient who speaks of 'diarrhoea' may either be referring to the frequency of bowel motions, or to the fact that motions are loose; it is therefore important to define the problem by history or examination if a diagnosis is to be reached

Causes / Risk Factors

1 Excess laxative use

2 Infections, including *Clostridium difficile*, *Candida* spp

3 Impacted faeces with overflow (spurious diarrhoea)

4 Subacute intestinal obstruction

5 Previous treatment: pelvic radiotherapy, extensive bowel resection

6 Pancreatic insufficiency, characterized by bulky, offensive stools which float

Management

1 **Specific tretment**

Ensure no excess laxative use

Screen for infections, and prescribe appropriate antibiotics

Octreotide* (see p18) for faecal fistulae, subacute obstruction, carcinoid

Prednisolone enemata or foam for radiation induced diarrhoea

Pancreatic enzymes (Creon capsules; 2 strengths) for steatorrhoea

2 **Symptomatic treatment**

Loperamide 2 - 4mg every 6 hours; binds to opioid receptors in gut

Cophenotrope (Lomotil) 2 tablets four times a day

Codeine Phosphate 30 - 60mg tds - qds

Fistulae

Management

1 Assess fistula size and site, and patient's overall condition

2 A colostomy bag is often needed for collecting effluent. A good seal is needed and advice should be given about skin care and frequent emptying of bag

3 A well-fitted appliance minimizes the risk of odour. **Metronidazole** may be helpful if there is a blind loop or overgrowth of anaerobes

4 **Octreotide*** may be helpful in reducing effluent (p18)

ASCITES

Diagnosis

1 Clinical examination - shifting dullness, fluid thrill, ballot abdominal organs
2 Abdominal ultrasound
3 Diagnostic tap
4 Exclude urinary retention, organomegaly, tumour, gastrointestinal distension

Causes / Risk factors

1 Peritoneal tumour
2 Venous compression or thrombosis
3 Hypoalbuminaemia

Management

1 Take no action if symptoms are not troublesome
2 Perform **paracentesis** if appropriate, unless bowel is distended. Unsuccessful if fluid is loculated (consider ultrasound scan). Drain 2 litres in first hour then 6 litres per day. Monitor carefully: sudden release of abdominal tension may allow venous pooling and rapid reaccumulation of ascites, with hypotension. If leakage continues after drain is removed, consider placing ostomy bag over the puncture site
3 If patient has oedema use stockings and/or massage (see p51)
4 Peritoneo-venous shunt can be valuable in severe recurrent ascites
5 If concurrent intestinal obstruction: see p16
6 **Drug therapy**

Cytotoxic chemotherapy (local or systemic) if appropriate

Diuretics: **Frusemide** (especially if dependent oedema) 40 - 80mg daily
Spironolactone (especially if hypoalbuminaemia) 100mg od/bd
Adjust doses according to response

Steroids: **Dexamethasone** 2 - 4mg om can help to mobilize fluid

Antiemetics: **Domperidone** or **metoclopramide** (see p15) for gastric stasis

Analgesics: If painful stretching of abdominal wall, see pp5 - 11

SYRINGE DRIVERS

A syringe driver is a small portable battery operated pump which administers drugs subcutaneously by continuous infusion. It offers an alternative route of drug administration without limiting patient mobility or independence, and by maintaining very steady blood levels **may** improve symptomatic control

See **cautionary note**, p3

Indications

For administering medication when the oral route is inappropriate or difficult

1 Severe nausea and/or vomiting
2 Dysphagia
3 Severe oral tumours, sores or infection
4 Profoundly weak, unconscious or heavily sedated patients
5 Poor absorption of oral medication

If problems resolve, consider a return to oral medication

Practical Points

1 The syringe driver should be set according to the rate of infusion required
2 Site inflammation may occur for various reasons, and the infusion site should be checked at least daily. Management includes changing the drug, changing to an alternative site or adding a small dose of steroid (hydrocortisone 50 - 100mg per day). If the problem persists, seek advice
3 Certain drug combinations are incompatible and cause precipitation. This may be overcome by:
   - using a larger syringe to allow greater dilution
   - using water rather than saline for dilution or vice versa
   - separating drugs into two syringe drivers
   - drawing up dexamethasone last when used in combination
   - substituting the drug with an equivalent alternative
   - avoiding exposure to sunlight as non-observable chemical reactions may occur
4 Use as few drugs in a syringe driver as possible
5 ***Diazepam, prochlorperazine and chlorpromazine*** should **never** be used in the syringe driver

Drugs used in the syringe driver

Cyclizine 50 - 150mg over 24 hours

Antihistamine and antimuscarinic antiemetic which acts at the vomiting centre in the brain. Often causes site irritation

Dexamethasone Up to 16mg over 24 hours

Used to relieve raised intracranial pressure, liver capsule and neuropathic pain, and as antiemetic. May precipitate when mixed in syringe with other drugs

Diamorphine 10mg - 1g over 24 hours

Preferred to morphine for subcutaneous use as it has greater solubility, requiring a smaller volume. See section on opioid equivalents - p9

Glycopyrronium 200 - 600mcg over 24 hours

Used to reduce respiratory secretions if hyoscine causes confusion or over-sedation. Precipitates with dexamethasone. Cheaper than hyoscine

Haloperidol 2.5 - 10mg over 24 hours

Antidopaminergic antiemetic - see pp12 - 15. Higher doses occasionally used for sedation - see p39. Extrapyramidal side-effects occur with high doses

Hyoscine butylbromide 20 - 80mg over 24 hours

Anti-spasmodic used to relieve gastrointestinal spasm, pain and nausea and vomiting. Useful for drying secretions

Hyoscine hydrobromide 0.4 - 2.4mg over 24 hours

Useful for reducing secretions; some smooth muscle antispasmodic activity. An excellent sedative but may cause agitation or confusion (eg in elderly)

Methotrimeprazine 6.25 - 25mg (antiemetic - see p15)
25 - 100mg (sedative - see p39) over 24 hours

Related to chlorpromazine but more potent; also has analgesic activity

Metoclopramide 10 - 30mg over 24 hours

Anti-emetic - see pp12 - 15. Extrapyramidal effects may occur at higher doses particularly in younger women

Midazolam 5 - 60mg over 24 hours

Benzodiazepine sedative with short half-life; anticonvulsant. Higher doses should only be used for terminal sedation

Octreotide* See p18

BREATHLESSNESS

Diagnosis

Breathlessness is usually multifactorial. Investigations such as chest x-rays/scans or blood gases may be of limited value. A therapeutic trial of medications, singly or in combination, is often necessary to find out what works in an individual patient. There is inevitably a psychological component - breathlessness is always frightening

Causes / Risk factors

A	**Impaired gas exchange**	
1	Airflow obstruction	
	a) Large airways	tumour extrinsic compression laryngeal palsy radiation stricture
	b) Small airways	chronic obstructive airways disease lymphangitis carcinomatosa
2	Decreased effective lung volume	effusions pneumothorax extensive tumour collapse infection ascites
3	Increased lung stiffness	pulmonary oedema lymphangitis carcinomatosa fibrosis
4	Decreased alveolar gas exchange	pulmonary embolism pericardial effusion thrombotic tumour
5	Pain	pleurisy chest wall infiltration rib/vertebral fractures
6	Neuromuscular failure	paraplegia phrenic nerve palsy cachexia paraneoplastic syndromes
B	**Increased demand**	
1	Anxiety	
2	Anaemia	
3	Metabolic acidosis	

Management

General treatments

These can be employed whilst investigating a more specific cause; general and specific managements should be used in parallel

A Non drug treatments

General and specific reassurance (that the patient will not suffocate)
Explanation of the mechanisms of breathlessness
Fan or cool air across the face is often helpful
Proper positioning for easier breathing
Explore the significance of breathlessness for the patient
Breathing exercises, relaxation training) 'pulmonary rehabilitation' by
Counselling and readaptation) physiotherapist/specialist nurse
Acupuncture, aromatherapy, reflexology

B Drug treatments

Nebulised saline often helps where there are tenacious secretions

Opioids are often helpful in easing the subjective sensation of breathlessness; there is no evidence that they shorten life. If opioid naive, start on 2.5mg of oral **morphine** 4 hourly and titrate upwards. If the patient already takes morphine for pain, the dose may have to be increased by up to 50% for co-existing breathlessness. The use of nebulised opioids is not supported by scientific evidence; they may induce bronchospasm

Benzodiazepines are often used in combination with opioids for their anxiolytic effect. Use **diazepam** 2 - 15mg daily for background control with addition of quick-acting **lorazepam** 1 - 2mg sublingually for acute crises and panic. **Midazolam** 2.5 - 10mg sc stat or 5 - 50mg per 24 hours by csci if patient not able to take oral medication

Oxygen has variable effects; it is difficult to predict who will benefit other than by therapeutic trial, but some patients derive psychological benefit rather than any improvement in blood gases. Best used in 10 minute bursts before or after exercise unless hypoxic at rest when continuous use, usually by nasal prongs, may be appropriate

Specific treatments

1 **Steroids** such as dexamethasone 8 - 12mg daily may be useful in airway compression by intrinsic or extrinsic tumour, post radiation stricture/fibrosis, bronchoconstriction, and lymphangitis carcinomatosa
2 **Radiotherapy/brachytherapy, endoscopic laser/diathermy, bronchial stents** may all help large airway obstruction due to intrinsic or extrinsic compression
3 **Antibiotics** for infection, if appropriate - symptomatic medication can be given whether antibiotics are prescribed or not
4 **Drainage of pleural effusion** with or without pleurodesis
5 **Paracentesis** of ascites, and/or diuretics (see p24)
6 **Chest drain** for pneumothorax
7 **Diuretics** for pulmonary oedema
8 **Inhaled bronchodilators** - can be helpful for patients with carcinoma of bronchus who may have previously undiagnosed COAD
9 **Hyoscine/glycopyrronium** - for drying excessive upper airway secretions
10 **Anticoagulation** for pulmonary emboli. Warfarin is potentially hazardous in malignant disease and has many drug interactions.It therefore needs meticulous monitoring. Low molecular weight heparin given by sc injection may be as effective and safer
11 **Aspiration of pericardial effusion** with or without formation of a pericardial window
12 **Analgesics** - pain on respiration can lead to inadequate ventilation. Opioids, NSAIDs, nerve blocks, radiotherapy and rarely cordotomy may be appropriate for pleurisy, tumour infiltration of the chest wall, rib/vertebral fractures
13 **Teflon vocal cord injection** for laryngeal nerve palsy (seek ENT opinion)
14 **Blood transfusion** should be considered if haemoglobin < 9 g/dl
15 **Physiotherapy** for bronchiectatic secretions

COUGH

Diagnosis

1 Ask about sputum (and if possible observe) - quantity, consistency, colour
2 Is cough affected by position?
3 Examine chest

Causes / Risk factors

1 Nasopharyngeal - post-nasal drip, candidosis, tumour
2 Laryngeal - tumour, inflammation, infection
3 Bronchial - inflammation tumour, infection, ACE inhibitors, tracheo-oesophageal fistula
4 Pulmonary - pneumonia, alveolitis, abscess, bronchiectasis, oedema, fibrosis
5 Gastric reflux with inhalation

Management

1 More upright body position
2 Steam inhalations, nebulised saline qds for thick secretions
3 Chest physiotherapy where appropriate
4 Treat infections unless the chest infection is a terminal event
5 Radiotherapy may help if cough is caused by tumour
6 **Drug therapy**

General: Inhalations: **tinct benz co, menthol**
Simple linctus
Low dose opioids: **codeine, pholcodine, methadone, morphine**

Specific:

1 Nasopharyngeal - post-nasal drip: **antibiotics, nasal steroid spray**
2 Laryngeal - **steroids** via inhaler or nebuliser
- **local anaesthetics*** via nebuliser - bupivacaine 0.5%, 5ml tds, at least 30 minutes before any food or drink; risk of idiosyncratic bronchospasm, sometimes severe
3 Bronchial - **bronchodilators** in standard doses
- **steroids** orally, inhaled or nebulised
- **local anaesthetics*** (see above)
4 Gastric reflux - **antacids** containing dimethicone
- **prokinetic agents** (see p15)

HICCUP

Causes / Risk factors

1 Peripheral (diaphragm, phrenic nerve stimulation)
gastric distension or irritation
liver enlargement/involvement
intrathoracic nodes/tumour
2 Central (medullary stimulation)
raised intracranial pressure
brain stem CVA/tumour
uraemia

Management

1 Rebreathing with a paper bag (raises pCO_2 levels)
2 Drinking cold water or taking a teaspoon of granulated sugar (pharyngeal stimulation)
3 **Drug therapy**

Peripheral causes: **Metoclopramide** 10mg qds
Domperidone 10 -20mg 4 - 8 hourly
Antacids containing dimethicone (**Gaviscon, Asilone**)
Dexamethasone 4 - 12mg od
Ranitidine 150mg bd

Central causes: **Chlorpromazine** 10 - 25mg tds
Haloperidol 0.5mg tds
Diazepam 2mg tds
Dexamethasone 4 - 12mg od
Nifedipine 10mg tds
Baclofen 5mg tds

None of these treatments is consistently reliable

RAISED INTRACRANIAL PRESSURE

Diagnosis

1 Primary carcinoma known to spread to the brain
2 Severe headache worse when lying down
3 Vomiting, convulsions, mental symptoms, diplopia, restlessness
4 Papilloedema may be present
5 CT/MRI scan may be appropriate

Causes/risk factors

1 Cerebral metastases
2 Primary cerebral tumour
3 Other causes - abscess, cerebro-vascular accident, hypertension

Management

1 Raise head of the bed
2 **Drug therapy**

Dexamethasone up to 16mg per day. Avoid doses after 2pm as may contribute to insomnia. Gradually reduce dose to minimum effective, monitoring carefully to check that symptoms remain controlled. Withdraw dexamethasone if no improvement after 7 days on 16mg daily. Carbamazepine and phenytoin may reduce therapeutic effect by 50%

Anti-convulsants should be considered in the presence of cerebral malignancy, eg phenytoin 200-300mg at night, carbamazepine 0.8-1.2g per day in divided doses (also available as suppositories), sodium valproate 600mg to 2gm daily in divided doses

Midazolam given by csci as an anti-convulsant when oral anti-convulsant can no longer be taken; dose 30 - 100mg by csci over 24 hours titrated to effect

Diazepam suppositories (5 - 10mg) may stop convulsions if they occur

Analgesics for headache

3 Consider cranial irradiation if there is a good response to dexamethasone

SPINAL CORD COMPRESSION

Diagnosis

Be alert for early signs, which can be subtle (eg heaviness of the legs). Do not wait for signs to become unequivocal: early diagnosis and urgent treatment (within hours) are vital to improved outcome, mobility and continence. Once paralysed, only 5% walk again, but some survive more than one year.

1 Often back pain with or without radiation in the territory of a nerve root, followed by leg weakness, sensory changes and bladder or bowel disturbance, but can be any combination of these
2 If higher level, there is likely to be a sensory level with brisk reflexes; if cauda equina compression, reflexes may be diminished

Causes/risk factors

1 Epidural invasion from vertebral body metastases or paravertebral nodes
2 Bony deformity from vertebral body collapse
3 Blood borne epidural or intradural metastases
4 Primary spinal cord tumour

Management

Depending on patient's general condition:

1 Immediate
- Dexamethasone 16mg per day
- Urgent referral to radiotherapist or neuro/orthopaedic surgeon
- Emergency CT/MRI scan

2 a) If gradual onset, or if rapid onset but paraplegia present less than 24 hours, surgical decompression may be possible; otherwise radiotherapy

b) If rapid onset and established paraplegia, radiotherapy may not help except for pain relief

3 Established paraplegia:
- pressure area care
- urinary catheter
- bowel regulation - allow some constipation and use regular enemas or suppositories
- physio and OT assessment - wheelchair, home modifications
- psychological readjustment

4 Specialist palliative care assessment for management and/or rehabilitation is recommended

DEPRESSION

In palliative care it is important to distinguish between clinical depression, profound sadness and dementia. The diagnosis is further complicated by the fact that many of the usual somatic symptoms of depression such as anorexia, weight loss and sleep disturbance may already be present in patients with malignant disease. A therapeutic trial of antidepressives may be acceptable.

Diagnosis

1 Persistent, pervasive low mood with loss of pleasure and enjoyment
2 Diurnal variation in mood; may be agitation
3 Sleep disturbance, especially with frequent or early morning waking
4 Anorexia that does not improve with steroids
5 Morbid guilt, feelings of helplessness and worthlessness/low self esteem
6 Depression may be hidden behind a brave but hollow smile or behind anger

Causes/risk factors

1 Past history of depression
2 Need to adjust to many life changes over a short period of time
3 Poor symptom control
4 Immobility and isolation with poor quality of life and lack of support
5 Inadequate or inaccurate information about illness or prognosis
6 Drugs - corticosteroids (predominantly on withdrawal), some cytotoxics, some anti-hypertensives, some neuroleptics, benzodiazepines

Management

1 Minimise the causes, especially 3 - 5 above
2 Provide psychological support
3 **Drug therapy**

for depression with agitation or insomnia
amitriptyline or **dothiepin** 25 - 100mg at night (start at a low dose; higher doses often confuse); **lofepramine** and **mianserin** may be safer in the elderly
for retarded depression
protriptyline 5 - 10mg tds
if no response to above
sertraline (50mg increasing to 100mg daily) or **fluoxetine** (20mg daily), but these may exacerbate anorexia and nausea; dose titration is not required
for depression with neuroses or panic
trazodone (100 - 300mg at night) or **clomipramine** (10-75mg per day)

ANXIETY

Diagnosis

1 Feeling of being on edge, restless or agitated
2 Inability to concentrate
3 Difficulty in getting to sleep
4 Physical effects such as sweating, tachycardia, staring eyes with dilated pupils

Causes/risk factors

1 Past history of anxiety
2 Poor symptom control
3 Inadequate/inaccurate information
4 Unfamiliar surroundings
5 Steroid treatment/salbutamol therapy
6 Withdrawal of drugs eg opioids/benzodiazepines
7 Uncertainty about the future
8 Concern for family/finances etc

Management

1 Support for patient and family
2 Appropriate information and discussion with patient and family
3 Relaxation techniques
4 Drug treatment, eg
Diazepam 2mg bd and 5mg at night
Propranolol 40mg bd to tds for somatic symptoms
Lorazepam 0.5 - 1mg given sublingually may be helpful in panic attacks

If the patient is unable to swallow or has a syringe driver for other reasons, consider **midazolam** 10 - 20mg per 24 hours by csci

INSOMNIA

Diagnosis

Insomnia is a subjective complaint of poor sleep. This can mean insufficient, interrupted or non-restorative sleep or sleep at the wrong time. It is important to distinguish an inability to get to sleep (part of anxiety spectrum; responds to anxiolytics) and a tendency to wake early or repeatedly (part of depression spectrum; responds to antidepressives)

Causes/risk factors

1 Anxiety or depression

2 Poor symptom control

3 Nocturia

4 Environmental changes - inpatient admission, interruptions by staff

5 Fear - eg of going to sleep or of nightmares. Beware of well-intentioned reassurance that 'you will die in your sleep'

6 Drugs - stimulants (caffeine etc), steroids (worse if given later than midday), diuretics, opioids (nightmares & hallucinations), fluoxetine, propranolol (nightmares)

7 Drug withdrawal - alcohol, benzodiazepines, barbiturates

Management

1 Minimise the causes - control symptoms as far as possible, keep interruptions to a minimum, reduce drug therapy or give stimulants early in the day, counsel about fears and anxieties

2 Establish a good sleep pattern - allow a siesta to prevent going to bed too early

3 Encourage a consistent bedtime ritual

4 A warm milky drink at bedtime may help

5 Encourage relaxation techniques

6 **Drug therapy** (all given as a single dose at night):

Lormetazepam (0.5 - 1.5mg) or **temazepam** (10 - 20mg) - for short-term use

Zopiclone (3.75 - 7.5mg) - may have fewer residual effects than benzodiazepines

Chlormethiazole (1 - 2 capsules) - short duration of action

Chloral hydrate (500mg - 1g) - caution with alcohol

Amitriptyline (10 - 100mg) or **dothiepin** (25 - 75mg) if repeated or early morning waking

DROWSINESS

Causes/risk factors

Organic

1 Impending death

2 Infection, especially within respiratory and urinary tracts

3 Raised intracranial pressure

Biochemical

1 Metabolic abnormalities: uraemia, especially if on opioids
hypercalcaemia
hyper/hypoglycaemia
hepatic failure (palpable liver?)
respiratory failure (blood gas analysis likely to be inappropriate)

2 Drugs opioids, tricyclic antidepressives, benzodiazepines, anticholinergics, antipsychotics, antihistamines

Other

1 Fatigue

2 Insomnia

3 Psychological withdrawal

4 Postictal

Management

1 Assess accurately; if patient is near to death due to advanced disease, further interventions are unlikely to be appropriate

2 Correct physical causes listed above if indicated

3 **Drug therapy**

Dexamethasone up to 16mg daily for raised ICP

Protriptyline for retarded depression

Dexamethasone 2 - 4mg daily may act as stimulant

CONFUSION

Delirium is typified by confusion, often with visual illusions or hallucinations with increased or decreased psychomotor activity and fluctuating level of consciousness. It must be distinguished from **dementia**, which is associated with poor short-term memory and no impairment of consciousness, and which will not be considered here.

Diagnosis

1 Disturbance of consciousness with reduced ability to focus attention
2 Change in cognition (memory deficit, disorientation, language disturbance) or development of a perceptual disturbance that is not dementia
3 Short history (usually hours to days) with a tendency to fluctuate during the day
4 Evidence from the history, examination, or investigations that there may be a physical cause

Causes/risk factors

1 Drugs - opioids, tricyclic antidepressives, anticholinergics, benzodiazepines, phenothiazines, NSAIDs, cimetidine, some cytotoxics, baclofen, any other drug with sedative effects; corticosteroids may cause a syndrome resembling hypomania
2 Infection, especially within respiratory and urinary tracts
3 Biochemical abnormalities - especially hypercalcaemia, uraemia, liver failure
4 Environment changes - unfamiliar excessive stimuli, inpatient admission
5 Poor symptom control - pain, constipation, urinary retention, anxiety, depression
6 Alcohol or drug withdrawal
7 Intracerebral causes: space-occupying lesions, infections, strokes

Morphine toxicity exacerbated by uraemia* is an important cause of confusion. Look for constricted pupils, myoclonic jerks, skin hyperaesthesia

Management

1 Treat or minimise the possible causes, especially drugs and infections
2 Minimise stimuli - nurse in a room with diffused lighting, little extraneous noise, and few staff changes
3 Attempt to keep patient in touch with reality and environment - eye contact and touch are often helpful
4 Allay fear and suspicion - explain all procedures, don't change position of patient's bed, if possible have a friend or relative of patient present
5 Stress that patient is not going mad and that there may well be lucid intervals
6 **Drug therapy**

If paranoid, deluded, agitated or hallucinating

Haloperidol 1.5 - 3mg up to three times a day orally
Thioridazine 10 - 25mg up to four times a day orally

Review early as symptoms may be exacerbated by sedative effects. Watch for extrapyramidal side-effects

If agitated patient and unable to swallow

Midazolam 10mg im stat then 10-100mg over 24 hours sc
Methotrimeprazine 25 - 100mg over 24 hours sc

Dexamethasone up to 16mg per day - if cerebral tumour/raised ICP
Oxygen if cyanosed/hypoxic

TERMINAL RESTLESSNESS

This may be akin to delirium in someone very close to death, or may occasionally reflect unresolved psychological or spiritual distress

Causes/risk factors

1 Physical discomfort - unrelieved pain, distended bladder or rectum, inability to move, insomnia, uncomfortable bed, breathlessness
2 Infection
3 Raised intracranial pressure
4 Biochemical abnormalities - hypercalcaemia, uraemia, hypoxia
5 Drugs - opioid toxicity (especially in conjunction with uraemia), hyoscine, phenothiazines
6 Psychological/spiritual distress - anger, fear, guilt. Beware especially if patient has been unwilling to discuss illness

Management

Must be a multi-disciplinary approach involving family or main carers

1 Accurately assess the patient
2 Ameliorate all physical elements if possible, eg analgesia, catheterisation
3 Listen to the patient and discuss anger, fear and guilt if possible
4 May be very distressing for the family who will need much support. Their presence may help or worsen the patient's agitation
5 **Drug therapy**

Diazepam	20 - 60mg per 24 hours orally or rectally
Midazolam	10 - 60mg per 24 hours by csci or im
Methotrimeprazine	25 - 100mg per 24 hours orally or by csci

WEAKNESS

Causes / Risk factors

1 Cachexia - cancer-related, inadequate nutrition
2 Metabolic - hyponatraemia, hypokalaemia, uraemia, hypercalcaemia, anaemia, diabetes mellitus, adrenal insufficiency, hyperthyroidism, hypothyroidism, liver failure
3 Neuromuscular damage - by tumour to brain, spinal cord or peripheral nerves, MND, myopathy, peripheral neuropathy, myasthenia gravis, Lambert-Eaton myasthenic syndrome
4 Drugs - steroids, sedatives, diuretics, antihypertensives (via hypotension)
5 Emotional - anxiety, depression, fear, isolation, apathy
6 Prolonged bed rest
7 Infection

Management

1 Take a good history and examine thoroughly to elucidate and treat possible reversible causes
2 Review drug regimen and minimise possible causes
3 Correct any metabolic/biochemical abnormalities as far as possible
4 Provide dietary support as appropriate (see p21)
5 Rehabilitation for specific weakness by a multiprofessional team. Help with coping and acceptance if appropriate

HYPERCALCAEMIA

Hypercalcaemia is commonly found in the terminal phase of cancer, particularly of breast and squamous carcinomas. It occurs in 30 % of myeloma

Diagnosis

1 Corrected serum calcium of greater than 2.6 mmol/l; symptoms usually only become troublesome above 2.9 mmól/l

2 Any combination of the following: thirst, polyuria, constipation, nausea, abdominal pain, loss of appetite, fatigue, confusion, and emotional disturbances

Causes / Risk factors

1 Bone metastases

2 PTHrP-secreting tumours, eg carcinoma of lung

3 Dehydration, renal impairment

4 Tamoxifen flare

Management

1 Decide if further treatment is appropriate - is this a terminal event?

2 Correct dehydration

Mild to moderate (2.7 - 3.0mmol/L)

initially oral or iv rehydration

Moderate to severe (3.0 - 3.5 mmol/L)

initially iv rehydration with 2-4 litres saline per 24 hours with frusemide (enhances urinary calcium excretion)

3 Relieve associated symptoms

4 Bisphosphonates: **Pamidronate** 30 - 60mg iv over 4 hours or
Sodium clodronate 1500mg iv

These take 48 - 72 hours to be effective, so avoid rechecking calcium before day 4. Their effect lasts 20 to 30 days so recheck calcium three weeks after treatment. Oral **sodium clodronate** has no place in the acute treatment of hypercalcaemia but may be used to maintain normocalcaemia and as prophylaxis particularly for myeloma and breast carcinoma

ANAEMIA

Diagnosis

1 Symptoms - tiredness, weakness, breathlessness

2 Blood counts - haemoglobin, RBC indices, platelets and WBC

Causes / Risk factors

1 Increased rate of RBC loss

- Bleeding - acute or chronic (microcytic, reticulocytes, thrombocytosis)
- Haemolysis - primary or secondary - autoimmune, drugs, infection (macrocytosis, reticulocytes, raised bilirubin)

2 Reduced RBC production

- Chronic disease and renal disease (normochromic, normocytic)
- Bone marrow infiltration - leukaemia, lymphoma, carcinoma (prostate, breast)
- Aplastic - especially drugs
- Sideroblastic secondary to malignancy
- Infection, debility
- Deficiency of iron (microcytic), B_{12} or folate (macrocytic)

Management

1 Treat cause if appropriate - see bleeding/haemorrhage, review medication

2 Consider transfusion if symptomatic, specific benefit is anticipated and if Hb < 9 g/dl and not macrocytic. Transfusion carries the risk of causing acute heart failure in debilitated patients and the elderly. If transfusion is appropriate use packed cells with diuretic cover at a rate of 2-4 units maximum per day, depending on clinical status

If chronic anaemia, patients adapt even if Hb 8.0 - 9.5 g/dl. Do not transfuse unless a specific benefit has been identified

3 Reassess one week after transfusion to assess any symptomatic relief afforded by the transfusion and review as symptoms may have had other causes. If little relief then transfusion need not be repeated if the haemoglobin falls again; consider other causes and treatments

BLEEDING/HAEMORRHAGE

Causes / Risk factors

1 Tumour invasion
2 Platelet or coagulation disorders, disseminated intravascular coagulation
3 Infection - eg haemoptysis, haematuria, vaginal bleed, fungating wounds
4 Drugs - heparin, warfarin, aspirin, NSAID (may cause GI bleeds)
5 Peptic ulceration

Management

General

1 Stop anticoagulants and review medication; Consider reversing warfarin with fresh frozen plasma (rapid) or vitamin K 1 - 5mg iv (acts in a few hours)
2 Consider replacement of blood, platelets, clotting factors, fluids
3 Treat any infection which may be exacerbating bleeding
4 Consider radiotherapy: helpful in > 75% cases of haemoptysis, also helpful for haematuria, visceral and cutaneous bleeding
5 Consider chemotherapy and palliative surgical techniques including endoscopic laser or cautery for tumour where feasible and appropriate
6 Embolisation is occasionally used for liver and renal malignancy
7 Severe terminal haemorrhage - stay with the patient, physical touch helps
If slow, use suction as appropriate and consider iv as below
If rapid, consider im or iv midazolam or diamorphine
If a terminal haemorrhage is anticipated carers can be given a supply of rectal diazepam 10mg. Dark towels or sheets may help to mask the blood
8 **Drug therapy**
tranexamic acid 500mg - 1.5g bd - qds orally (stabilises clots)
ethamsylate 500mg qds orally (enhances platelet adhesion)

Specific

1 Nasal bleeding	• packing and cautery
2 Oral bleeding	• oxycellulose (Surgicell), sucralfate suspension
3 Haemoptysis	• consider radiotherapy
4 Upper GI bleeding	• consider stopping any NSAIDs
	• H_2 blockers or proton pump inhibitors
5 Lower GI bleeding	• rectal steroids
	• tranexamic acid 0.5g in 50mls of water bd rectally
6 Skin	• Kaltostat dressing
	• topical adrenaline 1 in 1000 to soak dressings

ITCHING

Causes/risk factors

1 Allergies
2 Hepatic disease - biliary obstruction
3 Chronic renal failure
4 Lymphoma
5 Parasites - scabies, fleas
6 Skin diseases - eczema, psoriasis
7 Iron deficiency

Management

1 Alleviate causes if possible
2 Avoid provocative influences, eg rough clothing, vasodilators, overheating
3 Try to break the itch/scratch cycle - clip nails short, wear cotton gloves, apply paste bandages
4 Avoid washing with soap and bubble bath; add a handful of sodium bicarbonate to a cool bath. Pat rather than rub dry
5 Use emulsifying ointment as a soap substitute, a bath emollient, eg **Oilatum** or **Balneum** and an emollient after bathing, eg **Aqueous cream** or **Diprobase cream**. Apply surface cooling agents with emollients, eg 0.25% - 1% **Menthol in Aqueous cream, Calamine lotion BP**
6 **Drug therapy**

Sedating antihistamines	**Chlorpheniramine** 4mg qds
	Hydroxyzine 25mg nocte
Non-sedating antihistamines	**Loratidine** 10mg od
In obstructive jaundice	Consider referral for stent
	Cholestyramine 6-8 g per day
	Aludrox 10-15 mls tds or qds
	Stanazolol 5mg bd
	Ondansetron 8mg od
Other drugs	**Cimetidine** 400mg bd, **diazepam** 2mg tds
	Chlorpromazine po or **methotrimeprazine** by csci may be needed in intractable itch

7 Consider early advice from dermatologist or palliative care physician

SWEATING

Causes/risk factors

1 Fever & environmental temperature changes
2 Emotional - fear and anxiety (confined to axillae, palms and soles)
3 Extensive malignancy, lymphomas and carcinoid - drenching night sweats
4 Autonomic disturbance
5 Intense pain
6 Drugs - alcohol, tricyclic antidepressives, opioids, steroids
7 Hormonal disturbance - menopause, tamoxifen, goserelin

Management

1 Alter environment - fans, reduce room temperature
2 Treat underlying disease
3 Alleviate other causes as far as possible
4 **Drug therapy** - various drugs have been used with varying success:
Cimetidine 400 - 800mg nocte
Clonidine 50mcg bd
NSAIDs, eg diclofenac SR 100mg nocte
Propantheline 15mg tds
Thioridazine 10 - 30mg nocte
Dexamethasone 4mg daily - effective in lymphoma
Propranolol 40mg once to four times daily

PRESSURE AREA CARE

Causes/risk factors

1 Extrinsic factors - pressure, shear, friction, incontinence
2 Immobility, malnutrition, dehydration, old age
3 Contributing medical condition and treatment (eg steroids)
4 Cachexia

Management - General

1 Assess patient using appropriate "risk factor scale" (preferably Waterlow) at regular intervals - daily for high risk, weekly for low risk
2 Assess patient for pressure relieving aids according to risk - static or air mattress, bed cradle
3 Assess for aids to movement as appropriate - monkey pole, cot sides, slings
4 Turn bedbound patients every 4 hours as appropriate, encourage chair-bound patients to stand every 2 hours
5 Improve nutritional state if possible - offer dietary advice, dietary supplements, drugs. Refer to dietitian if appropriate
6 Avoid rubbing pressure areas. Use barrier creams sparingly if patient is incontinent - consider catheterisation
7 Assess pain particularly at dressing changes
8 **Drug therapy**
Ascorbic acid and **zinc** may be useful in sore prevention
Antibiotics may be used as appropriate if infected
Metronidazole (topical or systemic) may be used if offensive (putrid) odour
Flamazine is useful for painful excoriated skin
Paracetamol or NSAID may alleviate wound pain
When dressing changes are painful consider -
short acting **morphine** preparations, **dextromoramide** or **Entonox**
applying **lignocaine gel** to wound or dressings
If wound pain uncontrolled mix **diamorphine** 10mg with **Intrasite gel**

Management - Pressure sores

1 **Grade 1** - skin discoloration, non-blancheable redness
Management - relieve pressure

2 **Grade 2** - partial thickness skin loss or damage
Management - leave blisters intact and apply **Opsite** or **Duoderm**

3 **Grade 3** - extends to subcutaneous fat
Management - dress with alginate **(Sorbsan)** or hydrocolloid **(Granuflex)**
- if sloughy use hydrogel **(Intrasite** or **Granugel)** **+/- Granuflex**

4 **Grade 4** - deep fascia or bony involvement
Management - if necrotic - use hydrogel **(Intrasite** or **Granugel)** + cover with **Granuflex**
- if green - use alginate **(Sorbsan)** and take a wound swab
- if malodorous - use **Intrasite** mixed with **metronidazole gel**, and a charcoal dressing **(Clinisorb)** may be added
- if red - granulating: use **Intrasite** covered with **Granuflex**

FUNGATING WOUNDS

Causes / Risk factors

Tumour infiltration of epithelium and its surrounding blood and lymphatic vessels

General Management

1 Assess wound and patient's overall condition. Consider management goal
2 Radiotherapy may reduce bleeding and discharge; surgery and skin grafting may aid healing
3 Consider antibiotics if appropriate
4 Clean wound with 0.9% sodium chloride solution
5 Ensure adequate analgesia

Specific Management

1 Depending on the wound problem:
- light exudate - use **Granuflex** or **Sorbsan**
- heavy exudate - use **Sorbsan, Kaltostat or Intrasite** covered with absorbent pads
- cavity - use alginate rope **(Sorbsan)**, foam dressing **(Allevyn)** or **Dermasorb**, filling 50% of cavity
- bleeding - use alginate **(Kaltostat or Sorbsan)**
- may need to soak dressings with saline before removing
- can use adrenaline 1:1000 to stop bleeding
- infected - use **Intrasite** or **Granugel** mixed with **metronidazole gel,** and charcoal dressing **(Clinisorb)**
- painful - see p47

2 **Drug therapy**
- Analgesics - **NSAID, morphine**
- Antibiotics - **metronidazole** orally (cheap) or topically (expensive)
- Anti-pruritic - sedative antihistamine, eg **chlorpheniramine**

LYMPHOEDEMA

Diagnosis

Differentiate from heart failure, low albumin, venous insufficiency

Causes / Risk factors

1 Primary congenital lymphoedema
2 Secondary obstruction from radiotherapy, surgery, tumour spread
3 Recurrent streptococcal infections

Management

1 Early referral to the local lymphoedema service produces best results in achieving maximal improvement and long-term control (cure is not possible)
2 Explanation of lymph flow and cause of swelling will encourage compliance
3 Clear infections before beginning treatment, usually with at least 2-week course of penicillin V or erythromycin
4 Instructions on daily skin care - often with aqueous or Diprobase cream. Also general advice - avoid injections and any cuts, dry carefully after washing
5 Monitor progress by measuring limbs regularly
6 Regular gentle, superficial, proximal massage can be very effective, with specific exercises where appropriate
7 Containment hosiery of appropriate size and strength should be worn all day
8 Compression bandaging may be necessary initially for a few weeks
9 Occasionally a multi-chamber sequential pneumatic compression is effective in reducing limb volume. This needs to be built up to four hours per day and should be used in conjunction with hosiery and massage/exercises
10 With advanced disease and severe obstruction, pain may be exarcerbated by compression or massage - the level of intervention will need to be balanced against the patient's overall condition and tolerance of the treatment
11 **Drug therapy**

Diuretics may be appropriate in addition to the above, especially where there is an element of heart failure

Steroids may shrink lymphadenopathy or tumour but can increase fluid retention

Antibiotics may be needed long term if there is recurrent cellulitis

PSYCHOLOGICAL AND SPIRITUAL CARE

Palliative care extends far beyond pain relief and the alleviation of symptoms. An essential component of palliative care is the need to address psychological and spiritual needs of both the patient and their family/carers. This does not necessarily require specialist help. All doctors and nurses should be prepared to address these issues and make initial assessments

The way in which patients adapt to their illness will be influenced by several variables including:

- age and stage of family development
- the nature of the disease
- the pattern of the illness
- the individual and family's previous experience with disease and death
- the socio-economic status
- culture
- personality and learned coping mechanisms

Documenting a **family tree** often helps to reveal:

- family dynamics
- family support and location
- the health of the spouse
- previous experience of illness and death
- family history of illness eg cancer of breast
- vulnerability to bereavement

A **social history** is important to ensure that the patient and family have optimal support at home. Aspects to be considered include:

- with whom does the patient live?
- where does the patient live?
  - house, flat, bungalow
  - owner, rented, tied accomodation
  - which floor? (accessibility)
  - are appropriate support services involved?
  - have appropriate allowances been applied for?
  - present or previous occupation and social contacts

Knowledge of these aspects is important for effective discharge planning. Before discharge confirmation should be sought from the patient, family and primary healthcare team that the planned arrangements are both appropriate and acceptable

BREAKING BAD NEWS

Good communication underpins successful patient care, especially if the patient is seriously ill. A key aspect of communication is that of **breaking bad news**.

Bad news is any information which alters a patient's view of their future for the worse. The bigger the gap between what the patient expects and the reality, the worse the news is. The way in which bad news is given has been shown to affect how the patient and family cope in the future.

Patients often feel that they lack information and thus lack control over their situation. By giving adequate opportunity for discussion it is possible to:

- reduce uncertainty about the future, or at least discuss it
- reduce inappropriate hope (which is demoralising) - but may be difficult
- encourage informed choice of management options
- enable appropriate adjustments to the reality of the situation
- maintain trust between the patient, the carers and the professionals

Remember that **it is impossible not to communicate.** Avoidance of discussion and negative body language usually leaves the patient feeling abandoned, anxious, guilty or depressed. A conspiracy of silence or the raising of false hope may deny the patient the opportunity to use his/her remaining time the way s/he would wish.

When it can be anticipated that bad news is to be given, consider the following points:

1 **The meeting:**
- ensure you have time, and are not exhausted
- arrange for privacy, sufficient seating; avoid interruptions
- whenever possible, offer the opportunity to have a close family member or friend present

2 **Ask** what the patient understands of their situation. 'What do you think is going on?' 'Would you like me to tell you more about your illness?' Do not impose information. If the patient does not want to know, would s/he like you to explain to a family member? Ask them and document this.

3 **Give a warning shot to the patient.** By using the patient's own phrases and avoiding medical jargon wherever possible, start to give a range of possibilities. This may include using euphemisms, eg. shadow, lump, growth - which may subsequently require fuller explanation. Allow the patient to absorb the information at their own pace. If they do not ask questions or deny or protest at information given, do not continue to give more information at this stage: every patient has the right to know about their illness but also has the right not to know. Allow denial.

4 **Avoid assumptions.** If a patient asks a question, never assume that you know what they are referring to. Ask a question to clarify, or you may give an inappropriate answer - 'How long will it be?' may be referring to discharge home, not prognosis. If in doubt, reflect the question back: 'How long will what be?'.

5 **Explanations must be clear and simple,** in terms the patient can understand. Diagrams often help, but may also become a barrier between patient and professional. Avoid detailed explanations and treatment options; these are best discussed at a subsequent meeting. "Once he told me it was cancer, I did not hear anything else."

6 **Be positive:** optimism is supportive, pessimism is not. Say for example 'we may not be able to cure you but there are things we can do to make you feel better and cope with your illness'.

7 **Confirm** that the patient has understood the information so far. 'Is this making sense?'

8 **Allow ventilation of feelings.** Do not discourage emotions and acknowledge distress - say for example 'have you been surprised by what I have told you?', 'How are you feeling?', 'You look as if you are having a bit of a tough time', or 'I'm sorry' - simple but powerful. Use prompts as necessary, such as 'Is there anything that you are worried about?' or 'Is there anything (else) you would like to ask me - anything at all?'. Listen and allow them time to think how to phrase the questions.

9 **Summarise** the situation and arrange for a follow up meeting, stating the day and time if possible. In summarising, emphasise the positive, and outline future treatment plans if appropriate. Printed information may be useful.

10 **Ask who may be told** about the diagnosis - 'Would you like me to talk to your family?'.

11 **Ensure that the General Practitioner is informed** of what was said, although what was said and what the patient heard may be quite different. Giving the patient a recording of the interview is popular and effective. Offer to speak with other family members.

12 **The Do's and Don'ts of Communicating Bad News** printed on the following two pages is based on advice given by a Macmillan Nursing team, and is reproduced with permission, from 'Improving communication between doctors and patients: A working party report', London: Royal College of Physicians, 1997.

The Do's and Don'ts of Communicating Bad News

Do:

- Wherever possible, sit down to be on the same level as the patient - this is reassuring and courteous and signifies that you are 'with' them
- Spend the first part of the interviewing **listening** to what the patient is saying or asking
- Note questions or topics avoided by the patient
- Watch for non-verbal messages, eg posture, eye contact, hands, facial expression
- Respect the patient's right to 'denial'. Patients will often 'selectively perceive' only that information they can cope with at that point in time
- Remember that more than 60% of what you communicate is by non-verbal means, eg posture, eye contact, attitude
- Allow pauses for taking in and digesting what you said - move at patient's pace
- Attempt to give information that is appropriate for that individual patient's needs at that particular point in time
- Realise that most patients become aware of their situation gradually rather than in a 'once off' confrontation
- Realise that it is possible to communicate the 'gentle' rather than the 'bitter' truth by one's attitude and by emphasising positive aspects of the present or future situation
- Realise that patients can and do cope positively with truth about their illness
- Realise that certain euphemisms may be appropriate, eg tumour or growth Try to find out what the patient understands by these words
- Use the word "cancer" if appropriate
- Realise that the patient who 'denied' or did not want the information about his illness in the past may need and be ready for information at another time
- Realise that there is no general rule as to how much to tell
- Try to include all the family (including children) in the sharing of information
- Realise that hope is best communicated by genuine concern and reassurance of continuing care 'no matter how things develop'
- Express your humanity and warmth

- Realise that patients will often be shocked on hearing bad news and that their many questions may only surface later
- End meeting in which bad news is imparted by arranging to meet again in the near future to answer any questions. This also demonstrates to the patient your commitment to them
- Write any information or insight you may have given or received in the patient's notes
- Tell staff on duty what you have said. They may be involved in future discussions

On the other hand:

- **Do not ask the relatives whether or not the patient should be told. (This is unfair both on them and the patient)**
- Do not agree not to tell the patient because the family forbids this
- Do not be afraid of patients or relatives expressing negative feelings or crying. This reaction may be entirely appropriate and not caused by your clumsiness
- Do not tell lies which would lead to a breakdown of trust at a later stage
- Do not give more information than the patient needs or is asking for
- Do not use language that is too technical for the patient or family to understand
- Do not use misleading euphemisms, eg ulcer
- Do not have general rules about "telling", eg "Everybody must be told everything" or "Nobody must be told anything"
- Do not always answer direct questions directly. It may be appropriate to do so but often direct questions such as "It may be cancer" or "Am I dying?" contain a hidden question such as "Will I have uncontrolled pain?" or "Should I make a will?". These hidden questions can be discovered by replying initially with a question such as "I wonder what makes you ask that?". One may discover that the patient already knows, tells you and is, in fact, looking for clarification or reassurance
- Do not talk from the end of the bed with one foot in the door!

And finally:

- **Be aware that it is unethical and technically a breach of confidentiality to tell the relatives without the patient's consent**

DEALING WITH DENIAL AND COLLUSION

Denial

Denial is a basic primitive coping mechanism to protect us from information or events with which we cannot cope. By blotting out unpleasant facts it allows us to continue to function. Denial may be practised by the patient, by the family and/or by the professionals. Denial can be a very normal protective measure but in some situations it can be harmful and should then be challenged.

Professionals who feel that denial is unhealthy need to be sure that they are intervening in the best interest of the patient, not just because they feel the patient and family should fully accept the situation.

It should nevertheless be remembered that, in order for patients to be able to deal with their emotions, they usually need good symptom control.

Management

1 The first step in assessing denial must be to establish that the patient has been told the diagnosis in terms which he/she can understand. Is there written confirmation in the notes? What terms were used?

2 If the patient is in denial, decide if this is healthy or unhealthy. There are two main aspects to consider:
(i) Is the denial reducing emotional distress?
(ii) Is the denial affecting help-seeking behaviour and compliance?
If the patient is functioning well and the denial is not prejudicing treatment, then it may be quite healthy. On the other hand, if the denial acts as a barrier and prevents the patient from seeking treatment (for example, a woman denying the significance of early breast cancer) then it should be tackled.
It is also appropriate to intervene in cases where the patient is in denial but is displaying a great deal of distress or pain that is not responding to treatment.

If the patient has dependants for whom provision must be made and planning is blocked by the patient's denial then this too is a situation where the denial should be challenged.

By gently exploring the patient's understanding and helping them to a more realistic view point it may help to resolve distressing symptoms/situations.

3 Denial can be difficult for professionals to work with, particularly when they prefer to communicate openly. However we must respect the needs of the patient and their ability to cope with the information at that particular time. Any attempts to modify denial should be for a specific reason, for example improving compliance with treatment, reducing emotional distress or planning care of dependants.

Phrases such as 'what if"...?' and 'it's sometimes best to plan for the worst and hope for the best' can help to open up the conversation, but it is unrealistic to expect all patients to come to terms with their mortality, indeed some are too ill and too close to death to open up the conversation.

4 Carers may deny the seriousness of the illness and expect too much of the patient. They need extra support to understand that life cannot continue as before.

5 Doctors and nurses may also deny the seriousness of the patient's condition and thus continue with or initiate inappropriate treatments. Teamwork and cross-referral often help in the transition from curative to palliative treatment.

Collusion

Collusion occurs when the family conspire among themselves or with professionals to withold information from, or lie to, the patient.

Collusion is a common probem particularly in the early stages of illness. We must remember that families are often well-intentioned and acting in what they believe to be the best interest of the patient. In trying to shield the patient, the family's actions are of a protective and loving nature attempting to spare their loved one from further pain and distress.

We should also respect the fact that the patient has the right to information about his/her diagnosis first. Has the patient given permission for you to disclose information about their diagnosis to their family? It is important to establish whether the family is trying to protect themselves or the patient.

Management

1 Listen to the family: they know the patient better than you do and may have very valid concerns which should be explored. "What do you think s/he is expecting to hear?" "How has he coped with bad news in the past" "Has anyone else in the family had cancer?'. Having given them an opportunity to express their concerns, show that you empathise with their feelings and help them to understand that the patient has the right to the information. Do not rush this, or the family can become quite antagonistic and this may be hard to reverse.
2 Reassure them that you will not walk in to the patient and impose information, but that if s/he asks questions you should answer them honestly but gently. 'If s/he is brave enough to ask, s/he deserves an honest answer'.
3 Explain to the relatives that if the patient asks a question we often answer it with a question in order to establish exactly what information the patient is seeking, eg. "is it cancer doctor?" If we reply "is that what you think the tests may show?", the patient may then go on to confirm their suspicion or may declare that they do not want all the details, or that they would like their spouse to be present.
4 The relatives are usually distressed and coming to terms with the bad news themselves, with a whole host of concerns and worries for the future. They have often not considered the consequences of their actions and not yet appreciated how difficult it can be to live with a lie and how isolated the patient will become, if the professionals and the family collude and pretend that all will be well. "How many years have you been married? This will be the biggest secret that you have ever tried to keep, they (the patient) may feel more and more lonely and not know who to trust"
5 Usually the family can be reassured that no one is going to blurt out the bad news and that the issue will be handled sensitively. They may initially find talking openly to the patient daunting which is where a joint conversation between patient, family and professionals can help to open up channels of communication.
6 Summarise your perspective:
   - The rate and information given will be dictated by cues from the patient
   - The patient's questions will be clarified and if they insist on a direct answer, this will be given honestly

Further reading Buckman R and Kason Y (1992) How to Break Bad News: A Guide for Healthcare Professionals, Papermac

SPIRITUAL CARE

All patients have **spiritual** needs whilst only some patients have **religious** needs. **Religion** pertains to the outward practice of a spiritual understanding and/or the framework for a system of beliefs, values, codes of conduct and rituals. The term **spiritual** can be taken broadly to mean a person's belief in a power outside or other than their own existence. Some people may use the word God, others may be less specific. Strength of belief in this power can, however, be regarded as distinct from any concept held about the precise nature of that power.

When a person experiences a life crisis they will look to their belief system to help them make sense of it. This then becomes a spiritual issue which may be expressed by patients in questions such as 'Why is this happening to me?'.

If a person's spiritual values, beliefs, attitudes and religious practices do not enable him to deal satisfactorily with questions concerning the infinite realities and ultimate meaning and purpose in life, then this may well lead to a state of **spiritual dis-ease** or **spiritual pain**.

Possible indicators of spiritual pain include:

- A break with religious/cultural ties
- Sense of meaning/hopelessness
- Sense of guilt/shame/loss of identity
- Intense suffering
- Unresolved feelings/fear about death and dying
- Anger

Principles of assessing and helping with spiritual pain

There are many ways in which to help directly or indirectly with Spiritual Pain. They include a wide range of aspects of care that all help the patient to find meaning and purpose. It is important to ask the patient/family whether they wish to see a chaplain and to explain that chaplains will not be 'into hard sell religion' but can help people explore these issues.

1 Provide a secure, caring environment

- caring: need for a good positive relationship
- freedom: to explore safely
- symptom control
- care for role and appearance
- care for patients' family and friends

2 Listen

- to questions
- and join patients search for meaning
- to share emotional pain with sensitivity and compassion
- to enable expression of fear, anger, etc

3 Assess in terms of

- past: regrets, guilt, shame
- present: anger, grief for future loss of own life, lost sense of purpose
- future: hopes/fears of dying and death

4 Reassure

- about physical care in illness and dying
- with information - as desired and appropriate
- by personal affirmation and support
- with respect of patient's integrity, worth and values
- about concern for and provision for family/dependants

5 Prepare for Death

- help with unfinished business
- help with reviewing of life - in talking, looking at photographs
- help family to face patient's death and own feelings about it
- spiritual counselling - help to face mortality and reality of situation

6 Provide religious & sacramental care, according to faith

- make available suitable religious literature (if desired)
- provide opportunity for worship, prayer, communion, anointing or other religious ministry

Above all - be there

Further reading

The above summary of areas of spiritual pain commonly experienced has been adapted from:
Speck P 'Being There - Pastoral Care in Times of Illness' (SPCK)

CULTURE

Culture has an impact on the way an individual lives and dies.

In our society there are wide variations between people of different faiths, ethnic backgrounds and countries of origin. Within each ethnic/faith group, each person will express his/her cultural attitudes uniquely. This is influenced by upbringing, background, environment, beliefs and life experiences.

Areas where cultural influences play the greatest part include: attitudes towards food and diet; how symptoms are described; language and the use of colloquialisms; the role of the family, of individual family members and the family hierarchical structure; issues of autonomy and confidentiality; attitudes towards ill-health, western medicine and other therapies; attitudes towards death; rituals surrounding death.

Healthcare professionals may minimise conflicts over cultural issues by:

- ensuring that language is not a barrier by using appropriate interpretation services;
- demonstrating a willingness to listen and a wish to understand the culture;
- meeting the specific requirements (such as food, privacy, opportunity to practce religious observances, etc) wherever possible;
- maintaining a dialogue and checking out where there is uncertainty about cultural implications;
- being prepared to negotiate boundaries and details of care.

Note that it is not always possible to meet all cultural requirements - professionals must balance the needs of individuals with those of other patients. However, it is always possible to attempt careful negotiation.

Above all, understand that each person is unique, regardless of his/her cultural or ethnic background and professed faith

Do not make assumptions - ASK

Further reading

1 Neuberger J. Care for Dying People of Different Faiths. London: Lisa Sainsbury Foundation, 1987

2 Sheldon F. Psychosocial palliative care. Cheltenham: Stanley Thornes, 1997

BEREAVEMENT

Grief is a natural process experienced by anyone who has to adjust to a significant loss. To recognise when and what type of intervention is needed an appreciation of what is 'normal' is required. Parkes describes bereavement in terms of **phases of grief**:

1 **Initial shock**, numbness and disbelief before emotional reality of the loss is felt. Seeing the body after death, attending the funeral or visiting the grave are often important in facilitating acceptance of the reality of the death.

2 **The pain of separation** which affect behaviour and emotions. The bereaved usually suffer overwhelming periods of sadness as they are faced with the day-to-day reality of their loss. They may try to reduce this by avoiding reminders of the deceased. They may also find themselves 'searching' for the bereaved, dreaming about them or actually seeing or hearing them. Visual or auditory hallucinations at this time are normal. Agitation, restlessness and an inability to concentrate can result from the conflict between this searching and avoiding behaviour - attempts to avoid the reality of the situation.

A range of emotions other than sadness may be experienced. Anxiety may be due to loss of the familiar routine and feelings of insecurity. Anger may be directed towards the deceased for abandoning them, towards God, or (justly or unjustly) towards professionals. It may simply manifest as general irritability. Feelings of guilt may occur when anger is directed internally.

It is common for physical symptoms related to over-activity of the autonomic nervous system to be experienced, eg palpitations, insomnia, diarrhoea and fatigue. A transient hypochondriasis can occur, but it is abnormal if it persists.

3 **Despair or depression.** As the pangs of grief and anxiety reduce in frequency and severity the bereaved may lose interest and purpose in life. They feel hopeless and become withdrawn. This may last for months.

4 Eventually the loss is **accepted** and life without the deceased is adjusted to.

5 The final phase of **resolution and reorganisation** is entered as emotional energy is reinvested in new relationships and activities, although anniversaries often trigger renewed grief.

For some, part of the work of grieving may be undergone before the actual death of the deceased (anticipatory grieving). **Although described in sequence, bereavement reactions usually oscillate between phases.**

For most people, no formal psychotherapeutic intervention is needed as their personality, previous life experiences, social network and loving relationship with the bereaved enables them to come to terms with their loss, and often to grow personally through it. All that is often required is a watchful eye to check that their grief is continuing normally.

6 For those with unresolved/abnormal grief professional intervention is required. The needs of children and adolescents are often quite complex and they may also benefit from specialist support. Recognition of those likely to develop an abnormal grief reaction can also allow early supportive intervention and prevent its development. Risk factors include an:

- unexpected/untimely death
- unpleasant death
- ambivalent relationship
- excessively dependent relationship
- child/adolescent (may be protected/excluded)
- social isolation
- excessive use of denial preventing anticipatory grieving
- unresolved anger
- previously unresolved losses
- previous psychiatric illness
- history of alcoholism/drug abuse
- other concurrent stressful life events

For many a trained volunteer who listens may be all that is needed in order for the bereaved to recognise and express their feelings and fears, enabling them to make sense for themselves of the events which have occurred. Reassurance that what they are experiencing is 'normal' is extremely helpful. A chaplain may also be helpful to those whose faith is shaken, destroyed or awakened.

Some find meeting with a group of individuals who have undergone a simiilar experience can be supportive. These groups may or may not have a trained facilitator.

Written information explaining what may be experienced and giving useful contact numbers is often appreciated.

UNRESOLVED/ABNORMAL GRIEF

There is no clear boundary between what is 'normal' and what is 'abnormal' grief, and it is often a question of unusual intensity, of reaction or timing. The following guide indicates when professional intervention may be required.

1 **Delayed grief** is defined by an absence of grieving within the first weeks or months after the death. It is often precipitated many years later by further loss. It is more likely to be severe and chronic when it finally occurs. Help is often neeeded in emotionally accepting the reality of the past loss.

2 **Inhibited grief** occurs when all reminders of the bereaved are avoided. This mechanism of avoidance may work for some, but can present as irritability, restlessness or depression. Guided mourning is employed to encourage the bereaved to face the reality of the loss.

3 **Chronic grief (mummified grief)** may be severe and occurs when a person fails to progress through all the tasks of mourning. There is no fixed time period. Assistance is needed in helping the bereaved to move on in the grieving process.

4 **Persistent hypochondriasis** can occur and may block grief. The bereaved may take on the symptoms of the deceased or develop symptoms related to anxiety or depression. Explaining to the patient what is happening may be all that is required. However, note that mortality and morbidity of widows and widowers is increased in the first year after the death, mainly due to cardiovascular disease.

5 **Psychiatric disorder**. A severe depressive illness may develop with delusional ideas of guilt and suicidal intent. It can require hospitalisation. **Mania** can be precipitated as can **phobic disorders,** and **alcoholism** and addiction to drugs, especially hypnotics.

Some of these abnormal grief reactions can be dealt with by the primary health care teams, social workers or trained counsellors. In addition, many areas have their own voluntary bereavement and counselling groups including branches of CRUSE (126 Sheen Road, Richmond, Surrey TW9 1UR): see health centres, hospitals or Citizens' Advice Bureaux for information, or contact The National Association of Bereavement Services, 10 Norton Folgate, London E1 6DB. Others require specialist help from psychotherapists or psychiatrists, and it is important for all professionals to realise their own skills and limitations.

FORMULARY

This list of drugs, dressings and other preparations recommended in this booklet is intended as an aid to pharmacists and others. The list is neither exhaustive nor exclusive, and other products may be recommended or be more appropriate in some circumstances. Often, only one drug is recommended from a whole class of compounds: this should not be taken to imply that other preparations may not be equally effective. Generic names are given for drugs with single constituents, proprietary names for most compound formulations and for dressings.

Adcortyl	20
Adrenaline	44, 49
Allevyn	49
Aludrox	45
Amitriptyline	10, 11, 20, 34, 36
Aqueous cream	45
Arachis oil enema	22
Ascorbic acid	19, 47
Asilone	31
Baclofen	10, 11, 31
Balneum	45
Betadine	19
Bisacodyl	22
Bupivacaine	11, 30
Buprenorphine	9
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These guidelines on clinical management are derived from the Bath District Health Authority clinical standards for palliative medicine and terminal care written by Dr Roderick MacLeod and Jane Vella-Brincat, Dorothy House Foundation, in 1993.

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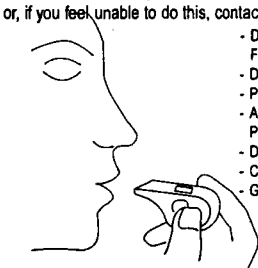
If you are concerned about any of the matters on the reverse of this card we hope that you will feel able to raise them first with your immediate manager, nurse manager or consultant or, if you feel unable to do this, contact one of the following:-

- Medical Director
- Nurse Director
- Director of Services
- Director of Finance and Information Technology
- Director of Information Technology
- Director of Policy and Information
- Head of Information and Health Records



- Director of Corporate Services and Facilities
- Director of Works Operations
- Projects Director
- Assistant Director of Facilities Procurement
- Director of Occupational Health
- Clinical Directors
- General Managers

Or

* Director of Human Resources who is appointed as the Responsible Senior Officer under this policy

If you want to talk to them in confidence just say so or put it in writing if you prefer.

For more details see the Trust Policy & Procedure Public Interest Disclosure Act 1998. Available from Human Resources and on the Trust Intranet

'Whistleblowing' - Public Interest Disclosure Act 1998

If you have a reasonable belief:-

(a) That a criminal offence has been committed, is being committed or is likely to be committed,

(b) That a person has failed, is failing or is likely to fail to comply with any legal obligations to which s/he is subject,

(c) That a miscarriage of justice has occurred, is occurring or is likely to occur,

(d) That the health or safety of any individual has been, is being or likely to be endangered,

(e) That the environment has been, is being or is likely to be damaged, or

(f) That information tending to show any matter falling within any one of the preceding paragraphs has been, is being or likely to be deliberately concealed.

You may not know what to do next - please see reverse of this card.

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#TEXT Code A TEXT Code A

Chief Pharmacist 7.1.02
#CODENC
Pharmacy Services Manager for Portsmouth NHS Trust. Before that: SE Hants. In post since 1983.
#CODEB1
Responsibilities across Portsmouth and SE Hants.
#CODEB2
Accountable to Division Manager for Clinical Support in Portsmouth . He provides services through SLA to this Trust. Liaises with F inance Director.
#ENDCODE
#CODENC
Non-trading part 87 staff 23 or 24 are pharmacists. He is based a t QA. Service from QA, St Mary's and St James' (three locations).
#ENDCODE
#CODEF1
Service to Trust is managed by a Grade E Pharmacist (Code A and 2 pharmacists elderly and mental health + community. She als o has staff at QA.
#ENDCODE
#CODEB2
Service to Trust is managed by a Grade E Pharmacist (Code A and 2 pharmacists elderly and mental health + community. She als o has staff at QA.
#ENDCODE
#CODED4
Service to Trust is managed by a Grade E Pharmacist (Code A and 2 pharmacists elderly and mental health + community. She als o has staff at QA.
#ENDCODE
#CODED4
Pharmacists appraised annually, but seen 3 monthly formally, and i nformally monthly.
#ENDCODE
#CODED4
Paula Diaper is accountable to Code A
#ENDCODE
#CODED4
Code A deals with elderly pharmacy matters, accountable to Code A who concentrates on Psych services.
#ENDCODE
#CODENC
Code A is lead for elderly and works independently and works with An n Dow, one of the geriatricians.
#ENDCODE
#CODEF1
Inappropriate use of medicines - unless serious it is taken up by the pharmacists; only involve chief if they do not make progress w ith clinical staff.
#ENDCODE
#CODENC

TEXT Code A Chief Pharmacist.txt

Some audit undertaken on his services, simplification of regimes. But struggle to provide the basic services.
#ENDCODE
#CODEI3
Training/supervision. Staff work towards Clinical Pharmacy diploma - at least it is on offer. Also might do Health Economies Diploma. Helps recruitment - training is funded 0.5 days a week.
#ENDCODE
#CODEF1
Guidelines. Formulary in medicine, approved by Committees. If involved with 1° care goes to a 1° care committee. Use external Guidelines if appropriate.
#ENDCODE
#CODENC
Specialist Use - System can designate special medication to certain specialities. Eg special for ophthalmology.
#ENDCODE
#CODEF1
Anybody can prescribe diamorphine/haloperidol/Midazolam. They do challenge large doses written by Junior Doctors.
#ENDCODE
#CODENC
Cannot improve checks without computerisation. In general the dose range of diamorphine has narrowed. A computer system would provide the historic use for an individual.
#ENDCODE
#CODEI1
Training to other staff. He regards as "totally inadequate" - Doctors & Nurses become theoretical rather than practical. Training not taken seriously by the pupils, even though pharmacists do regard it as serious. Participate in Induction.
#ENDCODE
#CODEI2
Training to other staff. He regards as "totally inadequate" - Doctors & Nurses become theoretical rather than practical. Training not taken seriously by the pupils, even though pharmacists do regard it as serious. Participate in Induction.
#ENDCODE
#CODEI1
No input into training GP Clinical Assistants. Does not know if pharmacists train nurses on syringe Drivers.
#ENDCODE
#CODEI2
Attended syringe driver/drug competency course - 98 - 01 from Dryad/Daedalus Wards.
#ENDCODE
#CODEF1
In process of putting guidelines on Intranet - but not generally available "Compendium of Drug Therapy Guidelines". Would not be aware if prescribing had changed since 1998.
#ENDCODE
#CODEF1

TEXT Code A Chief Pharmacist.txt
He does business orientated committees.
#ENDCODE
#CODEC4
Comments on culture of care 98 vs NOW - "I wouldn't know.".
#ENDCODE
#CODEA3
Services from Pharmacy have improved to Elderly Care Wards at QA - no resource to put in more time to "outposts" eg GWMH.
#ENDCODE
#CODEA3
SAFF process not helping bolter Pharmacy Services.
#ENDCODE
#CODENC
He was involved with Police Inquiry to explain controlled Drug records. Pharmacy have had limited involvement "not outrageous quantities" being used. Code A may be able to advise us better - goes to local hospice "The Rowans". Concerns do get flagged up. Much is settled at a lower level. He get to know if it is not resolved.
#ENDCODE
#CODEB1
Eg. Intrathecal drugs, DoH wanted consultant only use. Trust wanted a Waiver agreed to by the CEO.
#ENDCODE
#CODEI3
At the time the doses were not considered excessive, but not in a position to comment on the appropriateness of the use in the individual case.
#ENDCODE
#CODENC
Active service is in MAU and Medicine - help check patients in and help with discharge.
#ENDCODE
#CODEB1
Audit Commission "spoonful of sugar" - recommended more pharmacy involvement in clinical areas, warning of high doses.
#ENDCODE

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1101 Code A Pharmacist.txt

#TEXT1101 Code A Pharmacist
#CODENC
Employed by Portsmouth Hospital Trust, not this Trust.
#ENDCODE
#CODENC
Policy development - pharmacist always involved. Each policy has named Pharmacist included - check who it is for - syringe drivers?
#ENDCODE
#CODED1
Pharmacist previous to her went off on long-term sick. VL had 2 y ear break. Started Sept 99. Cover for pharmacist Code A - G osport pharmacist for many years - July 2000 - went sick. Then VL got the extra work. Code A retired June 2001. Code A line manager. Code A looks after several units and overnight had Gospo rt added on. 108 extra patients on top of existing workload. Recently Code A job advertised - which VL has taken.
#ENDCODE
#CODED10
Vacancy rate is 30% in Portsmouth for pharmacists. How does this compare with national picture?
#ENDCODE
#CODED4
Code A visits wards weekly. No cover if on leave. Code A covers for p eriods over two weeks length.
#ENDCODE
#CODED4
Employed by Portsmouth Hospital Trust. Based at QA. Spends much time travelling.
#ENDCODE
#CODED4
Code A - based at QA - line Code A is accountable to Code A
#ENDCODE
#CODED11
IPR in Code A yearly. But too busy to see Code A often. Code A 3/7 per week. Code A works part time daily.
#ENDCODE
#CODED4
IPR in Code A yearly. But too busy to see Code A often. Code A 3/7 per week. VL works part time daily.
#ENDCODE
#CODEI3
IPR in Code A yearly. But too busy to see Code A often. Code A 3/7 per week. Code A works part time daily.
#ENDCODE
#CODED4
Staff meetings at QA but Code A comes to Gosport instead. Minutes are circulated. C grades which she was - do not attend. D grade whi ch she is now do attend.
#ENDCODE
#CODED7
Staff meetings at QA but VL comes to Gosport instead. Minutes are circulated. C grades which she was - do not attend. D grade whi

ch she is now do attend.
#ENDCODE
#CODED1
Rearranged timetable QA Mon and Fri
#ENDCODE
#CODEG?
How does she find out about policy? Code A deals with these matters. Information is e:mailed.
#ENDCODE
#CODEG?
IT for Pharmacy is good. Good technicians.
#ENDCODE
#CODED4
If Code A has concerns? Probably does it via Code A, then she would de al with it. Code A tries to sort out ward matters herself.
#ENDCODE
#CODED1
GDMH works school hours
Tuesday Mulberry, D/H, Sultan
Wednesday Daedalus/Dryad
Does elderly, EMH, Adult Phsych., Palliative care at Rowan.
#ENDCODE
#CODED4
Code A was Gosport Pharmacist. Covered for Code A late 90s and early 90s.
#ENDCODE
#CODEE?
Policy Development. Always a pharmacist involved. Code A involved . Drug policy covers both Trusts.
Code A not involved in Policy Development. Included policies have a l ink pharmacist eg. Code A Eg. Code A - alcohol withdrawal po licy, named pharmacist? Who for syringe driver.
#ENDCODE
#CODED4
Communication of new policy? Code A is main link, but may occasion ally forget to tell her of changes.
#ENDCODE
#CODEG?
Communication of new policy? Code A is main link, but may occasion ally forget to tell her of changes.
#ENDCODE
#CODED7
Liaising with other members of the team Only contacts nurses/doct ors if there is a problem. No time to be proactive. Good relatio nship in Staff Grade - easy channel of communication. Easy, positi ve relationship with staff grade.
#ENDCODE
#CODED7
Harder on Sultan Ward, will write in notes. Does not get to see G Ps. Thinking of designing a form for GPs rather than leaving scra ppy bits of paper. Drug chart problems - queries about doses. Pr oblem is the weekly visit and time lag. Code A had other duties NH/St Christophers and Gosport. 10/12 overlap Code A (ie. Code A at GWMH

and Code A covering elsewhere in Trust - did not actually work togethe
r).
#ENDCODE
#CODEE3
Code A goes to the Rowans? Opened 1996. the greenbank - Palliative C
are Guidelines - across the Trust.
#ENDCODE
#CODEE3
Code A knows about syringe-drivers, drug info from QA and on call phar
macy service.
#ENDCODE
#CODEE3
Not seen Countess Mountbatten guidelines.
#ENDCODE
#CODED1
Sept 99 - July 00. Code A supervised both. But "hardly ever saw Code A
Code A - Friday am would see each other. Only came here with Code A was
away.
#ENDCODE
#CODED4
In September 99 VKL job was new then could attend Department meet
ings as well - department relocation. "Dropped in deep end" no pr
ior familiarisation. She just disappeared. No local induction.
#ENDCODE
#CODEE3
Policy Implementation. Now at Rowans and here - doctor writes spe
cific doses.
#ENDCODE
#CODEF1
Code A checks charts.
#ENDCODE
#CODEF1
Stocks maintained.
#ENDCODE
#CODEF3
Stock lists extended as case mix altered. Orders faxed for non-st
ock.
#ENDCODE
#CODEF1
PRN diamorphine - not used much - if it is used not syringe driver
.
#ENDCODE
#CODEF2
PRN diamorphine - not used much - if it is used not syringe driver
.
#ENDCODE
#CODEF1
PRN On D&H and MD "I can't remember".
#ENDCODE
#CODEF2
PRN On D&H and MD "I can't remember".
#ENDCODE

110 Code A acist.txt

#CODEF2
One now (driver) can't remember previous one. She checks the dose
.
#ENDCODE
#CODEI7
No drug training at Gosport WMH.
#ENDCODE
#CODEI3
Code A has done course at Countess Mountbatten.
#ENDCODE
#CODED7
Nurses ask for advice not doctors.
#ENDCODE
#CODEF1
Nurses ask for advice not doctors.
#ENDCODE
#CODEF3
Nurses ask for advice not doctors.
#ENDCODE
#CODEA3
Review in progress of pharmacy services for PCT change.
#ENDCODE
#CODED1
Review in progress of pharmacy services for PCT change.
#ENDCODE

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David Jarratt
Interviews

#TEXT Code A
LeadConsultant08.01.02
#CODENC
Consultant since 1989 & Lead Consultant since start of Trust (94).
Acute pts, day hosp & OP at Petersfield. ?? for Trust Liaise with Dean. Lead Consultant - almost 2 sessions (was I - increase reflects in > complexity)
#ENDCODE
#CODED7
Liaise with colleagues, management, appraisal & support of colleagues, operational issues, central Trust.
#ENDCODE
#CODENC
9 fulltime cons, some part-time and prof (2 sessions).
#ENDCODE
#CODEB3
Forming into 3 groups as per localities with lead clinicians in each patch. Advertising for extra post, really need 12 % 3 groups of 4.
#ENDCODE
#CODENC
Busy year - dissolution of Trust, PFI at QA (131 acute beds), govt? policies eg. NHS Plan.
#ENDCODE
#CODED11
Appraisal of staff. He appraises Med Dir on his clinical work.
#ENDCODE
#CODED2
Cons appraisal happening. Junior doctor and staff grade been happening for several years.
#ENDCODE
diff c MD -
#CODED11
What about GP/Clinical Assistants (CA) - we haven't but we need to ?? in light of type of work that they do. Had at 40CA - across whole patch.
#ENDCODE
#CODED1
Sessions - nature of work has changed over last decade & more so in last 4/5 years - changing ?? of continuing care & changing expectations of pts/relatives ??. Care pts much iller, more complex medical. Has lead to review of GP sessions.
#ENDCODE
#CODED1
Changing role of cont care beds to include stroke rehab.
#ENDCODE
#CODENC
Not convinced that what was happening at GWMH was in anyway different to what happening elsewhere. Have investigated but not afforded the info from CPS or info from Prof Livesley. Code A complaint bypassed the normal procedure & went straight to the police. Thought trust had it.
Not ?? to what happening & police & Code A has actively campaigned through press. Code A actively campaigning in hospital, so been difficult to investigate in usual way.
#ENDCODE
#CODED1
Re: Dr Code A letter of Jan 2000. You were aware of increased workload and complexity. At 98/99/ critical incident at QA re: (cont care ward) ?? led them to review the way in which wards staffed - GP to do ward round with consultant.
#ENDCODE
#CODED1
Led to appointment of G staff grade here who is ?? good but been difficult to recruit to CC/?? wards at St Mary's - staff grades not been good.
#ENDCODE

#CODED10
Led to appointment of G staff grade here who is ?? good but been difficult to recruit to CC/?? wards at St Mary's - staff grades not been good.
#ENDCODE
#CODED7
Did you know Dr Barton at that time? Yes but not well. She came to meetings, was lead GP for PCE.
#ENDCODE
#CODED7
Was not really involved in dialogues with Dr B re: letters/situation.
#ENDCODE
#CODEG2
Breaking bad news to relatives - I think it is very important, I personally spend a lot of time - including Reg & Ho Dr's, can't really comment re: GWMH.
#ENDCODE
#CODEH5
Teachers pre Reg HO module, its really complex, no right/wrong, I speak to the families & let them talk, try to ascertain what their expectations are, it takes time, listening, humility, getting down physically to their level. Have d/w colleagues a lot since 98.
#ENDCODE
#CODED1
You describe ideal practice and increased workload/complexity - did there ever come a time when tension led to cutting corners? My honest answer is that I do not know - with 20:20 vision perhaps should have got ?? in sooner.
#ENDCODE
#CODEC1
when asked again about tension - honestly don't know.
#ENDCODE
#CODEE1
Patient flows from acute, every dept, other than Eld Med end to overgloss pts cond/function.
#ENDCODE
#CODEE1
Any pt transferred by Eld Med, med ???? etc & pats/rels understanding OK/realistic.
#ENDCODE
#CODEG2
Any pt transferred by Eld Med, med ???? etc & pats/rels understanding OK/realistic.
#ENDCODE
#CODEH5
But other specialities often med input has been quite junior and image given to rels unrealistic. Can't really comment re: Haslar as do not tend to transfer to Petersfield (ie ?? rehab facilities).
#ENDCODE
#CODEG2
But other specialities often med input has been quite junior and image given to rels unrealistic. Can't really comment re: Haslar as do not tend to transfer to Petersfield (ie ?? rehab facilities).
#ENDCODE
#CODED6
Dosage - range whip at one time is it fairly usual? Its not usual now & was prob not usual then throughout the service but prob reflects the out of hours commitment of Jane's partners - ie for her colleagues convenience.
#ENDCODE
#CODEE1
Dosage - range whip at one time is it fairly usual? Its not usual now & was prob not usual then throughout the service but prob reflects the out of hours commitment of Jane's partners - ie for her colleagues convenience.
#ENDCODE

#CODEF2
Now we're developed more robust guidelines.
#ENDCODE
#CODEF1
Whether people actually received the too high dose - I would say no & in Mr Wilson's case - independent Ombudsman found not??.
#ENDCODE
#CODED6
GP out of hour cover - do they call on consultant - they can but they don't tend to.
#ENDCODE
#CODEI5
When GP's change or start - Induction? Induction for junior drs. In all honesty, not for the Clinical Assistants or GP's on call.
#ENDCODE
#CODED1
He has letter (in our file?) that for hosp locum staff outlining service etc.
#ENDCODE
#CODEC1
General comment re: nursing & therapy. Not worked here so can't comment as such, but always enjoy coming here, I hear good things.
#ENDCODE
#CODENC
Since 1994, has been on call 1 in 8 - has never been rung.
#ENDCODE
#CODEC1
When asked if he wanted to say anything else, his view - Staff have been through huge turmoil cannot underestimate suffering - staff interviewed under caution??, for hours, ?? with Code A feeding in questions.
#ENDCODE
#CODEC2
Feel care here is good - if relative of his here - would have no worries.
#ENDCODE
#CODEC5
Feel care here is good - if relative of his here - would have no worries.
#ENDCODE
#CODEI6
Need for com hosp doing IC to ensure training & robust supervision.
#ENDCODE
#CODENC
Local press have not helped the local community through this.
#ENDCODE
#CODENC
Acknowledges that some complaints can not be solved, some due to bereavement process/ reaction & has on occasion suggested bereavement counselling.
Conciliation service ever used? No
#ENDCODE
#CODEA4
CC - HA/SS agreement. Continuing care criteria?
#ENDCODE
#CODEE11
CC - HA/SS agreement. Continuing care criteria?
#ENDCODE
#CODEE1
Health - complex medical & nursing needs that require specialist input eg swallowing/fits. If unfilled C/C beds - may more stable pts awaiting NH bed in to free up acute beds. Rehab emphasis / eg slow stream stroke rehab.
#ENDCODE

#CODEB3
Health - complex medical & nursing needs that require specialist input eg swallowing/fits. If unfilled C/C beds - may more stable pts awaiting NH bed in to free up acute beds. Rehab emphasis / eg slow stream stroke rehab.
#ENDCODE
#CODEE11
Health - complex medical & nursing needs that require specialist input eg swallowing/fits. If unfilled C/C beds - may more stable pts awaiting NH bed in to free up acute beds. Rehab emphasis / eg slow stream stroke rehab.
#ENDCODE
#CODENC
Jubilee House pilot NHS N Home.
#ENDCODE
#CODENC
Total of C/C beds @ 150 - would not be accurate check? St Mary's, Jubilee House, Q Alex (George), St Christophers, Gosport & Petersfield.
#ENDCODE
#CODENC
Is there not a waiting list for C/C beds? Usually - but not always - interpret C/C criteria very strictly, but lack of N.Home beds combination of lack of actual beds as several homes have shut and to some extent awaiting SS funding for placement.
#ENDCODE

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FOLDER 1 of 2

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Section E: NAW/DoH/Ombudsman

Section F: Treasury Solicitor

Document 1: Email from Code A, Medical Director, CHI regarding GMC powers and email dated 17 July 2002 from Code A Investigations Manager to Code A regarding Legal Advice 2.7.02

Document 2: Email dated 13 June 2002 from Code A Investigations Manager to Code A Investigations Coordinator regarding Legal Drug Para

Document 3: Email dated 12 June 2002 from Code A Capsticks Legal Advice to Code A regarding Gosport War Memorial Hospital Report

Document 4: Letter dated 2 April 2002 from Code A The Treasury Solicitor to Code A Investigations Manager regarding Gosport War Memorial Hospital – Draft Report

Document 5: Letter dated 21 May 2002 from Code A The Treasury Solicitor to Code A Investigations Manager regarding Gosport War Memorial Hospital – Draft Report

Document 6: Email dated 23 April 2002 from Code A Investigations Manager to Code A Treasury Solicitor regarding Legal Advice dated 2.4

Document 7: Email dated 20 February 2002 from Code A Investigations Manager regarding Gosport and Release by Police Expert Witness reports

Document 8: Email dated 18 January 2002 from Code A ns Manager to Code A The Treasury Solicitor regarding CHI Gosport Investigation and request for legal advice

Document 9: Email dated 16 January 2002 from Code A nvestigations Manager to Code A regarding CHI comments on inquiry unit guidance

Document 10: Guidance to the Commission for Health Improvement on obtaining and disclosing information under the Health Act 1999 – document dated May 2000

Document 11: Letter dated 11 January 2002 from Code A The Treasury Solicitor to Code A, Investigations Manager regarding West of London Breast Screening Service – draft report

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Document 12: Email dated 19 December 2001 from Code A The Treasury Solicitor to Code A Investigations Manager regarding Gosport Investigation and a local journalist

Document 13: Email dated 18 December 2001 from Code A Investigations Manager to Code A The Treasury Solicitor regarding Gosport Advice

Document 14: Handwritten notes dated December 2001 from Code A, The Treasury Solicitor

Document 15: Letter dated 16 November 2001 from Code A Investigations Coordinator to Code A The Treasury Solicitor regarding return ticket and travel details

Document 16: Email dated 26 November 2001 from Code A Investigations Manager to Code A, Investigations Coordinator regarding Gosport and comments from meeting with Code A

Document 17: Email dated 21 November 2001 from Code A The Treasury Solicitor to Code A Investigations Manager regarding legal advice for Gosport

Document 18: Email dated 9 November 2001 from Code A Investigations Manager to Code A Investigations coordinator regarding email to Code A

Document 19: Fax dated 17 October 2001 from Code A The Treasury Solicitor to Code A s, CHI regarding proposed investigation of Portsmouth Healthcare NHS Trust

Document 20: Fax dated 5 October 2001 from Code A The Treasury Solicitor to Code A CHI regarding disclosure of information within CHI

Document 21: Letter dated 12 July 2000 from Code A ury Solicitor to Code A, Investigations Manager, CHI regarding Code A Investigation

Document 22: Investigations and Inquiries: note of a meeting with Code A Code A Cardiff University dated 19 January 2000

Section G: Police

Document 1: Email dated 27 May 2002 from Code A regarding ACPO contact

Document 2: Email dated 11 April 2002 from Code A regarding Gosport War Memorial Hospital and additional information from the police

Document 3: Email dated 20 February 2002 from Code A regarding Gosport and release by Police of Expert Witness Reports

Document 4: Letter dated 13 February 2002 from Code A Detective Superintendent Code A Hampshire Constabulary regarding copies of notes from interviews with stakeholders

Document 5: Letter dated 6 February 2002 from Detective Superintendent Code A Code A Hampshire Constabulary to Code A regarding patients at Gosport War Memorial Hospital

Document 6: Letter dated 21 February 2002 from Detective Code A Code A Hampshire Constabulary to Code A regarding patients at Gosport War Memorial Hospital

Document 7: Email dated 21 January 2002 from Code A regarding update on Gosport Investigation

Document 8: Fax dated 3 January 2002 from Code A Investigations Coordinator to Detective Code A Hampshire Constabulary regarding biographies

Document 9: Letter dated 7 December 2001 from Detective Superintendent Code A Code A Hampshire Constabulary to Code A regarding reference: Gosport War Memorial Hospital

Document 10: Letter received 8 February 2002 from Detective Code A Code A Hampshire Constabulary to Code A regarding copies of letter to Code A

Document 11: Email dated 6 November 2001 from Code A to Code A, CHI regarding Police Investigations Protocol

Document 12: Fax dated 18 October 2001 from Code A to Detective Superintendent Code A Hampshire Constabulary regarding letter dated 18 October 2001 concerning the terms of reference.

Document 13: Gosport War Memorial Hospital – Final Terms of Reference dated 18 October 2001

Document 14: News Release dated 22 October 2001 – CHI investigation at Gosport War Memorial Hospital

Document 15: Initial medical report for discussion only dated 9 November 2000

Document 16: Letter dated 22 November 2001 from Dr K I Mundy, Consultant Physician and Geriatrician to Detective Superintendent J James, Hampshire Constabulary regarding Confidential Medical Report regarding medical management of patients at Gosport War Memorial Hospital (contains various letters)

Document 17: Letter dated 14 December 2001 from Gary A Ford, Professor of Pharmacology of Old Age to Detective Superintendent J James, Hampshire Constabulary regarding copy of report

Document 18: 'Appendix 1' – MORPHINE

Section H: NHS Executive – South East

Document 1: Email dated 26 June 2002 from Code A regarding publication details of the CHI report

Document 2: Email dated 6 March 2002 from Code A regarding ways in which Portsmouth Healthcare Trust has handled previous internal investigations

Document 3: 'Scoping – Health Authority'

Document 4: Dated 21 June 2001 from Code A SERO Briefing Unit to Andrew Larter, APS, PS(H) regarding SUI: Suspicious deaths at Gosport Memorial Hospital

Document 5: Dated 30 July 2001 from Code A, S Code A Mr Code A PS,PS(H) regarding SUI: Portsmouth Healthcare NHS Trust – Suspicious Deaths of Patients

Document 6: Dated 16 October 2001: Briefing for Prime Minister's Questions, CHI investigation of Gosport War Memorial Hospital

Document 7: dated 1 July 1999 Incident Reporting to NHS Executive South East Regional Office

Document 8: Documents from SERO (dated 19 November 2001)

Document 9: Letter dated 28 September 2001 from Code A, Medical Director to Code A Regional Director of Nursing regarding Clinical Governance Development Plan 2001/2002

Document 10: Dated 5 April 2001 from Code A Briefing Unit, SERO to Mr Code A APS,PS(H) regarding SUI: Portsmouth Healthcare NHS Trust – Suspicious Deaths of Patients

Document 11: Untoward incidents and reporting flows: an update, dated 31 October 2001

Document 12: Notes of meeting dated 10 October 2001 – Health Authority Chief Executives

Document 13: Information: Serious untoward incident guidance – issued by the South East Regional Office dated January 2001

Document 14: Fax dated 18 October 2002 from Code A to Code A regarding terms of reference

Section 1: Isle of Wight, Portsmouth and SouthEast Hampshire HA

Document 1: 'All SUI by Date Reported' document dated 11 December 2001

Document 2: Letter dated 16 July 2002 from Code A, Assistant Investigations Coordinator to Code A Project Director regarding the enclosure of the investigation report

Document 3: Letter dated 16 July 2002 from Code A Assistant Investigations Coordinator to Code A regarding the enclosure of the investigation report

Document 4: Letter dated 12 July 2002 from Code A Fitness to Practice to Commission for Health Improvement regarding Gosport War Memorial Hospital

Document 5: Letter dated 10 July 2002 from Code A n regarding CHI's report

Document 6: Email dated 26 June 2002 from Code A regarding publication details of the CHI report

Document 7: Letter dated 24 May 2002 from Code A Director of Public Code A, Hampshire and Isle of Wight Health Authority to Code A Chief Executive, Fareham and Gosport PCT regarding Gosport War Memorial Hospital

Document 8: Email dated 7 May 2002 from Code A and Gosport

Document 9: Joint Press Statement – Gosport War Memorial Hospital (undated)

Document 10: Email dated 22 February 2002 from Code A regarding Alternative body parts containing the same information

Document 11: Fax dated 7 February 2002 from Code A regarding letter regarding meeting on 12 February

Document 12: Letter dated 31 January 2002 from Code A Acting Chief Executive to Code A Hampshire Constabulary regarding Reference: Code A

Document 13: Fax dated 27 January 2002 from Code A to Health Authority regarding terms of reference

Document 14: Fax dated 18 October 2001 from Code A regarding terms of reference

Document 15: Letter dated 3 July 2001 from Code A Chief Executive to Code A Chief Executive, CHI regarding assistance with local inquiry

Document 16: File Note – Telephone Call 4 July 2001 from Professor Code A

Document 17: File Note – Gosport Community Trust, telephone conversation between Code A, Wednesday 8 August 2001

Document 18: File Note – 10 July 2001 with Code A

Document 19: File Note – Telephone call with Code A (Portsmouth Healthcare Trust) dated 11 July 2001

Document 20: Letter dated 15 August 2001 from Max Millet, Chief Executive to Code A Investigations Manager, CHI regarding police investigation into a patient at Gosport War Memorial Hospital

Document 21: File Note – dated 31 August 2001: meeting to discuss concerns relating to Gosport War Memorial Hospital

Document 22: Report for the Investigations and Fast Track Clinical Governance Review Programme Board meeting on 18 September 2001

Document 23: Letter dated 3 July 2001 from Code A, to Code A Chief Executive, CHI regarding assistance with a local inquiry

Section J: Miscellaneous

Document 1: Email dated 31 May 2002 from Code A British Medical Association regarding CHI investigation – GP clinical assistants

Document 2: Letter dated 12 July 2002 from Code A Investigations Coordinator to Code A regarding sharing views with CHI and contribution to the report

Document 3: Letter dated 6 July 2002 from Code A to Code A regarding comments on the report

Document 4: Royal Mail Track & Trace results for item ref: Code A

Document 5: Fax dated 3 July 2002 from Code A regarding sending of the CHI report

Document 6: Email dated 2 July 2002 from Code A regarding Letter from Code A re CHI investigation

Document 7: Letter dated 2 July 2002 from Code A Haslam regarding CHI investigation – Gosport War Memorial Hospital

Document 8: Letter dated 2 July 2002 from Code A CHI to Dr Code A British Medical Association regarding CHI investigation – Gosport War Memorial Hospital

Document 9: Letter dated 26 June 2002 from Code A to Dr Code A regarding details of the publication of the report

Document 10: Letter dated 26 June 2002 from Code A to Dr Code A regarding details of the publication of the report

Document 11: Email dated 26 June 2002 from Code A to Ursula Ward regarding details of the publication of the report

Document 12: Fax dated 18 June 2002 from J Code A regarding ATO Code A Chief Executive (term of reference, appendix D and two further documents)

Document 13: Letter dated 7 May 2002 from Code A Chief Officer, CHC Portsmouth and South East Hants to CHI regarding the billing for CHI investigation

Document 14: Email dated 27 April 2002 from Code A r to Code A and Code A regarding CHI investigation – GP clinical assistants

Document 15: Letter dated 23 April 2002 from Code A regarding acknowledgment of letter dated 18 April 2002

Document 16: Letter dated 15 April 2002 from Code A to Code A regarding providing CHI with additional information

Document 17: Letter dated 6 March 2002 from Code A to Code A Clinical Discharge Coordinator, regarding attendance at CHI interview

Document 18: Letter dated 6 March 2002 from Code A to Code A regarding attendance at CHI interview

Document 19: Letter dated 6 March 2002 from Code A regarding attendance at CHI interview

Document 20: Letter dated 6 March 2002 from Code A regarding attendance at CHI interview

Document 21: Fax dated 26 February 2002 from Code A regarding terms of reference and information sheet for the meeting

Document 22: Fax dated 28 February 2002 from K Code A regarding Terms of reference and information sheet

Document 23: Letter dated 25 February 2002 from Code A Associate Complaints Convenor regarding information about lay members role

Document 24: Letter dated 21 February 2002 from Code A Associate Complaints Convenor to Code A regarding joining CHI as a lay member

Document 25: Letter dated 14 February 2002 from Code A to Code A Code A Legal Department regarding confirmation of appointment with Dr Code A

Document 26: Fax dated 31 January 2002 from Code A regarding forwarding of documents to Code A

Document 27: Letter dated 21 December 2001 from Code A regarding request to provide a brief summary of particular issues to be addressed in the interview

Document 28: Letter dated 19 December 2001 from Code A regarding request to provide a brief summary of particular issues to be addressed in the interview

Document 29: Letter from Code A Chief Executive, Portsmouth Hospitals NHS Trust regarding visit of the review team

Document 30: Interim Orders Committee: Referral Criteria dated 12 December 2001

Document 31: Letter dated 4 December 2001 from Code A, The Beneficial Centre, regarding use of their facilities

Document 32: Letter dated 4 December 2001 from Code A Community Association regarding use of their facilities

Document 33: Email dated 19 November 2001 from Code A to Code A regarding Gosport Investigation

Document 34: Portsmouth and South East Hants CHC – unannounced visit made on 23 January 1998

Document 35: Email dated 23 September 2001 from Code A to Code A regarding Investigation announcement

Section K: QUAL

Document 1: Letter dated 24 June 2002 from Code A to Code A Inquiries and Clinical Excellence Awards Branch regarding copy of the next to final draft of the report

Document 2: CHI Gosport War Memorial Hospital Investigation: QUAL Briefing 15 October 2001

Document 3: Email dated 16 October 2001 from Code A to Code A regarding Gosport Information

Section L: Analyst

Document 1: Investigation at Gosport War Memorial Hospital: Nan Newberry et ac. Senior Analyst presentation

Document 2: Pharmacy Service: Summary Medicines Use 1999-2001

Document 3: Gosport War Memorial Hospital (Portsmouth Healthcare NHS Trust) Briefing Paper dated 2001/02

Document 4: Distribution List (undated)

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Initial medical report for discussion only

Concerning the case of Code A deceased

TEAM:
Code A

Prepared for:

Hampshire Constabulary
Major Crime Complex, Fratton Police Station, Kingston Crescent,
North End, Portsmouth, Hampshire PO2 8BU

how folder set up + Scoping Volume II — correspondence

by: Code A
The University of London's Professor in the Care of the Elderly
Imperial College School of Science, Technology, & Medicine
The Chelsea and Westminster Hospital, London SW10 9NH

For the purpose of … providing an independent view about whether, or not, there is evidence to support criminal proceedings against any party to the care of Mrs Gladys RICHARDS.

Summary

1. At the age of 91 years, Mrs Gladys RICHARDS was an in-patient in Daedalus ward at Gosport War Memorial Hospital.

1.1. Dr Jane Ann BARTON, a registered medical practitioner, prescribed the drugs **diamorphine**, **haloperidol**, **midazolam**, and **hyoscine** for Mrs Gladys RICHARDS in such a manner as to cause her death.

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

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

Handwritten comments in text are those of police.
TM

15

Initial medical report for discussion only

Concerning the case of Gladys Mable Richards deceased

TEAM -

Code A

Prepared for:

Hampshire Constabulary
Major Crime Complex, Fratton Police Station, Kingston Crescent,
North End, Portsmouth, Hampshire PO2 8BU

by: Code A
The University of London's Professor in the Care of the Elderly
Imperial College School of Science, Technology, & Medicine
The Chelsea and Westminster Hospital, London SW10 9NH

For the purpose of ... providing an independent view about whether, or not, there is evidence to support criminal proceedings against any party to the care of Code A Code A

Summary

1. At the age of 91 years, Mrs Gladys RICHARDS was an in-patient in Daedalus ward at Gosport War Memorial Hospital.

1.1. Dr Jane Ann BARTON, a registered medical practitioner, prescribed the drugs **diamorphine, haloperidol, midazolam,** and **hyoscine** for Mrs Gladys RICHARDS in such a manner as to cause her death.

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

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

Handwritten comments in text are those of police.
JM

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Introduction

2. The documents with which I have been provided and the visits I have made to the hospitals involved in this enquiry are listed in the Appendix A.

2.1. Appendix B contains facts of the environment provided by the statements of Mrs Gillian MACKENZIE (the elder daughter of Mrs Gladys RICHARDS (deceased)) and Mrs Lesley Frances LACK (the younger daughter).

2.2. I have indicated any medical terms in **bold type**. I have defined these terms in a glossary in Appendix C.

2.3. I have included in Appendix D references to published material.

2.4. Appendix E contains details of my qualifications and experience.

2.5. This report has been presented on the basis of the information available to me—should additional information become available my opinions and conclusions may be subject to review and modification.

Information relating to Mrs Gladys Richards (deceased)

3. Mrs Gladys Mable RICHARDS (née Beech) was born on Code A and died on 21st August 1998 aged 91 years.

3.1. Mrs Richards has two daughters. They are Mrs Gillian MACKENZIE (the elder daughter) and Mrs Lesley Frances LACK.

3.1.1. Mrs Lack is a retired Registered General Nurse. She retired during 1996 after 41 years continuously in the nursing profession. For 25 years prior to her retirement she was involved in the care of elderly people. For 20 years prior to retirement she held supervisory and managerial positions in this particular field of nursing.

3.2. The Glen Heathers Nursing Home is a private registered nursing and residential home at Lee on the Solent, Hampshire. I Code A a general practitioner who visits.

3.3. The Royal Hospital Haslar is an acute general hospital in Gosport, Hampshire serviced by the Armed Forces at the time of the incident but available as a National Health Service facility to local people.

3.4. Gosport War Memorial Hospital is part of the Portsmouth Healthcare NHS Trust.

3.4.1. Daedalus ward is a continuing care and rehabilitation ward at Gosport War Memorial Hospital.

3.5. Dr Jane Ann BARTON is a registered medical practitioner who in 1988 took up a part-time post as clinical assistant in elderly medicine. This post became centered at Gosport War Memorial Hospital. She retired from this part-time post in the year 2000.

3.6. Mr Philip James BEED is the clinical manager and charge nurse on Daedalus ward at Gosport War Memorial Hospital. Ms Margaret COUCHMAN and Ms Christine JOICE are registered general nurses who were working on Daedalus ward at the time of the incident.

3.7. Dr Anthea Everista Geredith LORD is a consultant physician, within the department of elderly medicine of Portsmouth Healthcare NHS Trust, who was usually responsible for the patients on Daedalus ward and who was on study leave on 17/18 August 1998.

3.7.1. Other consultant physicians from the department of elderly medicine provide on-call consultant physician cover when Dr LORD is absent from duty.

Synopsis

4. Mrs Gladys Mable RICHARDS died on 21st August 1998 while receiving treatment on Daedalus ward at Gosport War Memorial Hospital.

4.1. Some fours years earlier, on 5th August 1994, Mrs RICHARDS had become resident at the Glen Heathers Nursing Home.

4.2. On 29th July 1998, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred to the Royal Hospital Haslar, Gosport.

4.3. Despite her confused state, Mrs RICHARDS was considered by medical staff at the Royal Hospital Haslar to be suitable for implantation of an artificial hip joint. This took place on 30th July 1998.

4.4. On 11th August 1998, and having been seen by a consultant geriatrician, Mrs RICHARDS was transferred for rehabilitation to Daedalus ward at Gosport War Memorial Hospital.

4.5. Later on 11th August 1998 Dr BARTON saw Mrs RICHARDS. Dr BARTON recorded that Mrs RICHARDS was not obviously in pain but despite this Dr BARTON prescribed **Oramorph** [an oral morphine preparation] four hourly orally. Dr BARTON also prescribed for Mrs RICHARDS large dose-ranges of diamorphine, hyoscine, and midazolam. These were to be given subcutaneously and continuously over periods of 24 hours for an undetermined number of days. At the end of a short case note, Dr

BARTON wrote 'I am happy for nursing staff to confirm death'. Although prescribed, these drugs were not administered at that time.

4.6. On 13th August 1998, Mrs RICHARDS artificial hip joint became dislocated9.

4.7. The following day, 14th August 1998, Dr BARTON arranged for Mrs RICHARDS to be transferred back to Haslar Hospital where the dislocation of the hip was reduced.

4.8. Three days later, on 17th August 1998, Mrs RICHARDS was returned to the Gosport War Memorial Hospital on a sheet and not on a stretcher. She was very distressed when she reached Daedalus ward.

✓ accepted

4.9. There is no evidence that Mrs RICHARDS, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.

4.10. Despite this, and on 18th August 1998, Dr BARTON did not seek any other medical opinion but prescribed diamorphine, midazolam, haloperidol, and hyoscine to be given continuously subcutaneously over periods of 24 hours.

4.10.1. Neither midazolam nor haloperidol is licensed for subcutaneous administration.

4.11. During this period when a **syringe driver** was being used to administer the subcutaneous drugs, there is no evidence that Mrs RICHARDS was given fluids or food in any appropriate manner.

4.12. There is no evidence that in fulfilling her duty of care Dr BARTON reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment being given was indicated.

4.13. There is no evidence that in fulfilling their duty of care Mr Philip BEED, Ms Margaret COUCHMAN and Ms Christine JOICE reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment they were administering was indicated.

4.14. There is, however, indisputable evidence that the subcutaneous administration of drugs by syringe driver continued without modification and during every 24 hours from 18th August 1998 until Mrs RICHARDS died on 21st August 1998.

4.15. Although Dr Barton recorded that death was due to bronchopneumonia there is no clinical or pathological evidence this was correct.

Two type. of Bpneu.
i) Viral / infective.
ii) Accumulation from respiratory depression arises from drugs prescription

accepts that there was Pneumonia over Pneumonia leads to bronchopneumonia.

Professor Code A

not correct.

4.16. It is beyond reasonable doubt that the death of Mrs RICHARDS was the result of the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine in the dosages given above.

4.17. Dr Jane Ann BARTON had a duty of care to Mrs RICHARDS.

4.18. Mr Philip BEED, Ms Margaret COUCHMAN, and Ms Christine JOICE had a duty of care to Mrs RICHARDS.

4.19. There was a breach of the duty of care.

4.20. Foreseeable injury occurred as a consequence of the breach and resulted in the death of Mrs RICHARDS.

4.21. It is my opinion that Mrs Gladys RICHARDS was unlawfully killed.

Relevant aspects of Mrs RICHARDS's medical history

5. Mrs RICHARDS became resident at the Glen Heathers Nursing Home on 5th August 1994 at the age of 87 years and although disorientated and confused she was able to wash and dress herself and able to go up and down stairs and walk well.

5.1. At the beginning of 1998, she had become increasingly forgetful and less able physically but was inclined to wander and she had about a six months' history of falls.

5.2. She also had a past medical history of bilateral deafness for which she required hearing aids (unfortunately these were lost by December 1997 while she was at the Glen Heathers Nursing Home and had not been replaced by July 1998). She had had operations for the removal of cataracts and required glasses (unfortunately these were also lost at the Glen Heathers Nursing Home).

5.2.1. On 8th July 1998 her general practitioner, Code A wrote to the audiologist at Queen Alexandra Hospital, Cosham requesting an '**URGENT** [sic]' domiciliary visit to Glen Heathers Nursing Home. This was '... with a view to supplying her [Mrs RICHARDS] with two new hearing aids.... Since her poor hearing probably contributes to her confusional state I would be grateful if you would visit with a view to fitting of replacement aids as soon as possible please.'

5.3. On 29th July 1998, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred to the Royal Hospital Haslar, Gosport.

5.3.1. In the Accident & Emergency department she was given 2.5mg of **morphine** and 50 mg of **cyclizine** at 2300 hours to relieve her pain and distress. She

was known to be taking **haloperidol** 1mg twice daily and **Tradazone** 100mg at night.

5.4. On 30th July 1998 Mrs RICHARDS had a right cemented hemiarthroplasty [an artificial hip joint inserted].

5.4.1. Post-operatively she was given 2.5 mg morphine intravenously on July 30th at 0230 hours, 31st at 0150 and 1905 hours, and on August 1st at 1920 hours and 2nd at 0720 hours. From August 1st –7th she was weaned over to two tablets of **co-codamol,** requiring these on average twice daily for pain relief.

5.4.2. On 3rd August 1998 it was noted 'All well. Sitting out early mobilization'.

5.5. On 5th August 1998, Dr REID, a consultant geriatrician, saw her. He stated in a letter that '... she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport Memorial Hospital.'

5.5.1. Dr REID also noted that Mrs RICHARDS had continued on Haloperidol and '... her Trazodone has been omitted. According to her daughters it would seem that since her Tradozone has been omitted she has been much brighter mentally and has been speaking to them at times.'

5.6. A discharge letter, dated 10th August 1998, was sent by the sergeant staff nurse at the Royal Hospital Haslar and addressed to 'The Sister in Charge Ward [sic] Memorial Hospital, Bury Road, Gosport, Hants.' It contained the following information:-

5.6.1. After the operation Mrs RICHARDS became '...fully weight bearing, walking with the aid of two nurses and a **Zimmer frame**.' She was noted to require 'total care with washing and dressing, eating and drinking....' She was '... continent, when she become[s] fidgety and agitated it means she wants the toilet....' She 'Occasionally says recognisable words, but not very often.' Her wound 'Is healed, clean and and dry.'

5.7. On 11th August 1998, Mrs RICHARDS was transferred to Daedalus ward at the Gosport War Memorial Hospital.

5.7.1. There is an unsigned 'Summary' record which is apparently a Nursing record and this states:-

5.7.1.1. '11-8-98 Addmitted [sic] from E6 Ward Royal Hospital Haslar, into a continuing care bed. Gladys had sustained a right fractured neck of Femur on 30th July 1998 in Glen Heathers Nursing Home. She has had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a

Zimmer frame. Daughter visits regularly and feeds mother. She wishes to be informed Day or night of any deterioration in mothers condition....'

5.7.2. The contiguous 'Assessment Sheet' states, 'Patient has no apparent understanding of her circumstances due to her impaired mental condition ... Deaf in both ears ... Cataract operation to both eyes ... occasionally says recognisable words, but not very often ... soft diet. Enjoys a cup of tea ... requires feeding ... Dental/Oral status Full "Set" – keeps teeth in at night.'

5.7.3. The 'Patient Medication Information' states, '11.8.98 ... Haloperidol O[rally] 1 mcg [looks like 'mcg' but probably is 'mg' since this drug is not prescribed in single **microgram** doses] B.D. [twice daily]'

5.8. ??[initials]B [subsequently identified as Code A has written in the medical case records '11-8-98 Transferred to Daedalus Ward Continuing Care.... O/E [on examination] Impression frail demented lady [paragraph] not obviously in pain [paragraph] Please make comfortable [paragraph] transfers with hoist Usually continent needs help with **ADL [activities of daily living]**.... I am happy for nursing staff to confirm death.'

5.9. At 1300 hours on the 13th August 1998 the Nursing Contact Record states 'Found on floor at 13.30hrs [sic]. Checked for injury none apparent at time hoisted into safer chair 20.00 [hours][altered on record to 19.30] pain Rt [right] hip internally rotated. Code A Code A contacted advised Xray AM [in the morning] & **analgesia** during the night. Inappropriate to transfer for Xray this PM [evening] [initialled signature (? by whom)] RGN [Registered General Nurse] [next line] Daughter informed.'

5.10. Dr BARTON has recorded '14-8-98 Sedation/pain relief has been a problem screaming not controlled by haloperidol 1 [illegible symbol or word] but very sensitive to oramorph. Fell out of chair last night ... Is this lady well enough for another surgical procedure?'

5.11. In her contiguous note Dr BARTON has recorded '14-8-98 Dear [?] Cdr [Commander] Code A Further to our telephone conversation thank you for taking this unfortunate lady who slipped from her chair at 1.30 pm yesterday and appears to have dislocated her R[ight] hip.... She has had 2.5ml of 10mg/5ml Oramorph at midday.'

5.11.1. According to the letter signed by Philip BEED, Mrs RICHARDS was given 10mgs of Oramorph at 1150 hours on 14th August 1998 prior to being transferred back to the Royal Hospital Haslar.

5.12. The Nursing Contact Record at Daedalus ward continues:-

5.12.1. '14/8/98 am [morning] R[ight] Hip Xrayed – Dislocated [paragraph] Daughter seen by Dr BARTON & informed of situation. For transfer to Haslar A&E [accident and emergency department] for reduction under sedation [initialled signature]'

5.12.2. 'pm [afternoon or evening of 14th August 1998] Notified that dislocation has been reduced. [Mrs RICHARDS] To stay in Haslar [hospital] for 48 hours then return to us [[initialled signature] Family aware.'

5.13. At the Royal Hospital Haslar (at 1400 hours) Xray having confirmed that the hemiarthroplasty had dislocated, intravenous sedation using 2 mgs of midazolam allowed the dislocation to be corrected by traction. The procedure was described as 'Under sedation c [with] CVS/RS [cardiovascular and respiratory systems] monitoring. ... Easy reduction.' Mrs RICHARDS was noted to be 'rather unresponsive following the sedation. The [She] gradually became more responsive....' She was then admitted the Royal Hospital for 48 hours observation.

5.14. Apart from two tablets of co-codamol on the 15th August 1998, she did not need to be given any pain relief following the reduction of her hip dislocation.

5.14.1. Two days later, on 17th August 1998, it was recorded that 'She was fit for discharge that day and she was to remain in straight knee splint for four weeks. In the discharge letter from Haslar Hospital it was also recorded that Mrs RICHARDS was to return to Daedalus Ward. It was further stated that 'She has been given a canvas immobilising splint to discourage any further dislocation, and this must stay in situ for four weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing.'

5.15. On 17th August 1998 it was also recorded that she was 'Fit for discharge today (Gos[port] War Mem[orial hospital). To remain in straight knee splint for 4/52 [four weeks] ... No follow-up unless complications.'

5.16. She was returned to Daedalus ward in the Gosport War Memorial Hospital later that day but in a very distressed state. Their nursing record states 'Returned from R.N. Haslar, patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew To remain in straight knee splint for 4/52 [four weeks] For pillow between legs at night (abduction) No follow-up unless complications.'

5.16.1. Mrs RICHARDS was given Oramorph 2.5 mg in 5mls. The nursing record for 17th August 1998 further states '1305 [hours] ... Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an Xray. M. COUCHMAN. [paragraph] pm Hip Xrayed at 1545 [hours] Films seen by Dr PETERS & radiologist &

no dislocation seen. For pain control overnight & review by Dr BARTON mane [in the morning]. ?[illegible nurse signature]

5.16.1.1. This radiograph was reported by Code A I, Consultant Radiologist as showing 'RIGHT HIP: The right hemiarthroplasty is relocated in the **acetabulum**.'

5.17. On 17th August 1998, Dr BARTON noted 'Readmission to Daedalus from RHH [Royal Hospital Haslar] Closed reduction under iv [intravenous] sedation remained unresponsive for some hours now appears peaceful. Plan Continue haloperidol [paragraph] Only give oramorph if in severe pain See daughter again.'

5.18. On 18th August 1998, Dr BARTON recorded 'Still in great pain [paragraph] Nursing a problem. [paragraph] I suggest sc[subcutaneous] diamorphine/Haloperidol/midazolam [paragraph] I will see daughters today [paragraph] please make comfortable.'

5.19. The nursing Contact Record on Daedalus ward in the Gosport War Memorial Hospital continues:-

5.19.1. '18/8/98 am Reviewed by Dr Barton. For pain control via syringe driver. [paragraph] 1115 Treatment discussed with both daughters [Mrs LACK and Mrs MACKENZIE]. They agree to use of syringe driver to control pain [Mrs LACK disagrees with this statement] & allow nursing care to be given. [paragraph] 1145 Syringe driver diamorphine 40 mg. Haloperidol 5 mg, Medazolam [midazolam] 20 mg commenced'

5.19.2. '18/8/98 20.00 Patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs. [paragraph] Daughter quite upset and angry about mother's condition, but appears happy that she is pain free at present. C JOICE.'

5.19.3. The nursing Contact Record continues 'Daughter, Jill, stayed the night with Gladys [Mrs RICHARDS], grandson arrived in early hours of morning [initialled signature; dated '19/8/98'] [paragraph] He would like to discuss Grand mother's condition with someone – either Dr. Barton or Phillip Beed later today [initialled signature]' [paragraph] '19/8/98 am Mrs Richards comfortable. [paragraph] Daughters seen. Unhappy with various aspects of care, complain[t] to be handled officially by Mrs S Hutchings Nursing co-ordinator [initialled signature]'

5.19.4. It is noted that there is no continuing nursing Contact Record for the 20th August 1998.

5.19.5. The contiguous nursing Contact Record states '21/8/98 12.13 [hours] Patient's [Mrs RICHARDS] overall condition deteriorating, medication keeping her comfortable. Daughters visited during the morning. C JOICE'

5.20. Dr BARTON's next contiguous medical record was on 21st August 1998 when she wrote 'Much more peaceful [paragraph] needs Hyoscine for rattly chest'. Nurse GRIFFIN made the next note in the medical records on 21st August 1998 stating that Mrs Richards was dead at 2120 hours.

5.21. The Nursing Care Plan records state:-

5.21.1. '12.8.98 Requires assistance to settle and sleep at night.... 12.8.98 Haloperidol given at 2330 [hours] as woke from sleep very agitated shaking and crying. Didn't settle for more than a few minutes at a time. Did not seem to be in pain.'

5.21.2. '13.8.98 oromorph at 2100 [hours] Slept well [initialled signature] [paragraph] For Xray tomorrow morning [initialled signature]'

5.21.3. '14.8.98 Same pain in rt[right] leg / ?[query] hip this am. [initialled signature]'

5.21.4. 'Re-admitted 17/8/98'

5.21.5. '17.8.98 Oromorph [Oramorph] 10mg/5ml at present.'

5.21.6. '18.8.98 Now has a syringe driver with 40mgs Diamorphine – comfortable. Daughters stayed. [initialled signature]'

5.21.7. 'Daughters stayed with Gladys [Mrs RICHARDS] overnight. [initialled signature]'

5.21.8. There is no record of continuance of the Nursing Care Plan for 20th and 21st August 1998.

5.21.9. After Mrs RICHARDS had been readmitted to Daedalus ward on 17th August 1998, there is no record between 17th and 21st August 1998 in the patient Nursing Care Plan for 'Nutrition'. On 21st August the record states 'no food taken [initialled signature]'.

5.21.9.1. There is no record that Mrs RICHARDS was offered any fluids.

5.21.10. Similarly, the Nursing Care Plan for 'Constipation' shows no record between 17th and 21st August1998. On 21st August the record states 'BNO [bowels not open] [initialled signature]'

5.21.11. The Nursing Care Plan for 'Personal Hygiene' states:-

5.21.11.1. '18.8.98 Complete Bed Bath given plus oral [Signature] Hygiene [second signature]'

5.21.11.2. '18.8.98 Night: oral care given frequently'

5.21.11.3. '19.8.98 Nightie changed & washed, repositioned. Apparently pain free during care [initialled signature]'

5.21.11.4. It is noted that there is no record of Mrs Richards being attended to for 'Personal Hygiene' on 20th August 1998.

5.21.11.5. '21.9.98 General care and oral hygiene given [initialled signature]'

5.22. The drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital from the time of her admission there on 11th August 1998 are described below.

Drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital

6. Dr BARTON wrote the following drug prescriptions for Mrs RICHARDS.

6.1. On 11th August 1998:-

6.1.1. Oramorph 10mgs in 5mls to be given orally four hourly. On the Administration Record these doses are recorded as being given

6.1.1.1. twice on 11th August 1998 (10mg at 1015 [?1215] and 10mg at 1145 [?pm]),

6.1.1.2. once on 12th August (10mg at 0615),

6.1.1.3. once on 13th August (10mg at 2050),

6.1.1.4. once on 14th August (5ml [10mg] at 1150),

6.1.1.5. four times on 17th August (2.5ml [5mg] at 1300, 2.5ml [5mg] at ????[time illegible], 2.5ml [5mg] at1645, and 5ml [10mg] at 2030),

6.1.1.6. and twice on 18th August 1998 5ml [10mg] at 01230[sic and ? meaning 0030 hours] and 5ml [10mg] at [?]0415).

6.1.2. Diamorphine at a dose range of 20 – 200 mg to be given subcutaneously in 24 hours.

6.1.2.1. None of this diamorphine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

6.1.3. Hyoscine at a dose range of 200 – 800 mcg [micrograms] to be given subcutaneously in 24 hours.

6.1.3.1. None of this hyoscine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

6.1.3.2. This prescription was administered at a dose level of 400mcg [micrograms] on 19th, 20th, and 21st August 1998 commencing at 1120, 1045, and 1155 hours respectively.

6.1.4. Midazolam at a dose range of 20-80 mgs to be given subcutaneously in 24 hours.

6.1.4.1. None of this midazolam prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

6.1.4.2. This prescription was administered at a dose level of 20mg on 19th, 20th, and 21st August 1998 commencing at 1120, 1045, and 1155 hours respectively.

6.1.5. Haloperidol 1mg orally twice daily. It is noted that at the top of this prescription chart 'TAKES MEDICINE OFF A SPOON' [sic] is clearly written.

6.1.5.1. She was give 1mg of haloperidol at 1800 hours on 11th August 1998, at 0800 and 2330 hours on 12th August 1998, at 0800 and 1800 hours on 13th August 1998.

6.1.5.2. In addition, on 13th August 1998, Mrs RICHARDS was prescribed haloperidol 2mgs in 1ml to be administered orally as required at a dose of 2.5ml [this figure has been altered and also can be read as 0.5 ml] to be given 'IF NOISY' [sic]. She was given a dose [quantity not stated bearing in mind the altered prescription] at 1300 on 13th August 1998.

6.1.5.3. She was also given 1mg of haloperidol at 0800 hours on 14th and also at 1800 hours on 17 August 1998.

6.1.6. It is noted that, apart from 2330 hours on 12 August 1998, at the above times when Mrs RICHARDS was given haloperidol she was also give 10ml of **Lactulose** [a purgative].

6.2. On 12th August 1998:-

6.2.1. Oramorph 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly [equivalent to 5mgs of oramorph].

6.2.1.1. Although this drug was apparently not administered its prescription was written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].

6.2.2. Oramorph 10mgs in 5mls to be given orally once at night.

6.2.2.1. Although this drug was apparently not administered its prescription was also written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].

6.3. 18th August 1998:-

6.3.1. Diamorphine at a dose range of 40-200mg to be administered subcutaneously in 24 hours

6.3.2. Haloperidol a dose range of 5-10 mgs to be administered subcutaneously in 24 hours.

6.4. On 18th, 19th, 20th, and 21st August 1998, Mrs RICHARDS was given simultaneously and subcutaneously midazolam 20mgs [this had been prescribed on 11th August 1998 but was first administered on 18th August 1998], diamorphine 40mgs, and haloperidol 5mgs in 24 hours.

6.4.1. These drugs are recorded as being administered at the same time of day on each of the four days they were given. They were administered at 1145, 1120, 1045, and 1155 for 18th, 19th, 20th, and 21st August 1998 respectively. All these drugs were administered at the times stated and were signed off by initials as being co-administered by the same person each day. Over the four days of 18th, 19th, 20th, and 21st August 1998, at least three nurses were involved in administering these drugs.

6.4.2. It is noted that on the 19th, 20th, and 21st August 1998 the drugs midazolam 20mgs, diamorphine 40mgs, and haloperidol 5mgs were also co-administered

subcutaneously in 24 hours with 400mcg of hyoscine [this last drug had been prescribed by Dr BARTON to be given as required on 11th August 1998 but its administration was not commenced until 19th August 1998].

6.4.3. It is also noted that the drugs for subcutaneous administration were all not prescribed at specific starting dosages but each was prescribed for a wide range of dosages and for continuous administration over 24-hour periods.

6.4.4. According to the prescription charts these drugs were signed for as being administered to Mrs RICHARDS via the syringe driver by Mr Philip BEED on 18th and 19th August 1998, by Ms Margaret COUCHMAN on 20th August 1998, and by Ms Christine JOICE on 21st August 1998.

Death certification and cremation

7. The circumstances of Mrs RICHARDS death have been recorded as follows:

7.1. In a document [Case no. 1630/98] initialled by the Coroner on 24th August 1998 'Reported by Dr BARTON [sic]. Deceased had undergone surgery for a fractured neck of femur. Repaired. Death cert[ificate] issued. [paragraph] THOMAS [sic]

7.2. The cause of death was accepted by the Coroner on 24th August 1998 as being due to:-

7.2.1. '1(a) Bronchopneumonia'.

7.2.2. The death was certified as such by Dr J A BARTON and registered on 24th August 1998.

7.3. The body was cremated.

My opinion

8. At the age of 91 years, and despite her confused mental state, Mrs RICHARDS had been considered well enough for two operations on her right hip.

8.1. After her second operation she was transferred back to Daedalus ward at Gosport War Memorial Hospital on 17th August 1998. Following the transfer she was in severe pain.

8.2. There is no evidence to show that Mrs RICHARDS, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover. not correct

8.3. It is my opinion, and there is evidence to show, that Mrs RICHARDS was capable of receiving oral medication for the relief of the pain she was experiencing on 17th August 1998.

8.4. Mrs RICHARDS was known by Dr BARTON to be very sensitive to Oramorph, an oral morphine preparation, and to have had a prolonged sedated response to intravenous midazolam.

8.5. Despite this and without consultation with any other medical person, Dr BARTON prescribed the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine.

8.6. The administration of these drugs continued on a 24-hours regime without modifying their dosages according to Mrs RICHARDS's response to them and until Mrs RICHARDS died.

8.7. Dr BARTON had a duty of care towards Mrs RICHARDS and was in breach of that duty of care.

8.8. Mr Philip BEED, Ms Margaret COUCHMAN, and Ms Christine JOICE each had a duty of care towards Mrs RICHARDS and were in breach of that duty of care.

8.9. No other event occurred to break the chain of causation and Mrs RICHARDS's death was directly attributable to the administration of the drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998.

8.10. The terminal sedation Mrs RICHARDS received profoundly compromised her dignity and distorted the memory she left behind for her attentive daughters.

8.11. Without the induction of stupor and unconsciousness due to the continuous subcutaneous administration of prescribed drugs it is beyond reasonable doubt that Mrs RICHARDS would have lived longer before succumbing to illness.

8.12. Without the withholding of appropriate quantities of food and water it is beyond reasonable doubt that Mrs RICHARDS would have lived longer before succumbing to illness.

8.13. There is no clinical or pathological evidence that Mrs RICHARDS' death was caused by pneumonia.

8.14. It is beyond reasonable doubt that the cause of Mrs RICHARDS' death was a result of the drugs she was administered continuously by syringe driver from 18th August 1998 until her death on 21st August 1998.

My conclusions

9. My conclusions are as follows:-

9.1. Mrs RICHARDS was unlawfully killed by the continuous administration of drugs actively prescribed by Dr BARTON.

9.2. Mr Philip BEED, Ms Margaret COUCHMAN, and Ms Christine JOICE knowingly and continuously administered diamorphine, haloperidol, midazolam, and hyoscine to Mrs RICHARDS when they should have recognised the fatal consequences of so doing.

APPENDIX A

14. I have received and read the following documents:-

14.1. The letter of DCI BURT dated 22nd November 1999 that gave an initial overview of the case.

14.2. The documents in the file DCI BURT presented at our meeting on 28th January 2000 as follows:-

14.2.1. 1) Draft (unsigned) statement (MG11) of Code C
14.2.2. 2) Copy of PEC (NHS) T Health Record (LH/1/C).
14.2.3. 3) Copy of RHH Medical Record (AF/1/C).
14.2.4. 4) Draft (unsigned) statement (MG11) of Gillian MACKENZIE.
14.2.5. 5) Draft (unsigned) statement of Lesley LACK.

14.3. The documents in the file DCI BURT presented at our meeting on 8th March 2000 including those pursuant to my request of 28th January 2000 (documents WX1, WX2, and YZ were forward to me on 9 March 2000) as follows:-

14.3.1.	A	Typed copy of Notes prepared by Mrs LACK and given to Portsmouth Healthcare NHS Trust
14.3.2.	B	Typed copy of additional page of notes which was prepared by Mrs LACK but, apparently, not passed to Portsmouth Healthcare NHS Trust
14.3.3.	C	Typed copy of Notes prepared by Mrs LACK and given to Social Services
14.3.4.	D	Typed copy of comments made by Mrs LACK in respect of letter from Portsmouth Healthcare NHS Trust which represented a response to her Notes of complaint (A)
14.3.5.	E	Typed copy of comments made by Mrs LACK in respect of a Report prepared by Portsmouth Healthcare NHS Trust which resulted in the letter referred to above
14.3.6.	F	As D above but made by Mrs MACKENZIE
14.3.7.	G	As E above but made by Mrs MACKENZIE
14.3.8.	HI	Copy of letter written by Mrs MACKENZIE to DI MORGAN (OIC of initial investigation) plus 5 copies newspaper cuttings
14.3.9.	JK	Copy of Coroner's Officer's Form
14.3.10.	L	Copy of letter from Dr REID to S/Cdr SCOTT
14.3.11.	M	Copy of Report made by Dr LORD during original investigation
14.3.12.	N	Copy of additional newspaper cutting
14.3.13.	O (1)	Typed copy of signed statement of Code A)
14.3.14.	O (2)	Typed copy of signed statement of (Portsmouth Healthcare NHS Trust)
14.3.15.	O (3)	Copy of signed statement of Lesley LACK

14.3.16.	O (4)	Copy of final draft of Gillian MACKENZIE's statement
14.3.17.	PQ	Copy of schedule of x-ray images (RHH)
14.3.18.	R	Copy of Risk Event Record (Portsmouth Healthcare NHS Trust)
14.3.19.	S (1)	Copy of letter which DCI BURT has sent to L Code A (Portsmouth Healthcare NHS Trust) raising various issues
14.3.20.	S (2)	Copy of entries in medical directories 1998/1999 - Dr Jane Ann BARTON
14.3.21.	S (3)	Copy of letter from Mrs MACKENZIE to DCI BURT
14.3.22.	S (4)	Copy of documents which accompanied the two Portsmouth Healthcare NHS Trust x-ray images
14.3.23.	T	Copy of various documents which featured in a Social Services Case Conference stemming from receipt of Mrs LACK's Notes of complaint (C above)
14.3.24.	UV	Copy of Death Certificate - Mrs RICHARDS
14.3.25.	WX1	Witness Statement of Mrs Gillian MACKENZIE dated March 6 2000
14.3.26.	WX2	Copy of letter from DR J.H. BASSETT to Mrs MACKENZIE with an addendum of five pages being a photocopy from 'Toxic Psychiatry' a book by Dr Peter BREGGEN published by Harper Collins.
14.3.27.	YZ	Two extracts from 'Criminal Law. Diana Rowe. Hodder & Stoughton 1999.'

14.4. On 8th March 2000, in the presence of DCI BURT, I visited:-

14.4.1. the Gosport Memorial Hospital and followed the passageways along which Mrs Richards was conveyed and the ward areas in which she was treated; and,

14.4.2. the Royal Hospital Haslar and followed the passageways along which Mrs Richards was conveyed and the ward area in which she was treated.

14.4.2.1. At the Royal Hospital Haslar, on 8th March 2000, in the presence of DCI BURT, I was also shown twelve (12) radiographs relating to Mrs Richards' treatment there on 12th April 1998, 17th July 1998, 14th August 1998, 29th July 1998, and 31st July 1998.

14.5. In addition I have read the following the documents given to me by DCI BURT on 12th May 2000 consisting of the following which are numbered below as listed in the two containing ring binders:

14.5.1.	E 25	Copy of Glen Care Homes file Re: Gladys RICHARDS supplied by Glen Care Homes
14.5.2.	E 22	Copy of Hampshire County Council Social Services file Re: Gladys RICHARDS

14.5.3. E23 Copy of Glen Care Homes file Re: Gladys RICHARDS supplied Nursing Homes Inspectorate
14.5.4. E 24 Copy Portsmouth and South East Hampshire Health Authority GP Patient Records of Gladys RICHARDS
14.5.5. D 63 Police letter 090300 to Code A, Haslar Hospital with further questions
14.5.6. D 65 Letter 100400 from Miss CROSS at Haslar including Patient transfer order and further medical records
14.5.7. D 104 Letter 080200 from Mrs. MACKENZIE with notes Re: draft statement
14.5.8. D 108 Portsmouth NHS Trust Dept. of Diagnostic Imaging report folder
14.5.9. D 110 Copy typed Gladys RICHARDS Death Certificate dated 240898

14.6. I have also read the documents given to me by DCI BURT on 19th July 2000, consisting of copies of the statements made by:-

14.6.1. JOICE Christine
14.6.2. GIFFIN Sylvia Roberta
14.6.3.
14.6.4.
14.6.5.
14.6.6.
14.6.7.
14.6.8.
14.6.9.
14.6.10.
14.6.11.
14.6.12.
14.6.13.
14.6.14.

Code A

14.7. I have also read statements, provided on 30th August 2000 by DCI BURT, made by:

14.7.1. Doctor Jane Ann BARTON
14.7.2. Phillip James BEED

14.8. I have also received from DCI BURT on 8th September 2000 and read copies of:-

14.8.1. A letter dated 18th August 2000 from Mrs Gillian MACKENZIE to DCI BURT.

14.8.1.1. Enclosed with this letter was a copy of a letter dated 9th August 2000 from Code A to Mrs Gillian MACKENZIE to which had been added a petition form.

14.9. A letter dated 21st August 2000 from Mrs Gillian MACKENZIE to DCI BURT.

14.9.1. Enclosed with this letter was a copy of a letter dated 14th December 1998 from Code A Quality Manager at Portsmouth Healthcare NHS Trust Central Office to Mrs Gillian MACKENZIE. This had enclosed with it a copy of a letter dated 22nd September 1998 from Mr Max MILLETT, Chief Executive of Portsmouth Healthcare NHS Trust.

14.10. Copies of Witness Statements (taken by Mrs S HUTCHINGS who led the initial Internal Inquiry as Investigating Officer of Portsmouth Healthcare NHS Trust) as follows:-

14.10.1. On 3rd September 1998 statement consisting of four pages from Mrs Jenny BREWER – Staff Nurse Daedalus Ward to which is attached an additional statement (three pages) by Staff Nurse Brewer (the first page of this three pages is headed Portsmouth Healthcare NHS Trust and has been signed on page three by S. N J Brewer RGN and dated 9-9-98 (Reference D142)).

14.10.2. On 8th September 1998 statement consisting of five pages from Mr Philip BEED – Clinical Manager Daedalus Ward (Reference D143).

14.10.3. On 9th September 1998 statement consisting of three pages from Ms Christine JOICE – Staff Nurse Daedalus Ward (Reference D144).

14.10.4. On 8th September 1998 statement consisting of two pages from Ms Monica PULFORD – Enrolled Nurse Daedalus Ward (Reference D145).

14.10.5. On 3rd September 1998 statement consisting of four pages from Ms Margaret COUCHMAN – Staff Nurse Daedalus Ward (Reference D146).

14.11. A copy of the National Council for Hospice and Specialist Palliative Care Services paper entitled 'Ethical decision-making in palliative care'.

14.12. On 5th and 6th October 2000 I received from Hampshire Constabulary and subsequently read:-

14.12.1. The records of the interviews conducted with Dr Anthea Everista Geredith LORD on 27th September 2000.

14.12.2. During these interviews Dr LORD produced as listed in the Officer's Report by DC McNally the following documents:-

14.12.2.1. Drug Therapy Guidelines for subcutaneous fluid replacement as approved by the Elderly Medicine and Formulary & Medicines Group of Portsmouth Hospitals and Portsmouth Healthcare updated for 1998.

14.12.2.2. Consultants' Rota for August 1998 of the Department of Medicine for Elderly People (Ref: CI/28.7.98).

14.12.2.3. Memorandum from N Code A of Portsmouth Health Care NHS Trust to Dr. LORD dated 17th December 1998 and headed 'Mrs. Richards deceased, Gosport War Memorial Hospital, 21st August, 1998.'

14.12.2.4. Letter from Dr R I REID, Medical Director of Portsmouth Health Care NHS Trust giving approval of study leave for Dr. LORD for the dates of 17/18 August 1998.

14.12.2.5. Consultants' Timetable of the Department of Medicine for Elderly People from 4.5.98 – 8.2.99.

Appendix B

Facts of the environment obtained from the statements of Mrs RICHARDS's daughters

15. Mrs MACKENZIE is the elder of Mrs RICHARDS's two daughters. It is noted that her sister, Mrs LACK, is a retired Registered General Nurse.

15.1. Mrs LACK retired in 1996 after 41 years continuously in the nursing profession. For 25 years prior to retirement she was involved in the care of elderly people. For 20 years prior to retiring she held supervisory and managerial positions in this field of nursing.

15.2. By July 1998, Mrs RICHARDS had been resident at the Glen Heathers Nursing Home for some four years. She had a past medical history of bilateral deafness for which she required two hearing aids (unfortunately these were lost while she was at the Glen Heathers Nursing Home). She had had operations for the removal of cataracts and required glasses (unfortunately these were also lost at the Glen Heathers Nursing Home).

15.3. Also by July 1998, Mrs RICHARDS had become increasingly forgetful and less able physically. She had had 17 falls documented at the Glen Heathers Nursing Home between 29th January 1998 and 29th July 1998.

15.3.1. During this period Mrs MACKENZIE decided to meet and question her mother's general practitioner, Code A. Mrs MACKENZIE had formed the opinion that the drugs Dr Code A was prescribing could contribute to her mother's confused mental state and deterioration of her physical health. One drug was Trazodone and the other was haloperidol. Following this meeting she sent him a copy of a book entitled *Toxic Psychiatry*.

15.3.2. Code A replied, in a hand-written letter, thanking Mrs MACKENZIE and stating '... I have a reputation in Lee [-on-Solent] of being somewhat sparing with 'mood' drugs and especially antibiotics. ... most drugs are prescribed with more caution these days. [paragraph] Hopefully we can continue to keep your Mother's drugs to a minimum!'

15.4. It is convenient to mention here that both Mrs MACKENZIE and Mrs LACK have registered serious concerns about the care given to their mother in the Glen Heathers Nursing Home.

15.4.1. Jane PAGE, Principal Nursing Home Inspector, Portsmouth & S.E. Hants Health Authority investigated these concerns formally. On 11th August 1998, she made an unannounced visit to the Glen Heathers Nursing Home. She reported, on 26th August 1998, that 'From the written records obtained

and discussions held, I can find no evidence to substantiate that Mrs RICHARDS did not receive appropriate care and medication.'

15.4.2. These concerns were discussed further by the Social Services Department at a meeting held on 23rd November 1998 when Mrs LACK was present. The conclusion was that 'There was no evidence of deliberate abuse [of Mrs RICHARDS] although there seemed to be problems of complacency in some of the care practices which needed review.... However, there was no evidence of malpractice by the Home.'

15.5. On 29th July 1998, while in the Glen Heathers Nursing Home, Mrs RICHARDS sustained a fracture of the neck of her right femur (thighbone). According to Mrs LACK her mother underwent a surgical operation on 30th July 1998 'following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.'

15.6. Mrs LACK has also stated:-

15.6.1. 'My mother received a replacement hip, on her right side, and remained in the Haslar Hospital a further eleven days until Tuesday the 11th August 1998. [paragraph] I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.'

15.6.2. 'Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.'

15.6.3. 'She was with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.'

15.6.4. 'Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.'

15.6.5. 'Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.'

15.7. On 12th August 1998, the day after her mother's admission to the Gosport War Memorial Hospital, Mrs LACK visited her mother there and has recorded '... I was rather surprised to discover that I could not rouse her [Mrs RICHARDS]. As she was unrousable she could not take nourishment or be kept hydrated. [paragraph] I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days. [paragraph] I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar hospital during the period after the surgical operation to replace her hip. [paragraph] I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate the possible cause. I consider it likely that she was in need of the toilet. ... One of the consequences of being rendered unrousable, by the effects of 'Oramorph', was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.'

15.8. Mrs RICHARDS had a fall on 13th August 1998 (as described above). On the following morning (14th August 1998), Mrs LACK noted that while her mother was being taken to the X-ray department at the Gosport War Memorial Hospital 'She was still deeply under the effects of the 'Oramorph' drug.'

15.9. As described above Mrs RICHARDS was then transferred to the Royal Hospital Haslar for the reduction of her dislocated artificial hip. She was returned to the Gosport War Memorial Hospital on 17th August 1998 having been noted the previous day (16th August) by Mrs LACK [a nurse experienced in the care of elderly people] to be 'easily manageable'.

15.9.1. In accepting that he would transfer Mrs RICHARDS to the Gosport War Memorial Hospital, Dr REID (consultant geriatrician) had stated that '... despite her dementia, she [Mrs RICHARDS] should be given the opportunity to try to re-mobilise.'

15.10. On visiting her mother at the Gosport War Memorial Hospital at about 1215 hours on 17th August 1998, Mrs LACK accompanied by her sister [Mrs MACKENZIE], found her mother to be screaming and in pain. The screaming ceased 'within minutes' when Mrs LACK and a registered general nurse repositioned Mrs Richards.

15.11. Subsequently, the X-ray at the Gosport War Memorial Hospital showed no fresh dislocation of the artificial hip.

15.12. Following this further X-ray, Mrs LACK told Dr BARTON that Haslar Hospital would be prepared to readmit her mother. Dr BARTON is reported to have '... felt that was

inappropriate.' Mrs LACK '... considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.'

15.12.1. Dr BARTON is stated to have said to Mrs LACK that, '..."It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery." '

15.13. Mrs LACK states that, on 18th August 1998, the Ward Manager [Mr Philip BEED] explained to her and her sister that a syringe driver was going to be used. This was to ensure Mrs RICHARDS 'was pain free at all times' so that she would not suffer when washed, moved, or changed in the event she should become incontinent. Mrs LACK has also described in her contemporaneous notes (as well as in her Witness Statement, see below) that 'A little later Dr BARTON appeared and confirmed that a haematoma was present and that this [the use of a syringe driver] was the kindest way to treat my mother. She [Dr BARTON] also stated "And the next thing will be a chest infection." '.

15.13.1. In her Witness Statement, Mrs LACK has recorded 'The outcome of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I [Mrs LACK] knew that the continuous use of morphine, as means of relieving her pain, could result in her death. She [Mrs RICHARDS] was, at the time, unconscious from the effects of previous doses of 'Oramorph'.... [paragraph] As result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, "Are we talking about euthanasia? It's illegal in this country you know." The Ward Manager replied, "Goodness, no, of course not." I was upset and said, "Just let her be pain free". [paragraph] The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998. [paragraph] A little later Dr BARTON [sic] appeared and confirmed that a haemetoma [sic] was present and that this was the kindest way to treat my mother. She also stated, "And the next thing will be a chest infection." .... [In her witness statement Mrs Mackenzie has stated that ' DR BARTON [sic] then said, "Well, of course, the next thing for you to expect is a chest infection".'][paragraph] I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'. [paragraph] I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death. [paragraph] I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON [sic] more strongly on this issue. [paragraph] In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have

prevented Dr BARTON [sic] from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and where an offer had already been made to do so. [paragraph] I accept that my mother was unwell and that her physical, reserves had been depleted. However, she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely, been aggravated by poor quality service and avoidable delay experienced whilst in the hands of those whose responsibly [responsibility] it was to care for her. [paragraph] My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure on 19th August and no further urine was passed. The same catheter remained in place until her death. [paragraph] Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would, and she died on Friday the 21st August 1998.'

15.14. It is noted that Mrs LACK had made contemporaneous hand-written notes comprising five numbered pages. In her Witness Statement she records these '... are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Mrs Sue HUTCHINGS [sic] on 20.8.98.'

15.14.1. Mrs LACK also made a further one page of contemporaneous hand-written notes. In these she states she was so appalled about her mother's condition, discomfort and severe pain that she visited Haslar Hospital at about lunchtime on 17th August 1998 to ask questions about her mother's condition before she [Mrs RICHARDS] had left the Haslar Hospital ward for her second transfer to Gosport War Memorial Hospital. She learned that, prior to her discharge from Haslar Hospital on 17th August 1998, her mother had been eating, drinking, using a commode and able to stand if aided. Mrs Code A also states in this contemporaneous record that 'On leaving the ward [at Haslar Hospital at about lunchtime on 17th August 1998] I bumped into the Dr [doctor] who had been in casualty theatre for my mothers [sic] second [sic] operation. He was with consultant when all the procedures were explained to me on Friday 14th [August 1998] He said "How's your mother". I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said "We've had no referral. Get them to refer her back. We'll see her."

15.15. It is noted that a Discharge Letter from the Royal Hospital Haslar describes Mrs RICHARDS' condition on discharge on 17th August 1998 as "She can, however, mobilise fully weight bearing."

15.16. It is also noted that Code A has stated that she and her sister were constantly at the Gosport War Memorial Hospital, day and night, from 17th August 1998 until the time their mother died.

15.16.1. Mrs MACKENZIE has stated that 'I stayed with my mother until very late that Tuesday night [18th August 1998]. it was past midnight, in fact, when my son arrived from London. As from the Wednesday night my sister also sat with me all night long and we both remained, continuously, until twenty past nine on the following Friday evening [21st August 1998] when my mother died. During that time Dr Barton [sic] did not visit my mother. I am quite certain about this because our mother was not left alone, in her room, at any time apart from when she was washed by the nursing staff. Either my sister or I, [sic] was with her throughout.'

15.16.2. Mrs MACKENZIE has also stated that although she did not sign the contemporaneous notes made by Mrs LACK she '... was a party, at times, to the preparation process and where, on occasions, my sister has referred to 'I' in fact it could read 'we' as we were together when certain events occurred.'

15.16.3. Mrs MACKENZIE continues 'It seems to me that she [Mrs RICHARDS] must have had considerable reserves of strength to enable her to survive from Monday until Friday, five days, when all she had was a diet of Diamorphine and no hydration whatsoever, apart from porridge, scrambled eggs and a drink, at the Royal Hospital Haslar, before transfer to the Gosport War Memorial Hospital.'

Appendix C

GLOSSARY

Acetabulum is the name given to the two deep socket into which the head of the thigh bone (femur) fits at the hip joint.

ADL [activities of daily living] are those physical activities of daily life necessary for normal human functioning and include getting up, washing, dressing, preparing a simple meal, etc.

Analgesia is the relief of pain. This can be achieved by physical means including warmth and comfortable positioning as well as by the use of drugs. The aim is to keep patients pain free with minimal side effects from medication.

Bronchopneumonia is inflammation of the lung caused by bacteria. Appropriate antibiotic therapy, based on the clinical situation and on microbiological studies, will result in complete recovery in the majority of patients.

Co-codamol is a drug mixture consisting of paracetamol and codeine phosphate, which is used for the relief of mild to moderate pain.

Cyclizine is a drug used to prevent nausea and vomiting, vertigo, and motion sickness.

Dementia is the name given to a condition associated with the acquired loss of intellect, memory, and social functioning.

Diamorphine, also known as heroin, is a powerful opioid analgesic.

Haematoma is an accumulation of blood within the tissues, which clots to form a solid swelling.

Haloperidol, a drug used in the treatment of psychoses including schizophrenia and mania and also for the short-term management of agitation, excitement, and violent or dangerously impulsive behaviour. Dosage for all indications should be individually determined and it is best initiated and titrated under close clinical supervision. For patients who are elderly the normal starting dose should be halved, followed by a gradual titration to achieve optimal response. It is not licensed for subcutaneous administration (see **licensed** below).

Hemiarthroplasty is the surgical remodelling of a part of the hip joint whereby the bone end of the femur is replaced by a metal or plastic device to create a functioning joint.

Hyoscine is a drug used to reduce secretions and it also provides a degree of amnesia and sedation, and has an anti-vomiting effect. Its side effects include drowsiness.

Lactulose is a preparation taken by mouth to relieve constipation.

A **microgram** is one millionth of a gram and is not to be confused with a milligram dosage of a drug, which is one thousand times larger.

Midazolam is a sedative drug about which there have been reports of respiratory depression. It has to be use with caution in elderly people. It is used for intravenous sedative cover for minor surgical procedures. It is also used for sedation by intravenous injection in critically ill patients in intensive care. It can be given intramuscularly. In the management of overdosage special attention should be paid to the respiratory and cardiovascular functions in intensive care. It is not licensed for subcutaneous administration (see **licensed** above).

Morphine is an opioid analgesic used to relieve severe pain.

Oramorph is a drug used in the treatment of chronic pain. It contains morphine and is in the form of a liquid. 10mls of Oramorph at a strength of 10mgs of morphine sulphate in 5mls of liquid is an appropriate first dose to give to a person in severe pain, which had not responded to other less potent, pain relieving drugs.

Respiratory depression is the impairment of breathing by drugs or mechanical means which leads to asphyxia and, if uncorrected, to death.

Subcutaneous means beneath the skin.

A **syringe driver** is a power driven device for pushing the plunger of a syringe forward at an accurately controlled rate. It is an aid to administering medicinal preparations in liquid form over much longer periods than could be achieved by injecting by hand. In this case the syringe driver used was a Sims Graseby MS 26 Daily rate syringe driver which operates over periods of 24-hours.

Tradazone is a drug used in the treatment of depressive illness, particularly when sedation is required.

Unlicensed medicines. In order to ensure that medicines are safe, effective and of suitable quality, they must have a product licence (now called a market authorisation) before being marketed in the United Kingdom. Unlicensed drugs are not licensed for use for any indication or age group. Licensing arrangements constrain pharmaceutical companies but not prescribers. The Medicines Act 1968 and European legislation make provision for doctors to use unlicensed medicines. Individual prescribers of unlicensed medicines, however, are always responsible for ensuring that there is adequate information to support the quality, efficacy, safety and intended use of a drug before using it.

A **Zimmer frame** is a lightweight, but sturdy, frame the patient can use for support to assist safe walking.

APPENDIX D

10. Texts used for reference have included:

10.1. Adam J. ABC of palliative care: The last 48 hours. *British Medical Journal* 1997; 315: 1600-1603.

10.1.1. This paper is from the widely read, British Medical Journal which is published weekly and received by about 30,000 general practitioners and 45,000 hospital doctors in England and Wales. It records that treatment with opioids (viz. morphine and diamorphine) should be individually tailored, the effect reviewed, and the dose titrated accordingly.

10.2. *ABPI Compendium of data sheets and summaries of product characteristics 1998-99: with the code of practice for the Pharmaceutical Industry.* Datapharm Publications Limited, 12 Whitehall, London SW1A 2DY.

10.3. Breggin P R. *Toxic psychiatry. Drugs and electroconvulsive therapy: the truth and the better alternatives.* 1993. HarperCollins Publishers. London. pp. 578.

10.4. British Medical Association and the Royal Pharmaceutical Society of Great Britain. *British National Formulary.* Number 32 (September 1996). The Pharmaceutical Press. Oxford.

10.5. Letter from Clive Ward-Able (Medical and Healthcare Director) and I Code A BSc (Hons) (New Product Specialist), Roche Pharmaceuticals.

10.5.1. This letter is reproduced as a supplement to this appendix (**page S1**) and reports that the product licence does not cover the administration of Hypnovel® (midazolam) by subcutaneous injection.

10.5.2. Roche Pharmaceuticals. Hypnovel® [midazolam]. Summary of product characteristics.

10.6. Letter from Dr R Code A Medical Director of Janssen-Cilag Ltd.

10.6.1. This letter is reproduced as a supplement to this appendix (**page S2**) and reports that Haldol™ decanoate (haloperidol) is not licensed for subcutaneous use.

10.7. Letter from Miss Code A Manager of Medical Information and Pharmacovigilance, Norton Pharmaceuticals.

10.7.1. This letter is reproduced as a supplement to this appendix (**page S3**) and reports that Serenace™ (haloperidol) ampoules are not licensed for subcutaneous administration.

10.8. MeReC. Pain control in palliative care. *MeReC Bulletin National Prescribing Centre*. 1996; 7 (7); 25-28.

10.8.1. MeReC is the abbreviation for the 'Medicines Resource Centre'. This bulletin is sent free to all general practitioners in England and Wales and also to NHS Hospital and Community Pharmacists. The list of those who receive this bulletin is updated every few weeks.

10.9. Sims Graseby Limited. *MS 16A Syringe Driver. MS 26 Syringe Driver: Instruction manual*. Sims Graseby Limited. 1998.

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Dear DS James

CONFIDENTIAL MEDICAL REPORT REGARDING MEDICAL MANAGEMENT OF PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL

Further to our telephone call yesterday, please find enclosed my Confidential Medical Report regarding Medical Management of Patients at Gosport War Memorial Hospital.

I apologise for the delay which was made worse by my Secretary's absence.

The time taken to prepare the Report was approximately 6 hours and I would be grateful for remuneration at the normal agreed fee at your earliest convenience.

I look forward to hearing from you.

Yours sincerely

Code A

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18 October 2001

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Dear DS James

CONFIDENTIAL MEDICAL REPORT REGARDING MEDICAL MANAGEMENT OF PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL

Thank you for asking me to give a report on the management of four patients who died at Gosport War Memorial Hospital. I have based my personal opinion on my qualification as a specialist in geriatric medicine, my 13 years experience as a Consultant Geriatrician with several years experience working at the local hospice.

USE OF OPIOID ANALGESICS

Opioid analgesics are used to relieve moderate to severe pain and also can be used to relieve distressing breathlessness and cough. The use of pain killing drugs in palliative care (ie the active total care of patients whose disease is not responsive to curative treatment) is described in the British National Formulary which is the standard reference work circulated to all doctors in Great Britain. The guidance in the BNF suggests that non-opioid analgesics such as Aspirin or Paracetamol should be used as first line treatment and occasionally non-steroidal anti-inflammatory drugs may help in the control of bone secondaries. If these drugs are inadequate to control the pain of moderate severity then a weak opioid such as Codeine or Dextropropoxyphene should be used either alone or in combination with the simple pain killers in adequate dosage. If these weak opioid preparations are not controlling the pain Morphine is the most useful opioid analgesic and is normally given by mouth as an oral solution every 4 hours, starting with a dose between 5 mg and 20 mg, the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and use of other drugs should also be considered. If the pain is not well controlled the dose should be increased in a step-wise fashion to control the pain.

Sometimes modified release preparations of Morphine are given twice daily once the required dose of Morphine is established, as this may be more convenient for the patient.

If the patient becomes unable to swallow the equivalent intra-muscular dose of Morphine is half the total 24 hour dose given orally. Diamorphine is preferred for injections over Morphine as it is more soluble and can be given in smaller volume, therefore with less distress to the patient.

Subcutaneous infusions of Diamorphine by syringe driver are standard practise if the patient requires repeated intra-muscular injections, to save the patient unnecessary distress. This is standard treatment in Hospices and other medications can be added to deal with anxiety, agitation and nausea as they can safely be mixed with Diamorphine (such as Haloperidol, Cyclizine and Midazolam). The other indications for use of the parenteral route are when the patient is unable to take medicines by mouth due to upper gastro-intestinal problems and occasionally if the patient does not wish to take regular medication by mouth.

The BNF has a table showing the equivalent doses of oral Morphine and parenteral Diamorphine for intramuscular injection or subcutaneous infusion as a guide to the dosage when switching from the oral to the injection route, eg 10 mg of oral Morphine 4 hourly is equivalent to 20 mg of Diamorphine by a subcutaneous infusion every 24 hours, and 100 mg oral Morphine 4 hourly is equivalent to 240 mg of Diamorphine subcutaneously every 24 hours.

SUMMARY

It is clear from the above that a doctor trying to control pain should first start the patient on a non-opioid analgesic, move on to a weak opioid analgesic if the pain is not controlled, consider changing the patient to regular oral Morphine if the pain remains poorly controlled and only start parenteral Diamorphine if the patient is unable (or unwilling) to take Morphine by mouth and would otherwise need regular painful injections of Diamorphine to try and control the pain. There is clear guidance on the dose of Morphine to use in a syringe driver when transferring from oral Morphine to the subcutaneous route. Finally the dose of Morphine or Diamorphine should be reviewed regularly and only increased if the symptom of pain is not adequately controlled.

CASE NOTE REVIEWS

1 ARTHUR CUNNINGHAM

Mr Cunningham was known to suffer with depression, Parkinson's disease and cognitive impairment with poor short term memory. He suffered with long standing low back pain following a spinal injury sustained in the Second World War which required a spinal fusion. He suffered with hypertension and non insulin diabetes mellitus, had a previous right renal stone removed, and bladder stones, and had a previous trans-urethral prostatectomy. Myelodysplasia had been diagnosed (a bone marrow problem affecting the production of the blood constituents). Mr Cunningham had a one month admission under the care of Dr Banks for depression in July and August 1998.

Mr Cunningham was admitted by Dr Lord, Consultant Geriatrician from the Dolphin Day Hospital to Dryad Ward at Gosport War Memorial Hospital on 21 09 1998 because of a large necrotic sacral ulcer with a necrotic area over the left outer aspect of the ankle (these are signs of pressure sores). Dr Lord's intention was to give more aggressive treatment to the sacral ulcer. He was seen by Dr Barton. A dose of 2.5 mg to 10 mg of Oromorph 4 hourly was prescribed and he was given 5 mg prior to his sacral wound dressing at 1450 and a further dose of 10 mg at 2015. Diamorphine via a syringe driver was prescribed at a dose of 20 mg to 200 mg in 24 hours and this was commenced at a dose of 20 mg for 24 hours with Midazolam at 2300 on 21 09 1998. Dr Barton reviewed the patient on 23 September when he was said to be "chesty", Hyoscine was added to the syringe driver and the dose of Midazolam was increased. The patient was noted to be in some discomfort when moved on that day and the next day he was said to be "in pain" and the Diamorphine dose was increased to 40 mg for 24 hours, then 60 mg the following day and 80 mg on the 26 September, there being no further comments as to the patient's condition. The dose of Midazolam and Hyoscine was also increased. The patient died at 2315 on 26 09 1998.

Comments

All the prescriptions for opiod analgesia are written in the same hand, and I assume they are Dr Barton's prescriptions although the signature is not decipherable. Morphine was started without any attempts to control the pain with less potent drugs. There was no clear reason why the syringe driver needed to be started as the patient had only received two doses of oral Morphine, the 24 hour dose requirement of Diamorphine could not therefore be established. The dose of Diamorphine prescribed gave a tenfold range from 20 mg to 200 mg in 24 hours which is an unusually large dose range in my experience. The patient was reviewed by Dr Barton on at least one occasion and the patient was noted to be in some discomfort when moved. The dose was therefore appropriately increased to 40 mg per 24 hours but there are no further comments as to why the dose needed to be progressively increased thereafter. In my view Morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication.

2 ALICE WILKIE

Miss Wilkie was known to suffer with severe dementia, depression and rectal bleeding attributed to piles. She had been admitted to Philip Ward with a urinary tract infection and immobility under the care of Dr Lord and a decision was made to transfer her to Daedalus ward at Gosport War Memorial Hospital for a few weeks observation prior to a decision on placement. She was transferred on the 6 August and was seen by Dr Peters. The nurses recorded that the patient was complaining of pain but it was difficult to establish the nature or site of this pain. Diamorphine was prescribed on 20 08 1998 in a dose of 20 mg to 200 mg per 24 hours and the signature is identical to that on Mr Cunningham's case which I assume is Dr Barton's. A dose of 30 mg was given on 20 08 1998 with Midazolam and an entry in the notes, again apparently by Dr Barton, comments on a "marked deterioration over last few days". The patient was given another 30 mg of Diamorphine on 21 08 1998 and died that day at 1830. The patient was said to be comfortable and pain free by the nursing staff on the final day.

Comments

There was no clear indication for an opiod analgesic to be prescribed, and no simple analgesics were given and there was no documented attempt to establish the nature of her pain. In my view the dose of Diamorphine that was prescribed at 30 mg initially was excessive and there is no evidence that the dose was reviewed prior to her death. Again the Diamorphine prescription gave a tenfold range from 20 mg to 200 mg in 24 hours.

3 ROBERT WILSON

Mr Wilson was known to suffer with alcohol abuse with gastritis, hypothyroidism and heart failure. He was originally admitted via Accident & Emergency on the 22 September with a fractured left humerus and transferred to Dickens Ward under the care of Dr Lord. His fracture was managed conservatively. In view of the severe pain he received several doses of Morphine and was prescribed regular Paracetamol.

He was reviewed by Dr Luznat, Consultant Psychogeriatrician, who felt he had an early dementia and depression and recommended an anti-depressant. He was also noted to have poor nutrition.

Dr Lord made a decision to transfer Mr Wilson for a "short spell to a long term NHS bed" with the aim of controlling his pain and presumably to try to rehabilitate him. He was accordingly moved to Dryad ward at Gosport War Memorial Hospital on the 14 October. The transfer letter from Dickens

ward shows that he was still " in a lot of pain in arm".

The prescription appears to have been written by Dr Barton once again. Paracetamol was prescribed but never given by the nursing staff. Oramorph was prescribed 10 mg 4 hourly and 20 mg nocte commencing on 15 10 1998 and the night time dose was given with "good effect" as judged by the nursing staff. The nursing report goes on to say that Mr Wilson had become "chesty" and had "difficulty in swallowing medications". Oramorph was also prescribed 5 mg to 10 mg as required 4 hourly and four doses were given, suggesting Mr Wilson was in persisting pain. on 16 10 1998 the patient was seen by Dr Knapman. The patient was said to be unwell, breathless, unresponsive with gross swelling of the arms and legs. No ECG or oxygen saturation was recorded but the patient's dose of Frusemide (a diuretic) was increased, so I assume the patient was thought to have worsening heart failure. The nurses report a "very bubbly chest". A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16 10 1998 again, in Dr Barton's handwriting, the dose range from 20 mg to 200 mg in 24 hours. 20 mg of Diamorphine was given on 16 10 1998 and the nurses commented later that the "patient appears comfortable", the dose was increased to 40 mg the next day when copious secretions were suctioned from Mr Wilson's chest. On 18 10 1998 the patient was seen by Dr Peters and the dose of Diamorphine was increased to 60 mg in 24 hours and Midazolam and Hyoscine were added. The patient died on 18 10 1998 at 2340 hours.

Comments

Mr Wilson was clearly in pain from his fractured arm at the time of transfer to Dryad ward. Simple analgesia was prescribed but never given (there was an entry earlier in the episode of care that Mr Wilson had refused Paracetamol). No other analgesia was tried prior to starting morphine. Mr Wilson had difficulty in swallowing medication. The Oramorphine was converted to subcutaneous Diamorphine in appropriate dose as judged by the BNF guidelines. The patient was reviewed by a doctor prior to the final increase in Diamorphine. Once again the Diamorphine prescription had a tenfold dose range as prescribed.

It is clear that Mr Wilson's condition suddenly deteriorated probably due to a combination of worsening heart failure and terminal bronchopneumonia and I consider that the palliative care given was appropriate. A Do Not Resuscitate decision had been made by Dr Lord on 29 09 1998.

4 EVA PAGE

Mrs Page was known to suffer with hypertension, ischaemic heart disease with heart failure and paroxysmal atrial fibrillation, depression, episodic confusion and had sustained a minor stroke in the past. She was admitted on 06 02 1998 to Victory Ward with nausea, anorexia and dehydration and had recently been treated for depression. She was transferred to Charles Ward on 19 02 1998 and had been noted to have a 5 cm mass on chest

x-ray compatible with a lung cancer. She was transferred to Dryad ward, Gosport Memorial Hospital on 27 02 1998 for palliative care. On arrival she was noted to be calling out frequently, and anxious. She was prescribed Thioridazine (a tranquilliser) but this did not relieve her distress and she was prescribed Oramorph 5 mg to 10 mg as required 4 hourly, I believe, by Dr Barton. The nurses report "no relief". She was seen by another doctor who was not named in the nursing record who prescribed regular Thioridazine and Heminevrin at night. On 01 03 1998 it is recorded that Mrs Page "spat out medication", on 02 03 1998 there was an entry, I believe by Dr Barton, stating "no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain". He prescribed a Fentanyl patch 25 mg (another opioid which can be given as a skin patch) and the prescription was countersigned by Dr Lord, I believe. The nursing records state she was "very distressed", she was reviewed by Dr Barton and Diamorphine 5 mg intramuscularly was given. She was then seen by Dr Lord and a further dose of intramuscular 5 mg Diamorphine was given. On 03 03 1998 a syringe driver was started, prescribed, I believe, by Dr Barton, at a dose of 20 mg to 200 mg in 24 hours. The initial dose given was 20 mg of Diamorphine with Midazolam which was started at 1050. The nurses record "rapid deterioration ..... right side flaccid" . The patient died at 2130 that evening.

Comments

Mrs Page had a clinical diagnosis of lung cancer. There was no documentation of any symptoms relevant to this and no evidence of metastatic disease. There was no documentation of any pain experienced by the patient. When she was transferred to Dryad Ward most medication was stopped but she required sedative medication because of her distress and anxiety. No psychogeriatric advice was taken regarding her symptom control and she was started on opioid analgesia, in my view, inappropriately. Following her spitting out of medication she was given a topical form of an opioid analgesic (Fentanyl). A decision was taken to start a syringe driver because of her distress. This included Midazolam which would have helped her agitation and anxiety.

The prescription for subcutaneous Diamorphine infusion again showed a tenfold range from 20 mg to 200 mg. It was clear that her physical condition deteriorated rapidly and I suspect she may have had a stroke from the description of the nursing staff shortly prior to death.

CONCLUSIONS

I felt that the nursing records at Gosport War Memorial Hospital were comprehensive on the whole. The reason for starting opioid therapy was not apparent in several of the cases concerned. There had been no mention of any pain, shortness of breath or cough requiring relief. In several of the cases concerned oral morphine was not given for long enough to ascertain the patient's dose requirements, the reason for switching to parenteral Diamorphine via subcutaneous infusion was not documented and the prescription of a tenfold range (20 mg to 200 mg) of

Diamorphine on the "as required" section of the drug chart is, in my view, unacceptable. In my view the dose of Diamorphine should be prescribed on a regular basis and reviewed regularly by medical staff in conjunction with the nursing team. There was little indication why the dose of Diamorphine was increased in several of the cases and the dose appears to have been increased without the input of medical staff on several occasions.

Specimen signatures of Dr Lord and Dr Barton are necessary to confirm the identity of the prescribers and doctors making entries into the clinical notes.

I believe that the use of Diamorphine as described in these four cases suggest that the prescriber did not comply with standard practise. There was no involvement, as far as I could tell, from a palliative care team or specialist nurse advising on pain control. I believe these two issues require further consideration by the Hospital Trust.

I trust this report contains all the essential information you require. Please let me know if you wish me to give any further comment.

Yours sincerely

DR K I MUNDY FRCP
CONSULTANT PHYSICIAN AND GERIATRICIAN

TEAM

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Dear DS James

CONFIDENTIAL MEDICAL REPORT REGARDING MEDICAL MANAGEMENT OF PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL

Thank you for asking me to give a report on the management of four patients who died at Gosport War Memorial Hospital. I have based my personal opinion on my qualification as a specialist in geriatric medicine, my 13 years experience as a Consultant Geriatrician with several years experience working at the local hospice.

USE OF OPIOID ANALGESICS

Opioid analgesics are used to relieve moderate to severe pain and also can be used to relieve distressing breathlessness and cough. The use of pain killing drugs in palliative care (ie the active total care of patients whose disease is not responsive to curative treatment) is described in the British National Formulary which is the standard reference work circulated to all doctors in Great Britain. The guidance in the BNF suggests that non-opioid analgesics such as Aspirin or Paracetamol should be used as first line treatment and occasionally non-steroidal anti-inflammatory drugs may help in the control of bone secondaries. If these drugs are inadequate to control the pain of moderate severity then a weak opioid such as Codeine or Dextropropoxyphene should be used either alone or in combination with the simple pain killers in adequate dosage. If these weak opioid preparations are not controlling the pain Morphine is the most useful opioid analgesic and is normally given by mouth as an oral solution every 4 hours, starting with a dose between 5 mg and 20 mg, the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and use of other drugs should also be considered. If the pain is not well controlled the dose should be increased in a step-wise fashion to control the pain.

Sometimes modified release preparations of Morphine are given twice daily once the required dose of Morphine is established, as this may be more convenient for the patient.

If the patient becomes unable to swallow the equivalent intra-muscular dose of Morphine is half the total 24 hour dose given orally. Diamorphine is preferred for injections over Morphine as it is more soluble and can be given in smaller volume, therefore with less distress to the patient.

Subcutaneous infusions of Diamorphine by syringe driver are standard practise if the patient requires repeated intra-muscular injections, to save the patient unnecessary distress. This is standard treatment in Hospices and other medications can be added to deal with anxiety, agitation and nausea as they can safely be mixed with Diamorphine (such as Haloperidol, Cyclizine and Midazolam). The other indications for use of the parenteral route are when the patient is unable to take medicines by mouth due to upper gastro-intestinal problems and occasionally if the patient does not wish to take regular medication by mouth.

The BNF has a table showing the equivalent doses of oral Morphine and parenteral Diamorphine for intramuscular injection or subcutaneous infusion as a guide to the dosage when switching from the oral to the injection route, eg 10 mg of oral Morphine 4 hourly is equivalent to 20 mg of Diamorphine by a subcutaneous infusion every 24 hours, and 100 mg oral Morphine 4 hourly is equivalent to 240 mg of Diamorphine subcutaneously every 24 hours.

SUMMARY

It is clear from the above that a doctor trying to control pain should first start the patient on a non-opioid analgesic, move on to a weak opioid analgesic if the pain is not controlled, consider changing the patient to regular oral Morphine if the pain remains poorly controlled and only start parenteral Diamorphine if the patient is unable (or unwilling) to take Morphine by mouth and would otherwise need regular painful injections of Diamorphine to try and control the pain. There is clear guidance on the dose of Morphine to use in a syringe driver when transferring from oral Morphine to the subcutaneous route. Finally the dose of Morphine or Diamorphine should be reviewed regularly and only increased if the symptom of pain is not adequately controlled.

CASE NOTE REVIEWS

1 ARTHUR CUNNINGHAM

Mr Cunningham was known to suffer with depression, Parkinson's disease and cognitive impairment with poor short term memory. He suffered with long standing low back pain following a spinal injury sustained in the Second World War which required a spinal fusion. He suffered with hypertension and non insulin diabetes mellitus, had a previous right renal stone removed, and bladder stones, and had a previous trans-urethral prostatectomy. Myelodysplasia had been diagnosed (a bone marrow problem affecting the production of the blood constituents). Mr Cunningham had a one month admission under the care of Dr Banks for depression in July and August 1998.

Mr Cunningham was admitted by Dr Lord, Consultant Geriatrician from the Dolphin Day Hospital to Dryad Ward at Gosport War Memorial Hospital on 21 09 1998 because of a large necrotic sacral ulcer with a necrotic area over the left outer aspect of the ankle (these are signs of pressure sores). Dr Lord's intention was to give more aggressive treatment to the sacral ulcer. He was seen by Dr Barton. A dose of 2.5 mg to 10 mg of Oromorph 4 hourly was prescribed and he was given 5 mg prior to his sacral wound dressing at 1450 and a further dose of 10 mg at 2015. Diamorphine via a syringe driver was prescribed at a dose of 20 mg to 200 mg in 24 hours and this was commenced at a dose of 20 mg for 24 hours with Midazolam at 2300 on 21 09 1998. Dr Barton reviewed the patient on 23 September when he was said to be "chesty", Hyoscine was added to the syringe driver and the dose of Midazolam was increased. The patient was noted to be in some discomfort when moved on that day and the next day he was said to be "in pain" and the Diamorphine dose was increased to 40 mg for 24 hours, then 60 mg the following day and 80 mg on the 26 September, there being no further comments as to the patient's condition. The dose of Midazolam and Hyoscine was also increased. The patient died at 2315 on 26 09 1998.

Comments

All the prescriptions for opiod analgesia are written in the same hand, and I assume they are Dr Barton's prescriptions although the signature is not decipherable. Morphine was started without any attempts to control the pain with less potent drugs. There was no clear reason why the syringe driver needed to be started as the patient had only received two doses of oral Morphine, the 24 hour dose requirement of Diamorphine could not therefore be established. The dose of Diamorphine prescribed gave a tenfold range from 20 mg to 200 mg in 24 hours which is an unusually large dose range in my experience. The patient was reviewed by Dr Barton on at least one occasion and the patient was noted to be in some discomfort when moved. The dose was therefore appropriately increased to 40 mg per 24 hours but there are no further comments as to why the dose needed to be progressively increased thereafter. In my view Morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication.

2 ALICE WILKIE

Miss Wilkie was known to suffer with severe dementia, depression and rectal bleeding attributed to piles. She had been admitted to Philip Ward with a urinary tract infection and immobility under the care of Dr Lord and a decision was made to transfer her to Daedalus ward at Gosport War Memorial Hospital for a few weeks observation prior to a decision on placement. She was transferred on the 6 August and was seen by Dr Peters. The nurses recorded that the patient was complaining of pain but it was difficult to establish the nature or site of this pain. Diamorphine was prescribed on 20 08 1998 in a dose of 20 mg to 200 mg per 24 hours and the signature is identical to that on Mr Cunningham's case which I assume is Dr Barton's. A dose of 30 mg was given on 20 08 1998 with Midazolam and an entry in the notes, again apparently by Dr Barton, comments on a "marked deterioration over last few days". The patient was given another 30 mg of Diamorphine on 21 08 1998 and died that day at 1830. The patient was said to be comfortable and pain free by the nursing staff on the final day.

Comments

There was no clear indication for an opiod analgesic to be prescribed, and no simple analgesics were given and there was no documented attempt to establish the nature of her pain. In my view the dose of Diamorphine that was prescribed at 30 mg initially was excessive and there is no evidence that the dose was reviewed prior to her death. Again the Diamorphine prescription gave a tenfold range from 20 mg to 200 mg in 24 hours.

3 ROBERT WILSON

Mr Wilson was known to suffer with alcohol abuse with gastritis, hypothyroidism and heart failure. He was originally admitted via Accident & Emergency on the 22 September with a fractured left humerus and transferred to Dickens Ward under the care of Dr Lord. His fracture was managed conservatively. In view of the severe pain he received several doses of Morphine and was prescribed regular Paracetamol.

He was reviewed by Code A Consultant Psychogeriatrician, who felt he had an early dementia and depression and recommended an anti-depressant. He was also noted to have poor nutrition.

Dr Lord made a decision to transfer Mr Wilson for a "short spell to a long term NHS bed" with the aim of controlling his pain and presumably to try to rehabilitate him. He was accordingly moved to Dryad ward at Gosport War Memorial Hospital on the 14 October. The transfer letter from Dickens

ward shows that he was still " in a lot of pain in arm".

The prescription appears to have been written by Dr Barton once again. Paracetamol was prescribed but never given by the nursing staff. Oramorph was prescribed 10 mg 4 hourly and 20 mg nocte commencing on 15 10 1998 and the night time dose was given with "good effect" as judged by the nursing staff. The nursing report goes on to say that Mr Wilson had become "chesty" and had "difficulty in swallowing medications". Oramorph was also prescribed 5 mg to 10 mg as required 4 hourly and four doses were given, suggesting Mr Wilson was in persisting pain. on 16 10 1998 the patient was seen by Dr Knapman. The patient was said to be unwell, breathless, unresponsive with gross swelling of the arms and legs. No ECG or oxygen saturation was recorded but the patient's dose of Frusemide (a diuretic) was increased, so I assume the patient was thought to have worsening heart failure. The nurses report a "very bubbly chest". A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16 10 1998 again, in Dr Barton's handwriting, the dose range from 20 mg to 200 mg in 24 hours. 20 mg of Diamorphine was given on 16 10 1998 and the nurses commented later that the "patient appears comfortable", the dose was increased to 40 mg the next day when copious secretions were suctioned from Mr Wilson's chest. On 18 10 1998 the patient was seen by Dr Peters and the dose of Diamorphine was increased to 60 mg in 24 hours and Midazolam and Hyoscine were added. The patient died on 18 10 1998 at 2340 hours.

Comments

Mr Wilson was clearly in pain from his fractured arm at the time of transfer to Dryad ward. Simple analgesia was prescribed but never given (there was an entry earlier in the episode of care that Mr Wilson had refused Paracetamol). No other analgesia was tried prior to starting morphine. Mr Wilson had difficulty in swallowing medication. The Oramorphine was converted to subcutaneous Diamorphine in appropriate dose as judged by the BNF guidelines. The patient was reviewed by a doctor prior to the final increase in Diamorphine. Once again the Diamorphine prescription had a tenfold dose range as prescribed.

It is clear that Mr Wilson's condition suddenly deteriorated probably due to a combination of worsening heart failure and terminal bronchopneumonia and I consider that the palliative care given was appropriate. A Do Not Resuscitate decision had been made by Dr Lord on 29 09 1998.

4 EVA PAGE

Mrs Page was known to suffer with hypertension, ischaemic heart disease with heart failure and paroxysmal atrial fibrillation, depression, episodic confusion and had sustained a minor stroke in the past. She was admitted on 06 02 1998 to Victory Ward with nausea, anorexia and dehydration and had recently been treated for depression. She was transferred to Charles Ward on 19 02 1998 and had been noted to have a 5 cm mass on chest

x-ray compatible with a lung cancer. She was transferred to Dryad ward, Gosport Memorial Hospital on 27 02 1998 for palliative care. On arrival she was noted to be calling out frequently, and anxious. She was prescribed Thioridazine (a tranquilliser) but this did not relieve her distress and she was prescribed Oramorph 5 mg to 10 mg as required 4 hourly, I believe, by Dr Barton. The nurses report "no relief". She was seen by another doctor who was not named in the nursing record who prescribed regular Thioridazine and Heminevrin at night. On 01 03 1998 it is recorded that Mrs Page "spat out medication", on 02 03 1998 there was an entry, I believe by Dr Barton, stating "no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain". He prescribed a Fentanyl patch 25 mg (another opioid which can be given as a skin patch) and the prescription was countersigned by Dr Lord, I believe. The nursing records state she was "very distressed", she was reviewed by Dr Barton and Diamorphine 5 mg intramuscularly was given. She was then seen by Dr Lord and a further dose of intramuscular 5 mg Diamorphine was given. On 03 03 1998 a syringe driver was started, prescribed, I believe, by Dr Barton, at a dose of 20 mg to 200 mg in 24 hours. The initial dose given was 20 mg of Diamorphine with Midazolam which was started at 1050. The nurses record "rapid deterioration ..... right side flaccid" . The patient died at 2130 that evening.

Comments

Mrs Page had a clinical diagnosis of lung cancer. There was no documentation of any symptoms relevant to this and no evidence of metastatic disease. There was no documentation of any pain experienced by the patient. When she was transferred to Dryad Ward most medication was stopped but she required sedative medication because of her distress and anxiety. No psychogeriatric advice was taken regarding her symptom control and she was started on opioid analgesia, in my view, inappropriately. Following her spitting out of medication she was given a topical form of an opioid analgesic (Fentanyl). A decision was taken to start a syringe driver because of her distress. This included Midazolam which would have helped her agitation and anxiety.

The prescription for subcutaneous Diamorphine infusion again showed a tenfold range from 20 mg to 200 mg. It was clear that her physical condition deteriorated rapidly and I suspect she may have had a stroke from the description of the nursing staff shortly prior to death.

CONCLUSIONS

I felt that the nursing records at Gosport War Memorial Hospital were comprehensive on the whole. The reason for starting opioid therapy was not apparent in several of the cases concerned. There had been no mention of any pain, shortness of breath or cough requiring relief. In several of the cases concerned oral morphine was not given for long enough to ascertain the patient's dose requirements, the reason for switching to parenteral Diamorphine via subcutaneous infusion was not documented and the prescription of a tenfold range (20 mg to 200 mg) of

Diamorphine on the "as required" section of the drug chart is, in my view, unacceptable. In my view the dose of Diamorphine should be prescribed on a regular basis and reviewed regularly by medical staff in conjunction with the nursing team. There was little indication why the dose of Diamorphine was increased in several of the cases and the dose appears to have been increased without the input of medical staff on several occasions.

Specimen signatures of Dr Lord and Dr Barton are necessary to confirm the identity of the prescribers and doctors making entries into the clinical notes.

I believe that the use of Diamorphine as described in these four cases suggest that the prescriber did not comply with standard practise. There was no involvement, as far as I could tell, from a palliative care team or specialist nurse advising on pain control. I believe these two issues require further consideration by the Hospital Trust.

I trust this report contains all the essential information you require. Please let me know if you wish me to give any further comment.

Yours sincerely

Code A

DR K I MUNDY FRCP
CONSULTANT PHYSICIAN AND GERIATRICIAN

Team

Code A

(17)

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14 December 2001

Dear DS James

Further to your letter of 15th August 2001 I enclose a copy of my report on five patients who died at the Gosport War Memorial Hospital. I will separately mail a paper copy with appendices attached.

I apologise for the delay in providing this report which involved review of a large amount of material.

Yours sincerely

Code A

Gary A Ford
Professor of Pharmacology of Old Age
Consultant Physician

enc

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MEDICO-LEGAL REPORT

Re: **Gladys Mabel RICHARDS**
Arthur "Brian" CUNNINGHAM
Alice WILKE
Robert WILSON
Eva PAGE

Prepared by:
Professor Code A **MA, FRCP**
Consultant Physician, Freeman Hospital
Newcastle upon Tyne
Professor of Pharmacology of Old Age, University of Newcastle upon Tyne

For: **Hampshire Constabulary**

Date: **12th December 2001**

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Introduction and Remit of the Report

1.1 I am Professor of Pharmacology of Old Age in the Wolfson Unit of Clinical Pharmacology at the University of Newcastle upon Tyne, and a Consultant Physician in Clinical Pharmacology at Freeman Hospital. I am a Doctor of Medicine and care for patients with acute medical problems, acute poisoning and stroke. I have trained and am accredited on the Specialist Register in Geriatric Medicine, Clinical Pharmacology and Therapeutics and General Internal Medicine. I provide medical advice and support to the Regional Drugs and Therapeutics Centre Regional National Poisons Information Service. I was previously clinical head of the Freeman Hospital Care of the Elderly Service and have headed the Freeman Hospital Stroke Service since 1993. I undertake research into the effects of drugs in older people. I am co-editor of the book 'Drugs and the Older Population' and in 2000 was awarded the William B Abrams award for outstanding contributions to Geriatric Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a Fellow of the Royal College of Physicians and have practised as a Consultant Physician for nine years.

1.2 I have been asked by Detective Superintendent John James of Hampshire Constabulary to examine the clinical notes of five patients (Code A Richards, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson, Eva page) treated at the Gosport War Memorial Hospital and to apply my professional judgement to the following:

- The gamut of patient management and clinical practices exercised at the hospital
- Articulation of the leadership, roles, responsibilities and communication in respect of the clinicians involved
- The accuracy of diagnosis and prognosis including risk assessments
- An evaluation of drugs prescribed and the administration regimes
- The quality and sufficiency of the medical records
- The appropriateness and justification of the decisions that were made
- Comment on the recorded causes of death
- Articulate the duty of care issues and highlight any failures

1.3 I have prepared individual reports on each case and an additional report commenting on general aspects of care at Gosport War Hospital from a consideration of all five cases.

1.4 I have been provided with the following documents by Hampshire Constabulary, which I have reviewed in preparing this report:

- Comment on the recorded causes of death
- Letter DS J James dated 15th August 2001
- Terms of Reference document
- Hospital Medical Records of Gladys Richards, Brian Cunningham, Alice Wilkie, Robert Wilson and Eva Page
- Witness statements by Leslie France Lack, and Gillian MacKenzie
- Report of Professor Brian Livesley
- Transcripts of police interviews with Gosport War Memorial staff Dr Barton, Mr Beed, Ms Couchman, Ms Joice

- Transcript of police interviews with Royal Hospital Haslar staff Dr Reid and Flt. Lt Code A
- Transcript of interviews with patient transfer staff Code A and Code A
- Transcript of police interviews with or statements from following medical and nursing staff: Code A Code A

Gladys Mabel RICHARDS

Course of Events

2.1 Gladys Richards was 91 years old when admitted as an emergency via the Accident & Emergency Department to Haslar Hospital on 29th July 1998. She had fallen onto her right hip and developed pain. At this time she lived in a nursing home and was diagnosed as having dementia. She had experienced a number of falls in the previous 6 months and the admission notes comments "*quality of life has ↓↓ markedly last 6/12*". She was found to have a fracture of the right neck of femur. An entry in the medical notes by Surgeon Commander Code A Consultant orthopaedic surgeon dated 30 July 1998 states '*After discussion with the patient's daughters in the event of this patient having a cardiac arrest she is NOT for cardiopulmonary resuscitation. However she is to be kept pain free, hydrated and nourished.*' Surgery (right hemiarthroplasty) was performed on 30 July 1998.

2.2 On 3rd August she was referred for a geriatric opinion and seen by Dr Reid, Consultant Physician in Geriatrics on 3rd August 1998. In his letter dated 5th August 1998 he notes she had been on treatment with haloperidol and trazadone and that her daughters thought she had been 'knocked off' by this medication for months, and had not spoken to them for 6-7 months. Her mobility had deteriorated. Her daughters commented to Dr Reid that she had spoken to them and had been brighter mentally since the trazadone had been omitted following admission. Dr Reid found Mrs Richards to be confused but pleasant and cooperative, unable to actively lift her right leg from the bed but appeared to have little discomfort on passive movement of the right hip. He commented '*I understand she has been sitting out in a chair and I think that despite her dementia, she should be afforded the opportunity to try to re-mobilise her.* He arranged for her transfer to Gosport War Memorial Hospital.

2.3 Following Dr Reid's entry in the notes on 3rd August two further entries are made in the medical notes by the on call house officer (Dr Code A ?) on 8th August 1998. Dr Code A was asked to see Mrs Richards who was agitated on the ward. She had been given 2mg haloperidol and was asleep when first seen at 0045h. At 0230 hr a further entry records Mrs Richards was '*noisy and disturbing other patients n ward. Unable to reason with patient. Prescribed 25mg thioridazine*'. A transfer letter for Sergeant Code A staff nurse to the Sister in Charge dated 10th August 1998 describes Mrs Richards status immediately prior to transfer and notes '*Is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Gladys needs total care with washing and dressing eating and drinking. Gladys is continent, when she becomes fidgety and agitated it means she wants the toilet. Occasionally incontinent at night, but usually wakes.*

2.4 On 11th August 1998 Mrs Richards was transferred to Daedalus ward. Dr Barton writes *in the medical notes "Impression frail demented lady, 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".* The summary admitting nursing notes record *"now fully weight bearing and walking with the aid of two nurses and a Zimmer frame".* On 12th August the nursing notes record "*Haloperidol given at 2130 as woke from sleep. Very egitated, shaking and crying. Didn't settle for more than a few*

minutes at a time. Did not seem to be in pain". On 13th August nursing notes record "*found on floor at 1330h. Checked for injury none apparent at time. Hoisted into safet chair. 1930 pain Rt hip internally rotated, Dr Brigg contacted advised Xray am and analgesia during the night. Inappropriate to transfer for Xray this pm.*"

2.5 On 14th August 1998 Dr Barton wrote '*sedation/pain relief has been a problem. Screaming not controlled by haloperidol 1g ? but very sensitive to Oramorph. Fell out of chair last night. R hip shorter and internally rotated, Daughter nurse and not happy. Plan Xray . Is this lady well enough for another surgical procedure?*" A further entry the same day states "*Dear Cdr* Code A *further to our telephone conversation thank you for seeing this unfortunate lady who slipped from her chair and appears to have dislocated her R hip. Hemiarthroplasty was done on 30-8-98. I am sending Xrays. She has had 2.5ml of 10mg/5ml oramoroph at midday. Many thanks*"

2.6 Following readmission to Haslar hospital Mrs Richards underwent manipulation of R hip under iv sedation (2 mg midazolam) at 1400h. At 2215h the same day she was not responding to verbal stimulation but observations of blood pressure, pulse, respiration and temperature were all in the normal range. A further entry on 17th August by Code A House Officer) states "*fit for discharge today (Gosport War Mem) To remain in straight knee splint for 4/52. For pillow between legs (abduction) at night.*" A transfer letter to the nurse in charge at Daedalus ward states "*Thank you for taking Mrs Richards back under your care... was decided to pass an indwelling catheter which still remains in situ. She has been given a canvas knee immobilising splint to discourage any further dislocation and this must stay in situ for 4 weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing*"

2.7 Nursing notes record on 17th August " 1148h *returned from R.N.Haslar patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew.*" Later that day at 1305h "*in pain and distress, agreed with daughter to give her mother Oramorph 2.5mg in 5ml*". A further hip Xray was performed which demonstrated no fracture. Dr Barton writes on 17th August 1998 "*readmission to Daedalus ward. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See daughter again*" and on 18th August "*still in great pain, nursing a problem, I suggest sc diamorphine/ haloperidol/midazolam. I will see daughters today. Please make comfortable*". Nursing notes record "*reviewed by Dr Barton for pain control via syringe driver*". At 2000h "*patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs*". On 19th August the nursing notes record "*Mrs Richards comfortable*" and in a separate entry "*apparently pain free*". There are no nursing entries I can find on 20th August. I can find no entries in the nursing notes describing fluid or food intake following admission on 17th August.

2.8 The next entry in the medical notes is on 21st August by Dr Barton "*much more peaceful. Needs hyoscine for rattly chest*". The nursing notes record "*patient's overall condition deteriorating. Medication keeping her comfortable*". A staff

nurse records [Code A] death in the notes at 2120h later that day. The cause of death was recorded as bronchopneumonia.

2.9 Medication charts record the following administration of opiate, analgesic and sedative drugs during [Code A] first admission to Haslar Hospital.

29 July 2000h Trazadone 100mg (then discontinued)
29 July to 11th August. Haloperidol 1mg twice daily
30 July 0230h Morphine iv 2.5mg
31 July 0150h morphine iv 2.5mg
1905h morphine iv 2.5 mg
1 Aug 1920h morphine iv 2.5mg
2 Aug 0720h morphine iv 2.5mg
Cocodamol two tablets as required taken on 16 occasions at varying times between 1-9th August

2.10 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards second admission to Haslar Hospital

14 Aug 1410h midazolam 2mg iv
15 Aug 0325h cocodamol two tablets orally
16 Aug 0410h haloperidol 2mg orally
0800h haloperidol 1mg orally
1800h haloperidol 1mg orally
2310h haloperidol 2mg orally
17 Aug 0800h haloperidol 1mg orally

2.11 Medication charts record the following administration of opiate and sedative drugs on Daedalus ward:

11 Aug	1115h	5mg/5ml Oramorph
	1145h	10 mg Oramorph
	1800h	1 mg haloperidol
12 Aug	0515h	10 mg Oramorph
		haloperidol
13 Aug	2050h	10mg Oramorph
14 Aug	1150h	10mg Oramorph
17 Aug	1900h	5mg Oramorph
	?	5 mg Oramorph
	1845h	5mg Oramorph
	2030h	10mg Oramorph
18 Aug	0230h	10mg Oramorph
	?	10mg Oramorph
	1145h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hrby
19 Aug	1120h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
20 Aug	1045h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
21 Aug	1155h	diamorphine 40mg/24h, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

2.12 Primary responsibility for the medical care of Mrs Richards during her two admissions to Gosport Hospital lay with Dr Lord, as the consultant responsible for his care. My understanding is that day-to-day medical care was delegated to the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital (statement of Dr Lord in interview with DC Colvin and DC McNally). Primary responsibility for the medical care of Mrs Richards during her two admissions to Queen Alexandra Hospital lay with Surgeon Commander Code A Consultant Orthopaedic Surgeon. Junior medical staff were responsible for day-to-day medical care of Mrs Richards whilst at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Richards and informing medical staff of any significant deterioration.

2.13 Dr Reid, Consultant Geriatrician was responsible for assessing Mrs Richards and making recommendations concerning her future care following her orthopaedic surgery, and arranged transfer to Gosport Hospital for rehabilitation.

Accuracy of diagnosis and prognosis including risk assessments

2.14 The initial assessment by the orthopaedic team was in my opinion competent and the admitting medical team obtained a good history of her decline in the previous six months. Surgeon Commander Code A discussed management options with the family and a decision was made to proceed with surgery but for Mrs Richards to not undergo cardiopulmonary resuscitation if she sustained a cardiac arrest, with a clear decision to keep Mrs Richards pain free, hydrated and nourished. There are good reasons to offer surgery for a fractured neck of femur to very frail patients with dementia even when a high risk of peri-operative death or complications is present. This is because without surgery patients continue to be in pain, remain immobile and nearly invariably develop serious complications such as pneumonia and pressure sores, which are usually fatal. From the information I have seen I would, as a consultant physician/geriatrician recommended the initial management undertaken. I consider it good management that the trazadone as discontinued when the history from the daughters suggested this might have been responsible for decline in the recent past.

2.15 After Mrs Richards was stable a few days following surgery it was appropriate to refer her for a geriatric opinion, and Dr Reid rapidly provided this. Dr Reid's assessment was in my opinion thorough and competent. He identified the potential for her to benefit from rehabilitation. I would consider his decision to refer her for rehabilitation despite her dementia to be appropriate. An elderly care rehabilitation, rather than an acute orthopaedic ward is in general a preferable environment to undertake such rehabilitation. It is implicit in his decision to transfer her to Gosport War Memorial Hospital that she would receive rehabilitation there and not care on a continuing care ward without input from a rehabilitation team. Dr Lord in an interview with DC McNally and DC Colvin describes Daedalus ward as "*Back in '98 .. Daedalus was a continuing care ward with 24 beds of which 8 beds were for slow stream stroke*

rehabilitation". Although Mrs Richards had a fractured neck of femur and not stroke as her primary problem requiring rehabilitation I would assume, in the light of Dr Reid's letter that she was transferred to one of the 8 slow stream rehabilitation beds on Daedalus ward.

2.16 The transfer letter from Sergeant Code A provides a clear description of Mrs Code A status at the time of transfer. The observation that she was walking with the aid of two nurses and a zimmer frame, and the usual cause of agitation was when she needed to use the toilet are relevant to subsequent events following transfer to Gosport Hospital. The use of a Barthel Index score as a measure of disability is good practice and demonstrates that Mrs Richards was severely dependent at the time of her transfer to Gosport Hospital.

2.17 The initial entry by Dr Barton following Mrs Richards transfer to Daedalus ward does not mention that she has been transferred for rehabilitation, and focuses on keeping her 'comfortable' despite recording that she is "*not obviously in pain*". The statement "*I am happy for nursing staff to confirm death*" also suggests that Dr Barton's assessment was that Mrs Richards might die in the near future. Dr Barton in her statement to DS Code A and DC Colvin, confirms this when she states "*I appreciated that there was a possibility that she might die sooner rather than later*". Dr Barton refers to her admission as a "*holding manoeuvre*" and her statement suggests a much more negative view of the potential for rehabilitation. She does not describe any rehabilitation team or focus on the ward and suggests her transfer was necessary because she was not appropriate for an acute bed, rather than her being appropriate for rehabilitation- "*.her condition was not appropriate for an acute bed. ....seen whether she would recover and mobilise after surgery. 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 clam environment away from the stresses of an acute ward*". In my opinion this initial note entry and the statement by Dr Baron indicate a much less proactive view of rehabilitation, less appreciation than Dr Reid of the potential for Mrs Richards to recover to her previous level of functioning, and probably a failure to appreciate the potential benefits of appropriate multidisciplinary rehabilitation to Code A This leads me to believe that Dr Code A approach to Code A was in the context of considering her as a continuing care patient who was likely to die on the ward. It was not wrong or incorrect of Dr Barton to believe Mrs Richards might die on the ward, but I would consider her apparent failure to recognise Mrs Barton's rehabilitation needs may have led to subsequent sub-optimal care.

2.18 There are a number of explanations and contributory factors that may have led to Dr Barton possibly not recognising Mrs Richard's rehabilitation needs in addition to her nursing and analgesic needs. First she may have not clearly understood Dr Reid's assessment that she needed rehabilitation. In her statement Dr Barton states " *Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to remobilise*" which suggests Dr Barton may not have considered the necessity for Mrs Richards to receive Physiotherapy as a necessary part of her opportunity to remobilise. Second the ward had both continuing care and rehabilitation beds and these patients may require very different care. It is not uncommon for "slow stream" rehabilitation beds to be in the same ward as continuing care beds, but it does

require much broader range of care to meet the medical and social needs of these patients. I would anticipate that some patients would move from the slow stream rehabilitation to continuing care category. Dr Lord describes the existence of fortnightly multidisciplinary ward case conference suggesting there was a structured team approach that would have made Dr Barton and nursing staff aware of rehabilitation needs of patients. In Mrs Richards's case no such case conference took place because she became too unwell in a short period. Third Dr Barton may not have received sufficient training or gained adequate experience of rehabilitation or geriatrics despite working under the supervision of Dr Lord. Dr Lord states that Dr Barton was "*an experienced GP*" who had rights of admission to a GP ward and that Dr Lord had admitted patients "*under her care say for palliative care*". Experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

2.19 The assessment of Mrs Richard's agitation the following day on 12th August was in my opinion sub-optimal. The nursing records state that she did not appear to be in pain. There is no entry from Dr Barton this day but in her statement she states which I have some difficulty in interpreting: "*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 totalling 20mg over the first 24 hours and 10mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure*".

2.20 I am unable establish from the notes and Dr Barton's statement whether she saw Mrs Richards in pain after she wrote in the notes and then wrote up the opiate drugs later on the 11th August, or if she wrote up these drugs after seeing her when she was not in pain, because she considered she might develop pain and agitation. In either case there is no evidence that the previous information provided by Sergeant Code A that Mrs Richards usually required the toilet when she was agitated was considered by Dr Barton. Screaming is a well-described behavioural disturbance in dementia (Dr Barton was clearly aware of this), which can be due to pain but is often not. In some cases it is not possible to identify a clear precipitating cause although a move to a new ward could precipitate such a behavioural disturbance. I would consider the assumption by Dr Barton that Mrs Richards screaming was due to pain was not supported by her own recorded observations. There is no evidence from the notes that Dr Barton examined Mrs Richards in the first two days to find any evidence on clinical examination that pain from her hip was the cause of her screaming. If the screaming had been worse on weight bearing or movement of the hip this would have provided supportive evidence

that her screaming was due to hip pain. Staff Nurse Jennifer Brewer in her interview with DC Code A and DC Code A states that the nursing staff had considered the need for toileting and other potential causes of Mrs Richards screaming.

2.21 Mrs Richards pain following surgery had been controlled at Haslar hospital by intermittent doses of intravenous morphine and then intermittent doses of cocodamol (paracetamol and codeine phosphate). Dr Barton did not prescribe cocodamol or another mild or moderate analgesic to Mrs Richards to take on a prn basis when she was transferred. This makes me consider it probable that Dr Barton prescribed prn Oramorph, diamorphine, hyoscine and midazolam when she first saw Mrs Richards and she was not in pain. If this is the case it is highly unusual practice in a patient who has been transferred for rehabilitation, was not taking any regular or intermittent analgesics for 36 hours prior to transfer, and had last taken two tablets of cocodamol. In a rehabilitation or continuing care ward without resident medical staff I would consider it reasonable and usual practice to prescribe a mild or moderate analgesic to take on an as required basis in case further pain developed. In Mrs Richards's case a reasonable choice would have been cocodamol since she had been taking this a few days earlier without problems. I do not consider it was appropriate to administer intermittent doses of oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. It is not appropriate to prescribe powerful opiate drugs as a first line treatment for pain not clearly due to a fracture or dislocation to a patient such as Mrs Richards 12 days following surgery. Dr Barton's statement that diamorphine and oramorph were appropriate analgesics at this stage following surgery when she had been pain free is incorrect and in my opinion would not be a view held by the vast majority of practising general practitioners and geriatricians.

2.22 The management of Mrs Richards when sustained a dislocation of her hip on 13th August was in my opinion sub-optimal. The hip dislocation most likely occurred following the fall from her chair at 1330h. The nursing notes suggest signs of a dislocation were noted at 1930h. If there was a delay in recognising the dislocation I would not consider this indicates poor care, as hip fractures and dislocations can be difficult to detect in patients who have dementia and communication difficulties. Mrs Richards suspected dislocation or fracture was discussed with the on-call doctor, Dr Briggs, who I would assume is a medical house officer. Given the concern about a fracture or dislocation I would judge it would have been preferable for her to b transferred to the orthopaedic ward that evening and be assessed by the orthopaedic team. I certainly consider the case should have been discussed with either the on call consultant geriatrician or the orthopaedic team. The benefits of transfer that evening in a patient where it was highly probable a fracture or dislocation were present would have been Mrs Richards could have received manipulation earlier the following morning and possibly that same evening, and that traction could have been applied even if reduction was not attempted.

2.23 Mrs Richards was found to have a dislocation of her right hip and this was manipulated under intravenous sedation the same day. Although she was initially unresponsive, most probably due to prolonged effects of the intravenous midazolam, 3 days later on 17th August she was mobilising and

fully weight bearing and not requiring any analgesia. Although there are few medical note entries, the management at Haslar hospital during this period appears to be appropriate and competent. Shortly after transfer back to Daedalus ward Mrs Richards again became very distressed. The nursing notes indicate there was an incorrect transfer by the ambulance staff of Mrs Richards onto her bed. Repeat dislocation of the right hip was reasonably suspected but not found on a repeat Xray. My impression is that this transfer may have precipitated hip or other musculoskeletal pain in Mrs Richards but that other causes of screaming were possible.

2.24 Intermittent doses of oral morphine were first administered to Mrs Richards, again without first determining whether less powerful analgesics would have been helpful. On 18th August Dr Barton suggested commencing subcutaneous diamorphine, haloperidol and midazolam. The diamorphine and midazolam had been prescribed 7 days earlier. An infusion of the three drugs was commenced later that morning and hyoscine was added on 19th August. Both Dr Barton's notes and the nursing notes indicate Mrs Richards was in pain, although it is not clear what they considered was the cause of the pain at this stage, having excluded a fracture or dislocation of the right hip. Dr Barton states in her prepared statement "*... 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*".

2.25 Although there are no clear descriptions of Mrs Richards conscious level in the last few days, her level of alertness appears to have deteriorated once the subcutaneous infusion of diamorphine, haloperidol and midazolam was commenced. It also seems that she was not offered fluids or food and intravenous or subcutaneous fluids were not considered as an alternative. My interpretation is that this was most probably because medical and nursing staff were of the opinion that Mrs Richards were dying and that provision of fluids or nutrition would not change this outcome. In her prepared statement Dr Barton states "*As their mother was not eating or drinking or able to swallow, subcutaneous infusion of pain killers was the best way to control her pain.*" and "*I was aware that Mrs Richards was not taking food or water by mouth*". She then goes on to say "*I believe I would have explained to the daughters that subcutaneous fluids were not appropriate*".

Evaluation of drugs prescribed and the administration regimens

2.26 The decision to prescribe oral opiates and subcutaneous diamorphine to Mrs Richards initial admission to Daedalus ward was in my opinion inappropriate and placed Mrs Richards at significant risk of developing adverse effects of excessive sedation and respiratory depression. The prescription of oral paracetamol, mild opiates such as codeine or non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen would have been appropriate oral and preferable with a better risk/benefit ratio. The prescription of subcutaneous diamorphine, haloperidol and midazolam infusions to be taken if required was inappropriate even if she was experiencing pain. Subcutaneous opiate infusions should be used only in patients whose pain is not controlled by oral analgesia and who cannot swallow oral opiates. The prescription by Dr Barton on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Mrs Richards at serious risk of developing coma and respiratory depression had these been administered by

the nursing staff. It is exceptionally unusual to prescribe subcutaneous infusion of these three drugs with powerful effects on conscious level and respiration to frail elderly patients with non-malignant conditions in a continuing care or slow stream rehabilitation ward and I have not personally used, seen or heard of this practice in other care of the elderly rehabilitation or continuing care wards. The prescription of three sedative drugs is potentially hazardous in any patient but particularly so in a frail older patient with dementia and would be expected to carry a high risk of producing respiratory depression or coma.

2.27 I consider the statement by Dr Barton "*my use of midazolam in the dose of 20mg over 24 hours was as a muscle relaxant, to assist movement of* Code A *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.*" Indicates poor knowledge of the indications for and appropriate use of midazolam administered by subcutaneous infusion to older people. Midazolam is primarily used for sedation and is not licensed for use as a muscle relaxant. Doses of benzodiazepine that produce significant muscle relaxation in general produce unacceptable depression of conscious level, and it is not usual practice amongst continuing care and rehabilitation wards to administer subcutaneous midazolam to assist moving patients.

Quality and sufficiency of the medical records

2.28 The medical and nursing records relating to Mrs Richards admissions to Daedalus ward are in my opinion not of an adequate standard. The medical notes fail to adequately account for the reasons why oramorph and then infusions of diamorphine and haloperidol were used. The nursing records do not adequately document hydration and nutritional needs of Mrs Richards during her admissions to Daedalus ward.

Appropriateness and justification of the decisions that were made

2.29 There are a number of decisions made in the care of Mrs Richards that I consider to be inappropriate. The initial management of her dislocated hip prosthesis was sub-optimal. The decision to prescribe oral morphine without first observing the response to milder opiate or other analgesic drugs was inappropriate. The decision to prescribe diamorphine, haloperidol and midazolam by subcutaneous infusion was, in my opinion, highly inappropriate.

Recorded cause of death

2.30 The recorded cause of death was bronchopneumonia. I understand that the cause of death was discussed with the coroner. A post mortem was not obtained and the recorded cause was certainly a possible cause of Mrs Richards's death. I am surprised the death certificate makes no mention of Mrs Richards's fractured neck of femur or her dementia. It is possible that Mrs Richards died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mrs Richards was at high risk of developing pneumonia because of the immobility that resulted following her transfer back to Daedalus ward even if she had not received sedative and opiate drugs. Bronchopneumonia can also occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of

Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia was possible. However given the rapid decline in conscious level that preceded the development of respiratory symptoms (rattly chest) I would consider it more likely that Mrs Richards became unconscious because of the sedative and opiate drugs she received by subcutaneous infusion, that these drugs caused respiratory depression and that Mrs Richards died from drug induced respiratory depression and/or without bronchopneumonia resulting from immobility or drug induced respiratory depression. There are no accurate records of Mrs Richards respiratory rate but with the doses used and her previous marked sedative response to intravenous midazolam it is highly probable that respiratory depression was present.

Duty of care issues

2.31 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care to attempt to monitor Mrs Richards and to document the effects of drugs prescribed. In my opinion this duty of care was not adequately met. The prescription of diamorphine, midazolam and haloperidol was extremely hazardous and Mrs Richards was inadequately monitored. The duty of care of the medical and nursing staff to meet Mrs Richard's hydration and nutritional needs was also in my opinion probably not met.

Summary

2.32 Gladys Richards was a frail older lady with dementia who sustained a fractured neck of femur, successfully surgically treated with a hemiarthroplasty, and then complicated by dislocation. During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Baron. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death. In my opinion it is likely the administration of the drugs hastened her death. There is some evidence that Mrs Richards was in pain during the three days prior to her death and the administration of opiates can be justified on these grounds. However Mrs Richards was at high risk of developing pneumonia and it possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Arthur "Brian" CUNNINGHAM

Course of Events

3.1 Mr Cunningham was 79 years old when admitted to Dryad ward, Gosport Hospital under the care of Dr Lord. Dr Lord had assessed him on a number of occasions in the previous 4 years. A letter dated 2nd December 1994 from Dr Bell, Clinical Assistant, indicates Parkinson's disease had been diagnosed in the mid 1980s and that he was having difficulties walking at this time. In 1998 it was noted he had experienced visual hallucinations and had moved into Merlin Park Rest Home. His weight was 69Kg in August 1998. In July 1998 he was admitted under the care of Dr Banks, Consultant in Old Age Psychiatry to Mulberry Ward A and discharged after 6 weeks to Thalassa Nursing Home. He was assessed to have Parkinson's disease and dementia, depression and myelodysplasia. Dr Lord in a letter dated 1 September 1998 summarises her assessment of Mr Cunningham when she saw him on Mulberry Ward A on 27 August 1998 before he was discharged to Thalassa Nursing Home. At this time he required 1-2 people to transfer and was unable to wheel himself around in his wheelchair. She commented that more levodopa might be required but was concerned it would upset his mental state. She arranged to review him at the Dolphin Day Hospital.

3.2 On 21st September 1998 he was seen at the Dolphin Day Hospital by Dr Code A who recorded *'very frail, tablets found in mouth, offensive large necrotic sacral sore with thick black scar. PD - no worse. Diagnoses listed as sacral sore (in N/H), PD, old back injury, depression and element of dementia, diabetes mellitus –diet, catheterised for retention. Plan – stop codanthramer and metronidazole. looks fine. TCI Dyad today –aserbine for sacral ulcer – nurse on side – high protein diet – oramorph prn if pain. N/Home to keep bed open for next 3/52 at least. Pt informed of admission agrees. Inform N/Home Dr* Code A *and social worker. Analgesics prn.'* He was admitted to Dyad ward. An entry by Dr Baron on 21 September states *'make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death'*. On 24th September Dr Lord has written *'remains unwell. Son has ??? again today and is aware of how unwell he is. sc analgesia is controlling pain just. I am happy for nursing staff to confirm death.'* The next entry by Dr Code A is on 25th September *'remains very poorly. On syringe driver. For TLC'.*

3.3 Medication charts record the following administration of opiate and sedative drugs:

21 Sep 1415h Oramorph 5mg
1800h Coproxamol two tablets
(subsequent regular doses not administered)
2015h Oramorph10mg
21 Sep 2310h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
22 Sep 2020h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
23 Sep 0925h Diamorphine 20mg/24hr, hyoscine 200microg/24hr
midazolam 20 mg/24hr infusion sc
2000h Diamorphine 20mg/24hr, hyoscine 200microg/24hr
midazolam 60mg/24hr infusion sc
24 Sep 1055h Diamorphine 20mg/24hr, hyoscine 800microg/24hr
midazolam 80mg/24hr infusion sc
25 Sep 1015h Diamorphine 60mg/24hr, hyoscine 1200mg/24hr

midazolam 80mg/24hr infusion
26 Sep 1150h Diamorphine 80mg/24hr, hyoscine 1200mg/24hr
midazolam 100mg/24hr infusion
Sinemet 110 5 times/day was discontinued on 23rd September

3.4 The nursing notes relating to the admission to Dyad ward record on 21st Sept *'remained agitated until approx 2030h. Syringe driver commenced as requested* (unclear who made this request) *diamorphine 20mg, midazolam 20mg at 2300. Peaceful following".* On 22nd Sep *'explained that a syringe driver contains diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode where Arthur tried to wipe sputum on a nurse saying he had HIV and going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself.'*

3.5 On 23rd Sep *'Has become chesty overnight to have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked is this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed.'* A later entry *'now fully aware that Brian is dying and needs to be made comfortable. Became a little agitated at 2300h, syringe driver adjusted with effect. Seems in some discomfort when moved, driver boosted prior to position change'.* On 24th Sept *'report from night staff that Brian was in pain when attended to, also in pain with day staff – especially his knees. Syringe driver renewed at 1055".* On 25th Sept *'All care given this am. Driver recharged at 1015 - diamorphine 60mg, midazolam 80mg and hyoscine 1200mcg at a rate of 50nmols/hr. Peaceful night - unchanged, still doesn't like being moved.'* On 26th September *'condition appears to be deteriorating slowly'.*

3.6 On 26th September staff nurse Tubbritt records death at 2315h. Cause of death was recorded on the death certificate as bronchopneumonia with contributory causes of Parkinson's disease and Sacral Ulcer.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

3.7 Primary responsibility for the medical care of Mr Cunningham during his last admission lay with Dr Lord, as the consultant responsible for his care. She saw Mr Cunningham 5 days before his death in the Dolphin Day Hospital, and 2 days before his death on Dyad ward. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Cunningham and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

3.8 Initial assessment by Dr Lord was comprehensive and appropriate with a clear management plan described. The nursing staff record Mr Cunningham was agitated following admission on 21st September. Dr Lord had prescribed prn (intermittent as required) oramorph for pain. Nursing staff made the decision to

administer oramorph but there is no clear recording in the nursing notes that he was in pain or the site of pain. The nursing entry on 22nd Sept indicates a syringe driver was commenced for 'pain relief and to allay anxiety. Again the site of pain is not states. My interpretation of the records is that the nursing staff considered his agitation was due to pain from his sacral ulcer. The medical and nursing teams view on the cause of Mr Cunningham's deterioration on 23rd September when he became 'chesty' are not explicitly stated, but would seem to have been thought to be due to bronchopneumonia since this was the cause of death later entered on the death certificate. The medical and nursing staff may not have considered the possibility that Mr Cunningham's respiratory symptoms and deterioration may have been due to opiate and benzodiazepine induced respiratory depression. The nursing staff filed to appreciate that the agitation Mr Cunningham experienced on 23rd Sept at 2300h may have been due to the midazolam and diamorphine. It was appropriate for nursing staff to discuss Mr Cunningham's condition with medical staff at this stage.

3.9 When Dr Lord reviewed Mr Cunningham on 24th September the notes imply that he was much worse that when she had seen him 3 days earlier. There is clear recording by Dr Lord that Mr Cunningham was in pain. The following day the diamorphine dose was increased three fold from 20mg/24hr to 60mg/24hr and the dose was further increased on 26th September to 80mg/24hr although the nursing and medical notes do not record the reason for this. The notes suggest that the nursing and medical staff may have failed to consider causes of agitation other than pain in Mr Cunningham or to recognise the adverse consequences of opiates and sedative drugs on respiratory function in frail older individuals.

Evaluation of drugs prescribed and the administration regimens

3.10 The prescription of oramorph to be taken 4 hourly as required by Mr Cunningham was reasonable if his pain was uncontrolled from cocodamol. I consider the decision by Dr Barton to prescribe and administer diamorphine and midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate, particularly when there was a clear instruction by Dr Lord that he should be prescribed intermittent (underlined instruction) doses of oramorph earlier in the day. I consider the undated prescription by Dr Baron of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. In my opinion it is poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mr Cunningham. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

3.11 In my opinion it is doubtful the nursing and medical staff understood that when a syringe infusion pump rate is increased it takes an often appreciable effect of time before the maximum effect of the increased dose rate becomes evident. Typically the time period would be 5 drug half-lives. In the case of diamorphine this would be between 15 and 25 hours in an older frail individual.

Quality and sufficiency of the medical records

3.12 In my opinion the medical and nursing records are inadequate following Mr Cunningham's admission to Dryad ward. The initial assessment by Dr Lord on 21st September is in my opinion competent and appropriate. The medical notes following this are inadequate and do not explain why he was commenced on subcutaneous infusions of diamorphine and midazolam. The nursing notes are variable and at times inadequate.

Appropriateness and justification of the decisions that were made

3.13 An inappropriately high dose of diamorphine and midazolam was first prescribed. There was a failure to recognise or respond to drug induced problems. Inappropriate dose escalation of diamorphine and midazolam and poor assessment by Dr Lord. The assessment by Dr Lord on 21st September 1998 was thorough and competent and a clear plan of management was outlined. There is a clear note by Dr Lord that oramorph was to be given intermittently (PRN) for pain and not regularly. It is not clear from the medical and nursing notes why Mr Cunningham was not administered the regular cocodamol he was prescribed following the initial dose he received at 1800h following admission. It is good practice to provide regular oral analgesia, with paracetamol and a mild opiate, particularly when a patient has been already taking this medication and to use prn morphine for breakthrough pain. I consider the prescription by Dr Barton on admission of prn subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be unjustified, poor practice and potentially very hazardous. It is particularly notable that only hours earlier Dr Lord had written that oramorph was to be given intermittently and this had been underlined in the medical notes. There is no clear justification in the notes for the commencement of subcutaneous diamorphine and midazolam on the evening following admission. If increased opiate analgesia was required increasing the oramorph dose and frequency could have provided this. I would judge it poor management to initially commence both diamorphine and midazolam. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam.

3.14 I am concerned by the initial note entry by Dr Barton on 21st September 1998 that she was happy for nursing staff to confirm death. There was no indication by Dr Lord that Mr Barton was expected to die, and Dr Barton does not list the reason she would have cause to consider Mr Cunningham would die within the next 24 hours before he was reviewed the following day by medical staff. In my opinion it is of concern that the nursing notes suggest the diamorphine and midazolam infusions were commenced because of Mr Cunningham's behaviour recorded in the nursing entry on 22nd September.

3.15 Hyoscine was commenced on 23rd September after Mr Cunningham had become 'chesty' overnight. I consider it very poor practice that there is no record of Mr Cunningham being examined by a doctor following admission on 21st September, and a decision to treat this symptomatically with hyoscine appears to have been made by the medical staff. At this stage Mr Cunningham's respiratory signs are likely to have been due to bronchopneumonia or respiratory depression resulting in depressed clearance of bronchial secretions. A medical assessment was very necessary at this

stage to diagnose the cause of symptoms and to consider treatment with antibiotics or reduction in the dose of diamorphine and midazolam.

3.16 Again I consider it very poor practice that the midazolam was increased from 20mg/24hr to 60mg/24 hr at 2000h on 23rd September. There is no entry in the medical notes to explain this dose increase. The decision to triple the midazolam dose appears to have been made by a member of nursing staff as the nursing notes record "*agitated at 2300h, syringe driver boosted with effect*"

3.17 A medical assessment should have been obtained before the decision to increase the midazolam dose was made. At the very least Mr Cunningham's problems should have been discussed with on call medical staff. Mr Cunningham's agitation may have been due to pain, where increasing analgesia would have been appropriate, or hypoxia (lack of oxygen). If Mr Cunningham's agitation was due to hypoxia a number of interventions may have been indicated. Reducing the diamorphine and midazolam dose would have been appropriate if hypoxia was due to respiratory depression. Commencement of oxygen therapy and possibly antibiotics would have been appropriate if hypoxia was due to pneumonia. Reducing the dose diamorphine or midazolam would have been indicated if hypoxia was due to drug-induced respiratory depression. The decision to increase the midazolam dose was not appropriately made by the ward nursing staff without discussion with medical staff.

3.18 When Mr Cunningham was reviewed by Dr Lord on 24th September he was very unwell but there is not a clear description of his respiratory status or whether he had signs of pneumonia. At this stage Dr Lord notes Mr Cunningham is in pain, but does not state the site of his pain. It is not clear to me whether the subsequent alteration in infusion rate of diamorphine, hyoscine and midazolam was discussed with and sanctioned by Dr Lord or Dr Barton. I consider the increase in midazolam from 60mg/24 hr to 80mg/24 hr was inappropriate as a response to the observation that Mr Cunningham was in pain. It would have been more appropriate to increase the diamorphine dose or even consider treatment with a non-steroidal anti-inflammatory drug. The increase in midazolam dose to 80mg/24 hr would simply make Mr Cunningham less conscious than he already appears to have been (there is not a clear description of his conscious level at this stage).

3.19 The increase in hyoscine dose to 800microg/24 hr is also difficult to justify when there is no record that the management of bronchial secretions was a problem. The subsequent threefold increase in diamorphine dose later that day to 60mg/24 hr is in my view very poor practice. Such an increase was highly likely to result in respiratory depression and marked depression of conscious level, both of which could lead to premature death. The description of Mr Cunningham, was that analgesia was 'just' controlling pain and a more cautious increase in diamorphine dose, certainly no more than two fold, was indicated with careful review of respiratory status and conscious level after steady state levels of diamorphine would have been obtained about 20 hours later. A more appropriate response to deal with any acute breakthrough pain is to administer a single prn (intermittent) dose of opiate by the oral or intramuscular route, depending on whether Mr Cunningham was unable to swallow at this time.

3.20 The increase in both diamorphine dose and midazolam dose on 26th September is difficult to justify when there is no record in the medical or nursing notes that Mr Cunningham's pain was uncontrolled. Although it is possible to accept the increase in diamorphine dose may have been appropriate if Mr Cunningham was observed to be in pain, I find the further increase in midazolam dose to 100mg/24hr of great concern. I would anticipate that this dose of midazolam administered with 80mg/24hr of diamorphine would be virtually certain to produce respiratory depression and severe depression of conscious level. This would be expected to result in death in a frail individual such as Mr Cunningham. I would expect to see very clear reasons for the use of such doses recorded in the medical notes.

3.21 I can find no record of Mr Cunningham receiving food or fluids following his admission on 21st September despite a note from Dr Lord that Mr Cunningham was to receive a 'high protein diet'. There is no indication in the medical or nursing notes as to whether this had been discussed, but given that Mr Cunningham was admitted with the intention of returning to his Nursing Home (it was to be held open for 3 weeks) I would expect the notes to record a clear discussion and decision making process involving senior medical staff accounting for the decision to not administer subcutaneous fluids and/or nasogastric nutrition once Mr Cunningham was commenced on drugs which may have made him unable to swallow fluids or food.

Recorded causes of death

3.22 The recorded cause of death was bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer. A post mortem was not obtained and the recorded causes were in my opinion reasonable. It is possible that Mr Cunningham died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mr Cunningham was at high risk of developing pneumonia even if he had not received sedative or opiate drugs, bronchopneumonia can occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia as reasonable. Even if the staff had considered Mr Cunningham had drug-induced respiratory depression as a contributory factor, it would not be usual medical practice to enter this as a contributory cause of death where the administration of such drugs was considered appropriate for symptom relief.

Duty of care issues

3.23 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care to attempt to heal Mr Cunningham's sacral ulcer and to document the effects of drugs prescribed. In my opinion this duty of are was not adequately met and the denial of fluid and diet and prescription of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Cunningham's death.

Summary

3.24 In summary although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer, Dr Barton and the ward staff appear to have considered Mr Cunningham was dying and had been admitted for terminal care. The medical and nursing records are inadequate in documenting his clinical state at this time. The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression.

ALICE WILKIE

Course of Events

4.1 Alice Wilkie was 81 years old when admitted under the care of Dr Lord, by her general practitioner on 31st July 1998 from Addenbrooke Rest Home to Phillip Ward, Department of Medicine for Elderly People, at the Queen Alexandra Hospital, Portsmouth. The general practitioner referral letter states "*This demented lady has been in this psychogeriatric care home for a year. She had a UTI early this week and has not responded to trimetheprim. Having fallen last night, she is not refusing fluids and is becoming a little dry*". The medical admitting notes record she was taking prozac (fluoxetine) syrup 20 mg once daily, codanthramer 5-10ml nocte, lactulose 10ml once daily zopiclone 1.875 or 3.75mg nocte and promazine syrup 25mg as required. On examination she had a fever and bilateral conjunctivitis but no other significant findings. The admitting doctor diagnosed a urinary tract infection and commenced intravenous antibiotics to be administered after a blood culture and catheter specimen of urine had been obtained. The following day DNR (do not resuscitate) is recorded in the notes. On 3rd August 1998 the medical notes record the fever had settled, that she was taking some fluids orally, was taking the antibiotic Augmentin elixir orally and receiving subcutaneous fluids. The notes then record (date not clear) that her Mental Test Score was 0/10 and Barthel 1/20 (indicating severe dependency). Mrs Wilkie was to be transferred to Daedalus NHS continuing care ward on 6th August 1998 with a note that her bed was to be kept at Addenbrooke Rest Home.

4.2 Following transfer on 6th August an entry in the medical notes states "*Transferred from Phillips Ward. For 4-6/52 only. On Augmentin for UTI*". Dr Lord writes on 10th August 1998 '*Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrooke's. R/V* (review) *in 1/12* (one month) *–if no specialist medical or nursing problems D* (discharge) *to a N/Home. Stop fluoxetine*'. The next entry is by Dr Barton on 21st August "*Marked deterioration over last few days. sc analgesia commenced yesterday. Family aware and happy*". The final entry is on the same day at 1830h where death is confirmed. The most recent record of the patient's weight I can find is 56Kg in April 1998.

4.3 The nursing notes, which have daily entries during her one week stay on Phillip ward note she was catheterised, was confused at times and was sleeping well prior to transfer. The nursing notes on Daedalus ward record "6/8/98 *Transferred from Philip ward QAH for 4-6 weeks assessment and observation and then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration*" and that she was seen by Dr Peters. The nursing assessment sheet notes "*does have pain at times unable to ascertain where*". The nutrition care plan states on 6th August 1998 "*Due to dementia patient has a poor dietary intake*". And dietary intake is recorded between 12th August and 18th August but not before or following these dates. Nursing entries in the contact record state on 17th August 1998 "*Condition has generally deteriorated over the weekend Daughter seen- aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain*". There is no entry in the notes on 20th August or preceding few days indicating Mrs Wilkie was in pain.

4.4 A nursing entry on 21st August 1998 at 1255h states "*Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free*". There are a number of routine entries in the period 6th August 1998 to death on 21st August 1998 in nutrition, pressure area care, constipation, catheter care, and personal hygiene. The nursing care plan records no significant deterioration until 21st August where it is noted death was pronounced at 2120h by staff nurse Sylvia Roberts. Cause of death was recorded as bronchopneumonia.

4.5 The drug charts records that Dr Barton prescribed as a regular daily review (not intermittent as required) prescription diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr all to be administered subcutaneously. The prescription is not dated. Drugs were first administered on 20th August, diamorphine at 30mg/24hr and midazolam 20mg/24hr from 1350h and then again on 21st August. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her admission to Daedalus ward prior to administration of the diamorphine and midazolam infusions. During the period 16th-18th August she was prescribed and received zopiclone (a sedative hypnotic) 3.75mg nocte and co-danthramer 5-10ml (a laxative) orally.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

4.6 Primary responsibility for the medical care of Mrs Wilkie during her admission to Daedalus ward lay with Dr Lord, as the consultant responsible for her care. She saw Mrs Wilkie on 10th August 1998, 11 days prior to her death. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Wilkie and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

4.7 The initial diagnosis of a urinary tract infection and dehydration was reasonable and appears correct. Mrs Wilkie had a diagnosis of dementia, which there was clear evidence for. The entry by Dr Lord on 10th August 1998 provides a reasonable assessment of her functional level at this time, and a plan to review appropriate placement in one month's time. No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15th August. There is no medical assessment in the notes following 10th August except documentation on 21st August 1998 of a marked deterioration. There is no clear evidence that Mrs Wilkie was in pain although she was commenced on opiate analgesics.

Evaluation of drugs prescribed and the administration regimens

4.8 No information is recorded in the medical or nursing notes to explain why Mrs Wilkie was commenced on diamorphine and hyoscine infusions. In my opinion there was no indication for the use of diamorphine and hyoscine in Mrs Wilkie. Other oral analgesics, such as paracetamol and mild opiate drugs could and should first have been tried, if Mrs Wilkie was in pain, although there is no

evidence that she was. If these were inadequate oral morphine would have been the next appropriate choice. From the information I have seen in the notes it appears the diamorphine and midazolam may have been commenced for non-specific reasons, perhaps as a non-defined palliative reasons as it was judged she was likely to die in the near future.

4.9 I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. I consider it poor and hazardous management to initially commence both diamorphine and midazolam in a frail elderly underweight patient with dementia such as Mrs Wilkie. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

Quality and sufficiency of the medical records

4.10 The medical and nursing records during her stay on Daedalus ward are inadequate not sufficiently detailed, and do not provide a clear picture of Mrs Wilkie's condition. In my opinion the standard of the notes falls below the expected level of documentation on a continuing care or rehabilitation ward. The assessment by Dr Lord on 10th August 1998 is the only satisfactory medical note entry during her 15 day stay on Daedalus ward.

Appropriateness and justification of the decisions that were made

4.11 As discussed above I do not consider the decision to commence diamorphine and hyoscine was appropriate on the basis of the information recorded in the clinical notes.

Recorded causes of death

4.12 There was no specific evidence that bronchopneumonia was present, although this is a common pre-terminal event in frail older people and is often entered as the final cause of death in frail older patients. I am surprised the death certificate did not apparently refer to Mrs Wilkie's dementia as a contributory cause. It is possible Mrs Wilkie's death was due at least in part to respiratory depression from the diamorphine she received, or that the diamorphine led to the development of bronchopneumonia. However since there are no clear observations of Mrs Wilkie's respiratory observations it is difficult to know whether respiratory depression was present Mrs Wilkie deteriorated prior to administration of diamorphine and midazolam infusion, and in view of this, my opinion would be that although the opiate and sedative drugs administered may have hastened death, and these drugs were not indicated, Mrs Wilkie may well have died at the time she did even if she had not received the diamorphine and midazolam infusions.

Duty of care issues

4.13 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care, to monitor, and to document the effects of drugs prescribed to Mrs Wilkie. In my opinion this duty of care was not adequately met, the prescription of diamorphine and midazolam was poor practice and this may have contributed to Mrs Wilkie's death.

Summary

4.14 In my opinion the prescription of subcutaneous diamorphine and midazolam was inappropriate, and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death. However Mrs Wilkie was a frail very dependent lady with dementia who was at high risk of developing pneumonia. It is possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Robert WILSON

5.1 Mr Wilson was 75 years old man when he was admitted to Queen Alexandra Hospital on 22nd September 1998 after he sustained a proximal fracture of the left humerus. He was treated with morphine, initially administered intravenously and then subcutaneously. He developed vomiting. On 24th September he was given 5mg diamorphine and lost sensation in the left hand. On 29th September an entry in the medical notes states *"ref to social worker, review resus status. Not for resuscitation in view of quality of life and poor prognosis".*

5.2 On 7th October the notes record he was *"not keen on residential home and wished to return to his own home".* Code A Consultant in Old Age Psychiatry on 8th October 1998, saw him. Code A 's letter on 8th October notes that Mr Wilson had been sleepy and withdrawn and low in mood but was now eating and drinking well and appeared brighter in mood. His Barthel score was 5/20. Dr Lusznat noted he had a heavy alcohol intake during the last 5 years. At the time he was seen by Code A her was prescribed thiamine 100 mg daily, multivitamins two tablets daily, senna two tablets daily, magnesium hydroxide 10 mls twice daily and paracetamol 1g four time daily. On examination he had mildly impaired cognitive function (Mini Mental State Examination 24/30). Code A considered Mr Wilson might have developed an early dementia, which could have been alcohol related, Alzheimer's disease or vascular dementia. An antidepressant trazadone 50mg nocte was commenced. Code A states at the end of her letter *'On the practical side he may well require nursing home care though at the moment he is strongly opposed to that idea I shall be happy to arrange follow up by our team once we know when and where he is going to be discharged'.* On 13th October the medical notes record a ward round took place, that he required both nursing and medical care, was at risk of falling and that a short spell in long-term NHS care would be appropriate. Reviewing the drug charts Mr Wilson was taking regular soluble paracetamol (1g four times daily) and codeine phosphate 30mg as required for pain. Between 8th and 13th October Mr Wilson was administered four doses of 30mg codeine. Mr Wilson's weight in March 1997 was 93Kg

5.3 On the 14th October Mr Wilson was transferred to Dryad Ward. An entry in the medical notes by Dr Barton reads *'Transfer to Dryad ward continuing care. HPC fracture humerus. needs help with ADL (activities of Daily Living), hoisting, continent, Barthel 7. Lives with wife. Plan further mobilisation".* On 16th November the notes record; *'Decline overnight with S.O.B. o/e ? weak pulse. Unresponsive to spoken work. Oedema ++ in arms and legs. Diagnosis ?silent MI, ? decreased __ function. ↑frusemide to 2 x 40mg om '.* On 17th October the notes record *'comfortable but rapid deterioration'.* On 18th October staff nurse Collins records death at 2340h. Cause of death is recorded as congestive cardiac failure.

5.4 Nursing notes state in the summary section on 14th October *"History of left humerus fracture, arm in collar and cuff. Long history of heavy drinking. LVF chronic oedematous legs. S/B Dr Barton. Oramorph 10mg/5ml given. Continent of urine – uses bottles".* On 15th October *"Commenced oramorph 10mg/5ml 4 hrly for pain in L arm. Wife seen by sis. Hamblin who explained*

Robert's condition is poor'. An earlier note states "*settled and slept well*". On 16th October "*seen by Dr Knapman an as deteriorated over night. Increase frusemide to 80mg daily. For A.N.C (active nursing care)*. Later that day a further entry states "*Patient very bubbly chest this pm. Syringe driver commenced 20mg diamorphine, 400mcgs hyoscine. Explained to family reason for driver*". A separate note on 16th October in the nursing care plan states "*More secretions – pharyngeal – during the night, but Robert hasn't been distressed. Appears comfortable*". On 17th October 0515h "*Hyoscine increased to 600mcgs as oro-pharyngeal secretions increasing. Diamorphine 20mg.*" Later that day a further entry states "*Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver reviewed at 15.50 s/c diamorphine 40mg, midazolam 20mcgs, hyoscine 800 mcgs*". A later note states "*night: noisy secretions but not distressing Robert. Suction given as required during night. Appears comfortable*". On 18th October "*further deterioration in already poor condition. Syringe driver reviewed at 14:40 s/c diamorphine 60mg, midazolam 40mg, hyoscine 1200mcg. Continues to require regular suction*'.

5.5 The medication charts record administration of the following drugs:

14 Sep 1445h oramorph 10mg
2345h oramorph 10mg
16 Sep 1610h diamorphine 20mg/24 hr, hyoscine 400 microg/24hr subcutaneous infusion
17 Sep 0515h diamorphine 20mg/24hr, hyoscine 600 microg/24hr
1550h diamorphine 40mg/24hr, hyoscine 800 microg/24hr midazolam 20mg/24hr
18 Sep 1450h diamorphine 60mg/24hr, hyoscine 1200 microg/24hr midazolam 40mg/24hr

Frusemide was administered at a dose of 80mg daily at 0900h on 15th and 16th October. An additional 80 mg oral dose was administered at an unstated time on 16th October.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

5.6 Responsibility for the care of Mr Wilson during his admission to Dryad ward lay with Dr Lord as the consultant responsible for his care. My understanding is that day to day medical care was delegated to the clinical assistant Dr Barton and during the out of hours responsibility was with the on call doctor based at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Wilson and informing medical staff of any significant deterioration.

5.7 Dr Lusznat was responsible for assessing Mr Wilson and making further recommendations concerning his future care when he was seen at Queen Alexandra Hospital.

Accuracy of diagnosis and prognosis including risk assessments

5.8 Dr Barton assessed Mr Wilson on 14th October the day he was transferred to Dyad ward. There was a plan to attempt to improve his mobilisation through

rehabilitation. There is no record of any significant symptomatic medical problems, in particular any record that Mr Wilson was in pain in the medical notes. The nursing notes suggest Mr Wilson was prescribed oramorph for pain in his arm following his admission to Dryad Ward. He was prescribed paracetamol to take as required but did not receive any paracetamol whilst on Dryad Ward.

5.9 Mr Wilson deteriorated on 15th September when he became short of breath. The working diagnosis was of heart failure due to a myocardial infarct. I do not consider the assessment by the on call doctor of Mr Wilson was adequate or competent. There is no record of his blood pressure, clinical examination findings in the chest (which might have indicated whether he had signs of pulmonary oedema or pneumonia). In my opinion an ECG should have been obtained that night, and a Chest Xray obtained the following morning to provide supporting evidence for the diagnosis. Mr Wilson was admitted for rehabilitation not terminal care and it was necessary and appropriate to perform reasonable clinical assessments and investigations to make a correct diagnosis.

5.10 Following treatment Mr Wilson was noted to have had a rapid deterioration. The medical and nursing teams appear to have failed to consider that Mr Wilson's deterioration may have been due to the diamorphine infusion. In my opinion when Mr Wilson was unconscious the diamorphine infusion should have been reduced or discontinued. The nursing and medical staff failed to record Mr Wilson's respiratory rate, which was likely to have been reduced, because of respiratory depressant effects of the diamorphine. The diamorphine and hyoscine infusion should have been discontinued to determine whether this was contributing to his deteriorating state. There is no record of the reason for the prescribing of the midazolam infusion commenced the day before his death. At this time the nursing notes record he was comfortable. Mr Wilson did not improve. The medical and nursing teams did not appear to consider that the diamorphine, hyoscine and midazolam infusion could be a major contributory factor in Mr Wilson's subsequent decline. The infusion should have been discontinued and the need for this treatment, in my opinion unnecessary at the time of commencement, reviewed.

Evaluation of drugs prescribed and the administration regimens

5.11 The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate. His pain had been controlled with regular paracetamol and as required cocaine phosphate (a mild opiate) prior to his transfer, and in the first instance these should have been discontinued.

5.12 I am unable to establish when Dr Barton wrote the prescription for subcutaneous diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr, and midazolam 20-80mg/24hr as these are undated. The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate. The prescription of a single dose of intravenous opiate is standard treatment for a patient with chest pain following myocardial infarction is appropriate standard practice but was not indicated in Mr Wilson's case as he did not have pain. The prescription of an initial single dose of diamorphine is appropriate as a

treatment for pulmonary oedema if a patient fails to respond to intravenous diuretics such as frusemide. Mr Wilson was not administered intravenous frusemide or another loop diuretic. Instead only a single additional oral dose of frusemide was administered. In my opinion this was an inadequate response to Mr Wilson's deterioration. The prescription of continuous subcutaneous infusion of diamorphine and hyoscine is not appropriate treatment for a patient who is pain free with a diagnosis of a myocardial infarction and heart failure. When opiates are used to treat heart failure, close monitoring of blood pressure and respiratory rate, preferably with monitoring of oxygen saturation is required. This was not undertaken.

5.13 The increase in diamorphine dose to 40mg/24hr and then 60mg/24 hr in the following 48 hours is not appropriate when the nursing and medical notes record no evidence that Mr Wilson was in pain or distressed at this time. This was poor practice and potentially very hazardous. Similarly the addition of midazolam and subsequent increase in dose to 40mg/24hr was in my opinion highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive.

Quality and sufficiency of the medical records

5.14 The initial entry in the medical records by Dr Barton on 4th October is reasonable and sufficient. The subsequent entries relating to Mr Wilson's deterioration are in my opinion inadequate, and greater detail and the results of examination findings should have been recorded. No justification for the increases in diamorphine, midazolam and hyoscine dose are written in the medical notes. The nursing notes are generally of adequate quality but I can find no record of fluid and food intake by Mr Wilson.

Appropriateness and justification of the decisions that were made

5.15 I consider the prescription of oramorph was inappropriate. The subsequent prescription and administration of diamorphine, hyoscine and midazolam was highly inappropriate, not justified by information presented in the notes and could be expected to result in profound depression of conscious level and respiratory depression in a frail elderly man such as Mr Wilson.

Recorded causes of death

5.16 The recorded cause of death was congestive cardiac failure. The limited clinical information recorded in the absence of a chest X-ray result or post-mortem findings, suggest this may have been the cause of Mr Wilson's death. However in my opinion it is highly likely that the diamorphine, hyoscine and midazolam infusion led to respiratory depression and/or bronchopneumonia and it is possible that Mr Wilson died from drug induced respiratory depression.

Duty of care issues

5.17 Medical and nursing staff on Dryad ward had a duty of care to deliver appropriate medical and nursing care to Mr Wilson, and to monitor the effects of drugs prescribed. In my opinion this duty of care was not adequate. The administration of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Wilson's death.

Summary

5.18 Code A was a frail elderly man with early dementia who was physically dependent. Following his admission to Dryad ward he was, in my opinion, inappropriately treated with high doses of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and/or the development of bronchopneumonia and may have contributed to his death.

Eva PAGE

6.1 Eva Page was 87 years old when admitted as an emergency on 6th February 1998 to the Department of Medicine for Elderly People at Queen Alexandra Hospital. The medical notes record that she had experienced a general deterioration over the last 5 days was complaining of nausea and reduced appetite and was dehydrated. She had felt 'depressed' during the last few weeks. On admission she was taking ramipril 5mg once daily (a treatment for heart failure and hypertension), frusemide 40mg once daily (treatment for fluid retention), digoxin 125microg once daily (to control irregular heart rate), sotalol 40 mg twice daily (to control irregular heart rate), aspirin 75 mg once daily (to prevent stroke and myocardial infarction) and sertraline 50mg once daily (an antidepressant commenced by her general practitioner on 26th January 1998). A discharge summary and medical notes relating to an admission in May 1997 states that she was admitted with acute confusion, had reduced movement on the right side and was discharged back to her residential home on aspirin. No admitting diagnosis is recorded in the clerking notes written by Dr Harris on 6th February 1998 but they record that *"patient refuses iv fluids and is willing to accept increased oral fluids"*.

6.2 On 7th February 1998 the medical notes record an opacity seen on the chest Xray and sate *"mood low. Feels frightened – doesn't know why. Nausea and ??. Little else. Nil clinically."* An increased white cell count is noted (13.0) and antibiotics commenced. A subsequent chest Xray report (undated) states there is a 5cm mass superimposed on the left hilum highly suspicious of malignancy. The medical notes on 11 February 1998 record this at the Xray meeting. On 12th February 1998 the notes record (? Dr Shain) *'In view of advanced age and in the management should be palliative care. Charles Ward is suitable. Not for CPR'*. On 13th February the notes record *'remains v low Appears to have 'given up' d/w son re probably diagnosis d/w RH (residential home) re ability to cope'*. The notes record *'son agrees not suitable for invasive Tx (treatment). Matron from RH visiting today will check on ability to cope'*.

6.3 On 15th February the notes record she fell on the ward and experienced minor cuts. On 16th February *'gradual deterioration, no pain, confused. For Charles Ward she could be discharged to community from Charles Ward'*. On 19th February the notes summarise her problems *'probable Carcinoma of the bronchus, previous left ventricular failure, atrial fibrillation, digoxin toxicity and a transient ischaemic attack, that she was sleepy but responsive, states that she is frightened but doesn't know why. Says she has forgotten things, not possible to elicit what she can't remember, low MTS (mental test score). Plan encourage oral fluids, s/c fluid over night if tolerated. Continue antidepressants'*. On 18th February the medical notes state *"No change. Awaiting Charles Ward bed"*.

6.4 The nursing notes record she was confused but mobilised independently. On 19th February she was transferred to Charles Ward instead of the preferred option of a bed at Gosport Hospital, which the notes record was full ('no beds'). The Queen Alexandra Hospital medical notes record a summary of her problems on 19th February prior to transfer as follows *" Diagnosis CA bronchus probable [no histology] Diag based on CXR. PMH 95 L VF + AF 95 Digoxin toxicity 97 TIA. Admitted 6.2.98 general deterioration CXR ? Ca Bronchus.*

Well defined O lesion. Exam: sleepy but responsive answers appropriately. States that she is frightened but doesn't know why. Says she has forgotten things. Not possible to elicit what she can't remember. Low MTS" and *"Feels in general tired and very thirsty. Plan encourage oral fluids, s/c fluid overnight is tolerated continue antidepressants"*.

6.5 The medical notes on 23rd February record diagnoses of depression, dementia, ? Ca bronchus, ischaemic heart disease and congestive heart failure. On 25th February Dr Lord records in the medical notes "*confused and some agitation towards afternoon – evening try tds* (three times daily) *thioridazine, son in Gosport, transfer to Gosport 27/2, heminevrin prn nocte*. A further entry states *'All other drugs stopped by Dr Lord'*.

6.6 Mrs Page was transferred to Dryad ward at Gosport War Memorial Hospital on 27th February 1998. Dr Barton writes in the medical notes "*Transfer to Dryad ward continuing care, Diagnosis of Ca Bronchus on CXR on admission. Generally unwell off legs, not eating, bronchoscopy not done, catheterised, needs help with eating and drinking, needs hoisting, Barthel 0. Family seen and well aware of prognosis. Opiates commenced. I'm happy for nursing staff to confirm death*". The nursing notes state she was admitted for '*palliative care*', that she had a urinary catheter (inserted on 22nd February 1998) was incontinent of faeces, and was dependent for washing and dressing but could hold a beaker and pick up small amounts of food. Barthel Index was 2/20. The nursing action plan states '*encourage adequate fluid intake*'. On 28th February an entry in the medical notes by Dr Laing (duty GP) record '*asked to see: confused. Feels 'lost' agitated esp. night/evening, not in pain, to give thioridazine 25mg tds regular, heminevrin noct.* The nursing notes record she was very distressed and that she was administered thioridazine and Oramorph 2.5ml.

6.7 On 2nd March Dr Barton records '*no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain; Son to be seen by Dr Lord today*'. A subsequent entry by Dr Lord on the same day states ' *spitting out thioridazine, quieter on prn sc diamorphine. Fentanyl patch started today. Agitated and calling out even when staff present (diagnoses) 1) Ca Bronchus 2) ? Cerebral metastases. -ct* (continue) *fentanyl patches.*' A further entry by Dr Lord that day records '*son seen. Concerned about deterioration today. Explained about agitation and that drowsiness was probably due in part to diamorphine. He accepts that his mother is dying and agrees we continue present plan of Mx* (management)".

6.8 On 2nd March the nursing notes record "*commenced on Fentanyl 25mcg this am. Very distressed this morning seen by Dr Barton to have and diamorphine 5mg i/m (intramuscular) same given 0810h by a syringe driver.* A further entry the same day states "*S/B Dr Lord. Diamorphine 5mg i/m given for syringe driver with diamorphine loaded*". On 3rd March a rapid deterioration in Mrs Page's condition is recorded '*Neck and left side of body rigid – right side rigid,* At 1050h diamorphine and midazolam were commenced by syringe driver. Death is recorded later that day at 2130h, 4 days following admission to Dyad ward.

6.9 The prescription charts (which are incompletely copied in notes made available to me) indicate she received the following drugs during this admission
Two doses of intramuscular diamorphine 5 mg were administered at 0800 and 1500h (date not visible)

28 Feb 1998	1300h thioridazine 25mg
	1620h oramorph 5mg
	2200h heminevrin 250mg in 5ml
1 Mar 1998	0700h thioridazine 25 mg
	1300h thioridazine 25 mg
	2200h heminevrin 250mg
2 Mar 1998	0700h thioridazine 25mg
	0800h fentanyl 25microg
3 Mar 1998	1050h diamorphine 20mg/24hr, midazolam 20 mg/24hr by subcutaneous infusion

On 27th February Dr Barton prescribed thioridazine 25mg (prn tds) and Oramorph (10mg/5ml) 4hrly prn. On 2nd March Dr Barton prescribed fentanyl 25microg patch (x3 days) to take as required (prn). On 3rd March Dr Barton prescribed diamorphine 20-200mg/24hr, hyoscine 200-600ucg/24hr and midazolam 20-80mg/24hr by subcutaneous infusion.
The notes do not indicate that the fentanyl patch was removed and I would assume this was continued when the diamorphine and midazolam infusion was commenced.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

6.10 Primary responsibility for the medical care of Mrs Page during her admission to Dryad Ward lay with Dr Lord, as the consultant responsible for his care. She saw Mrs Page 2 days before her transfer to Dryad ward and two days following her admission, the day before she died. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Page and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

6.11 The assessment and management of Mrs Page at Alexandra Hospital was in my opinion competent and considered. From the information in the clinical notes I would agree with the diagnosis of probable carcinoma of bronchus. The decision to prescribe an antidepressant was in my opinion appropriate. Prior to transfer to Dryad ward she was not in pain but was transferred for palliative care. Although Mrs Page was clearly very dependent and unwell, it is not clear why Dr Barton prescribed opiates to Mrs Page on admission to Dryad ward when there is no evidence she was in pain. I suspect the reason was to provide relief for Mrs Page's anxiety and agitation. This is a reasonable indication for opiates in the palliative care of a patient with known inoperable carcinoma. Mrs Page was noted to be severely dependent, Barthel Index 0, and in conjunction with a probable carcinoma of the bronchus the assessment that she required palliative care and was likely to die in the near future was appropriate.

Evaluation of drugs prescribed and the administration regimens

6.12 The prescription of the major tranquilliser thioridazine for anxiety was reasonable and appropriate. The prescribing of the sedative/hypnotic drug heminevrin was similarly reasonable although potential problems of sedation from the combination need to be considered. Mrs Page was not in pain but I consider the prescription of oramorph on 28th February to attempt to improve her distress was reasonable. By 2nd March Mrs Page remained very distressed despite prescription of Oramorph, thioridazine and heminevrin. Since the notes reported she was more settled following intramuscular diamorphine and she had been spitting out her oral medication, I would consider it appropriate to prescribe a transdermal fentanyl patch to provide continuing opioid drugs to Mrs Page. The lowest dose patch was administered but it would have been important to be aware of the potential for depression of respiration and/or conscious level that could occur.

6.13 I do not understand why subcutaneous diamorphine and midazolam infusions were commenced on 3rd March when Mrs Page had deteriorated whilst on the fentanyl patch. There is no indication in the notes that Mrs Page was in pain or distressed. The notes describe her as having undergone a rapid deterioration, which could have been due to a number of different causes, including a stroke or an adverse effect of the fentanyl patch. In my opinion the prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr was poor practice and potentially very hazardous. I would judge it poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mrs Page who was already receiving transdermal fentanyl. I would expect very clear reasons to support the use of the drugs to be recorded in the medical notes. The combination could result in profound respiratory depression and there are no symptoms recorded which suggest the administration of either drug was appropriate.

Quality and sufficiency of the medical records

6.14 The medical and nursing records relating to Mrs Page's admission to Dryad ward are in my view of adequate quality, although as stated above the reasons for the use of midazolam and diamorphine are not recorded in either the medical or nursing notes.

Appropriateness and justification of the decisions that were made

6.15 In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death. From the information I have seen in the notes it appears that Dr Barton may have commenced the diamorphine and midazolam infusion for non-specific reasons or for non-defined palliative reasons when it was judged she was likely to die in the near future.

Recorded causes of death

6.16 In the absence of a post-mortem the recorded cause of death is reasonable. Mrs Page had a probable carcinoma of the bronchus and experienced a slow deterioration in her general health and functional abilities. It is possible that Mrs Page died from drug induced respiratory depression. However Mrs Page was at high risk of dying from the effects of her probable carcinoma of the

bronchus even if she had not received sedative and opiate drugs. Bronchopneumonia can also occur as a complication of opiate and sedative induced respiratory depression but also in patients deteriorating from malignancy. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mrs Page's respiratory rate I would consider the recorded cause of death was possible. The deterioration on between the 2nd March and 3rd March could have been secondary to the fentanyl patch she received but again could have occurred in the absence of receiving this drug. There are no accurate records of Mrs Page's respiratory rate but significant potentially fatal respiratory depression was likely to have resulted could have resulted from the combination of diamorphine, midazolam and fentanyl.

Duty of care issues

6.17 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care, to monitor Mrs Page and to document the effects of drugs prescribed. In my opinion this duty of care was adequately met except during the last day of her life when the prescription of diamorphine and midazolam was poor practice and may have contributed to Mrs Willie's death.

Summary

6.18 Mrs Page was a frail elderly lady with probable carcinoma of the bronchus who had been deteriorating during the two weeks prior to admission to Dryad ward. In general I consider the medical and nursing care she received was appropriate and of adequate quality. However I cannot identify a reason for the prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton on the 3rd March. In my view this was an inappropriate, potentially hazardous prescription. I would consider it highly likely that Mrs Page experienced respiratory depression and profound depression of conscious level from the combination of these two drugs and fentanyl but I cannot exclude other causes for her deterioration and death at this time such as stroke or pneumonia.

Opinion on clinical management at Gosport War Memorial Hospital based on review of five cases presented by Hampshire Police

7.1 My opinion on the five cases I have been asked to review at Gosport War Memorial Hospital must be considered in context. My understanding is that the five cases have been selected by Hampshire Police because of concerns expressed relating to the management of these patients. Therefore my comments should not be interpreted as an opinion on the quality of care in general at Gosport War Memorial Hospital or of the general quality of care by the clinicians involved. My comments also relate to a period 2-4 years ago and the current clinical practice at the hospital may be very different today. An opinion on the quality of care in general at the hospital or of the clinicians would require a systematic review of cases, selected at random or with pre-defined patient characteristics. Examination of selected cases is not an appropriate mechanism to comment on the general quality of care of an institution or individual practitioners.

7.2 However having reviewed the five cases I would consider they raise a number of concerns that merit further examination by independent enquiry. Such enquiries could be made through further police interviews or perhaps more appropriately through mechanisms within the National Health Service, such as the Commission for Health Improvement, and professional medical and nursing bodies such as the General Medical Council or United Kingdom Central Council for Nursery, Midwifery and Health Visiting.

7.3 My principle concerns relate to the following three areas of practice: prescription and administration of subcutaneous infusions of opiate and sedative drugs in patients with non-malignant disease, lack of training and appropriate medical supervision of decisions made by nursing staff, and the level of nursing and non-consultant medical skills on the wards in relation to the management of older people with rehabilitation needs.

7.4 In all five cases subcutaneous infusions of diamorphine and in combination with sedative drugs were administered to older people who were mostly admitted for rehabilitation. One patient with carcinoma of the bronchus was admitted for palliative care. Although intravenous infusion of these drugs are used frequently in intensive care settings, very close monitoring of patients is undertaken to ensure respiratory depression does not occur. Subcutaneous infusion of these drugs is also used in palliative care, but the British National Formulary indicates this route should be used only when the patient is unable to take medicines by mouth, has malignant bowel obstruction or where the patient does not wish to take regular medication (Appendix 2). In only one case were these criteria clearly fulfilled i.e. in Mrs Page who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive doses and in combination with often no indication for dose escalation that took place. There was a failure by medical and nursing staff to recognise or respond to severe adverse effects of depressed respiratory function and conscious level that seemed to have occurred in all five patients. Nursing and medical staff appeared to have little knowledge of the adverse effects of these drugs in older people.

7.5 Review of the cases suggested that the decision to commence and increase the dose of diamorphine and sedative drugs might have been made by nursing staff without appropriate consultation with medical staff. There is a possibility that prescriptions of subcutaneous infusions of diamorphine, midazolam and hyoscine may have been routinely written up for many older frail patients admitted to Daedalus and Dryad wards, which nurses then had the discretion to commence. This practice if present was highly inappropriate, hazardous to patients and suggests failure of the senior hospital medical and managerial staff to monitor and supervise care on the ward. Routine use of opiate and sedative drug infusions without clear indications for their use would raise concerns that a culture of "involuntary euthanasia" existed on the ward. Closer enquiry into the ward practice, philosophy and individual staff's understanding of these practices would be necessary to establish whether this was the case. Any problems may have been due to inadequate training in management of older patients. It would be important to examine levels of staffing in relation to patient need during this period, as the failure to keep adequate nursing records could have resulted from under-staffing of the ward. Similarly there may have been inadequate senior medical staff input into the wards, and it would be important to examine this in detail, both in terms of weekly patient contact and in time available to lead practice development on the wards. My review of Dr Lord's medical notes and her statement leads me to conclude she is a competent, thoughtful geriatrician who had a considerable clinical workload during the period the above cases took place.

7.6 I consider the five cases raise serious concerns about the general management of older people admitted for rehabilitation on Daedalus and Dryad wards and that the level of skills of nursing and non-consultant medical staff, particularly Dr Barton, were not adequate at the time these patients were admitted.

7.7 Having reviewed the five cases presented to me by Hampshire Police, I consider they raise serious concerns about nursing and medical practice on Daedalus and Dryad wards at Gosport War Memorial Hospital. In my opinion a review of practice at the institution is necessary, if this has not already taken place. I would recommend that if criminal proceedings do not take place, that these cases are brought to the attention of the General Medical Council and United Kingdom Central Council for Nursery, Midwifery and Health Visiting, in relation to the professional competence of the medical and nursing staff, and the Commission for Health Improvement, in relation to the quality of service provided to older people in the Trust.