

FEW/147/0

QEB HOLLIS WHITEMAN


510000378502 X378502

QEB HOLLIS WHITEMAN

Code A

Code A

BF

QEB Hollis Whiteman
3rd Floor,
Queen Elizabeth Building,
Temple,
London EC4Y 9BS LDE 482
Tel: 020 7887 5766

regular drug doses and the re-evaluation of patients. Increases in drug dose or substitution of a more powerful analgesic is required if analgesia is not achieved. If patients experience adverse effects a reduction in dose or change in drug is required.

5. The management of chronic pain is more complex and requires a consideration of potential long-term adverse effects of drugs and consideration of risks of addiction and the use of other psychological interventional approaches.¹
6. Good basic principles to follow are to keep drug regimens simple, to reassess patients frequently and recognise that drug doses need to be individualised and that in some patients large doses may be required. There have been concerns that older people may be denied adequate analgesia because of undue concerns about adverse effects from moderate and potent analgesics.
7. The analgesic ladder is a commonly used framework for using analgesic drugs. Drugs are grouped into 3 main classes related to the severity of pain for which they are suitable to be prescribed. For mild pain non-opioid analgesics such as aspirin, paracetamol and ibuprofen are recommended. If these are ineffective or if the patient has more severe pain more potent anti-inflammatory drugs, such as diclofenac or naproxen, or mild opioids (codeine or dihydrocodeine) should be given in combination with paracetamol. For patients who are in severe pain or fail to achieve pain control on drugs for moderate pain more potent opioids (morphine, diamorphine) are recommended.
8. In the majority of patients with acute pain initial treatment would therefore be with drugs from the first two steps of the analgesic ladder (mild or moderate pain) with initial use of opioids only in patients with very severe pain (such as a fractured limb) or in patients who have failed to respond to appropriate doses of drugs used for moderate pain. In addition other therapies particularly anti-depressants and anti-epileptic drugs are used in patients with severe or chronic pain.
9. The most important aspect of good pain management is regular review of the patient and identification of adverse effects. Initial use of potent opioid drugs carries a risk particularly in older people of adverse effects with respiratory depression, hypotension, constipation, drowsiness, nausea and vomiting which could be avoided if pain is controlled with mild or moderate analgesics.

Use of opioid medication

10. The most commonly prescribed opioid is morphine and unless patients are unable to swallow initial dosing should be orally. The British National Formulary² states that morphine should be given regularly every 4 hours orally with an initial dose of 5-10mg. In frail elderly patients a starting dose of 5mg is preferred. The BNF states "*to reduce doses recommended in elderly or debilitated patients*". If pain relief is not obtained or is not sustained for 4 hours dose is usually increased by 50%. When pain is controlled it is common practice to switch patients to an oral sustained release preparation to reduce the frequency with which patients need to take medication. Laxatives such as senna or lactulose should be commenced to avoid constipation when morphine or other potent opioids are prescribed, nausea and vomiting should be treated with metoclopramide or haloperidol as required.

11. The parenteral route and that is the administration of opioids by intramuscular intravenous or percutaneous injection is used where more rapid pain relief is required or patients are unable to swallow as is commonly the case in patients who are receiving palliative care and deteriorating. The parenteral route is also used if bowel obstruction is present and absorption may be impaired or if patients express the desire not to take the medication. Diamorphine is the preferred opioid to use for injection³ because it is more soluble than morphine and can be given in a smaller volume. The equivalent intramuscular or subcutaneous dose is approximately one third of the oral dose of morphine.
12. Syringe drivers are used to give a continuous subcutaneous infusion of a drug or drugs. This avoids the problems of repeated intramuscular or subcutaneous injections which can be a source of discomfort in older cachectic (frail, thin, muscle wasted) patients. The BNF confirms that indications for use of the parenteral route are patients unable to take medicines by mouth because of nausea and vomiting, drowsiness or coma, bowel obstruction and if the patient does not wish to take regular medication by mouth. Incorrect use of syringe drivers are common cause of drug errors therefore it is important that staff using syringe drivers are appropriately trained and the rate settings on syringe drivers are clearly identified and differentiated².
13. The BNF reports a number of potential problems with syringe drivers. If an infusion runs too quickly patients may experience considerable toxicity and adverse effects. If an infusion runs too slowly patients will not receive adequate analgesia. There may also be injection site reactions. Infusions can run too quickly if the rate setting is set incorrectly, or drug calculations have been incorrectly performed. Infusions can run too slowly if the start button has not been used correctly, the batteries run out or there are problems with the syringe driver or cannula connections. Use of a syringe driver is an important clinical decision and the reasons why this is done should always be clearly documented in the medical records.
14. The British National Formulary provides clear advice on the process of administering equivalent doses of orally administered morphine and parentally administered diamorphine². There are situations where it is appropriate to administer sedative drugs in conjunction with opioid analgesics. However in these circumstances close monitoring is required. Failing to adequately monitor patient may result in life-threatening respiratory depression.

Issues in elderly patients

15. It is well described that older individuals are more sensitive to opioid drugs and older individuals clear the drug less rapidly from the body and studies suggest the duration of pain relief is 50% more in individuals over the age of 70 compared to those under the age of 30 years. It is usual to start with 5 mg rather than 10mg initial oral dose of morphine in frail older people. If an older individual is in considerable acute severe pain or is not frail and above average height and weight is not necessarily unreasonable to start with 10mg dose but patients need to be closely monitored.
16. In the chapter on pain relief in 'Drugs and the Older Person;' Crome writes on the treatment of acute pain; *'Treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patients and the presence of comorbidity will dictate whether to start with a mild analgesic or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be*

followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of prescribing morphine for chronic pain is to start with standard oral morphine in a dose of 5-10mg every four hours. The dose should be halved in frail older people.

17. The British National Formulary states in the 'Prescribing for the Elderly' section: *'The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and anti parkinsonian drugs, all of which must be used with caution' (BNF 36 1998 page 15).*

Medical Assessment

18. Doctors have a responsibility to provide good standards of care. GMC guidelines on good medical practice (1995) state; *Patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence, good relationships with patients and colleagues and observance of professional ethical obligations.*" The section on good clinical care states;

"You must take suitable and prompt action when necessary. This must include:

- *An adequate assessment of the patient's condition based on the history and clinical signs including, where necessary, an appropriate examination*
- *providing or arranging investigations or treatment where necessary*
- *Referring the patient to another practitioner, when indicated*

In providing care you must:

- *recognise the limits of your professional competence*
- *be willing to consult colleagues*
- *be competent when making diagnoses and when giving or arranging treatment*
- *keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatment prescribed*
- *keep colleagues informed when sharing the care of patients*
- *pay due regard to efficacy and the use of resources*
- *prescribe only the treatment, drugs, or appliances that serve patients' needs*

The 1995 GMC Guidelines state in the section on delegating care to non-medical staff and students *"You may delegate medical care to nurses and other health care staff who are not registered medical practitioners if you believe it is best for the patient. But you must be sure that the person to whom you delegate is competent to undertake the procedure or therapy involved. When delegating care or treatment, you must always pass on enough information about the patient and the treatment needed. You will still be responsible for managing the patient's care."*

19. The 1995 GMC Guidelines state in the section on arranging cover *"You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors.'* The 1998 GMC Guidelines on Good Medical Practice which replaced the 1995 guidelines in July 1998 did not change any of the above recommendations.

20. There are important reasons why good medical practice places these responsibilities on doctors. Failing to undertake an adequate assessment of the patient's condition means that an inaccurate diagnosis may be made and inappropriate treatment given. Similarly failing to recognise limits of professional competence results in patients are put at risk from potentially incompetent treatment decisions. Failure to keep clear, accurate and contemporaneous patient records means there is no clear information in the notes concerning the patient's condition for other health professionals to refer to and appropriately base their care. If there are no entries in the medical notes that record the thinking, diagnosis and treatment plan put in place at the time, the doctor relies entirely on their memory for making future treatment decisions and for justifying treatment decisions if these are challenged at a future date. Failure to record any adverse effects of treatment means there is no record in the notes for health care professionals to avoid re-providing this treatment.
21. A medical assessment is generally performed in any patient admitted to hospital shortly after their arrival on a ward. In most cases unless clerical and nursing staff record patient details and nursing assessments before a patient is seen by a doctor. Medical assessment of a patient on arrival to a hospital ward to review their history and current problems, perform a physical examination, arrange any appropriate investigations and prescribe necessary drug and other treatments. This baseline assessment is important in establishing a diagnosis, and implementing an appropriate management plan. It also provides a baseline assessment against which future symptoms and problems can be assessed.
22. A medical assessment is required when a patient is transferred from one hospital to another for a number of reasons. The patient may develop new problems during transfer. The referring hospital may not have recorded or transferred all necessary information. For older patients transferring from an acute ward to a rehabilitation or continuing care environment a medical assessment is important to confirm they are medically stable and appropriate to stay in a ward environment where there is a lower level of medical and other support services.
23. It is important that the results of an initial medical assessment are recorded in the notes are available for other medical and health care staff to refer to if a patient has new symptoms or problems. On call doctors are called to assess patients and information on their baseline function active problems and level of intervention agreed to be appropriate, is important in helping staff to make appropriate decisions about treatment.
24. A general principle well recognised in medical practice is that if a doctor does not record the results of a history or clinical examination they undertake the assumption is that no such assessment was undertaken. Given the busy nature and multiple patient contacts doctors have, retrospective recall by doctors of the details of the assessment that they took in an individual patients in the absence of a record in the medical notes, either by themselves or another member of the medical team is unlikely to be reliable.
25. GMC guidance in 1995 and 1998 emphasised the importance that doctors recognise limits of their professional competence and be willing to consult colleagues. This is a particularly important for doctors who are trainees or non-specialists working under the supervision of a consultant specialist as was the case with Code A general practitioner acting as a Code A. In a setting such as Gosport War Memorial Hospital it would be appropriate to discuss and seek advice from the responsible consultant for any patient

where the management plan was unclear, where there were complex or difficult management issues where diagnosis or treatment was not clear-cut it would have also been appropriate to seek advice and discuss with the responsible consultants any major change in a patient's medical status particularly if there was unexpected deterioration. If a patient had not been identified and admitted for palliative terminal care I would consider it important any decision about palliative care was discussed with the responsible consultant.

26. When patients deteriorate in a setting such as Gosport War Memorial Hospital where modern diagnostic services and specialist advice is not easily available it may be necessary for patients to return to the main district general hospital for further assessment. It would be appropriate and expected for a Code A to discuss this with the responsible consultant or another consultant who was acting on behalf of the responsible consultant if he/she was not available.

Medical records and Drug Prescription Charts

27. As previously mentioned GMC guidance places clear emphasis on importance of keeping clear, accurate and contemporaneous patient records. Failing to follow this approach results in the problems already outlined in section 6.
28. Drug charts play an important role in treatment prescribed by doctors the details of the drug dose and time and route through the drug should be administered. It is important that drug charts are clearly completed by medical staff as drugs are generally given by nursing staff who need to be able to clearly identify the drug dose, date and time that drugs should be administered to patients.
29. Many drugs are prescribed at a fixed dose on a regular basis. Sometimes drugs are prescribed as a single dose or written on "as required" basis (often referred to as PRN *pro re nata* meaning as necessary). The administration of drug therapy is recorded in a column on the drug chart relating to a specific day and time usually the initialled signature of the member of nursing staff responsible for administering the medication. Treatment instructions may be given to discontinue treatment on a certain date. This is commonly the case for antibiotic prescriptions. If a drug is discontinued the prescription has a line put through and the date of discontinuation inserted along the initials of the doctor making this treatment change.
30. When drugs are prescribed on an "as required" basis nursing staff are able to use their judgement as to when the drug needs to be administered to the patient and to decide on an appropriate dose if there is a range of doses written. It is common for patients to be written up for a range of opiate doses when requiring potent analgesia. This allows a member of nursing staff to adjust the dose according to a response from previous doses. Usually the range of doses prescribed is small for example 5-10mg of morphine or 2.5mg of diamorphine. If a large dose range is written for a PRN drug there is a risk, unless the drugs are being administered according to a clear protocol understood by all nursing staff, that a patient may be administered an inappropriately high dose of opiate which could lead to respiratory depression, coma and in some cases death.

Standards and Guidelines

31. The British National Formulary is the main reference text doctors should generally refer to in obtaining information about drugs they prescribe to ensure an appropriate drug is

chosen for the condition being treated and is given at the correct dose. The BNF has a section on analgesics (4.7 BNF 36, September) with a section on the use of opioid analgesics. This states that a reduced dose is recommended in elderly or debilitated patients. Side effects are listed including respiratory depression, confusion and drowsiness. Recommended doses for individual drugs are listed. The BNF also contains sections on prescribing in the elderly and the use of syringe drivers in palliative care (see sections 8 and 9 of this report).

32. I have also seen The Palliative care Handbook produced by Portsmouth Healthcare NHS Trust known as the Wessex Protocols, produced to help GPs and other healthcare professionals in managing problems in specialist care. The general principles of symptom management in this document (page 4) state *'Accurate and full assessment is essential for both diagnosis and treatment'*, *'Be careful that drug side effects do not become worse than the original problem'* and *'continually reassess'*. The WHO analgesic ladder is described. In the use of morphine the recommendation is starting with a low dose and increase by 30-50% increments each day until pain is controlled or side effects prevent any further increase. In an older patient an appropriate low dose would be 5 mg morphine.
33. The 'Wessex Protocols' recommend that prn doses are prescribed at the same dose as the 4 hourly dose and repeated as often as necessary (hourly if necessary) for breakthrough pain and to review every 24 hours. A syringe driver is recommended when oral administration is not possible because of dysphagia, vomiting or weakness and the conversion of oral morphine to subcutaneous diamorphine should be one third to one half of the morphine dose i.e. a 24 hour oral dose of 30 mg morphine should be replaced with a 10-15 mg diamorphine infusion over 24hr.
34. In the management of anxiety, diazepam is recommended and if a patient is unable to swallow midazolam 10-20mg per 24 hours by continuous subcutaneous infusion. Opioids are not recommended as a treatment for anxiety. For terminal restlessness drug therapy with diazepam (20-60mg per 24 hours orally or rectally), midazolam (10-60mg per 24 hours orally or by subcutaneous infusion) are recommended as possible treatment options.

Matters specific to Gosport War Memorial Hospital

Code A Position

35. **Code A** posts are non-training service, usually part time posts established by hospitals generally undertaken by general practitioners. These posts generally work a number of half days (often referred to as sessions) and the person reports to a consultant responsible for the care of the patients. The job description (undated) for the post of **Code A** **Code A** to the Geriatric Division in Gosport that was undertaken by **Code A** states *'This is a new post of 5 sessions a week worked flexibly to provide a 24 hour Medical cover to the Long stay patients in Gosport. The patients are slow stream or slow stream rehabilitation but holiday relief and shared care patients are admitted.'*
36. How many hours **Code A** should have worked on the ward during the usual working week Monday – Friday 8am -5pm is unclear. I would estimate out of our calls to the wards would not account for more than 4 hours time in a working week on average so it might be reasonably expected that **Code A** in her position as **Code A** was present on the wards for 16 hours a week i.e. about 3 hours per day.

37. The job description suggests the post had responsibility for 11 patients at Gosport War Memorial Hospital, 12 patients at Northcott Annexe and 23 patients at Redclyffe Annexe. However the Commission for Healthcare Improvement report states that in [Code A] [Code A] had responsibility for Dryad (20 beds) and Daedalus (24 beds) wards. In 1997/8 there were 169 finished consultant episodes (which equates to admissions) for these wards and in 1998/99 197 finished consultant episodes⁵. Therefore on average [Code A] would have 3-4 newly admitted patients each week to assess. As many of the patients would be stable continuing care or 'slow stream' rehabilitation patients I would consider this was adequate time to assess new patients (which should take 30-40 minutes per patient to conduct a comprehensive medical assessment) and assess any deterioration or major problems in existing patients, to document such assessments in the medical notes and attend a weekly consultant ward round. It would be insufficient time to see all patients every day or document every contact with patients and relatives.
38. The Duties described include *'To visit the units on a regular basis and to be available 'on call' as necessary. To ensure that all new patients are seen promptly after admission. To be responsible for the day to day Medical management of the patients. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date. To take part in weekly consultant rounds. To prescribe, as required, drugs for the patients under the care of the consultant Physicians in Geriatric Medicine. To provide clinical advice and professional support to other members of the caring team.'* The job description states that the sessions may be split between two separate general Practitioners, ideally from the same Practice.
39. [Code A] are usually not required to have any specialist training in the specialty they are working in. Many [Code A] would not have had specialist training as a trainee in the area of practice they work in as a general practitioner. My understanding is that [Code A] had received no specialist training or qualifications in Geriatric Medicine such as the Diploma in Geriatric Medicine that some general practitioners take. Because of the lack of specialist training it is important that they seek advice from Consultant colleagues for any aspect of patient care where they lack specialist expertise or where decisions might be seen to be contentious with patients, relatives or other health care professionals.

Continuing Care, Slow Stream Rehabilitation and Palliative Care at Gosport War Memorial Hospital

40. There appears to have been some lack of clarity of the role of the wards at Gosport War Memorial Hospital. Although the wards were continuing care wards in practice patients who required a period of rehabilitation or further assessment prior or returning to their own home or entering residential or nursing home care were admitted to these wards. Transcribed interviews with nursing staff suggest there may have been insufficient rehabilitation and nursing staff to adequately meet the needs of such patients at all times.
41. A further problem is that having two different groups of elderly patients in the wards, those requiring continuing medical and nursing care with others requiring rehabilitation patients, may lead to confusion amongst staff about the management of individual patients unless patient management plans are very clearly understood by all staff. For some of the patients transferred to Gosport War Memorial Hospital it appears to have been unclear to all staff whether individual patients were for continuing care or a period of rehabilitation. Most elderly care services in the 1990s separated out continuing care from rehabilitation beds and often changed continuing care wards into rehabilitation wards and this process appears to have been eventually completed after 2000 at Gosport War Memorial Hospital.

42. Palliative care is a very important aspect of management in frail older people who develop acute illness they are unlikely to survive or have progressive disabling disease. By definition patients in NHS continuing care beds are very dependent and are expected to die on the ward. A significant number of older frail patients in rehabilitation beds will deteriorate and palliation of symptoms prior to death will be necessary. There is no generally agreed definition of palliative care but palliative care is not confined to end-of life care. NICE has defined palliative care as *'the holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families'*. Many frail older people require and benefit from such an approach.
43. In many frail older patients receiving palliative care a decision will have been made to limit the extent of other medical interventions, for example surgery, ventilation, and antibiotics. However treatment of active medical problems is compatible and often appropriate in patients receiving palliative care. Prediction of death in frail older people is difficult. Experienced clinicians recognise that patients may die and deteriorate more quickly than anticipated or alternatively that patients who are deteriorating may improve. For these reasons management plans need to be reviewed if a patients' condition changes significantly.

Use of Drug Charts in the Gosport War Memorial Hospital

44. The drug charts in use in Gosport War Memorial Hospital have a format used in most hospitals with a section for drugs given as a single dose, a section for regular drug prescriptions, a section for 'prn' drugs to be taken as required and a section for prescribing of infusions and fluid management. Drug therapy for the patients under the care of Consultant Geriatricians at Gosport War Memorial Hospital would usually be written up by Code A in her role as Code A and sometimes by one of the consultant physicians with patients on the wards.
45. A legal prescription requires a clear written record usually placed in a drug chart of the drug dose (usually in mg or other units), frequency (e.g. once, twice daily) and route of administration (oral, intramuscular etc), start and end date to be written with the signature and date of the prescribing doctor. The responsibility for the appropriateness, accuracy and legibility of a prescription lies with the prescribing doctor. When a drug is discontinued the doctor must draw a line through the prescription and sign their initials and date. The drug chart must have the name and hospital number of the patient inserted.
46. The term 'written up' indicates that a drug prescription has been written by a doctor in the notes. The term 'prescribed' means that the drug involved has been written in the drug chart and should be given to the patient as instructed; this may be a drug administered once, regularly or 'as required' where the drug is administered by the nursing staff if specific symptoms are present. A prescription is usually made by the writing up of a prescription by the responsible doctor or sometimes by a verbal order taken by a member of nursing staff. The term administered means that a drug has been given to the patient. This might be through oral, intravenous, intramuscular injection or infusion or other routes of administration.

47. It is the responsibility of registered nursing staff to administer prescribed drugs according to the instructions written in the drug chart. Registered nursing staff work within a code of professional practice and are expected to carry out administration of medicines to certain standards. Nurses are required to act in the best interest of their patients and this may require nursing staff to challenge prescribing decisions by medical staff.
48. As required or prn prescriptions are usually expected to include a specific instruction by doctors as to the circumstances under which the prescribed drug should be administered including how frequently the drug may be administered e.g. paracetamol up to 4g /24 hours. A prn prescription of GTN might include an instruction 'for angina' or for chest pain'. Prn prescriptions do not always include instructions for drugs which have a good safety profile where it would be expected nursing staff would understand the circumstances under which drugs should be administered e.g. senna or paracetamol where it would be expected nursing staff would understand that the drugs are indicated for constipation and mild pain respectively.
49. It is important that prn "as required" prescriptions for controlled drugs, such as opioids, and other drugs with potentially severe adverse effects, such as midazolam and haloperidol, include clear instructions of the circumstances under which the drugs should be administered. This can be done through the prescriber writing instructions such as 'for severe pain' for diamorphine or by nurses using an agreed protocols or policies for the drugs or the symptoms being managed. There were no unit policies or protocols for the use of opioids and other drugs or the management of pain in the late 1990s at Gosport War Memorial Hospital. Staff at the hospital did refer to the 'Wessex protocols' but these did not appear to be followed in all patients.
50. It is possible Code A trusted nursing staff to know the circumstances under which prescriptions for morphine, diamorphine and midazolam were appropriately administered and the appropriate dose that should be used. However this appears not to have been clear to nursing staff in some patients. For example patient F was prescribed prn morphine without any instructions that this was for pain. Patient F was then administered oral morphine for anxiety and distress when not in pain by nursing staff when this is not an appropriate indication.
51. If wide dose ranges are prescribe for prn drugs there needs to be clear instructions or a policy in place to ensure an appropriate starting dose is commenced by nursing staff. In many patients prn prescriptions of diamorphine and midazolam were very wide e.g. 20-200 mg/24 hr and 20-80mg/24hr. Without clear instructions in the medical notes and drug chart or a policy in place which details appropriate staring dose there is a risk that patients will be administered an inappropriately high dose of a prn drug by nursing staff.
52. Out of hours or when Code A was on leave, other general practitioners covering the hospital would be expected to write up any drugs required out of hours. It is not clear how often on call doctors visited the wards out of hours and in some cases drugs were prescribed by a 'verbal order'. In such a system the nurse writes down the drug prescribed over the phone by the doctor and this is usually confirmed by a second nurse to reduce the chances of any error on the drug or dose prescribed. The potential problem with 'verbal orders' for drug prescriptions is that they involve the prescription of a drug for a problem that may not have been assessed by a doctor taking a history, examining and investigating the patient where this might be required.

53. Review of the notes and interviews suggest that 'anticipatory prescribing' was undertaken where drugs were prescribed for problems that patients might develop. This is sometimes done to avoid the need for a doctor to come to a ward out of hours to prescribe for a simple complaint that does not require urgent medical evaluation.
54. It was common practice in many wards in the 1980s and 1990s for mild analgesics such as paracetamol, laxatives and hypnotic drugs such as temazepam. In recent years anticipatory prescribing of hypnotic drugs in patients who are not already receiving them is now not advised because of the risk of patients developing long term dependence on benzodiazepines as these may be continued after discharge. Because the use of benzodiazepines in older people is associated with falls and hip fracture, and may produce confusion and cognitive impairment, many geriatricians avoid and limit the use of benzodiazepines in older people.
55. Anticipatory prescribing of powerful opioids and sedatives in patients who do not require them when assessed is potentially highly dangerous as the prescribing of such drugs requires careful evaluation of the patient because of the risk of serious adverse effects such as respiratory depression and coma.
56. In the late 1990s the General Medical Council had not produced guidance on prescribing. However Good Practice in Prescribing Medicines was published by the GMC in 2006 and the principles applied in the 1990s. The Guidance refers to the importance of ensuring familiarity with guidance published in the BNF, the need to be in possession of or take an adequate history from the patient, to reach agreement with the patient on the use of any proposed medication, establishing the patient's priorities, preference and concerns, to satisfy oneself that the patient has been given appropriate information in a way they can understand about drug therapy. The guidance also states that doses should be prescribed appropriate for the patient and their condition and that there must be a clear, accurate, legible and contemporaneous record of all medicines prescribed.
57. **Declaration**
- a) I understand that my overriding duty is to the panel, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
 - b) I have set out in my report what I understand from those instructing me to the questions in respect of which my opinions as an expert are required.
 - c) I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed.
 - d) I have drawn to the attention of the court all matters, of which I am aware which might adversely affect my opinion.
 - e) Wherever I have no personal knowledge, I have indicated the source of factual information.
 - f) I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me without forming my own independent view of the matter.
 - g) Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
 - h) At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires correction or qualification.

- i) I understand that the report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
- j) I have included in this and the supplementary reports a statement setting out the substance of all acts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.
- k) I have read and understood the Civil Procedure Rules Part 35 –Experts and Assessors.

Statement of Truth

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

.....

Code A

References

1. Drugs in the Older Population. Edited Crome & Ford. Imperial College Press. 2000; 580-600.
2. British National Formulary 36 1998 page 11
3. British National Formulary 36 1998 page 11
4. British National Formulary 36 1998 page 14
5. Commission for Healthcare Improvement Investigation of Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. July 2002

GMC and Code A

Generic Report on Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital

Code A

Consultant Physician

1 April 2009

This report is provided for the General Medical Council at the request of Field Fisher Waterhouse solicitors. It covers principles of medical care and matters of specific to Gosport Memorial Hospital and relates to separate individual reports provided on 12 patients.

Principles of Medical Care

Pain Relief

1. Pain is a common health problem faced by older people and relief of pain is one of the most important duties of a doctor. Pain may be defined as "*an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage*".¹ Pain is usually grouped into 4 main classes: nociceptive, neuropathic, undetermined and psychological. These are usually managed in different ways. Nociceptive pain such as due to arthritis is generally treated with analgesics. Neuropathic pain due to the nervous system is treated with anti-depressants and/or anticonvulsants. Pain of unclear or undetermined origin is treated with these and other approaches and psychological pain due to sanitization of conversion disorders with psychological approaches.
2. The principles of treatment of acute pain are to determine the underlying cause from history examination and appropriate investigation and to then treat the underlying cause and give adequate pain relief. The nature of the underlying cause and the severity of pain reported by the patient would influence the decision whether to start with a mild analgesic or proceed to use a more potent drug. Because the response to analgesia is unpredictable and there is a risk, particularly in older people, of drug toxicity the general approach of starting low and progressively increasing the dose and potency of drugs used is followed in older people. However to avoid patients remaining in pain with inadequate analgesia good management of severe pain requires the use of as required (prn) drugs in addition to regular drug doses and the re-evaluation of patients. Increases in drug dose or substitution of a more powerful analgesic is required if analgesia is not achieved. If patients experience adverse effects a reduction in dose or change in drug is required.
3. The management of chronic pain is more complex and requires a consideration of potential long-term adverse effects of drugs and consideration of risks of addiction and the use of other psychological interventional approaches.¹
4. Good basic principles to follow are to keep drug regimens simple, to reassess patients frequently and recognise that drug doses need to be individualised and that in some patients

¹ Drugs in the Older Population. Edited Crome & Ford. Imperial College Press, 2000; 580-600.

large doses may be required. There have been concerns that older people may be denied adequate analgesia because of undue concerns about adverse effects from moderate and potent analgesics.

5. The analgesic ladder is a commonly used framework for using analgesic drugs. Drugs are grouped into 3 main classes related to the severity of pain for which they are suitable to be prescribed. For mild pain non-opioid analgesics such as aspirin, paracetamol and ibuprofen are recommended. If these are ineffective or if the patient has more severe pain more potent anti-inflammatory drugs, such as diclofenac or naproxen, or mild opioids (codeine or dihydrocodeine) should be given in combination with paracetamol. For patients who are in severe pain or fail to achieve pain control on drugs for moderate pain more potent opioids (morphine, diamorphine) are recommended.
6. In the majority of patients with acute pain initial treatment would therefore be with drugs from the first two steps of the analgesic ladder (mild or moderate pain) with initial use of opioids only in patients with very severe pain (such as a fractured limb) or in patients who have failed to respond to appropriate doses of drugs used for moderate pain. In addition other therapies particularly anti-depressants and anti-epileptic drugs are used in patients with severe or chronic pain.
7. The most important aspect of good pain management is regular review of the patient and identification of adverse effects. Initial use of potent opioid drugs carries a risk particularly in older people of adverse effects with respiratory depression, hypotension, constipation, drowsiness, nausea and vomiting which could be avoided if pain is controlled with mild or moderate analgesics. To

Use of opioid medication.

8. The most commonly prescribed opioid is morphine and unless patients are unable to swallow initial dosing should be orally. The British National Formulary ⁽²⁾ states that morphine should be given regularly every 4 hours orally with an initial dose of 5-10mg. In frail elderly patients a starting dose of 5mg is preferred. The BNF states "to reduce doses recommended in elderly or debilitated patients". If pain relief is not obtained or is not sustained for 4 hours dose is usually increased by 50%. When pain is controlled it is common practice to switch patients to an oral sustained release preparation to reduce the frequency with which patients need to take medication. Laxatives such as senna or lactulose should be commenced to avoid constipation when morphine or other potent opioids are prescribed, nausea and vomiting should be treated with metoclopramide or haloperidol as required.
9. The parenteral route and that is the administration of opioids by intramuscular intravenous or percutaneous injection is used where more rapid pain relief is required or patients are unable to swallow as is commonly the case in patients who are receiving palliative care and deteriorating. The parenteral route is also used if bowel obstruction is present and absorption may be impaired or if patients express the desire not to take the medication. Diamorphine is the preferred opioid to use for injection ⁽²⁾ because it is more soluble than morphine and can be given in a smaller volume. The equivalent intramuscular or subcutaneous dose is approximately one third of the oral dose of morphine. Syringe drivers are used to give a continuous subcutaneous infusion of a drug or drugs. This avoids

the problems of repeated intramuscular or subcutaneous injections which can be a source of discomfort in older cachectic patients. The BNF confirms that indications for use of the parenteral route are patients unable to take medicines by mouth because of nausea and vomiting, drowsiness or coma, bowel obstruction and if the patient does not wish to take regular medication by mouth. Incorrect use of syringe drivers are common cause of drug errors therefore it is important that staff using syringe drivers are appropriately trained and the rate settings on syringe drivers are clearly identified and differentiated (²).

10. The BNF reports a number of potential problems with syringe drivers. If infusion runs too quickly patients may experience considerable toxicity and adverse effects, infusion runs too slowly patients will not receive adequate analgesia there may also be injection site reactions. Infusions can run too quickly if the rate setting or drug calculations has been incorrectly formed, infusion can run too slowly if the start button has not been used correctly, the batteries run out or there are problems with the syringe driver or cannula connections. Use of a syringe driver is an important clinical decision and the reasons why this is done should always be clearly documented in the medical records.
11. The British National Formulary provides clear advice on the process of administering equivalent doses of orally administered morphine and parenterally administered diamorphine ² (BNF page 19). There are situations where it is appropriate to administer sedative drugs in conjunction with opioid analgesics. However in these circumstances close monitoring is required. Failing to adequately monitor patient may result in life-threatening respiratory depression.

Issues in elderly patients.

12. It is well described that older individuals are more sensitive to opioid drugs (BNF page 19) and older individuals clear the drug less rapidly from the body and studies suggest the duration of pain relief is 50% more in individuals over the age of 70 compared to those under the age of 30 years. It is usual to start with 5 mg rather than 10mg initial oral dose of morphine. (BNF page 234). If an older individual is in considerable acute severe pain or is not frail and above average height and weight is not necessarily unreasonable to start with 10mg dose but patients need to be closely monitored.

Medical Assessment

13. Doctors have a responsibility to find good standards of care. GMC guidelines on good medical practice (1995) ³ states that good clinical care must include:
- ◆ An adequate assessment of patients condition based on the history and clinical findings and including where necessary an appropriate examination
 - ◆ Providing or arranging investigations where necessary
 - ◆ Referring the patient to another practice where indicated
- The guidance also states that doctors must
- ◆ Recognise limits of their professional confidence
 - ◆ Be willing to consult colleagues
 - ◆ Be comfortable when making diagnosis when giving or arranging treatment
 - ◆ Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
 - ◆ Keep colleagues informed when sharing the care of patients
 - ◆ Pay due regards to use of resources

- Prescribe only the treatment, drugs or appliances that serve patient's needs

14. The guide also states that doctors may delegate medical care to nurses and other health care staff where not registered medical practitioners if they believe that it is best for the patient that the doctor must be sure that the person to whom they delegate such tasks is competent to undertake the procedure or therapy involved when delegating care or treatment a doctor must always pass on enough information that the patient and the treatment needed the doctor remains responsible for managing the patient's care. Failing to undertake adequate assessment of the patient's condition means that an inaccurate diagnosis may be made and inappropriate treatment given. Similarly failing to recognise limits of professional confidence means patients are put at risk from potentially incompetent treatment decisions. Failure to keep clear, accurate and contemporaneous patient records means there is no clear information in the notes concerning the patient's condition for other health professionals to refer to and appropriately base their care. It also means that there are no medical notes to record the thinking diagnosis and treatment plan put in place by the responsible doctor at the time, the result is the doctor relies entirely on their memory for making future treatment decisions. Failure to record any adverse effects of treatment means there is no record in the notes for health care professionals to avoid re-providing this treatment.

15. GMC guidance in 1995 emphasise the importance that doctors recognise limits of their professional competence and being willing to consult colleagues. This is particularly important for doctors who are trainees or non-specialists working under the supervision of a consultant specialist as was the case with **Code A** a general practitioner acting as a **Code A** **Code A**. In a setting such as Gosport War Memorial Hospital it would be appropriate to discuss and seek advice from the responsible consultant for any patient where the management plan was unclear, where there were complex or difficult management issues where diagnosis or treatment was not clear-cut it would have also been appropriate to seek advice and discuss with the responsible consultants any major change in a patient's medical status particularly if there was unexpected deterioration. If a patient had not been identified and admitted for palliative terminal care I would consider it important any decision about palliative care was discussed with the responsible consultant. When patients deteriorate in a setting such as Gosport War Memorial Hospital where modern diagnostic services and specialist advice is not easily available it may be necessary for patients to return to the main district general hospital for further assessment. It would be appropriate and expected for a clinical assistant to discuss this with the responsible consultant or another consultant who was acting on behalf of the responsible consultant if he/she was not available.

Medical records and Drug Prescription Charts

16. As previously mentioned GMC guidance places clear emphasis on importance of keeping clear, accurate and contemporaneous patient records. Failing to follow this approach results in the problems already outlined in section 5.

17. Drug charts play an important role in treatment prescribed by doctors the details of the drug dose and time and route through the drug should be administered. It is important that drug charts are clearly completed by medical staff as drugs are generally given by nursing staff who need to be able clearly identify the drug dose, date and time that drugs should be administered to patients.

18. Many drugs are prescribed at a fixed dose on a regular basis. Sometimes drugs are prescribed as a single dose or written on as - as required basis (often referred to as PRN). The administration of drug therapy is recorded in a column on the drug chart relating to a specific day and time usually the initialled signature of the member of nursing staff responsible for administering the medication. Treatment instructions may be given to discontinue treatment of a certain date. This is commonly the case for antibiotic prescriptions. If a drug is discontinued the prescription has a line put through and the date of discontinuation inserted along the initials of the doctor making this treatment change.
19. When drugs are prescribed on an as required basis nursing staff are able to use their judgement as to when the drug needs to be administered to the patient and to decide on an appropriate dose if there is a range of doses written. It is common for patients to be written up for a range of opiate dose when requiring potent analgesia. This allows a member of nursing staff to adjust the dose according to a response from previous doses. Usually the range of doses prescribed is small for example 5-10mg of morphine or 2.5mg of diamorphine. If a large dose range is written for a PRN drug there is a risk, unless the drugs are being administered according to a clear protocol understood by all nursing staff, that a patient may be administered an inappropriately high dose of opiate which could lead to respiratory depression, coma and in some cases death.

Standards and Guidelines

20. The British National Formulary is the main reference text doctors should generally refer to in obtaining information about drugs they prescribe to ensure an appropriate drug is chosen for the condition being treated and is given at the correct dose. The BNF has a section on analgesics (4.7 BNF 55, March 2008) with a section on the use of opioid analgesics. This states that a reduced dose is recommended in elderly or debilitated patients. Side effects are listed including respiratory depression, confusion and drowsiness. Recommended doses for individual drugs are listed. The BNF also contains sections on prescribing in the elderly and the use of syringe drivers in palliative care (see sections 8 and 9 of this report).
21. I have also seen The Palliative care Handbook produced by Portsmouth Healthcare NHS Trust known as the Wessex Protocols, produced to help GPs and other healthcare professionals in managing problems in specialist care. The general principles of symptom management in this document state *'Accurate and full assessment is essential for both diagnosis and treatment'*, *'Be careful that drug side effects do not become worse than the original problem'* and *'continually reassess'*. The WHO analgesic ladder is described. In the use of morphine the recommend starting with a low dose and increase by 30-50% increments each day until pain is controlled or side effects prevent further increase. In an older patient an appropriate low dose would be 5 mg morphine.
22. The 'Wessex Protocols' recommend that prn doses are prescribed at the same dose as the 4 hourly dose and repeated as often as necessary (hourly if necessary) for breakthrough pain and to review every 24 hours. A syringe drive is recommended when oral administration is not possible because of dysphagia, vomiting or weakness and the conversion of oral morphine to subcutaneous diamorphine should be one third to one half of the morphine dose i.e. a 24 hour oral dose of 30 mg morphine should be replaced with a 10-15 mg diamorphine infusion over 24hr.
23. In the management of anxiety diazepam is recommended and if a patient is unable to swallow midazolam 10-20mg per 24 hours by continuous subcutaneous infusion. Opioids

are not recommended as a treatment for anxiety. For terminal restlessness drug therapy with diazepam (20-60mg per 24 hours orally or rectally), midazolam (10-60mg per 24 hours orally or by subcutaneous infusion) are recommended as possible treatment options.

Matters specific to Gosport War Memorial Hospital

Code A Position

24. **Code A** posts are non-training service, usually part time posts established by hospitals generally undertaken by general practitioners. These posts generally work a number of half days (often referred to as sessions) and the person reports to a consultant responsible for the care of the patients. The job description (undated) for the post of **Code A** **Code A** to the Geriatric Division in Gosport that was undertaken by **Code A** states 'This is a new post of 5 sessions a week worked flexibly to provide a 24 hour Medical cover to the Long stay patients in Gosport. The patients are slow stream or slow stream rehabilitation but holiday relief and shared care patients are admitted.' How many hours **Code A** should have worked on the ward during the usual working week Monday – Friday 8am -5pm is unclear. I would estimate out of ours calls to the wards would not account for more than 4 hours time in a working week on average so it might be reasonably expected that **Code A** in her position as **Code A** was present on the wards for 16 hours a week i.e. about 3 hours a day covering up 46 beds. As many of these patients would be stable continuing care patients I would consider this was probably adequate time to assess new patients and any deterioration or major problems in existing patients and to document such assessments in the medical notes and attend a weekly consultant ward round. It would be insufficient time to see all patients every day.
25. The Duties described include 'To visit the units on a regular basis and to be available 'on call' as necessary. To ensure that all new patients are seen promptly after admission. To be responsible for the day to day Medical management of the patients. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date. To take part in weekly consultant rounds. To prescribe, as required, drugs for the patients under the care of the consultant Physicians in Geriatric Medicine. To provide clinical advice and professional support to other members of the caring team.' The job description states that the sessions may be split between two separate general Practitioners, ideally from the same Practice.
26. **Code A** are usually not required to have any specialist training in the specialty they are working in. Many **Code A** would not have had specialist training as a trainee in the area of practice they work in as a general practitioner. My understanding is that **Code A** had received no specialist training or qualifications in Geriatric Medicine such as the Diploma in Geriatric Medicine that some general practitioners take. Because of the lack of specialist training it is important that they seek advice from Consultant colleagues for any aspect of patient care where they lack specialist expertise or where decisions might be seen to be contentious with patients, relatives or other health care professionals.
27. There appears to have been some lack of clarity of the role of the wards at Gosport War Memorial Hospital. Although the wards were continuing care wards in practice patients were admitted to the wards who required a period of rehabilitation or further assessment prior to returning to their own home or entering residential or nursing home care. Transcribed interviews with nursing staff suggest there may have been insufficient rehabilitation and nursing staff to adequately meet the needs of such patients at all times. A

further problem is that having two different groups of elderly patients in the wards, those requiring continuing medical and nursing care with others requiring rehabilitation patients, may lead to confusion amongst staff about the management of individual patients unless patient management plans are very clearly understood by all staff. For some of the patients transferred to Gosport War Memorial Hospital it appears to have been unclear to all staff whether individual patients were for continuing care or a period of rehabilitation. Most elderly care services in the 1990s separated out continuing care from rehabilitation beds and often changed continuing care wards into rehabilitation wards and this process appears to have been eventually completed after 2000 at Gosport War Memorial Hospital.

Use of Drug Charts in the Gosport War Memorial Hospital

28. The drug charts in use in Gosport War Memorial Hospital have a format used in most hospitals with a section for drugs given as a single dose, a section for regular drug prescriptions, a section for 'prn' drugs to be taken as required and a section for prescribing of infusions and fluid management. Drug therapy for the patients under the care of Consultant Geriatricians at Gosport War Memorial Hospital would usually be written up by **Code A** in her role as **Code A** and sometimes by one of the consultant physicians with patients on the wards.
29. A legal prescription requires a clear written record usually placed in a drug chart of the drug dose (usually in mg or other units), frequency (e.g. once, twice daily) and route of administration (oral, intramuscular etc), start and end date to be written with the signature and date of the prescribing doctor. The responsibility for the appropriateness, accuracy and legibility of a prescription lies with the prescribing doctor. When a drug is discontinued the doctor must draw a line through the prescription and sign their initials and date. The drug chart must have the name and hospital number of the patient inserted.
30. The term 'written up' indicates that a drug prescription has been written by a doctor in the notes. The term 'prescribed' means that the drug involved has been indicated should be given to the patient, usually through the writing up of a prescription by the responsible doctor or sometimes by a verbal order taken by a member of nursing staff. The term administered means that a drug has been given to the patient. This might be through oral, intravenous, intramuscular injection or infusion or other routes of administration. It is the responsibility of
31. Out of hours or when **Code A** was on leave, other general practitioners covering the hospital would be expected to write up any drugs required out of hours. It is not clear how often on call doctors visited the wards out of hours and in some cases drugs were prescribed by a 'verbal order'. In such a system the nurse writes down the drug prescribed over the phone by the doctor and this is usually confirmed by a second nurse to reduce the chances of any error on the drug or dose prescribed. The potential problem with 'verbal orders' for drug prescriptions is that they involve the prescription of a drug for a problem that may not have been assessed by a doctor taking a history, examining and investigating the patient where this might be required.
32. Review of the notes and interviews suggest that 'anticipatory prescribing' was undertaken where drugs were prescribed for problems that patients might develop. This is sometimes done to avoid the need for a doctor to come to a ward out of hours to prescribe for a simple complaint that does not require urgent medical evaluation. This was common

practice in many wards in the 1980s and 1990s for mild analgesics such as paracetamol, laxatives and hypnotic drugs such as temazepam. Anticipatory prescribing of hypnotic drugs in patients who are not already receiving them is now not advised because of the risk of developing long term dependence on benzodiazepines. Anticipatory prescribing of powerful opioids and sedatives in patients who do not require them when assessed is potentially highly dangerous as the prescribing of such drugs requires careful evaluation of the patient because of the risk of serious adverse effects such as respiratory depression and coma.

33. In the late 1990s the General Medical Council had not produced guidance on prescribing. However Good Practice in Prescribing Medicines was published by the GMC in 2006 and the principles applied in the 1990s. The Guidance refers to the importance of ensuring familiarity with guidance published in the BNF, the need to be in possession of or take an adequate history from the patient, to reach agreement with the patient on the use of any proposed medication, establishing the patient's priorities, preference and concerns, to satisfy oneself that the patient has been given appropriate information in a way they can understand about drug therapy. The guidance also states that doses should be prescribed appropriate for the patient and their condition and that there must be a clear, accurate, legible and contemporaneous record of all medicines prescribed.

General Medical Council and
Report on (Patient A)

FRCP
Consultant Physician

21 April 2009

General Medical Council and [Code A]
Report on Patient A

1. This report is provided at the instruction of Field Fisher Waterhouse solicitors. I have been asked to prepare a report on the medical care of the above patient and comment upon the care and treatment carried out by [Code A] in relation to this patient to assist the GMC panel in determining whether [Code A] has fallen short what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the panel that [Code A] prescribed diamorphine, oramorphine, and midazolam in too wide a dose range that created a situation whereby drugs could be administered to Patient A excessive to his needs; that the prescriptions of diamorphine were excessive to Patient A's needs; and that [Code A]'s prescribing was inappropriate, potentially hazardous and not in the best interests of Patient A.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Patient A; statement of [Code A] re Patient A; witness statements of [Code A] [Code A] [Code A] statement made by [Code A] in relation to Patient A, interview of [Code A] dated 23 March 2005.

5. Course of events.

- 5.1 Patient A was 82 years of age when he was admitted to Dryad ward for continuing long-term care on the 5 January 1996 (p 152) and died on [Code A]. His past medical history was notable for recurrent depression which had been treated with electro convulsive therapy 1992. He was admitted under the care of [Code A] consultant psychiatrist in 1995 with depression he was noted to have a shuffling gait and mobility difficulties. He was discharged to a rest home on the 24 October 1995.
- 5.2 Patient A was admitted under [Code A] care again on the 13 December 1995 to Mulberry Ward. The notes at this time (p 63) record he was verbally aggressive, not mobilising, not eating well and felt hopeless and suicidal. On 22 December the notes record he had developed diarrhoea and left basal crepitations (crackles, audible in the lungs) and was thought to have a chest infection. This was treated with antibiotics. On the 27 December the notes record (p66) a ward round by [Code A]

and that Patient A was *“chesty, poorly, abusive, not himself at all”*. He was commenced on another antibiotic. He had been catheterised for urinary retention. A Chest x-ray was obtained which showed no evidence of focal lung disease. An abdominal x-ray recorded gaseous extension of the large bowel consistent with pseudo obstruction; a condition when the bowel stops moving which can be due to a number of different underlying medical conditions and is seen in frail older people who are acutely unwell.

- 5.3 On 2 January a referral was made by [Code A]’s team to [Code A] consultant geriatrician (page 67) states *‘his mobility initially deteriorated dramatically and then developed a chest infection which is now clearing but he remains bed bound expressing the wish to just die’*. The referral says *“this may well be secondary to his depression but we will be grateful for any suggestions as to how to improve his physical health”*.
- 5.4 On the 3 January on a ward round by [Code A] the notes record that Patient A *“needs more time to convalesce”* and that he would probably need a nursing home. On the 4 January the notes record Patient A was seen by [Code A] (page 68). [Code A] noted the issue of quite recent depression, that he was completely dependent, had a urinary catheter in place which was bypassing, had ulceration of the left buttock and hip and hypoproteinaemia (low blood protein). She suggested high protein drinks, bladder wash-outs, dressing to buttock ulcers with padding. She indicated she would transfer him to a long-stay bed at Gosport War Memorial Hospital and suggested that his residential home place be given up as he was unlikely to return to his residential home. In a letter summarising her assessment (page 188) [Code A] states that his prognosis is poor and that she understood Patient A’s [Code A] was aware of the poor prognosis. The nursing records at psychiatry ward (page 152) record that Patient A would transfer to Dryad ward for continuing long-term care.
- 5.5 On the 5 January (page 196) an entry by [Code A] in the medical notes at Gosport War Memorial Hospital states *‘Transfer to Dryad ward from Mulberry. Present problems immobility, depression, broken sacrum, small superficial areas on right buttock. Ankle dry lesion L ankle, both heels suspect. Catheterised. Transfers with hoist. May help to feed himself, long standing depression on lithium and sertraline’*. The next entry in the medical notes is on the 9 January by [Code A] and states *‘Painful R hand, held in flexion. Try arthrotec. Also increasing anxiety and agitation? sufficient diazepam ? needs opiates.’*
- 5.6 On Friday 10 January an entry by [Code A] states *dementia, catheterised, superficial ulcers, Barthel 0, will eat and drink. Transfer from Mulberry. For TLC. d/w [Code A] agrees(illegible)..... TLC’*. The next entry in the medical notes dated 18 January is by [Code A] and states *‘Further deterioration, sc analgesia continues, difficulty controlling symptoms try Nozinan.*
- 5.7 The next entry in the medical notes is dated 20 January (p198) and is unsigned but as it refers to a verbal order is likely to be by a member of nursing staff. *Has been unsettled on haloperidol in syringe driver. diamorphine (illegible) to higher dose (illegible words), Nozinan 50mg to 100m in 24 hrs (verbal order)*. There is an entry the following day dated 21 January 1996 (signature unclear) *‘much more settled, quiet breathing, respiratory rate 6 / minute, not distressed continue’*. There is an

- entry in the notes on [Code A] confirming death at 1.45 am. The recorded cause of death was bronchopneumonia.
- 5.8 Nursing assessment on the 5 January at Gosport on Dryad ward record Patient A had a poor physical condition with broken pressure areas to his buttocks and hip, and broken skin on scrotum. He was weight bearing to a very minimal degree, was low in mood but settled in behaviour (page 195). His fluid and diet intake was noted to be poor but that he was drinking supplement drinks (Fortisips).
- 5.9 An entry in the nursing notes on the 10 January states '*condition remains poor. Seen by [Code A] and [Code A] To commence on oramorph4 hourly this evening*'. A nursing entry on the 15 January states '*Seen by [Code A] has commenced syringe driver at 08.25 diamorphine 80mg, midazolam 60mg + hyoscine 400ug*'. A second entry that day states: [Code A] was informed of Patient A's deterioration during the afternoon, and that he was now unresponsive and unable to take fluids and diet.
- 5.10 On the 16 January the nursing notes record '*Condition remains very poor, some agitation was noticed when being attended to. Seen by [Code A] haloperidol 5-10mg to be added to the driver*'. An entry later that day at 1300h states '*previous driver dose discarded. Driver recharged with diamorphine 80mg, midazolam 60mg, hyoscine 400ug, and haloperidol 5mg given at a rate of 52mls hourly*'. There was a note to nurse him on his back and left side only.
- 5.11 An entry in the nursing note on 17 January indicates Patient A was seen by [Code A] and that his medication was increased as he remained '*tense and agitated, chest very "bubbly"*'. On the same day at 1430h the nursing notes record Patient A was again seen by [Code A] (page 210) his medication reviewed and altered, and that his syringe driver renewed at 15:30 with two drivers. The nursing records note at 2030h that he had deteriorated further but appeared more settled.
- 5.12 An entry on the 18 January in the nursing notes record that he appears comfortable. On 19 January '*marked deterioration in already poor condition*' is reported (page 211). Over the next 3 days the notes record he is settled and that an infusion of diamorphine, midazolam, Nozinan, haloperidol and hyoscine was continuing.
- 5.13 An entry in the medical notes dated 20 January records Patient A was unsettled and that Nozinan was to be increased from 50mg/24hr to 100mg/24hr (page 198). The nursing notes (page 211) record that [Code A] gave a verbal order to double the Nozinan and omit haloperidol.
- 5.14 The drug charts indicate on the 5 January that Patient A was prescribed the drugs he had been receiving prior to his transfer which were sertraline, lithium, diazepam and thyroxine (p195). There is an undated prescription by [Code A] (p200) for subcutaneous infusions of diamorphine 40-80mg/24 hours, hyoscine 200-400ug/24 hours, and midazolam 20-40mg/ 24 hours which were not administered. It is unclear when this prescription was written by [Code A] Regular oramorph (5mg 5 times a day) was prescribed on 10 January. Two doses were given at 2200h 10 January and 0600h on 11 January. On the 11 January a further prescription is written by [Code A] for oramorphine 2.5ml (5mg) 4 times daily with 5ml (10mg) at 2000h and this dose regimen of morphine is given until the morning of 15 January

with a last dose administered at 0600h with Patient A receiving a total of 30mg morphine daily (page 202).

- 5.15 On 11 January [Code A] prescribed diamorphine 80-120mg/24hr subcutaneous, hyoscine 200-400ug/24hr, midazolam 40-80mg/24hr, and diamorphine 80mg/24hr, hyoscine 400ug/24hr, midazolam 60mg/24hr are then commenced on 15 January and the oramorphine discontinued.
- 5.16 On 16 January, haloperidol 5-10mg/24hr was prescribed by [Code A] Haloperidol was administered on the 16 January (5mg/24hr) and 17 January (10mg/24hr) in addition to the continuing infusions of diamorphine and midazolam. There is a prescription dated 18 January by [Code A] where the dosage of drugs were increased to diamorphine 120mg/24hr, midazolam 80mg/24hr, hyoscine 1200ug/24hr, and haloperidol 20mg 24 hours and these were administered from 17 January onwards, until Patient A's death with the exception of haloperidol which was stopped on 20 January. It is unclear if this prescription was incorrectly dated by [Code A] and was written on 17 January.
- 5.17 On 18 January Nozinan 50mg/24hr was prescribed by [Code A] and commenced that day. The dose of Nozinan was then increased to 100mg/24hr on 20 January with a verbal prescription from [Code A] who I assume was the on call doctor. An entry in the nursing notes on 20 January (page 211) states 'verbal order taken to double nozinan and omit haloperidol'.
- 5.18 There is a prescription for diamorphine 120mg and hyoscine 600ug over 24 hours dated 18 January although the nursing entries on the drug chart suggest these were administered on 17 January.

Drug therapy received at Gosport War Memorial Hospital

6. Pages 189-191 and 199-204

All prescriptions written by [Code A] unless otherwise marked.

Regular Prescriptions

Page 199 (5-10 Jan) and page 202 (11 Jan onwards)

Sertaline 50mg bd	5 Jan - 11 Jan (discontinued)
Lithium carbonate 40mg od	5 Jan - 11 Jan (discontinued)
Diazepam 2mg tds	5 Jan -15 Jan (not administered after 0800h 15 Jan)
Thyroxine 50ug od	5 Jan - 15 Jan (dose not administered after 15 Jan)
<i>Illegible prescription</i>	<i>tick mark 7 Jan</i>
Arthrotec one tab bd	8 Jan - 10 Jan (discontinued after 0900 10 Jan)

Page 200

Oramorph (10mg/5ml) 5mg nocte	10 Jan	5mg nocte
Oramorph (10mg/5ml) 5mg qds	11 Jan	One 5mg dose

Page 202

Oramorph (10mg/5ml) 10 mg nocte	11 Jan	Three 5 mg doses
	11 Jan	10mg nocte
	12 Jan	Four 5 mg doses
	12 Jan	10mg nocte

	22 Jan 1515h	
	23 Jan 1805h	
Hyoscine subcut via syringe driver 1200ucg/24hr Prescribed 18 Jan	17 Jan ?h 18 Jan 1615h 19 Jan 1500h 20 Jan Entry crossed out 20 Jan 1800h 21 Jan 1745h 22 Jan 1515h 23 Jan 1500h	
Haloperidol subcut via syringe driver 20mg/24hr Prescribed 18 Jan	17 Jan ?h 18 Jan 1605h 19 Jan 1800h 20 Jan Entry crossed out. Discontinued	
Nozinan subcut 100mg/24hr Prescribed 22 Jan	23 Jan 1500h	
<i>As required prescriptions</i>		
<i>Page 201</i>		
Diamorphine subcut via syringe driver 80-120mg/24hr Prescribed 11 Jan	15 Jan ?h 80mg/24hr 16 Jan ?h 80mg/24hr 17 Jan ?h 80mg/24hr	
Hyoscine subcut via syringe driver 200-400 ucg/24hr Prescribed 11 Jan	15 Jan 0825h 400 ucg/24hr 16 Jan 0825h 400 ucg/24hr 17 Jan ?h 400 ucg/24hr	
Midazolam subcut via syringe driver 40-80mg/24hr Prescribed 11 Jan	15 Jan ?h 60mg/24hr 16 Jan h 60mg/24hr 17 Jan ?h 60 mg/24hr 18 Jan 0825h 60 mg/24hr	
Midazolam subcut via syringe driver 80mg/24hr Prescribed 16 Jan	None administered	
<i>Page 189</i>		
Nozinan subcut via syringe driver 50mg/24hr Prescribed 18 Jan	18 Jan ?h 19 Jan ?h	
Nozinan subcut via syringe driver 100mg/24hr Prescribed verbal order Code A 1720h	20 Jan ?h 21 Jan 1745h 22 Jan 1615h	

Opinion on Patient A's management

7. Patient A had a long standing history of depression which was severe and appears to be the most likely cause for his decline leading to his admission to a residential home in 1995. Immediately prior to his admission to Dryad ward he had developed when an inpatient in a psychiatry ward, a chest infection and pseudo obstruction, and had become immobile with malnutrition and bedsores. [Code A] assessment indicates he was very ill and would possibly not survive to leave hospital. [Code A] appears to have decided that at that stage it was not appropriate to consider finding a nursing home for Patient A, presumably because he was at this stage very medically unwell. The decision to transfer him to a long-stay ward suggests she had considered his medical condition was severe and unstable enough that he should continue to be managed in a continuing care bed.
8. There are limited entries in the medical notes during Patient A's time on Dryad ward where he spent 18 days prior to his death although the nursing records indicate Patient A was seen by [Code A] at regular intervals during this period. On admission [Code A] summarised Patient A's problems but there is no evidence in the medical notes that she undertook a physical examination. The notes do not record what history, if any she obtained from Patient A of his current symptoms and problems. Subsequent entries in the medical records are brief and I consider the medical records at Dryad are inadequate and not consistent with good medical practice. It is not clear from the admitting notes whether [Code A] considered Patient A was for palliative care only.
9. The previous assessment by [Code A] and nursing records describe a clear picture of a frail, older man who was deteriorating rapidly and highly likely to die in the next few weeks or months. Overall responsibility for the care of Patient A following his admission to Dryad ward lay with [Code A] as the responsible [Code A] Day to day medical care was the responsibility of [Code A] and during out of hours the on call doctors.
10. Despite the limited medical documentation the decision of [Code A] to prescribe 5mg of oramorph 4 hourly on 10 January was in my view reasonable given that Patient A was likely to be in significant discomfort and pain from his pressure sores. It would be difficult to determine whether restlessness and agitation in Patient A were due to pain or his depression. A decision had been made that day that Patient A was for "TLC" (tender loving care). This indicates [Code A] considered Patient A was likely to die within days or weeks and the focus of treatment at this stage was towards palliating any symptoms he might have rather than initiation of other medical interventions to treat or prevent active ongoing problems. Given Patient A's general condition this decision appears reasonable and was appropriately discussed with his relatives.
11. I consider the discontinuation of sertraline and lithium carbonate on 12 January was reasonable as Patient A was deteriorating, although the medical records should have recorded the rationale for this. When patients are rapidly deteriorating it is common practice to withdraw routine drugs and it would be unlikely the withdrawal of these drugs would lead to any major effects on Patient A's mood and general level of functioning when he was deteriorating.
12. The change on 15 January from regular oral doses of morphine to syringe driver subcutaneous infusion of a much higher dose of opioid (80mg diamorphine/24hr) in addition of midazolam 60mg/24hr is in my opinion not justified by any information recorded in the medical notes. The nursing notes suggest Patient A was agitated at times but there is no record that he was in pain. The medical records contain no

information that justifies the need to change from oral morphine to subcutaneous diamorphine infusion.

13. The diamorphine dose prescribed was not justified and was excessively high. Patient A was receiving 30mg oral morphine/24 hour on 14 January. The equivalent dose of subcutaneous diamorphine would have been 15-20mg/24hr. The prescription of diamorphine 80-120mg/24hr was at least a four-fold increase in the equivalent opioid dose he had been receiving. An appropriate dose to commence with if a diamorphine infusion had been justified would have been 15-20mg/24hr and up to 30mg/hr if Patient A was showing signs of still being in pain. The prescribed dose of midazolam of 40-80mg/24hr was excessively high and the notes contain no entry from [Code A] justifying such a high starting dose. An appropriate starting dose in a frail older man if a subcutaneous infusion had been indicated would have been 10mg/24hr particularly when a diamorphine infusion was also being administered. The prescription of diamorphine at an infusion rate of 80mg/24hr with midazolam at an infusion rate of 60 mg/24hr on 15 January carried a very high risk of producing respiratory depression and/or coma.
14. It would have been appropriate for [Code A] to perform a clinical assessment on 15 January prior to prescribing subcutaneous diamorphine and midazolam but there is no evidence in the notes that this took place. [Code A] does not appear to have considered the possibility that Patient A's agitation might be secondary to or exacerbated by the morphine he had received. As Patient A was deteriorating and expected to die in the near future I do not think [Code A] need necessarily have discussed Patient A's problems with the [Code A] but she should have examined patient A, documented her findings in the medical notes and explained her rationale for prescribing subcutaneous infusions of diamorphine, midazolam and hyoscine on 11 January when Patient A was able to swallow.
15. The medical notes contain no justification for the prescription by [Code A] of haloperidol on 16 January of 5-10mg/24hr. The nursing notes record Patient A was agitated. In my opinion this should have led to a medical assessment by [Code A] to assess the cause of is agitation but the medical records do not suggest this occurred. No rationale is recorded in the notes by [Code A] for the prescription of Haloperidol in addition to midazolam.
16. On 17 January the drug chart is difficult to interpret. The administered doses of diamorphine, midazolam and haloperidol were all increased; diamorphine from 80 to 120mg/24hr, midazolam from 60 to 80 mg/24hr and haloperidol from 10-20mg/24h. Patient A received an 'as required' infusion of diamorphine 80mg/24hr under the 11 January prescription by [Code A]. There is a further prescriptions by [Code A] dated 17 January of regular diamorphine 120mg/24hr which was administered (page 203). Confusingly there is another prescription dated 18 January for a for regular diamorphine 120 mg/24hr infusion which is administered at 1530h (page 190).
17. There are a number of possible explanations for the administration of drugs before the prescribed date but I consider the most likely explanation is that Dr Barton misdated the prescription and wrote it on 17 December intending the drugs be administered that day. This is supported by a statement in the nursing notes (page 210) dated 17 January 1430h that states 's/b [Code A] Medication reviewed and altered. Syringe driver renewed at

1530' which equates to the recorded administration time. Similar discrepancies are present for midazolam and haloperidol.

18. In my opinion the entry in the nursing notes that Patient A was 'tense and agitated' does not justify the combined increases in diamorphine (50%; 80 to 120mg/24h), midazolam (33%; 60 to 80mg/24hr) and haloperidol (400%; 5 to 20 mg/24hr). There was a further prescription of diamorphine by [Code A] for 120mg/24hr although this dose could have been administered under the existing 11 January as required prescription. I do not understand why a prescription for 120mg/24hr diamorphine appears to have been written twice that day. The prescribing by [Code A] was in my opinion extremely hazardous not only due to the increased doses of all three drugs which carried a high risk of producing respiratory depression and coma if administered but also because [Code A] left three active prescriptions for diamorphine, two of which were regular prescriptions (page 202 and 201) and did not cross out and discontinue two of these prescriptions. This was in my opinion extremely hazardous as it could have led to nursing staff administering two possibly three infusions of diamorphine to Patient A who would have received a total dose of 240mg/24hr diamorphine if these were administered as regular prescriptions.
19. Similarly there were two active prescriptions by [Code A] for the regular administration of haloperidol (pages 190 and 203) which was hazardous and put Patient A at risk of developing coma had both been administered. The risk also existed for midazolam to be administered from two active prescriptions (page 201) although these were 'as required' prescriptions. In my opinion the drug chart prescribing by [Code A] on these date was confusing, not consistent with good medical practice and was could have easily been misinterpreted by nursing staff. There were no instructions recorded in the medical records by [Code A] or nursing staff concerning the maximum dose of diamorphine, midazolam or haloperidol that was to be administered to Patient A. There was also the possibility that the undated prescriptions (page 200) for diamorphine and midazolam could have been administered in addition to the above.
20. On 18 January [Code A] prescribed levomepromazine (Nozinan), a more sedating neuroleptic drug that is used for treating terminal restlessness and agitation. [Code A] recorded in the medical notes that there was difficulty controlling Patient A's symptoms but does not state what symptoms these are. The failure to document which symptoms were not controlled is not optimal but would appear to suggest that Patient A experiencing agitation or other symptoms. The nursing records contain no information suggesting Patient A was agitated or restless on 18 January but record that he was deteriorating but comfortable. Whilst it would be a reasonable course of action if Patient A had been agitated and restless to substitute Nozinan for haloperidol, I consider the prescription of two neuroleptic drugs, haloperidol and Nozinan, in addition to midazolam and diamorphine carried a high risk of producing coma and respiratory depression. Overall I consider the prescribing of Nozinan was not consistent with good medical practice because the notes do not suggest a sufficiently detailed medical assessment was performed and the prescription of Nozinan in addition to the other drugs was hazardous.
21. On 20 January [Code A] who I assume was the on call doctor was contacted as Patient A was agitated. He did not assess the patient but increased the Nozinan and discontinued the haloperidol. I would consider this was reasonable action to take and avoided the potential interaction of using two neuroleptic drugs. Unless nursing staff specifically

requested [Code A] come and assess the patient I would not consider he or she should have attended the ward and assessed Patient A.

22. In my opinion the infusions of diamorphine, midazolam and haloperidol and then Nozinan, very likely led to respiratory depression and shortened Patient A's life span although he would have been expected to die in the near future even if he had not received these drugs.

Summary of Conclusions

23. Patient A was a frail, dependent man with a long history of severe depression who was deteriorating prior to his admission to Dryad Ward who was expected to die within a few weeks. The initial prescription of oral morphine was appropriate. The medical and nursing notes are limited but document he had persistent symptoms of agitation which merited treatment with a sedative such as diazepam or antipsychotic drug such as haloperidol. However there was inadequate assessment of Patient A by [Code A] as the doctor responsible for the day to day care of the patient with no clinical findings or other information recorded to justify the prescription of subcutaneous infusions of diamorphine and midazolam. The prescriptions of both these drugs in the wide dose ranges used were not justified and highly risky because of the risk of respiratory depression. The prescribing of diamorphine and haloperidol on 17 January was hazardous as more than one regular prescription for both these drugs was active on the drug chart. There was no clear justification in the medical or nursing notes for the prescription of levomepromazine (Nozinan) by [Code A].
24. In my opinion [Code A] in her care of Patient A failed to meet the requirements of good medical practice:
- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.
25. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
[Code A]

General Medical Council and Code A
Report on Code A **(Patient A)**

Code A
Consultant Physician

21 April 2009

General Medical Council and [Code A]
Report on Patient A

1. This report is provided at the instruction of Field Fisher Waterhouse solicitors. I have been asked to prepare a report on the medical care of the above patient and comment upon the care and treatment carried out by [Code A] in relation to this patient to assist the GMC panel in determining whether [Code A] has fallen short what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the panel that [Code A] prescribed diamorphine, oramorphine, and midazolam in too wide a dose range that created a situation whereby drugs could be administered to Patient A excessive to his needs; that the prescriptions of diamorphine were excessive to Patient A's needs; that the prescriptions of nozinan in combination with other drugs were excessive to his needs; and that [Code A]'s prescribing was inappropriate, potentially hazardous and not in the best interests of Patient A.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Patient A; statement of [Code A] re Patient A; witness statements of [Code A] [Code A] [Code A] statement made by [Code A] in relation to Patient A, interview of [Code A] dated 23 March 2005.

5. Course of events.

- 5.1 Patient A was 82 years of age when he was admitted to Dryad ward for continuing long-term care on the 5 January 1996 (p 152) and died on [Code A]. His past medical history was notable for recurrent depression which had been treated with electro convulsive therapy 1992. He was admitted under the care of [Code A] consultant psychiatrist in 1995 with depression he was noted to have a shuffling gait and mobility difficulties. He was discharged to a rest home on the 24 October 1995.
- 5.2 Patient A was admitted under [Code A] care again on the 13 December 1995 to Mulberry Ward. The notes at this time (p 63) record he was verbally aggressive, not mobilising, not eating well and felt hopeless and suicidal. On 22 December the notes

record he had developed diarrhoea and left basal crepitations (crackles, audible in the lungs) and was thought to have a chest infection. This was treated with antibiotics. On the 27 December the notes record (p66) a ward round by [Code A] and that Patient A was *“chesty, poorly, abusive, not himself at all”*. He was commenced on another antibiotic. He had been catheterised for urinary retention. A Chest x-ray was obtained which showed no evidence of focal lung disease. An abdominal x-ray recorded gaseous extension of the large bowel consistent with pseudo obstruction; a condition when the bowel stops moving which can be due to a number of different underlying medical conditions and is seen in frail older people who are acutely unwell.

- 5.3 On 2 January a referral was made by [Code A]’s team to [Code A] geriatrician (page 67) states *‘his mobility initially deteriorated dramatically and then developed a chest infection which is now clearing but he remains bed bound expressing the wish to just die’*. The referral says *“this may well be secondary to his depression but we will be grateful for any suggestions as to how to improve his physical health”*.
- 5.4 On the 3 January on a ward round by [Code A] the notes record that Patient A *“needs more time to convalesce”* and that he would probably need a nursing home. On the 4 January the notes record Patient A was seen by [Code A] (page 68). [Code A] noted the issue of quite recent depression, that he was completely dependent, had a urinary catheter in place which was bypassing, had ulceration of the left buttock and hip and hypoproteinaemia (low blood protein). She suggested high protein drinks, bladder wash-outs, dressing to buttock ulcers with padding. She indicated she would transfer him to a long-stay bed at Gosport War Memorial Hospital and suggested that his residential home place be given up as he was unlikely to return to his residential home. In a letter summarising her assessment (page 188) [Code A] states that his prognosis is poor and that she understood Patient A’s [Code A] was aware of the poor prognosis. The nursing records at psychiatry ward (page 152) record that Patient A would transfer to Dryad ward for continuing long-term care.
- 5.5 On the 5 January (page 196) an entry by [Code A] in the medical notes at Gosport War Memorial Hospital states *‘Transfer to Dryad ward from Mulberry. Present problems immobility, depression, broken sacrum, small superficial areas on right buttock. Ankle dry lesion L ankle, both heels suspect. Catheterised. Transfers with hoist. May help to feed himself, long standing depression on lithium and sertraline’*. The next entry in the medical notes is on the 9 January by [Code A] and states *‘Painful R hand, held in flexion. Try arthrotec. Also increasing anxiety and agitation ? sufficient diazepam ? needs opiates.’*
- 5.6 On Friday 10 January an entry by [Code A] states *dementia, catheterised, superficial ulcers, Barthel 0, will eat and drink. Transfer from Mulberry. For TLC. d/w [Code A] agrees(illegible)..... TLC’*. The next entry in the medical notes on 18th January 1996 is By [Code A] and states *‘Further deterioration, sc analgesia continues,(illegible)..... symptoms try nozinan.*
- 5.7 The next entry in the medical notes is dated 20 January (p198) and is unsigned but as it refers to a verbal order is likely to be by a member of nursing staff. *Has been unsettled on haloperidol in syringe drive diamorphine (illegible) to higher dose (illegible words), nozinan 50mg to 100m in 24 hrs (verbal order)*. There is an entry

the following day dated 21 January 1996 (signature unclear) '*much more settled, quiet breathing, respiratory rate 6 / minute, not distressed continue*'. There is an entry in the notes on [Code A] confirming death at 1.45 am. The recorded cause of death was bronchopneumonia.

- 5.8 Nursing assessment on the 5 January at Gosport on Dryad ward record Patient A had a poor physical condition with broken pressure areas to his buttocks and hip, and broken skin on scrotum. He was weight bearing to a very minimal degree, was low in mood but settled in behaviour (page 195). His fluid and diet intake was noted to be poor but that he was drinking supplement drinks (Fortisips).
- 5.9 An entry in the nursing notes on the 10 January states '*condition remains poor. Seen by [Code A] and [Code A] To commence on oramorph4 hourly this evening*'. A nursing entry on the 15 January states '*Seen by [Code A] has commenced syringe driver at 08.25 diamorphine 80mg, midazolam 60mg + hyoscine 400ug*'. A second entry that day states [Code A] was informed of Patient A's deterioration during the afternoon, and that he was now unresponsive and unable to take fluids and diet. On the 16 January the nursing notes record '*Condition remains very poor, some agitation was noticed when being attended to. Seen by [Code A] haloperidol 5-10mg to be added to the driver*'.
- 5.10 An entry later that day at 1300h states '*previous driver dose discarded. Driver recharged with diamorphine 80mg, midazolam 60mg, hyoscine 400ug, and haloperidol 5mg given at a rate of 52mls hourly*'. There was a note to nurse him on his back and left side only. An entry in the nursing note on 17 January indicates Patient A was seen by [Code A] and that his medication was increased as he remained '*tense and agitated, chest very "bubbly"*'. On the same day at 14:30h the nursing notes records Patient A was again seen by [Code A] (page 210) his medication reviewed and altered, and that his syringe driver renewed at 15:30 with two drivers. Further deterioration is noted at 2030h. On the 17 January he appears more settled.
- 5.11 An entry on the 18 January in the nursing notes record that he appears comfortable. On 19 January '*marked deterioration in already poor condition*' is reported. Over the next 3 days the notes record he is settled and that an infusion of diamorphine, midazolam, nozinan, haloperidol and hyoscine was continuing.
- 5.12 The drug charts indicate on the 5 January that Patient A was prescribed the drugs he had been receiving prior to his transfer which were sertraline, lithium, diazepam and thyroxine (p195). There is an undated prescription by [Code A] (p200) for subcutaneous infusions of diamorphine 40-80mg/24 hours, hyoscine 200-400ug/24 hours, and midazolam 20-40mg/ 24 hours which were not administered. It is unclear to me if these drugs were prescribed by [Code A] on the 5 January 1996. Regular oramorph (5mg 5 times a day) was prescribed on 10 January. Two doses were given at 2200h 10 January and 0600h on 11 January. On the 11 January the prescription is changed to 2ml (4mg) 4 hourly with 5ml (10mg) at 2000 at this dose regimen of morphine is given until the morning of 15 January 1996 with a last dose administered at 0600h with Patient A receiving a total of 26mg morphine daily (page 202).

- 5.13 On 11 January [Code A] prescribed diamorphine 80-120mg subcutaneous 24 hours, hyoscine 200-400ug subcutaneous 24 hours, midazolam 40-80mg subcutaneous 24 hours , 80 mg of diamorphine, hyoscine 400ug, midazolam 60mg are then administered over 24 hour periods during the 15, 16 and 17 January (page 201).
- 5.14 On 16 January, haloperidol 5-10mg/24hr was prescribed. Haloperidol was administered on the 16 January (5mg/24hr) and 17 January (10mg/24hr). On the 17 January the dosage of all drugs were increased by [Code A] to diamorphine 120mg/24hr, midazolam 80mg/24hr, hyoscine 1200ucg/24hr, haloperidol 20mg 24 hours and these were administered from 17 January onwards, until Patient A's death with the exception of haloperidol which was stopped on 20 January. On 18 January nozinan 50mg was prescribed by [Code A] and 2 doses administered (dates unclear) this was then increased to 100mg on 20 January and this appears to be administered subcutaneously each 24 hours over the following 3 days. An entry in the nursing notes on 20 January (page 211) states '*verbal order taken to double nozinan and omit halopeirdol*'.
- 5.15 There is a prescription for diamorphine 120mg and hyoscine 600ug over 24 hours dated 18 January although the nursing entries on the drug chart suggest these were administered on 17 January. I cannot find the drug charts for the period 18-24 January in the copies of the medical records provided to me.

Drug therapy received at Gosport War Memorial Hospital

6. Pages 189-191 and 199-204

All prescriptions written by [Code A] unless otherwise marked.

Regular Prescriptions

Sertaline 50mg bd	5 Jan - 11 Jan (discontinued)
Lithium carbonate 40mg od	5 Jan - 11 Jan (discontinued)
Diazepam 2mg tds	5 Jan -15 Jan (not administered after 0800h 15 Jan)
Thyroxine 50ucg od	5 Jan – 15 Jan (dose not administered after 15 Jan)
<i>Illegible prescription</i>	<i>tick mark 7 Jan</i>
Arthrotec one tab bd	8 Jan – 10 Jan (discontinued after 0900 10 Jan)

Oramorph (10mg/5ml) 5mg nocte	10 Jan	5mg nocte
Oramorph (10mg/5ml) 5mg qds	11 Jan	Four 5mg doses
Oramoprh (10mg/5ml) 10 mg nocte	11 Jan	10mg nocte
	12 Jan	Four 5 mg doses
	12 Jan	10mg nocte
	13 Jan	Four 5mg doses
	13 Jan	10mg nocte
	14 Jan	Four 5 mg doses
	14 Jan	10mg nocte
	15 Jan	one 5mg dose then discontinued

Diamorphine subcut via syringe driver 17 Jan 120 mg/24hr
120mg/24hr
Prescribed 18 Jan

Hyoscine subcut via syringe driver 17 Jan 600ucg/24hr

600ucg/24hr

Prescribed 18 Jan

Haloperidol subcut via syringe driver	16 Jan	5mg/24hr
5-10mg/24hr	17 Jan	10 mg/24hr
Prescribed 16 Jan		

Diamorphine subcut via syringe driver	17 Jan	120 mg/24hr
120mg/24hr	18 Jan	120 mg/24hr
Prescribed 18 Jan	19 Jan	120 mg/24hr
	20 Jan	120 mg/24hr
	21 Jan	120 mg/24hr
	22 Jan	120 mg/24hr
	23 Jan	120 mg/24hr

Midazolam subcut via syringe driver	17 Jan	80 mg/24hr
80mg/24hr	18 Jan	80 mg/24hr
Prescribed 18 Jan	19 Jan	80 mg/24hr
	20 Jan	80 mg/24hr
	21 Jan	80 mg/24hr
	22 Jan	80 mg/24hr
	23 Jan	80 mg/24hr

Hyoscine subcut via syringe driver	17 Jan	1200ucg/24hr
1200ucg/24hr	18 Jan	1200ucg/24hr
Prescribed ? Jan	19 Jan	1200ucg/24hr
	20 Jan	1200ucg/24hr
	21 Jan	1200ucg/24hr
	22 Jan	1200ucg/24hr
	23 Jan	1200ucg/24hr

Haloperidol subcut via syringe driver	17 Jan	20 mg/24hr
20mg/24hr	18 Jan	20 mg/24hr
Prescribed 16 Jan	19 Jan	20mg /24hr
	20 Jan	20 mg/24hr discontinued

Nozinan subcut	23 Jan	100mg/24hr
100mg/24hr		
Prescribed 22 Jan		

As required prescriptions

Diamorphine subcut via syringe driver	15 Jan	80mg/24hr
80-120mg/24hr	16 Jan	80mg/24hr
Prescribed 11 Jan	17 Jan	80mg/24hr

Hysoscine subcut via syringe driver	15 Jan	400 ucg/24hr
200-400 ucg/24hr	16 Jan	400 ucg/24hr
Prescribed 11 Jan	17 Jan	400 ucg/24hr

Midazolam subcut via syringe driver	15 Jan	60mg/24hr
40-80mg/24hr	16 Jan	60mg/24hr

Prescribed 11 Jan	17 Jan 60 mg/24hr
	18 Jan 80 mg/24hr

Midazolam subcut via syringe driver 80mg/24hr	None administered
Prescribed 16 Jan	

Nozinan subcut via syringe driver 50mg/24hr	18 Jan 50mg/24hr
Prescribed 18 Jan	19 Jan 50mg/24hr

Nozinan subcut via syringe driver 100mg/24hr	20 Jan 100mg/24hr
Prescribed Dr Brigg	21 Jan 100mg/24hr
	? 100mg/24hr

Opinion on Patient A's management

7. Patient A had a long standing history of depression which was severe and appears to be the most likely cause for his decline leading to his admission to a residential home in 1995. Immediately prior to his admission to Dryad ward he had developed when an inpatient in a psychiatry ward, a chest infection and pseudo obstruction and had become immobile with malnutrition and bedsores. [Code A]'s assessment indicates he was very ill and would possibly not survive to leave hospital. [Code A] appears to have decided that at that stage it was not appropriate to consider finding a nursing home for Patient A, presumably because he was at this stage very medically unwell. The decision to transfer him to a long-stay ward suggests she had considered his medical condition was severe and unstable enough that he should continue to be managed in a continuing care bed.
8. There are limited entries in the medical notes during Patient A's time on Dryad ward where he spent 18 days prior to his death although the nursing records indicate Patient A was seen by [Code A] at regular intervals during this period. On admission [Code A] summarised Patient A's problems but there is no evidence in the medical notes that she undertook a physical examination. The notes do not record what history, if any she obtained from Patient A of his current symptoms and problems. Subsequent entries in the medical records are brief and I consider the medical records at Dryad are inadequate and not consistent with good medical practice. It is not clear from the admitting notes whether [Code A] considered Patient A was for palliative care only.
9. The previous assessment by [Code A] and nursing records describe a clear picture of a frail, older man who was deteriorating rapidly and highly likely to die in the next few weeks or months. Overall responsibility for the care of Patient A following his admission to Dryad ward lay with [Code A] as the responsible [Code A]. Day to day medical care was the responsibility of [Code A] and during out of hours the on call doctors.
10. Despite the limited medical documentation the decision of [Code A] to prescribe 5mg of oramorph 4 hourly on 10 January was in my view reasonable given that Patient A was likely to be in significant discomfort and pain from his pressure sores. It would be difficult to determine whether restlessness and agitation in Patient A were due to pain or his depression. A decision had been made that day that Patient A was for "TLC" (tender loving care). This indicates [Code A] considered Patient A was likely to die within days or weeks and the focus of treatment at this stage was towards palliating any

symptoms he might have rather than initiation of other medical interventions to treat or prevent active ongoing problems. Given Patient A's general condition this decision appears reasonable and was appropriately discussed with his relatives.

11. I consider the discontinuation of sertaline and lithium carbonate on 12 January was reasonable as Patient A was deteriorating, although the medical records should have recorded the rationale for this. When patients are rapidly deteriorating it is common practice to withdraw routine drugs and it would be unlikely the withdrawal of these drugs would lead to any major effects on Patient A's mood and general level of functioning when he was deteriorating.
12. The change on 15 January from regular oral doses of morphine to syringe driver subcutaneous infusion of a much higher dose of opioid (80mg diamorphine/24hr) in addition of midazolam 60mg/24hr is in my opinion is not justified by any information recorded in the medical notes. The nursing notes suggest Patient A was agitated at times but there is no record that he was in pain.
13. The diamorphine dose prescribed was not justified and was excessively high. Patient A was receiving 30mg oral morphine/24 hour on 14 January. The equivalent dose of subcutaneous diamorphine would have been 15-20mg/24hr. The prescription of diamorphine 80-120mg/24hr was at least a four-fold increase in the equivalent opioid dose he had been receiving. An appropriate dose to commence with if a diamorphine infusion had been justified would have been 15-20mg/24hr and up to 30mg/hr if Patient A was showing signs of still being in pain. The prescribed dose of midazolam of 40-80mg/24hr was excessively high and the notes contain no entry from Code A justifying such a high starting dose. An appropriate starting dose in a frail older man if a subcutaneous infusion had been indicated would have been 10mg/24hr particularly when a diamorphine infusion was also being administered. The prescription of diamorphine at an infusion rate of 80mg/24hr with midazolam at an infusion rate of 60 mg/24hr on 15 January carried a very high risk of producing respiratory depression and/or coma.
14. It would have been appropriate for Code A to perform a clinical assessment at this stage but there is no evidence in the notes that this took place. Code A does not appear to have considered the possibility that Patient A's agitation might be secondary to or exacerbated by the morphine he had received. As Patient A was deteriorating and expected to die in the near future I do not think Code A need necessarily have discussed Patient A's problems with the Code A but she should have examined patient A, documented her findings in the medical notes and explained her rationale for prescribing subcutaneous infusions of diamorphine, midazolam, haloperidol and nozinan. The medical notes contain no justification for the commencement of haloperidol and then nozinan, a more sedating neuroleptic drug. However the prescription of haloperidol would have been reasonable if agitation was a continuing problem in Patient A.
15. The prescription of nozinan on 18 January was not justified by any information presented in the nursing or medical records as at this point as Patient A was reported to be comfortable. The combination of diamorphine midazolam, haloperidol and nozinan very likely shortened Patient A's life although he would not have been expected to live more than a few week following his admission to Dryad ward.

16. In my opinion the infusions of diamorphine, midazolam and haloperidol and then nozinan, very likely led to respiratory depression and shortened Patient A's life span although he would have been expected to die in the near future even if he had not received these drugs.

Summary of Conclusions

17. Patient A was a frail, dependent man with a long history of severe depression who was deteriorating prior to his admission to Dryad Ward who was expected to die within a few weeks. The initial prescription of oral morphine was appropriate. The medical and nursing notes are limited but document he had persistent symptoms of agitation which merited treatment with a sedative such as diazepam or antipsychotic drug such as haloperidol. However there was inadequate assessment of Patient A by [Code A] as the doctor responsible for the day to day care of the patient with no clinical findings or other information recorded to justify the prescription of subcutaneous infusions of diamorphine and midazolam. The prescriptions of both these drugs in the wide dose ranges used were not justified and highly risky because of the risk of respiratory depression. There was no justification in the medical or nursing notes for the prescription of nozinan by [Code A]. However the very poor quality of the medical and nursing notes make it difficult for me to be certain that these drugs were not justified given Patient A's clinical condition and reported pain and agitation.
18. In my opinion [Code A] in her care of Patient A failed to meet the requirements of good medical practice:
- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.
19. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
[Code A]

General Medical Council and Code A
Report on Code A **(Patient A)**

Code A
Consultant Physician

13 April 2009

**General Medical Council and Code A
Report on Patient A**

1. This report is provided at the instruction of Field Fisher Waterhouse solicitors. I have been asked to prepare a report on the medical care of the above patient and comment upon the care and treatment carried out by Code A in relation to this patient to assist the GMC panel in determining whether Code A has fallen short what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the panel that Code A prescribed diamorphine, oramorphine, and midazolam in too wide a dose range that created a situation whereby drugs could be administered to Patient A excessive to his needs; that the prescriptions of diamorphine were excessive to Patient A's needs; that the prescriptions of Nozinan in combination with other drugs wre excessive to his needs; and that Code A's prescribing was inappropriate, potentially hazardous and not in the best interests of Patient A.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Patient A; statement of Code A re Patient A; witness statements of Code A
Code A
Code A statement made by Code A in relation to Patient A, interview of Code A dated 23 March 2005.

5. Course of events.

- 5.1 Patient A was 82 years of age when he was admitted to Dryad ward for continuing long-term care on the 5 January 1996 (p 152). His past medical history was notable for recurrent depression which had been treated with electro convulsive therapy 1992. He was admitted under the care of Code A consultant psychiatrist in 1995 with depression he was noted to have a shuffling gait and mobility difficulties. He was discharged to a rest home on the 24 October 1995.
- 5.2 Patient A was admitted under Code A care again on the 13 December 1995 to Mulberry Ward. The notes at this time (p 63) record he was verbally aggressive, not mobilising, not eating well and felt hopeless and suicidal. On 22 December 1995 the notes record he had developed diarrhoea and left basal crepitations (crackles, audible in the lungs) and was thought to have a chest infection. This was treated

with antibiotics. On the 27 December 1995 the notes record (p66) a ward round by [Code A] and that Patient A was *"chesty, poorly, abusive, not himself at all"*. He was commenced on another antibiotic. He had been catheterised for urinary retention. A Chest x-ray was obtained which showed no evidence of focal lung disease. An abdominal x-ray recorded gaseous extension of the large bowel consistent with pseudo obstruction; a condition when the bowel stops moving which can be due to a number of different underlying medical conditions and is seen in frail older people who are acutely unwell.

- 5.3 On 2 January 1996 a referral was made by [Code A] team to [Code A] geriatrician (page 67) states *'his mobility initially deteriorated dramatically and then developed a chest infection which is now clearing but he remains bed bound expressing the wish to just die'*. The referral says *"this may well be secondary to his depression but we will be grateful for any suggestions as to how to improve his physical health"*.
- 5.4 On the 3 January 1996 on a ward round by [Code A] the notes record that Patient A *"needs more time to convalesce"* and that he would probably need a nursing home. On the 4th January 1996 the notes record Patient A was seen by [Code A] (page 68). [Code A] noted the issue of quite recent depression, that he was completely dependent, had a urinary catheter in place which was bypassing, had ulceration of the left buttock and hip and hypoproteinaemia (low blood protein). She suggested high protein drinks, bladder wash-outs, dressing to buttock ulcers with padding. She indicated she would transfer him to a long-stay bed at Gosport War Memorial Hospital and suggested that his residential home place be given up as he was unlikely to return to his residential home. In a letter summarising her assessment (page 188) [Code A] states that his prognosis is poor and that she understood Patient A's [Code A] was aware of the poor prognosis. The nursing records at psychiatry ward (page 152) record that Patient A would transfer to Dryad ward for continuing long-term care.
- 5.5 On the 5 January 1996 (page 196) an entry by [Code A] in the medical notes at Gosport War Memorial Hospital states *'Transfer to Dryad ward from Mulberry. Present problems immobility, depression, broken sacrum, small superficial areas on right buttock. Ankle dry lesion L ankle, both heels suspect. Catheterised. Transfers with hoist. May help to feed himself, long standing depression on lithium and sertraline'*. The next entry in the medical notes is on the 9th 1996 January by [Code A] [Code A] and states *'Painful R hand, held in flexion. Try arthrotec. Also increasing anxiety and agitation ? sufficient diazepam ? needs opiates.'*
- 5.6 On Friday 10 January 1996 an entry by [Code A] states *dementia, catheterised, superficial ulcers, Barthel 0, will eat and drink. Transfer from Mulberry. For TLC. d/w [Code A] - agrees(illegible)..... TLC'*. The next entry in the medical notes on 18th January 1996 is By [Code A] and states *'Further deterioration, sc analgesia continues,(illegible)..... symptoms try nozinan.*
- 5.7 The next entry in the medical notes is dated 20 January 1996 (p198) and is unsigned but as it refers to a verbal order is likely to be a member of nursing staff. *Has been unsettled on haloperidol in syringe drive diamorphine (illegible) to higher dose (illegible words), nozinan 50mg to 100m in 24 hrs (verbal order)*. There is an entry the following day dated 21 January 1996 (signature unclear) *'much more settled,*

quiet breathing, respiratory rate 6 / minute, not distressed continue'. There is a final entry in the notes on the [Code A] confirming death at 1.45 am. The recorded cause of death was bronchopneumonia.

- 5.8 Nursing assessment on the 5 January 1996 at Gosport on Dryad ward record Patient A had a poor physical condition with broken pressure areas to his buttocks and hip, and broken skin on scrotum. He was weight bearing to a very minimal degree, was low in mood but settled in behaviour (page 195). His fluid and diet intake was noted to be poor but that he was drinking supplement drinks (Fortisips).
- 5.9 Nursing note entry on the 10 January 1999 states 'condition remains poor. Seen by [Code A] and [Code A] To commence on diamorphine hourly this evening'. A nursing entry on the 15 January 1999 states 'Seen by [Code A] has commenced syringe driver at 08.25 diamorphine 80mg, midazolam 60mg + hyoscine 400ug'. A second entry that day states [Code A] was informed of Patient A's deterioration during the afternoon, and that he was now unresponsive and unable to take fluids and diet. On the 16 January 1999 the nursing notes record 'Condition remains very poor, some agitation was noticed when being attended to. Seen by [Code A] haloperidol 5-10mg to be added to the driver'.
- 5.10 An entry later that day at 1300h states 'previous driver dose discarded. Driver recharged with diamorphine 80mg, midazolam 60mg, hyoscine 400ug, and haloperidol 5mg given at a rate of 52mls hourly'. There was a note to nurse him on his back and left side only. An entry in the nursing note on 17 January 1999 indicates Patient A was seen by [Code A] and that his medication was increased as he remained 'tense and agitated, chest very "bubbly"'. On the same day at 14:30h the nursing notes records Patient A was again seen by [Code A] (page 210) his medication reviewed and altered, and that his syringe driver renewed at 15:30 with two drivers. Further deterioration is noted at 20:30. On the 17 January 1999 he appears more settled.
- 5.11 An entry on the 18 January 1999 in the nursing notes record that he appears comfortable. On 19 January 1999 heart deterioration and already poor condition is reported. Over the next 3 days the notes record he is settled and that an infusion of diamorphine 120mg midazolam 80mg, nozinan 50mg, haloperidol 20mg and hyoscine 1200ug was continued at 17:12 drugs received. The drug charts indicate on the 5 January 1999 that Patient A was prescribed the drugs he had been receiving prior to his transfer which were sertraline, lithium, diazepam and thyroxine (p195).
- 5.12 The drug charts contain an undated prescription by [Code A] (p200) for subcutaneous infusions of diamorphine 40-80mg/24 hours, hyoscine 200-400ug/24 hours, and midazolam 20-40mg/ 24 hours which were not administered. It is unclear to me if these drugs were prescribed by [Code A] on the 5 January 1996. Oramorph 5mg four times daily and a night time. Two doses were given at 2200h 10 January and 0600h on 11 January. On the 11 January the prescription is changed to 2ml (4mg) 4 hourly with 5ml (10mg) at 20:00 at this dose regimen of morphine is given until the morning of 15 January 1999 with a last dose administered at 0600h with Patient A receiving a total of 26mg morphine daily (page 202).
- 5.13 On 11 January 1999 [Code A] prescribed diamorphine 80-120mg subcutaneous 24 hours, hyoscine 200-400ug subcutaneous 24 hours, midazolam 40-80mg

subcutaneous 24 hours , 80 mg of diamorphine, hyoscine 400ug, medaziam 60mg are then administered over 24 hour periods during the 15, 16 and 17 January 1999 (page 201).

- 5.14 On 16 January 1996, haloperidol 5-10mg subcutaneous for 24 hours was prescribed, 5mg was administered on the 16 and 10mg on the 17 January 1999. On the 17 January 1999 the dosage of all drugs were increased by **Code A** to diamorphine 120mg subcutaneous 24 hours, midazolam 80mg 24 hours, hyoscine 1200 ug 24 hours, haloperidol 20mg 24 hours and this was administered from 17 January onwards, every day until Patient A's death with the exception of Haloperidol 20mg which was discontinued on the 20 January. On the 18 January nozinan 50mg was prescribed by **Code A** and 2 doses administered (dates unclear) this was then increased to 100mg on the 20th January and this appears to be administered subcutaneously each 24 hours over the following 3 days. There is a prescription for diamorphine 120mg and hyoscine 600ug over 24 hours dated the 18 January 1999 although the nursing entries on the drug chart suggest these were administered on the 17 January 1999.

Drug therapy received at Gosport War Memorial Hospital

6. Pages 199-204 All prescriptions written by **Code A** unless otherwise marked. Drug charts relating to medication administered between 18 -24 January 1996 appear to be missing from the medical records.

Regular Prescriptions

Sertaline 50mg bd	5 Jan - 11 Jan (discontinued)
Lithium carbonate 40mg od	5 Jan - 11 Jan (discontinued)
Diazepam 2mg tds	5 Jan -15 Jan (not administered after 0800h 15 Jan)
Thyroxine 50ug od	5 Jan - 15 Jan (dose not administered after 15 Jan)
<i>illegible prescription</i>	tick mark 7 Jan
Arthrotec one tab bd	8 Jan - 10 Jan (discontinued after 0900 10 Jan)

Diamorphine sc via syringe driver Prescribed 40-200mg/ 24hr	Date prescribed unclear. None administered
Hyoscine sc via syringe driver Prescribed 200-400 ug/24hr	Date prescribed unclear. None administered
Midazolam sc via syringe driver 20-40mg / 24hr	Date prescribed unclear. None administered

Oramorph (10mg/5ml) 5mg nocte	10 Jan 5mg nocte
Oramorph (10mg/5ml) 5mg qds	11 Jan Four 5mg doses
Oramorph (10mg/5ml) 10 mg nocte	11 Jan 10mg nocte
	12 Jan Four 5 mg doses
	12 Jan 10mg nocte
	13 Jan Four 5mg doses
	13 Jan 10mg nocte
	14 Jan Four 5 mg doses
	14 Jan 10mg nocte
	15 Jan one 5mg dose then discontinued
Diamorphine sc via syringe driver	15 Jan 80mg/24hr

Prescribed 80-120mg/ 24hr	16 Jan 80mg/24hr
	17 Jan 80mg/24hr
Diamorphine sc via syringe driver	17 Jan 120 mg/24hr
Prescribed 120mg/24hr	
Hysoscine sc via syringe driver	15 Jan 400 ucg/24hr
Prescribed 200-400 ucg/24hr	16 Jan 400 ucg/24hr
	17 Jan 400 ucg/24hr
Midazolam sc via syringe driver	15 Jan 60mg/24hr
Prescribed 40-60 (unclear) mg / 24hr	16 Jan 60mg/24hr
	17 Jan 60 mg/24hr
	18 Jan 80 mg/24hr
Haloperidol via syringe driver	16 Jan 5mg/24hr
Prescribed 5-10mg/24hr	17 Jan 10 mg/24hr

Opinion on Patient A's management

7. Patient A had a long standing history of depression which was severe and appears to be the most likely cause for his decline leading to his admission to a residential home in 1995. Immediately prior to his admission to Dryad ward he had developed when an inpatient in a psychiatry ward, a chest infection and pseudo obstruction and had become immobile with malnutrition and bedsores. Code A's assessment indicates he was very ill and would possibly not survive to leave hospital. Code A appears to have decided that at that stage it was not appropriate to consider finding a nursing home for Patient A, presumably because he was at this stage very medically unwell. The decision to transfer him to a long-stay ward suggests she had considered his medical condition was severe and unstable enough that he should continue to be managed in a continuing care bed.
8. There are limited entries in the medical notes during Patient A's time on Dryad ward where he spent 18 days prior to his death although the nursing records indicate Patient A was seen by Code A at regular intervals during this period. On admission Code A summarised Patient A's problems but there is no evidence in the medical notes that she undertook a physical examination. The notes do not record what history, if any she obtained from Patient A of his current symptoms and problems. Subsequent entries in the medical records are brief and I consider the medical records at Dryad are inadequate and not consistent with good medical practice. It is not clear from the admitting notes whether Code A considered Patient A was for palliative care only.
9. The previous assessment by Code A and nursing records describe a clear picture of a frail, older man who was deteriorating rapidly and highly likely to die in the next few weeks or months. Overall responsibility for the care of Patient A following his admission to Dryad ward lay with Code A as the responsible Code A. Day to day medical care was the responsibility of Code A and during out of hours the on call doctors.
10. Despite the limited medical documentation the decision of Code A to prescribe 5mg of Oramorph 4 hourly on 10 January 1996 was in my view reasonable given that Patient A was likely to be in significant discomfort and pain from his pressure sores. It would be difficult to

determine whether restlessness and agitation in Patient A were due to pain or his depression. A decision had been made that day that Patient A was for "TLC" (tender loving care). This indicates [Code A] considered Patient A was likely to die within days or weeks and the focus of treatment at this stage was towards palliating any symptoms he might have rather than initiation of other medical interventions to treat or prevent active ongoing problems. Given Patient A's general condition this decision appears reasonable and was appropriately discussed with his relatives.

11. I consider the discontinuation of sertaline and lithium carbonate on 12 January was reasonable as Patient A was deteriorating, although the medical records should have recorded the rationale for this. When patients are rapidly deteriorating it is common practice to withdraw routine drugs and it would be unlikely the withdrawal of these drugs would lead to any major effects on Patient A's mood and general level of functioning when he was deteriorating.
12. The change on 15 January 1996 from regular oral doses of morphine to syringe drivers subcutaneous infusion of a much higher dose of opioid (80mg diamorphine/24hr) in addition of midazolam 60mg/24hr is in my opinion is not justified by the information presented in the medical notes. There was a failure by [Code A] to perform an adequate clinical assessment and to consider the possibility that Patient A's agitation might be secondary to or exacerbated by the morphine he had received. As Patient A was deteriorating and expected to die in the near future I do not think [Code A] need necessarily have discussed Patient A's problems with the [Code A] but she should have examined patient A, documented her findings in the medical notes and explained her rationale for prescribing subcutaneous infusions of diamorphine, midazolam, haloperidol and nozinan.
13. In my opinion the infusions of diamorphine, midazolam and haloperidol and then nozinan, a sedating anti-psychotic drug, very likely led to respiratory depression and shortened Patient A's life span although he would have been expected to die in the near future even if he had not received these drugs. I consider Patient A probably did die with bronchopneumonia.

Summary of Conclusions

14. Patient A was a frail, dependent man with a long history of severe depression who was deteriorating prior to his admission to Dryad Ward who was not expected to die within a few weeks. The initial prescription of oral morphine was appropriate. The medical and nursing notes are limited but document he had persistent symptoms of agitation which merited treatment with a sedative such as diazepam or antipsychotic drug such as haloperidol. However there was inadequate assessment of Patient A by [Code A] as the doctor responsible for the day to day care of the patient with no clinical findings or other information recorded to justify the prescription of subcutaneous infusions of diamorphine and midazolam. The prescriptions of both these drugs in the wide dose ranges used was not justified and highly risky because of the risk of respiratory depression.
15. The prescription of diamorphine at an infusion rate of 80mg/24hr with midazolam at an infusion rate of 60 mg/24 hr on 15 January was not justified by the information recorded in the medical and nursing records and highly likely to result in depression of respiratory and/or conscious level depression. Patient A remained agitated despite receiving these infusions and although the assessment of Patient A was inadequate the prescription of haloperidol was in my view probably reasonable. The prescription of Nozinan on 18th January was not justified by any information presented in the nursing or medical records as at this

point as Patient A was reported to be comfortable. The combination of diamorphine, midazolam, haloperidol and nozinan very likely shortened Patient A's life although he would not have been expected to live more than a few weeks following his admission to Dryad ward. However the very poor quality of the medical and nursing notes make it difficult for me to be certain that these drugs were not justified given Patient A's clinical condition and reported pain and agitation.

16. In my opinion Code A in her care of Patient A failed to meet the requirements of good medical practice:
- to provide an adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.

Declaration

17. I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.
18. I have read and understood the Civil Procedure Rules Part 35 –Experts and Assessors.

Code A

Code A

GMC and
Report on **(Patient B)**

Consultant Physician

21 April 2009

GMC and [Code A]
Patient B

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient B commenting on the care and treatment carried out by [Code A] in relation to this patient, to assist the GMC Panel in determining whether [Code A] has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practise Panel that the prescriptions for diamorphine on 26 February and for diamorphine and midazolam on 5 March were too wide; that the lowest commencing dose of diamorphine on 5 March of 100mg per 24 hours was excessive to Patient B's needs; that these prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to her needs; that these prescriptions and the prescription of Morphine Slow Release (MST) tablets on 24 February were inappropriate, potentially hazardous and not in the best interests of Patient B; that [Code A] did not perform an appropriate examination or assessment of Patient B on admission or an adequate assessment when Patient B's condition deteriorated; did not provide a plan treatment or obtain the advice of a specialist when Patient B's condition deteriorated and that [Code A]'s actions and omissions in relation to Patient B were therefore inadequate and not in the best interests of Patient B.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Patient B; statements of [Code A]
[Code A] statement made by [Code A] in relation to Patient B; [Code A]
[Code A]'s police interview 24 March 2005.

5. **Course of events**

- 5.1 Patient B was 83 years of age when she was admitted to the Royal Hospital Haslar on 5 February 1996 following a fall, was transferred to Daedalus Ward, Gosport War Memorial Hospital on 22 February 1996. Patient B died on Daedalus Ward, Gosport War Memorial Hospital on [Code A] Prior to her fall and admission on 5 February 1996, Patient B lived alone at home with her bed downstairs. She had a history of long-standing insulin dependent diabetes and was registered blind due to cataracts (page 79). The admission

- clerking notes (page 127) record she could walk about 10 yards with a stick, that [Code A] did her shopping and she was supported with daily home help and nurse visits to administer her insulin.
- 5.2 On 5 February 1996, Patient B had been found at home, lying at the bottom of her stairs by her home help. Patient B was unable to recall events but it seemed clear that she had fallen down the stairs as she was complaining of pain in both shoulders and a sore head. She was taken to the Accident & Emergency Department at Royal Hospital Haslar where she was found to have a laceration on the scalp, laceration on the right lower leg and tenderness over the acromioclavicular region of the right shoulder and tenderness over the left humerus (page 130). X-rays were obtained of the skull and left and right shoulder. The notes record (page 134) that there was no bony injury evident. I could not find a formal report of these x-rays in the medical notes. On neurological examination she was found to have general weakness and was unable to move her right fingers. The impression of the assessing doctor in Accident & Emergency was that she had had a fall either due to a slip or stroke (CVA). She noted she was a little drowsy and arranged for admission.
- 5.3 On admission (page 140) the admitting doctor noted she looked frail but was fully alert and orientated. No focal arm or leg weakness was noted although power was generally weak throughout and an upgoing right plantar reflex was observed. Other findings were of a laceration (now sutured) and cut on the right leg with a small ulcer over the left tibia. Blood tests on admission were unremarkable and the electrocardiogram (ECG) showed atrial fibrillation (p143). Further enquiry into her history indicated she had had an episode of hypoglycaemia one month previously (page 143). The notes record (page 144) that she was independent but could only walk a few yards and went out of the house once a week when taken out by [Code A]
- 5.4 On 6 February the medical notes record that Patient B was complaining of pain in the right arm and had tenderness over the humerus and that the x-rays were not on the ward. Later that evening the medical notes record (page 145) that Patient B developed a temperature of 38.5°C. Examination reports chest and abdomen were normal and there was no obvious source of infection, however she was commenced on amoxicillin most likely to cover the possibility of a chest or urinary tract infection.
- 5.5 On 7 February the notes record that she still had left shoulder and upper arm pain and her hands were a problem (p145). On 8 February she was seen by [Code A] physiotherapist (page 146) who noted that Patient B was complaining of shoulder/upper limb tenderness and abdominal pain that she required the assistance of two people to move from sitting to standing with full support for a few steps. She noted the pain Patient B was having in her shoulder was a major problem leading her to require assistance with feeding, washing and dressing when she had previously been independent in these activities. An entry later that day indicates the need for analgesia. On 12 February the medical records note Patient B's shoulder was still very painful. On 13 February a referral was made to [Code A] [Code A] in Elderly Medicine. I have not been able to find a record of the analgesia and other drug therapy Patient B received at Royal Hospital Haslar in the medical notes.
- 5.6 The referral to [Code A] (page 146) state that x-rays showed no fractures, that her diabetes was under control, that she was not able to do anything for herself and that she needed help to walk. The medical records on 14 February record that "Patient B was still not able to do much for herself because of pain in her arms" (page 150).

- 5.7 On 16 February Patient B was seen by [Code A] Geriatrician in response to the referral made to [Code A] [Code A] noted the history of the fall on 5 February. That her full blood count suggested the presence of iron deficient anaemia and that Patient B still had pain in her arms and shoulders. At this stage she was walking a few steps with a physiotherapist, required two people to transfer and had no problems eating or drinking. [Code A] [Code A] noted (page 151) that she had been unable to use her fingers since admission, but this was improving.
- 5.8 [Code A] s examination of Patient B at this time indicated she had 4/5 weakness of the fingers and wrists in both arms and a decreased measurement in both shoulders. On sensory examination there was a possible loss of sensation in the median nerve territory of the right hand which [Code A] thought was long-standing. Reflexes were generally decreased, right plantar reflex was equivocal and left plantar was upgoing. [Code A] s impression was of a probable brain stem stroke (b. stem CVA page 152). [Code A] stated in the medical notes *"she had her neck x-rayed – I assume it was normal"*. Her notes record *"sounds as though only just managing at home prior – but would like to get back. Therefore to Daedalus GWMH"*. She requested (page 153) that notes and x-rays be sent with Patient B when a bed was available on the ward. [Code A] stated at the end of her assessment *"I am not sure whether we'll be able to get her home, but we will try"*.
- 5.9 An entry in the medical notes on 20 February stating mobility was improving in her arms and Patient B was now able to feed herself but was still unable to use cutlery. [Code A] s assessment is summarised in a letter dated 16 February 1996 (pages 242, 244).
- 5.10 Patient B was transferred to Daedalus Ward, Gosport War Memorial Hospital on 22 February 1996, under the care of [Code A] Geriatrician. An entry from [Code A] in the medical notes on 22 February 1996 (p175) states *"Transfer to Daedalus Ward, GWMH. Past medical history fall at home top to bottom of stairs, laceration on head. Leg ulcers. Severe incontinence, needs a catheter. Insulin dependent diabetes mellitus. Needs Mixtard insulin bd. Regular series blood sugar. Transfers with two. Incontinent of urine. Help to feed and dress. Barthel 2. Assess general mobility. ? suitable rest home if home found for cat"*.
- 5.11 The next entry from [Code A] in the medical notes on 23 February states *"catheterised last night. 500ml residue. Blood and protein. Trimethoprim"*. The next entry in the medical notes is on 26 February by [Code A] *"not so well over weekend. Family seen and well aware of prognosis and treatment plan. Bottom very sore, needs Pegasus mattress. Institute subcutaneous analgesia if necessary"*. As required prescriptions for subcutaneous infusions of diamorphine 80-160 mg/24hr, midazolam 40-80mg/24 hr and hyoscine 400-800ucg/24hr were written by [Code A] on 26 February but none administered.
- 5.12 The next entry is on 5 March 1996 by [Code A] in the medical notes and states *"has deteriorated over last few days. Not eating or drinking. In some pain therefore start subcutaneous analgesia. Let family know"*. On 6 March 1996 [Code A] writes in the medical notes (page 975) *"further deterioration. Subcutaneous analgesia commenced. Comfortable and peaceful. I am happy for medical staff to confirm death"*. There is an entry in the medical records on [Code A] at 2128h confirming death by a member of nursing staff. The death certificate records cause of death as 'CVA' with diabetes mellitus as a contributory factor (CVA is an abbreviation for cerebrovascular accident i.e. stroke).
- 5.13 The nursing summary records (page 1021) state *"patient having problems with grip in both hands and pain in her arms and shoulders"*. On 20 February the nursing summary states she

was referred to physiotherapy. On 24 February the nursing notes state "Patient B's pain was not controlled by DF118, that the patient was seen by [Code A] and commenced on morphine (MST 10mg bd)" (Page 1021). On 26 February 1996 the nursing notes record that Patient B was seen by [Code A] and the MST morphine dose increased to 20mg bd (page 1022). The nursing notes later that day (1430h) indicate [Code A] of Patient B and [Code A] were seen by [Code A], that the prognosis was discussed and "[Code A] is happy for us to just make Patient B comfortable and pain-free. Syringe driver explained".

- 5.14 On 4 March 1996 the notes record patient B was complaining of pain and of having extra as required doses of analgesia. Morphine sustained release tablets were increased to 30mg twice daily by [Code A]. On 5 March the nursing summary records Patient's B pain was uncontrolled and a syringe driver was commenced at 0930h with diamorphine 100mg/24hr and midazolam 40mg/24hr. On 6 March 1996 the nursing records state that patient B was seen by [Code A] and that medication other than that through the syringe driver was discontinued as Patient B was not unrousable.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 832-848. All prescriptions written by Dr Barton unless otherwise marked.

Regular prescriptions

Digoxin 125ug od 23 Feb – 4 Mar then discontinued
Prescribed 22 Feb

Digoxin 125ug od 5 Mar no further doses
Prescribed 4 Mar

Co-amilofruse 1 tablet once daily 23 Feb – 4 Mar then discontinued
Prescribed 22 Feb

Co-amilofruse 1 tablet once daily 4 Mar then no further doses
Prescribed 4 Mar

Ferrous sulphate 200mg bd 23 Feb – 4 Mar then discontinued
Prescribed 22 Feb and further continuation prescription 4 Mar

Beclomethasone inhaler 2 puffs twice daily
Prescribed 22 Feb 22 Feb – 4 Mar then discontinued

Salbutamol inhaler 2 puffs four times daily
Prescribed 22 Feb 22 Feb – 4 Mar then discontinued

Insulin mixtard 50 units once daily 0730h
Prescribed 22 February 1996 23-26 Feb

Insulin mixtard 50 units once daily 1800h
Prescribed 22 February 1996 22-25 Feb

Insulin mixtard dose unclear 23 Feb – 4 Mar (omitted 28 Feb)

Insulin mixtard dose unclear
Insulin mixtard 30 units morning 4-5 March
Prescribed 4 March

Insulin mixtard 20 units evening No doses administered
Prescribed 4 March

Trimethoprim 200mg bd 23-27 Feb then discontinued.
Prescribed 23 Feb

MST 10mg bd 0600h, 1800h 24-26 Feb discontinued after morning dose
Prescribed 24 Feb

MST 20mg bd Prescribed date unclear	26 Feb 2200h – 3 Mar 2200h then discontinued
MST 30mg bd Prescribed 4 Mar	4 Mar 2 doses then discontinued
Diamorphine subcut via syringe driver 100-200mg/24hr Prescribed 5 Mar	5 Mar 100mg/24hr 6 Mar 100mg/24hr
Midazolam subcut via syringe driver 40-80mg/24h Prescribed 5 March 1996	5 Mar 40mg/24hr 6 Mar 40mg/24hr
<i>As required prescriptions</i>	
Dihydrocodeine ? dose Prescribed 22 Feb	9 doses, 2 tablets received dates and times unclear
Diamorphine subcut via syringe driver 80-160mg/24hr Prescribed 26 Feb	None administered
Midazolam subcut via syringe driver 40-80mg/24hr Prescribed 26 Feb	None administered
Hyoscine sub-cut via syringe driver 400-800ug/24hr Prescribed 26 Feb	None administered

Opinion on Patient Management

7. Patient B was an elderly lady with long standing diabetes who had significant impairments and comorbidities prior to her fall and admission to hospital in February 1996. Although she was registered blind and had previous falls at home she was living alone at home with support. Following the fall her functional abilities were significantly impaired because she was unable to use her hands. This was attributed to a brain stem stroke although I consider the clinical evidence does not support this diagnosis. Bilateral hand weakness and arm and shoulder pain would be an unusual presentation for a brain stem stroke. No radiological brain imaging was undertaken which might have helped confirm the diagnosis. However as Code A rightly commented CT brain imaging at the time she assessed the patient would be unlikely to have demonstrated a brain stem stroke.
8. In a patient who has had a significant fall downstairs it is crucial to exclude injury to the head or cervical spine and in particular in patients with neurological deficits to exclude cervical cord compression. Code A recognised the importance of this through her comment asking whether the medical team responsible for her care had obtained and reviewed neck X-rays. I have been unable to find a record of any X-rays of Patient B's neck in the medical records and it is not clear that any X-rays of Patient B's cervical spine were obtained. In this context I think it is much more likely Patient B's symptoms were related to cervical spine cord injury. Her clinical symptoms are more in keeping with this diagnosis than a stroke. Ideally MR

scanning of the brain and cervical spine would have been requested to assess whether this was present and consideration given to obtaining a neurological or neurosurgical opinion. Notwithstanding the possible presence of cervical spine and cord injury Patient B eventually started to gain improved function of her hands although her general function was significantly reduced to that prior to her fall.

9. At the time of her transfer to Daedalus Ward the plan was to attempt to mobilise Patient B. The initial assessment of Patient B by [Code A] was in my view inadequate. There was no assessment of her pain and no neurological examination. The latter should have been performed because of the continuing arm weakness and the working diagnosis of a possible brain stem stroke. There was no record of the analgesia she had received prior to transfer to Daedalus Ward. The prescription of mild opioid drug dihydrocodeine for her pain was in my view reasonable and appropriate. It seems likely that her pain was attributed to musculoskeletal injuries although this is not stated by [Code A]. In my view continuing pain in the absence of fracture more than two weeks after a fall should have prompted a clinical review including a detailed history and re-examination of the patient with consideration of alternative causes of the pain.
10. The prescription by [Code A] of MST (sustained release morphine) on 24 February was in my view not justified or best practice by the information available in the medical records. The response to dihydrocodeine was not recorded. It would have been more appropriate to prescribe as required oral morphine before prescribing a sustained release preparation. Both the medical and nursing notes lack information on Patient B's symptoms of pain although it seems likely that she was having persisting pain as the MST dose was increased to a total of 60mg daily. However the medical and records do not record that Patient B remained in pain on the initial dose of MST and do not provide any justification for the increase in dose to 60 mg daily over the following days.
11. The prescriptions on 26 February of as required prescriptions for subcutaneous infusions of diamorphine 80-160 mg/24hr, midazolam 40-80mg/24 hr and hyoscine 400-800mcg/24hr were in my opinion, not justified, reckless and potentially very dangerous. In the event none of these were administered by nursing staff. At this time there was no evidence in the notes that Patient B was unable to swallow. She was receiving 40mg oral morphine in a 24 hour period and the equivalent dose of subcutaneous diamorphine would have been approximately 15-20mg/24hr. Had the diamorphine been administered this would have been 4-8 fold increase and would have been highly likely to cause respiratory depression and coma. Had the midazolam infusion been commenced this would have even more powerfully suppressed Patient B's respiration and conscious level.
12. [Code A] documents on the 5 March that Patient B was deteriorating and was not eating or drinking. No assessment was recorded or appears to have been made by [Code A] as to the cause of this deterioration. In particular she does not appear to have considered that the deterioration in patient B may have been due to adverse effects of the morphine prescribed to her. In this context it is difficult to know whether continuing opioid drugs was appropriate in Patient B. If Patient B's deterioration was not due to opiates it was appropriate to continue an equivalent opioid dose by the subcutaneous route. The equivalent diamorphine subcutaneous dose is one third to one half of the oral morphine dose received over a 24 hour period. Patient B was receiving 60mg/24hr of oral morphine. Therefore an equivalent dose of subcutaneous diamorphine would have been 20-30mg/24hr.

13. The prescription of a subcutaneous infusion of diamorphine that was 3-5 times higher than the oral morphine she had received was in my view reckless and dangerous and highly likely to precipitate respiratory depression and coma in Patient B. The prescription of 40mg/24hr midazolam was in my opinion also not justified as the medical and nursing notes do not record and agitation or other symptoms justifying the prescription of a sedative drug. The dose range prescribed was in my view excessive and reckless and likely to cause further respiratory depression and coma. If agitation or restlessness was present a single dose of haloperidol or other sedative would have been appropriate initial therapy. Close monitoring of Patient B was required once the combination of diamorphine and midazolam was infused with the nursing and medical staff understanding the high risk of respiratory depression and coma that these drugs can produce.
14. The subsequent deterioration of Patient B on 6 March is in my view most likely due to the combined effects of the diamorphine and midazolam infusions. The description of Patient B being comfortable and peaceful most likely reflects Patient B was in a drug induced coma at this stage. In my opinion the diamorphine infusion was inappropriately high and the midazolam infusion was not indicated in Patient B. I consider these drugs very likely produced respiratory depression and coma in Patient B and hastened her death.

Summary of Conclusions

15. Patient B was an elderly lady with diabetes who developed persisting bilateral hand weakness and shoulder and arm pain following a fall. The underlying cause of her persisting weakness and pain was in my opinion not clearly established. Patient B was transferred to Daedalus ward with the intent to try and mobilise her. The information in the notes suggests there was inadequate assessment of patient B by [Code A] as the doctor responsible for the day to day medical care of the patient. [Code A]'s prescription of Morphine Slow Release Tablets on 24 February was inappropriate because an adequate clinical assessment had not been performed and the response to paracetamol and moderate analgesia had not been assessed. The prescriptions of subcutaneous diamorphine and midazolam by [Code A] on 26 February were too wide a dose range and potentially hazardous. The prescriptions of subcutaneous diamorphine and midazolam on 5 March were not justified, reckless and in my opinion led to deterioration in Patient B contributing to her death.
16. In my opinion [Code A] in her care of Patient B failed to meet the requirements of good medical practice:
- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to consult colleagues;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.
17. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

Code A

GMC and Code A
Report on Code A Patient B)

Code A
Consultant Physician

10 April 2009

GMC and Code A
Patient B

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient B commenting on the care and treatment carried out by Code A in relation to this patient, to assist the GMC Panel in determining whether Code A has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that the prescriptions for diamorphine on 26 February and for diamorphine and midazolam on 26 February were too wide; that the lowest commencing dose of diamorphine on 5 March of 100mg per 24 hours was excessive to Patient B's needs; that these prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to her needs; that these prescriptions and the prescription of Morphine Slow Release (MST) tablets on 24 February were inappropriate, potentially hazardous and not in the best interests of Patient B; that Code A did not perform an appropriate examination or assessment of Patient B on admission or an adequate assessment when Patient B's condition deteriorated; did not provide a plan treatment or obtain the advice of a specialist when Patient B's condition deteriorated and that Code A's actions and omissions in relation to Patient B were therefore inadequate and not in the best interests of Patient B.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Patient B; statements of Code A Code A statement made by Code A in relation to Patient B; Code A's police interview 24 March 2005.

5. **Course of events**

- 5.1 Patient B was 83 years of age when she was admitted to the Royal Hospital Haslar on 5 February 1996 following a fall, was transferred to Daedalus Ward, Gosport War Memorial Hospital on 22 February 1996. Patient B died on Daedalus Ward, Gosport War Memorial Hospital on 6 March 1996. Prior to her fall and admission on 5 February 1996, Patient B lived alone at home with her bed downstairs. She had a history of long-standing insulin dependent diabetes and was registered blind due to cataracts (page 79). The admission

Code A

clerking notes (page 127) record she could walk about 10 yards with a stick, that Code A did her shopping and she was supported with daily home help and nurse visits to administer her insulin.

Code A

5.2 On 5 February 1996, Patient B had been found at home, lying at the bottom of her stairs by her home help. Patient B was unable to recall events but it seemed clear that she had fallen down the stairs as she was complaining of pain in both shoulders and a sore head. She was taken to the Accident & Emergency Department at Royal Hospital Haslar where she was found to have a laceration on the scalp, laceration on the right lower leg and tenderness over the acromioclavicular region of the right shoulder and tenderness over the left humerus (page 130). X-rays were obtained of the skull and left and right shoulder. The notes record (page 134) that there was no bony injury evident. I could not find a formal report of these x-rays in the medical notes. On neurological examination she was found to have general weakness and was unable to move her right fingers. The impression of the assessing doctor in Accident & Emergency was that she had had a fall either due to a slip or stroke (CVA). She noted she was a little drowsy and arranged for admission.

5.3 On admission (page 140) the admitting doctor noted she looked frail but was fully alert and orientated. No focal arm or leg weakness was noted although power was generally weak throughout and an upgoing right plantar reflex was observed. Other findings were of a laceration (now sutured) and cut on the right leg with a small ulcer over the left tibia. Blood tests on admission were unremarkable and the electrocardiogram (ECG) showed atrial fibrillation (p143). Further enquiry into her history indicated she had had an episode of hypoglycaemia one month previously (page 143). The notes record (page 144) that she was independent but could only walk a few yards and went out of the house once a week when taken out by Code A.

5.4 On 6 February 1996 the medical notes record that Patient B was complaining of pain in the right arm and had tenderness over the humerus and that the x-rays were not on the ward. Later that evening the medical notes record (page 145) that Patient B developed a temperature of 38.5°C. Examination reports chest and abdomen were normal and there was no obvious source of infection, however she was commenced on amoxicillin most likely to cover the possibility to cover the possibility of a chest or urinary tract infection.

5.5 On 7 February 1996 the notes record that she still had left shoulder and upper arm pain and her hands were a problem (p145). On 8 February 1996 she was seen by Code A physiotherapist (page 146) who noted that Patient B was complaining of shoulder/upper limb tenderness and abdominal pain that she required the assistance of two people to move from sitting to standing with full support for a few steps. She noted the pain Patient B was having in her shoulder was a major problem leading her to require assistance with feeding, washing and dressing when she had previously been independent in these activities. An entry later that day indicates the need for analgesia. On 12 February the medical records note Patient B's shoulder was still very painful. On 13 February 1996 a referral was made to Code A Consultant in Elderly Medicine. I have not been able to find a record of the analgesia and other drug therapy Patient B received at Royal Haslar Hospital in the medical notes.

5.6 The referral to Code A (page 146) state that x-rays showed no fractures, that her diabetes was under control, that she was not able to do anything for herself and that she needed help to walk. The medical records on 14 February record that "Patient B was still not able to do much for herself because of pain in her arms" (page 150).

- 5.7 On 16 February 1996 Patient B was seen by [Code A] Geriatrician in response to the referral made to [Code A] noted the history of the fall on 5 February 1996. That her full blood count suggested the presence of iron deficient anaemia and that Patient B still had pain in her arms and shoulders. At this stage she was walking a few steps with a physiotherapist, required two people to transfer and had no problems eating or drinking. [Code A] noted (page 151) that she had been unable to use her fingers since admission, but this was improving.
- 5.8 [Code A]’s examination of Patient B at this time indicated she had 4/5 weakness of the fingers and wrists in both arms and a decreased measurement in both shoulders. On sensory examination there was a possible loss of sensation in the median nerve territory of the right hand which [Code A] thought was long-standing. Reflexes were generally decreased, right plantar reflex was equivocal and left plantar was upgoing. [Code A]’s impression was of a probable brain stem stroke (b. stem CVA page 152). [Code A] stated in the medical notes “she had her neck x-rayed – I assume it was normal”. Her notes record “sounds as though only just managing at home prior – but would like to get back. Therefore to Daedalus GWMH”. She requested (page 153) that notes and x-rays be sent with Patient B when a bed was available on the ward. [Code A] stated at the end of her assessment “I am not sure whether we’ll be able to get her home, but we will try”.
- 5.9 An entry in the medical notes on 20 February stating mobility was improving in her arms and Patient B was now able to feed herself but was still unable to use cutlery. [Code A]’s assessment is summarised in a letter dated 16 February 1996 (page 242, 244).
- 5.10 Patient B was transferred to Daedalus Ward, Gosport War Memorial Hospital on 22 February 1996, under the care of [Code A] Geriatrician. An entry from [Code A] in the medical notes on 22 February 1996 (p175) states “Transfer to Daedalus Ward, GWMH. Past medical history fall at home top to bottom of stairs, laceration on head. Leg ulcers. Severe incontinence, needs a catheter. Insulin dependent diabetes mellitus. Needs Mixtard insulin bd. Regular series blood sugar. Transfers with two. Incontinent of urine. Help to feed and dress. Barthel 2. Assess general mobility. ? suitable rest home if home found for cat”.
- 5.11 The next entry from [Code A] in the medical notes on 23 February states “catheterised last night. 500ml residua. Blood and protein. Trimethoprim”. The next entry in the medical notes is on 26 February by [Code A] “not so well over weekend. Family seen and well aware of prognosis and treatment plan. Bottom very sore, needs Pegasus mattress. Institute subcutaneous analgesia if necessary”. As required prescriptions for subcutaneous infusions of diamorphine 80-160 mg/24hr, midazolam 40-80mg/24 hr and Hyoscine 400-800ug/24hr were written by [Code A] on 25 February but none administered.
- 5.12 The next entry is on 5 March 1996 by [Code A] in the medical notes and states “has deteriorated over last few days. Not eating or drinking. In some pain therefore start subcutaneous analgesia. Let family know”. On 6 March 1996 [Code A] writes in the medical notes (page 973) “further deterioration. Subcutaneous analgesia commenced. Comfortable and peaceful. I am happy for medical staff to confirm death”. There is an entry in the medical records on [Code A] at 2128h confirming death by a member of nursing staff. The death certificate records cause of death as ‘CVA’ with diabetes mellitus as a contributory factor (CVA is an abbreviation for Cerebrovascular Accident i.e. stroke).

- 5.13 The nursing summary records (page 1021) state "patient having problems with grip in both hands and pain in her arms and shoulders". On 20 February the nursing summary states she was referred to physiotherapy. On 24 February the nursing notes state "Patient B's pain was not controlled by DF118, that the patient was seen by [Code A] and commenced on morphine (MST 10mg bd)". (Page 1021). On 26 February 1996 the nursing notes record that Patient B was seen by [Code A] and the MST morphine dose increased to 20mg bd (page 1022). The nursing notes later that day (1430h) indicate [Code A] of Patient B and his wife were seen by [Code A] that the prognosis was discussed and [Code A] is happy for us to just make Patient B comfortable and pain-free. Syringe driver explained".
- 5.14 On 4 March 1996 the notes record Patient B was complaining of pain and of having extra as required doses of analgesia. Morphine sustained release tablets were increased to 30mg twice daily by [Code A]. On 5 March the nursing summary records Patient's B pain was uncontrolled and a syringe driver was commenced at 0930h with diamorphine 100mg/24hr and midazolam 40mg/24hr. On 6 March 1996 nursing states record that the patient was seen by [Code A] and that medication other than that through the syringe driver was discontinued as Patient B was unrousable.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 832-848. All prescriptions written by [Code A] unless otherwise marked.

Regular prescriptions

Digoxin 125ug od Prescribed 22 February 1996	23 Feb - 4 Mar then discontinued
Digoxin 125ug od Prescribed 4 March 1996	5 Mar no further doses
Co-amilofruse 1 tablet once daily Prescribed 22 February 1996	23 Feb - 4 Mar then discontinued
Co-amilofruse 1 tablet once daily Prescribed 4 March 1996	4 Mar then no further doses
Ferrous sulphate 200mg bd Prescribed 22 Feb and further continuation prescription 4 March	23 Feb - 4 Mar then discontinued
Beclomethasone inhaler 2 puffs twice daily Prescribed 22 February 1996	22 Feb - 4 Mar then discontinued
Salbutamol inhaler 2 puffs four times daily Prescribed 22 February 1996	22 Feb - 4 Mar then discontinued
Insulin mixtard 50 units once daily 07:30h Prescribed 22 February 1996	23-26 Feb
Insulin mixtard 50 units once daily 18:00h Prescribed 22 February 1996	22-25 Feb
Insulin mixtard dose unclear Prescribed 4 March	23 Feb - 4 Mar (omitted 28 Feb)
Insulin mixtard dose unclear Prescribed 4 March	4-5 March
Insulin mixtard 20 units evening Prescribed 4 March	No doses administered
Trimethoprim 200mg bd Prescribed 23 February	23-27 Feb then discontinued.

MST 10mg bd 0600h, 1800h Prescribed 24 February 1996	24-26 Feb discontinued after morning dose
MST 20mg bd Prescribed date unclear	26 Feb 2200h – 3 Mar 2200h then discontinued
MST 30mg bd Prescribed 4 March 1996	4 Mar 2 doses then discontinued
Diamorphine subcut via syringe driver 100-200mg/24 hr Prescribed 5 March 1996	5 Mar 100mg / 24 hours 6 Mar 100mg / 24 hours
Midazolam sub-cut via syringe driver 40-80mg/24h Prescribed 5 March 1996	5 Mar 40mg/24h 6 Mar 40mg/24h

As required prescriptions

Dihydrocodeine ?dose Prescribed 22 February 1996	9 doses, 2 tablets received dates and times unclear
Diamorpine 80-160mg/24h sub-cut via syringe driver Prescribed 26 February 1996	None administered
Midazolam 40-80mg/24h sub-cut via syringe driver Prescribed 26 February 1996	None administered
Hyoscine 400-800ug sub-cut via syringe driver Prescribed 26 February 1996	None administered

Opinion on Patient Management

7. Patient B was an elderly lady with long standing diabetes who had significant impairments and comorbidities prior to her fall and admission to hospital in February 1996. Although she was registered blind and had previous falls at home she was living alone at home with support. Following the fall her functional abilities were significantly impaired because she was unable to use her hands. This was attributed to a brain stem stroke although I consider the clinical evidence does not support this diagnosis. Bilateral hand weakness and arm and shoulder pain would be an unusual presentation for a brain stem stroke. No radiological brain imaging was undertaken which might have helped confirm the diagnosis. However as **Code A** rightly commented CT brain imaging at the time she assessed the patient would be unlikely to have demonstrated a brain stem stroke.
8. In a patient who has had a significant fall down stairs it is crucial to exclude injury to the head or cervical spine and in particular in patients with neurological deficits to exclude cervical cord compression. **Code A** recognised the importance of this through her comment asking whether the medical team responsible for her care had obtained and reviewed neck X Rays. I have been unable to find a record of any X rays of Patient B's neck in the medical records and it is not clear that any X rays of Patient B's cervical spine were obtained. In this context I think it is much more likely Patient B's symptoms were related to cervical spine cord injury. Her clinical symptoms are more in keeping with this diagnosis than a stroke. Ideally MR scanning would have been requested to assess whether this was present and consideration given to obtaining a neurological or neurosurgical opinion. Notwithstanding the possible presence of cervical spine and cord injury Patient B eventually started to gain improved function of her hands although her general function was significantly reduced to that prior to her fall.

9. At the time of her transfer to Daedalus Ward the plan was to attempt to mobilise Patient B. The initial assessment of Patient B by [Code A] was in my view inadequate. There was no assessment of her pain and no neurological examination. The latter should have been performed because of the continuing arm weakness and the working diagnosis of a possible brain stem stroke. There was no record of the analgesia she had received prior to transfer to Daedalus Ward. The prescription of mild opioid drug dihydrocodeine for her pain was in my view reasonable and appropriate. It seems likely that her pain was attributed to musculoskeletal injuries although this is not stated by [Code A] in my view continuing pain in the absence of fracture more than two weeks after a fall should have prompted a clinical review including a detailed history and re-examination of the patient with consideration of alternative causes of the pain.
10. The prescription by [Code A] of MST (sustained release morphine) on 24 February was in my view not appropriate. The response to dihydrocodeine was not recorded. It would have been more appropriate to prescribe as required oral morphine before prescribing a sustained release preparation. Both the medical and nursing notes lack information on Patient B's symptoms of pain although it seems likely that she was having persisting pain as the MST dose was increased to a total of 60mg daily.
11. The prescriptions on 26 February of as required prescriptions for subcutaneous infusions of diamorphine 80-160 mg/24hr, midazolam 40-80mg/24 hr and Hyoscine 400-800ucg/24hr were in my opinion, not justified, reckless and potentially very dangerous. In the event none of these were administered by nursing staff. At this time there was no evidence in the notes that Patient B was unable to swallow. She was receiving 40mg oral morphine in a 24 hour period and the equivalent dose of subcutaneous diamorphine would have been approximately 15mg/24hr. Had the diamorphine been administered this would have been 5-10 fold increase and would have been highly likely to cause respiratory depression and coma. Had the midazolam infusion been commenced this would have even more powerfully suppressed Patient B's respiration and conscious level.
12. [Code A] documents on the 5 March that Patient B was deteriorating and was not eating or drinking. No assessment was recorded or appears to have made by [Code A] as to the cause of this deterioration. In particular she does not appear to have considered that the deterioration in patient B may have been due to adverse effects of the morphine prescribed to her. In this context it is difficult to know whether continuing opioid drugs was appropriate in Patient B. If Patient B's deterioration was not due to opiates it was appropriate to continue an equivalent opioid dose by the subcutaneous route. The equivalent diamorphine subcutaneous dose is one third of the oral morphine dose received over a 24 hour period. Patient B was receiving 60mg/24hr of oral morphine. Therefore an equivalent dose of subcutaneous diamorphine would have been 20mg/24hr.
13. The prescription of a subcutaneous infusion of diamorphine that was 5-10 times higher than the oral morphine she had received was in my view reckless and dangerous and highly likely to precipitate respiratory depression and coma in Patient B. The prescription of 40mg/24hr midazolam was in my opinion also not justified as the medical and nursing notes do not record and agitation or other symptoms justifying the prescription of a sedative drug. The dose range prescribed was in my view excessive and reckless and likely to cause further respiratory depression and coma. If agitation or restlessness was present a single dose of haloperidol or other sedative would have been an appropriate initial therapy. Very close monitoring of Patient B as required once the combination of diamorphine and midazolam

were infused with the nursing and medical staff understanding the high risk of respiratory depression and coma that these drugs can produce.

14. The subsequent deterioration of Patient B on 6 March is in my view most likely due to the combined effects of the diamorphine and midazolam infusions. The description of Patient B being comfortable and peaceful most likely reflects Patient B was in a drug induced coma at this stage. In my opinion the diamorphine infusion was inappropriately high and the midazolam infusion was not indicated in Patient B. I consider these drugs very likely produced respiratory depression and coma in Patient B and hastened her death.

Summary of Conclusions

15. Patient B was an elderly lady with diabetes who developed persisting bilateral hand weakness and shoulder and arm pain following a fall. The underlying cause of her persisting weakness and pain was in my opinion not clearly established. Patient B was transferred to Daedalus ward with the intent to try and mobilise her. The initial assessment by [Code A] of Patient B was inadequate. [Code A]'s prescription of Morphine Slow Release Tablets on 24 February was inappropriate because an adequate clinical assessment had not been performed and the response to paracetamol and moderate analgesia had not been assessed. The prescriptions of subcutaneous diamorphine and midazolam by [Code A] on 26 February were too wide a dose range and potentially hazardous. The prescriptions of subcutaneous diamorphine and midazolam on 5 March were not justified, reckless and in my opinion led to deterioration in Patient B contributing to her death.
16. In my opinion [Code A] in her care of Patient B failed to meet the requirements of good medical practice:
- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to consult colleagues;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.

Declaration

17. I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.
18. I have read and understood the Civil Procedure Rules Part 35 – Experts and Assessors.

Code A

General Medical Council and Code A
Report on Code A (Patient C)

Code A
Consultant Physician

21 April 2009

**General Medical Council and [Code A]
Patient C**

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of patient C, commenting on the care and treatment carried out by [Code A] in relation to this patient to assist the GMC Panel in determining whether [Code A] has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegation presented to the Fitness to Practice Panel that the prescriptions of diamorphine and midazolam were made with too wide a dose range and were there inappropriate and potentially hazardous and not in the best interests of [Code A]

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I provided to Hampshire Constabulary dated 12 December 2001. In that report pages 30-34 I described the course of events relating to [Code A]'s admission to the Department of Medicine for Elderly People at Queen Alexandra Hospital on 6 February 1998 and subsequent care following her transfer to Dryad Ward at Gosport War Memorial Hospital on 27 February 1998 prior to her death on [Code A]
4. This report is based on my review of the following documents: medical records of patient C; statements of [Code A] and various nurse statements.

5. Course of events

I have described these in my report to Hampshire Constabulary dated 12 December 2001 and have no changes or corrections to make to my statement in that report.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In this section I list all drug therapy received providing more detail of [Code A]'s prescribing in section 6.9 of my report to Hampshire Constabulary (12 December 2001).

Pages 272 – 284. All prescriptions written by [Code A] unless otherwise marked.

Once only prescription

Diamorphine im 5mg

administered twice. First date unclear, 0800 h
Second date unclear, 1500 h

As required prescriptions

Thioridazine 25mg 28 Mar 1300h
 Prescribed 27 Feb

Oramorph 10mg per 5mls, 5mg 28 Feb 1620h
 Prescribed 27 Feb

Fentanyl '25' patch x 3 days 2 Mar 0800h
 Prescribed 2 Mar

Regular prescriptions

Digoxin 125ug od
 Frusemide 40mg od
 Ramipril 5mg od
 Sotalol 40mg od
 Sertraline 50mg od

All 5 drugs above prescribed 27 Feb
 No drugs administered, discontinued date unclear

Lactulose 10ml bd 27 Feb 1 dose
 Prescribed 27 Feb 28 Feb 2 doses
 29 Feb 1 dose

Thioridazine dose unclear tds 1 Mar 2 doses
 Prescribed 28 Feb 2 Mar 1 dose then discontinued

Heminevrin dose unclear nocte 28 Feb 1 dose
 Prescribed 28 Feb 1 Mar 1 dose then discontinued

Daily review prescriptions

Diamorphine sub cut via syringe driver 3 Mar 20mg/24hr 1050h
 20-200mg/24hr
 Prescription date unclear MARKED PRN

Hyoscine subcut via syringe driver None administered
 200-800ug/24hr
 Prescription date unclear

Midazolam subcut via syringe driver 3 Mar 20mg/24hr 1050h
 20-80mg/24hr
 Prescription date unclear

Opinion on Patient Management

- I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Code A's prescribing.

8. As previously stated I consider the prescription of oral morphine on 28 February was probably appropriate. If this had failed to control her symptoms which the notes suggest was the case by 2 March. Patient C had received oral morphine, thioridazine and heminevrin and was reported to be unsettled following intra-muscular diamorphine and to be spitting out oral medication. I would consider the decision to prescribe a transdermal patch was appropriate. [Code A] recorded the rationale for prescribing a fentanyl patch in her entry to the medical notes on 2 March.
9. After the fentanyl patch (25ug per hour) was applied Patient C became more drowsy. The fentanyl 25ug patch is equivalent to 90mg of oral morphine (ref BNF 36 September 1998 page 204). Patient C had received substantially less than the equivalent of 90mg oral morphine in the previous 24 hours. It is difficult to determine how much opioid drugs she had received because the dates of two administered 5 mg intramuscular doses of diamorphine are unclear. However if it is assumed these two doses were administered on 1 March this was equivalent to 20-30mg morphine. [Code A] had therefore prescribed at least a three fold higher dose of opioid, and if the diamorphine doses were administered on separate days the increase in opioid dose was even higher. There was a significant risk of adverse effects from the fentanyl patch and this was the most likely cause of Patient C developing drowsiness.
10. The notes record [Code A] was concerned about the deterioration. [Code A] appeared to recognise the deterioration could be due to adverse affects of opiates although she states in her entry that patient C was receiving diamorphine when she was only receiving a fentanyl patch at this point. It would have been appropriate for the fentanyl patch to be removed although it is not clear if this was done.
11. I cannot find any justification of the subsequent commencement of midazolam and diamorphine as a subcutaneous infusion on 3 March. [Code A] recorded no indication for this in the medical records. At this time the nursing records do not indicate patient was in any pain or distress. In my view there was no indication to prescribe additional opiates or sedative by continuous syringe driver infusion when patient C had already deteriorated following the application of the fentanyl patch. The infusion of diamorphine and midazolam would be expected to result in further depression of conscious level and respiratory depression. These drugs likely contributed to her death.
12. In my opinion the prescription of subcutaneous diamorphine and midazolam in the wide dose range was poor practice, potentially very hazardous and not consistent with good medical practice. The medical notes should have recorded clear reasons why these powerful drugs were being prescribed. In the absence of any clear protocol the prescription of such a wide dose range was hazardous in a patient such as Patient C.

Summary of Conclusions

13. Patient C was a frail elderly lady with probable carcinoma of the bronchus who had background problems of depression, dementia, ischaemic heart disease and congestive heart failure. [Code A] was responsible for her day to day medical care on Dryad Ward. The information recorded in the medical records suggests there was an inadequate medical assessment when she was initially admitted to Dryad ward. The medical records also suggest that an adequate medical assessment was not performed by [Code A] prior to the prescription of midazolam, diamorphine and hyoscine by subcutaneous infusion using a syringe driver. The dose ranges were inappropriate and potentially hazardous. In my

opinion the prescription of these drugs in conjunction with the previous prescription of a fentanyl patch at a much higher equivalent dose than the oral morphine may have contributed to her death. However Patient C was a frail woman with probable carcinoma of the bronchus who was deteriorating prior to her admission to Dryad ward and other medical problems may have caused her deterioration and death.

14. In my opinion, **Code A** in her care of patient C failed to meet the requirements of good medical practice to:

- provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
- keep clear accurate contemporaneous patient records to support the relevant clinical findings, decisions made, information given to patients and any drugs or other treatments prescribed
- prescribe only the treatment drugs or appliances that serve the patient's needs.

14. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

Code A

GMC and **Code A**
Report on **Code A**

Code A FRCP
Consultant Physician

5 April 2009

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of **Code A** commenting on the care and treatment carried out by **Code A** in relation to this patient to assist the GMC Panel in determining whether **Code A** has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegation presented to the Fitness to Practice Panel that the prescriptions of diamorphine and midazolam were made with too wide a dose range and were therefore inappropriate and potentially hazardous and not in the best interests of **Code A**.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital in the medico-legal report I provided to Hampshire Constabulary dated 12 December 2001. In that report pages 30-34 I described the course of events relating to **Code A**'s admission to the Department of Medicine for Elderly People at Queen Alexandra Hospital on 6 February 1998 and subsequent care following her transfer to Dryad Ward at Gosport War Memorial Hospital on 27 February 1998 prior to her death on **Code A**.
4. This report is based on my review of the following documents: medical records of **Code A** statements of **Code A** and various nurse statements.

5. Course of events

I have described these in my report to Hampshire Constabulary dated 12 December 2001 and have no changes or corrections to make to my statement in that report.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In the next section I list all drug therapy received providing more detail of **Code A**'s prescribing in section 6.9 of my report to Hampshire Constabulary (12 December 2001).

Pages 272 – 284. All prescriptions written by **Code A** unless otherwise marked.

Once only prescription

Diamorphine im 5mg administered twice. First date unclear, 0800 hours
Second date unclear, 1500 hours

As required prescriptions

Thioridazine 25mg 28 March 1300 hours
prescribed 27 February 1998

Oramorph 10mg per 5mls 28 February, 1620h
5mg prescribed 27 February 1998

Fentanyl '25' patch x 3 days 2 March 1998, 0800h
Prescribed 2 March 1998

Regular prescriptions

Digoxin 125ug od
Frusemide 40mg od
Ramipril 5mg od
Sotalol 40mg od
Sertraline 50mg od

All 5 drugs above prescribed 27 February 1998
No drugs administered, discontinued date unclear

Lactulose 10mls bd 27 February 1 dose
Prescribed 27 February 1998 28 February 2 doses
29 February 1 dose

Thioridazine dose unclear tds 1 March 2 doses
Prescribed 28 February 1998 2 March 1 dose then discontinued

Heminevrin dose unclear nocte 28 February 1 dose
Prescribed 28 February 1999 1 March 1 dose then discontinued

Daily review prescriptions

Diamorphine 20-200mg / 24 hours 3 March 20mg/ 24 hours 1050 h
marked prn Prescription date unclear

Hyoscine subcut 200-800ug / 24 hours None administered
Prescription date unclear

Midazolam subcut 20-80mg / 24 hours 3 March 20mls per 24 hours 1050 hours
Prescription date unclear

Opinion on Patient Management

- I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Code A's prescribing.

8. As previously stated I consider the prescription of oral morphine on 23 February 1999 was probably appropriate. If this had failed to control her symptoms which the notes suggest was the case by 2 March, [Code A] had received oral morphine, thioridazine and heminevrin and was reported to be unsettled following intra-muscular diamorphine and to be spitting out oral medication. I would consider the decision to prescribe a trans-arnal patch was appropriate. [Code A] recorded the rationale for prescribing a fentanyl patch in her entry to the medical notes on 2 March.
9. After the fentanyl patch (25ug per hour) was applied [Code A] became more drowsy. The fentanyl 25ug patch is equivalent to 90mg of oral morphine (ref BNF 56 September 2008 page 16). [Code A] had received substantially less than the equivalent of 90mg oral morphine in the previous 24 hours. It is difficult to determine how much opioid drugs she had received because the dates of two administered 5 mg intramuscular doses of diamorphine are unclear. However if it is assumed these two doses were administered on 1st March 1999 this was equivalent to 30mg morphine. [Code A] had therefore prescribed at least a three fold higher dose of opioid and it is not surprising that [Code A] then developed drowsiness. The notes record [Code A] was concerned about the deterioration. [Code A] appeared to recognise the deterioration could be due to adverse effects of opiates although she states in her entry that [Code A] was receiving diamorphine when she was only receiving a fentanyl patch at this point. It would have been appropriate for the fentanyl patch to be removed although it is not clear if this was done.
10. I cannot find any justification of the subsequent commencement of midazolam and diamorphine as a subcutaneous infusion on 3 March. [Code A] recorded no indication for this in the medical records. At this time the nursing records do not indicate [Code A] was in any pain or distress. In my view there was no indication to prescribe additional opiates or sedative by continuous syringe driver infusion when [Code A] had already deteriorated following the application of the fentanyl patch. The infusion of diamorphine and midazolam would be expected to result in further depression of conscious level and respiratory depression. These drugs likely contributed to her death.
11. In my opinion the prescription of subcutaneous Diamorphine, Hyoscine and Midazolam in the wide dose range was poor practice, potentially very hazardous and not consistent with good medical practice. The medical notes should have recorded clear reasons why these powerful drugs were being prescribed. In the absence of any clear protocol the prescription of such a wide dose range was hazardous in a patient such as [Code A].

Summary of Conclusions

12. [Code A] was a frail elderly lady with probable carcinoma of the bronchus who had background problems of depression, dementia, ischaemic heart disease and congestive heart failure. [Code A] was responsible for her day to day medical care on Dryad Ward. There was an inadequate medical assessment when she was initially admitted and a failure to subsequently assess [Code A] prior to the prescription of midazolam, diamorphine and hyoscine by subcutaneous infusion using a syringe driver. The dose ranges were inappropriate and potentially hazardous. My opinion is that the prescription of these drugs in conjunction with the previous prescription of a fentanyl patch at a much higher equivalent dose than the oral morphine she had been taking were likely to have contributed to her death.

13. In my opinion, [Code A] in her care of [Code A] failed to meet the requirements of good medical practice to:

- provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
- keep clear accurate contemporaneous patient records to support the relevant clinical findings, decisions made, information given to patients and any drugs or other treatments prescribed;
- prescribe only the treatment drugs or appliances that serve the patient's needs.

Declaration

Code A

**General Medical Council and Code A
Report on Code A (Patient D)**

Code A
Consultant Physician

21 April 2009

**General Medical Council and [Code A]
Report on Patient D**

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient D commenting on the care and treatment carried out by [Code A] in relation to this patient to assist the GMC Panel in determining whether [Code A] has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that the prescriptions of diamorphine and midazolam were in too wide a dose range, creating a situation whereby drugs could be administered to Patient D which were excessive to her needs and were inappropriate, potentially hazardous and not in the best interests of Patient D.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 21-24 of that report I describe the course of events relating to Patient D's admission to the Queen Alexandra Hospital on 31 July 1998, transfer to Daedalus Ward Gosport War Memorial Hospital on 6 August 1998 prior to her death on [Code A].
4. This report is based on my review of the following documents; medical records of Patient D; statements of [Code A] various nurse statements.

5. Course of events

5.1 I have described the course of events in my report to Hampshire Constabulary dated 12 December 2001. A correction I have to that statement relates to section 4.4 where I stated the nursing care plan recorded no significant deterioration until 21 August 1998. The nursing notes record a deterioration in Patient D's condition over the weekend on 17 August 1998 (p635). Otherwise I have no changes or corrections to make to my statement in that report.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In this section I list all drug therapy received providing more detail of [Code A]'s prescribing in section 4.5 of my report to Hampshire Constabulary (12 December 2001).

Pages 138-145. All prescriptions written by [Code A] unless otherwise marked.

Note the drug chart used at Queen Alexandra Hospital was used following transfer on 6 August 1998 to Daedalus Ward with the hospital and ward being changed from 'Q.A. to 'GWMH' and 'Philip' to 'Daedalus' ward.' (p139)

As required prescriptions

Promazine syrup 25mg
Prescribed 31 Jul 1998 by [Code A] None administered

Haloperidol subcut 2.5-10mg
maximum 60mg in 24 hours
Prescribed 1 Aug 1998 by [Code A] 1 Aug 2045h 2.5mg

Magnesium hydroxide 10mls
Prescribed 4 Aug 1998 [Code A] None administered

Regular prescriptions

Fluoxetine (Prozac) 20mg od
Prescribed 31 Jul 1998 [Code A] 1-9 Aug then discontinued

Co-danthramer 5-10mls
Prescribed 31 Jul 1998 [Code A] 31 Jul – 19 Aug

Zopiclone 3.75mg
Prescribed 31 Jul 1998 [Code A] 3-19 Aug

Lactulose 10mls
Prescribed 31 Jul 1998 [Code A] 1 - 4 Aug then discontinued

Promazine 25mg od
Prescribed 31 Jul 1998 [Code A] None administered

Augmentin 1.2 g iv tds
Prescribed 1 Aug 1998 [Code A] 1 Aug 2 doses

Augmentin elixir 250-62 500mg tds
Prescribed 2 Aug 1998 [Code A] Discontinued 2 August
2-9 Aug then discontinued

Prescribed 2 Aug 1998 [Code A]

Daily review prescriptions

Diamorphine subcut via syringe driver
Prescribed date unclear
20–200mg/24hr
20 Aug 30mg /24hr 1350h
21 Aug 30mg /24hr

Hyoscine subcut via syringe driver
200-800ug/24hr
Prescribed date unclear
None administered

Midazolam subcut syringe driver
20-80mg/24hr
Prescribed date unclear
20 Aug 20mg /24hr 1350h
21 Aug 20mg /24hr

Opinion on Patient Management

- I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to [Code A] prescribing.

8. Patient D was a frail elderly woman with dementia resident in a psychogeriatric care home (Addenbrooke's) prior to her admission to hospital. [Code A] had outlined the management plan for Patient D on 4 Aug 1998 (p99A) with continuation of oral antibiotics to treat her urinary tract infection, administration of subcutaneous fluids and transfer to Daedalus NHS Continuing Care Ward for 4-6 weeks for observation prior to a decision about placement. At this stage Patient D could not return to her bed at Addenbrooke's care home but her bed was to be kept there until it became clear whether she would recover sufficiently to return to the care home. A decision was made that Patient D was not for resuscitation in the event of a cardiac arrest but active treatment was continuing. I would consider both these decisions were appropriate and reasonable.
9. There are very few medical records following Patient D's transfer to Daedalus ward. There is a brief entry on 6 August by [Code A] documenting her transfer and plan for 4-6 weeks observation. The entry in the medical notes by [Code A] on 10 August indicates Patient D had shown some improvement and was eating and drinking better but remained confused and slow (page 99B). [Code A] made a decision that the place at Addenbrooke's care home should be given and Patient D reviewed in one month time to assess if she continued to have specialist medical or nursing problems which would have meant long term care in an NHS continuing care bed was appropriate.
10. The nursing notes indicated on 17 August that Patient D's condition had deteriorated over the weekend (p635). The nursing notes do not record Patient D was in pain or distress. The next entry in the nursing records on 21 August after Patient D had been commenced on diamorphine and midazolam by [Code A] do not record Patient D having any pain or distress. Subcutaneous infusions of diamorphine and midazolam were commenced on 20 August by nursing staff. It is unclear when the prescription for these drugs was written by [Code A] as this section of the drug chart does not have a date box to record the prescribing date. However [Code A] presumably wrote this prescription on or before Thursday 20 August and later made an entry in the notes on 21 August when she documents subcutaneous analgesia was commenced the previous day.
11. The deterioration that occurred in Patient D required a medical assessment to be performed to determine the cause of the deterioration such as infection or electrolyte disturbance. However the information in the medical records suggests that no such assessment was undertaken by [Code A] which was necessary to meet the requirements of good medical practice. In my opinion [Code A]'s failure to record any indication for the commencement of subcutaneous infusions of diamorphine and midazolam was not good medical practice and the decision to commence these drugs was not justified or appropriate.
12. In my opinion the prescription of subcutaneous diamorphine and midazolam in the wide dose range was poor practice, potentially very hazardous and not consistent with good medical practice. The prescription of large dose ranges of these drugs in the absence of a clear protocol understood by all nursing staff indicating the symptoms that should lead to the administration of the drugs, doses to be used and monitoring undertaken, placed Patient D at high risk of being administered an inappropriately high dose of opiate. In my opinion it is likely that the administration of the diamorphine and midazolam infusions produced depression of her respiration and conscious level. However as there are no clear observations of Patient D's respiratory rate it is difficult to assess whether significant deterioration occurred before or after administration of the diamorphine and midazolam and whether these drugs hastened death.

Summary of Conclusions

13. Patient D was a frail elderly woman with dementia who was transferred to Daedalus ward for observation prior to a decision about appropriate long term placement. After initial improvement following admissions to the ward Patient D deteriorated and was prescribed and commenced on diamorphine and midazolam subcutaneous infusions and died [Code A]. [Code A] The information in the notes suggests there was an inadequate assessment of patient D by [Code A] when the deterioration occurred. In my opinion the prescriptions of diamorphine and midazolam by subcutaneous infusion were not justified by the information recorded in the medical records, were in too wide a dose range and were potentially hazardous.
14. In my opinion [Code A] in her care of Patient D failed to meet the requirements of good medical practice to:
- Provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
 - Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
 - Prescribe only the treatment, drugs or appliances that serve the patient's need
13. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.
- I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
[Code A]

GMC and **Code A**
Report on **Code A**

Code A
Consultant Physician

6 April 2009

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of **Code A** commenting on the care and treatment carried out by **Code A** in relation to this patient to assist the GMC Panel in determining whether **Code A** has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that the prescriptions of diamorphine and midazolam were in too wide a dose range, creating a situation whereby drugs could be administered to **Code A** which were excessive to her needs and were inappropriate, potentially hazardous and not in the best interests of **Code A**.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 21-24 of that report I describe the course of events relating to **Code A**'s admission to the Queen Alexandra Hospital on 31 July 1998, transfer to Daedalus Ward Gosport War Memorial Hospital on 6 August 1998 prior to her death on **Code A**.

4. This report is based on my review of the following documents; medical records of **Code A**
Code A

5. Course of events

5.1 I have described the course of events in my report to Hampshire Constabulary dated 12 December 2001. A correction I have to that statement relates to section 4.4 where I stated the nursing care plan recorded no significant deterioration until 21 August 1998. The nursing notes record a deterioration in **Code A**'s condition over the weekend on 17 August 1998 (p635). Otherwise I have no changes or corrections to make to my statement in that report.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Midazolam subcut
 Prescribed date unclear
 20-80mg / 24hrs

20 Aug 20mg / 24 hrs 1350
 21 Aug 20mg /24 hrs

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to [Code A]'s prescribing.
8. [Code A] was a frail elderly lady with dementia resident in a psychogeriatric care home (Addenbrooke's) prior to her admission to hospital. [Code A] had outlined the management plan for [Code A] on 4 Aug 1998 (p99A) with continuation of oral antibiotics to treat her urinary tract infection, administration of subcutaneous fluids and transfer to Daedalus NHS Continuing Care Ward fro 4-6 weeks for observation prior to a decision about placement. At this stage [Code A] could not return to her bed at Addenbrooke's care home but her bed was to be kept there until it became clear whether she would recover sufficiently to return to the care home. A decision was made that [Code A] was not for resuscitation in the event of a cardiac arrest but active treatment was continuing. I would consider both these decisions were appropriate and reasonable.
9. There are very few medical records following [Code A]'s transfer to Daedalus ward. There is a brief entry on 6 August by [Code A] documenting her transfer and plan for 4-6 weeks observation. The entry in the medical notes by [Code A] on 10 August 1998 indicates [Code A] [Code A] had shown some improvement and was eating and drinking better but remained confused and slow (page 99B). [Code A] made a decision that the place at Addenbrooke's care home should be given and [Code A] reviewed in one month time to assess is she continued to have specialist medical or nursing problems which would have meant long term care in an NHS continuing care bed was appropriate.
10. The nursing notes indicated on 17 August 1998 that [Code A]'s condition had deteriorated over the weekend (p635). The nursing notes do not record [Code A] was in pain or distress. The next entry in the nursing records on 21st August 1998 after [Code A] had been commenced on diamorphine and midazolam by [Code A] do not record [Code A] having any pain or distress. Subcutaneous infusions of diamorphine and midazolam were commenced on 20 August 1998 by nursing staff. It is unclear when the prescription for these drugs was written by [Code A] as this section of the drug chart does not have a date box to record the prescribing date. However [Code A] presumably wrote this prescription on or before Thursday 20 August 1998 and did not make any record in the notes until 21 August 1998 when she documents subcutaneous analgesia was commenced the previous day. [Code A] [Code A] in failing to examine [Code A] to assess possible causes of her deterioration, such as recurrent sepsis or electrolyte disturbance was poor medical practice. In my opinion [Code A] [Code A]'s failure to record any indication for the commencement of subcutaneous infusions of opioid analgesia and sedatives was in also very poor medical practice and the decision to commence these drugs was not appropriate.
11. In my opinion the prescription of subcutaneous diamorphine, hyoscine and midazolam in the wide dose range was poor practice, potentially very hazardous and not consistent with good medical practice. The prescription of large dose ranges of these drugs in the absence of a clear protocol understood by all nursing staff indicating the symptoms that should lead to the administration of the drugs, dose to be used and monitoring undertaken, placed [Code A]

Code A at high risk of being administered an inappropriately high dose of opiate. In my opinion the administration of the diamorphine and midazolam infusions very likely led to further deterioration in Code A and contributed to her death which could lead to respiratory depression, coma and in some cases death the day after these were commenced.

12. In my opinion Code A in her care of Code A failed to meet the requirements of good medical practice to:
- Provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
 - Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
 - Prescribe only the treatment, drugs or appliances that serve the patient's need

Declaration

Code A

GMC and Code A
Report on Code A **(Patient E)**

Code A
Consultant Physician

21 April 2009

GMC and Code A
Report on Patient E

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient E, commenting on the care and treatment carried out by Code A in relation to this patient to assist the GMC Panel in determining whether Code A has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegations presented to the Fitness to Practice Panel that prescriptions by Code A on 11 August 1998 of diamorphine and midazolam were in too wide a dose range and created a situation whereby drugs could be administered to patient E which were excessive to her needs; that prescriptions of oramorphine, diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interests of Patient E.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I provided to Hampshire Constabulary dated 12 December 2001. In that report pages 4-13 I described the course of events relating to Patient E's admission to the Royal Hospital Haslar on 29 July 1998 subsequent care following her transfer to Daedalus ward, Gosport War Memorial Hospital on 11 August prior to her death on Code A.
4. This report is based on my review of the following documents: medical records of Patient E; statements of Code A Code A Code A police statements of Code A statement made by Code A in relation to patient E.

5. Course of events

I have described these in my report to Hampshire Constabulary dated 12 December 2001. I have no changes or corrections to make to my statement of the course of events as outlined in that report.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In the next section I list all drug therapy received providing more detail of Code A's prescribing previously outlined in section 2.11 of my report to Hampshire Constabulary (12 December 2001).

Pages 62-All prescriptions written by Code A unless otherwise marked.

As required prescriptions

Oramorphine 10mg/5ml	11 Aug 1115h	10mg
2.5-5ml	1145h	10mg
Prescribed 11 Aug	12 Aug 0615h	10mg
	13 Aug 2050h	10mg
	14 Aug 1150h	10mg
	17 Aug 1300h	5mg
	?	5mg
	1645h	5mg
	2030h	10mg
	18 Aug 0230h	10mg
	?	10mg

Diamorphine subcut via syringe driver
20-200mg/24hr
Prescribed 11 Aug
None administered

Hyoscine subcut via syringe driver	19 Aug 1120h	200ucg/24hr ? 400
200-800 ucg/24hr	20 Aug 1045h	400ucg/24hr
Prescribed 11 Aug	21 Aug 1155h	400ucg/24hr

Midazolam subcut via syringe driver	18 Aug 1145h	20mg/24hr
20-80mg / 24 hr	19 Aug 1120h	20mg/24hr
Prescribed 11 Aug	20 Aug 1045h	20mg/24hr
	21 Aug 1155h	20mg/24hr

Regular prescriptions

Haloperidol 2mg/ml oral	13 Aug	One dose administered
0.5ml 'if noisy'		

Heading 'REGULAR PRESCRIPTION' crossed out and replaced with 'PRN' for this prescription

Haloperidol 2mg/ml, 1 mg twice daily	11-14 Aug
Prescribed 11 Aug	17 Aug then none administered

Oramorphine 10mg/5ml	None administered
2.5 ml four times daily	

Prescribed 12 Aug. Marked 'PRN'

Oramorphine 10mg/5ml	None administered
5ml nocte	

Prescribed 12 Aug. Marked 'PRN'

Diamorphine subcut via syringe driver	18 Aug 1145h	40mg/24hr
40-200mg/24hr	19 Aug 1120h	40mg/24hr
Prescribed 17 Aug	20 Aug 1045h	40mg/24hr
	21 Aug 1155h	40mg/24hr

Haloperidol subcut via syringe driver	18 Aug 1145h	5mg/24hr
5-10mg/24hr	19 Aug 1120h	5mg/24hr
Prescribed 17 Aug	20 Aug 1045h	5mg/24hr
	21 Aug 1155h	5mg/24hr

Lactulose 10ml twice daily
 Prescribed 11 Aug

11-14 Aug
 17 Aug then none administered

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to **Code A**'s prescribing. I have the following corrections to make to my report to Hampshire Constabulary:
- i) 2.26 line 11 'The prescription by **Code A** on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate' is incorrect as **Code A** had prescribed two sedative drugs diamorphine and midazolam on 11th August. In this report I comment on the initial prescription of the two drugs in this report and the prescription of haloperidol by subcutaneous infusion on 17 August.
 - ii) 2.30 line 13 'in the absence of post-mortem. Radiological data (chest Xray) or recordings of Mr _____ respiratory rate...' should read 'in the absence of post-mortem. Radiological data (chest Xray) or recordings of Patient E's respiratory rate...?'
8. Patient E was a frail elderly woman with dementia who was living in a nursing home prior to admission following a fractured hip secondary to a fall. Following assessment by **Code A** (page 24,25 letter summarising assessment) on 3 Aug 1998 she was transferred to Daedalus Ward, Gosport War Memorial Hospital with the aim to improve her mobility. Prior to her transfer to Daedalus ward the orthopaedic nursing team documented on the 10 August that she was fully weight bearing and walking with the aid of two nurses and a Zimmer Frame.
9. The medical notes record a limited assessment by **Code A** of patient E on 11 August following her admission to Daedalus ward but indicate she was 'not obviously in pain'. The nursing records on 12 August also state that patient E did not appear to be in pain when she awoke from sleep very agitated. Prior to her transfer to Daedalus ward patient E had been taking coodamol (paracetamol and codeine) as required. As I have previously commented (section 2.21 report to Hampshire Constabulary) I do not consider it was appropriate to prescribe oramorphine and a subcutaneous diamorphine infusion to patient E on 11 August. The medical records contain no information suggesting patient E's pain would not be controlled by as required or regular coodamol which she had already been receiving.
10. The oramorphine patient E received between 11-13 August may have contributed to her confusion and agitation following admission to Daedalus ward and to her fall on 13 August leading to dislocation of the hip. However she had dementia, had been agitated prior to receiving the oramorphine and was also taking haloperidol, all of which increase the risk of falls and hip dislocation.
11. The prescription by **Code A** of diamorphine in the dose range 20-200mg/24hr was excessively wide and placed patient E at a high risk of developing respiratory depression and coma if a higher infusion rate had been commenced. In my opinion from the information available in the notes the prescriptions on 11 August of as required oramorphine and diamorphine by subcutaneous infusion by **Code A** were inappropriate and potentially hazardous to patient E. The recorded clinical assessment of patient E undertaken by **Code A** did not justify the prescription of powerful opioid drugs at this stage, and no instructions were recorded in the medical or nursing records as to the circumstances under which oramorphine or diamorphine should be administered.

12. I can find no justification in the medical or nursing notes for the prescription and commencement of the midazolam infusion prescribed by [Code A] to patient E on 11 August. Patient E had intermittent episodes of agitation and regular haloperidol with additional as required doses was appropriate to manage these symptoms. Midazolam is indicated for terminal restlessness and is also indicated in the Wessex Protocol for the management of anxiety in a palliative care setting for patients already receiving drugs through a syringe driver. None of these applied to patient E.
13. The dose of subcutaneous midazolam prescribed by [Code A] was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. In an older frail patient in whom a midazolam infusion as indicated an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 20mg/24hr was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr unacceptably high. The prescribed dose range of midazolam particularly in conjunction with the diamorphine prescribed placed Patient E at risk of developing life threatening complications if these doses were administered by nursing staff.
14. Following patient E's readmission to Daedalus ward on 17 August the medical and nursing notes document that Patient E had hip pain. I consider the administration of opioids at this point was reasonable and appropriate. The cause of the hip pain was unclear and it would have been good practice for [Code A] to discuss patient E with the responsible consultant and/or the orthopaedic team. However as no dislocation was present on the repeat XRay the focus would have been on the provision of effective pain relief. The medical and nursing notes Patient E was deteriorating rapidly at this stage. Hip fracture is often a pre-terminal event in frail patients with dementia. I would consider the focus of care was appropriately on palliating Patient E's symptoms of pain and agitation.
15. Oral morphine was initially used and a total of 45 mg morphine was administered to patient E between 17 August 1300h and 18 August 1145h when a diamorphine infusion was commenced. The medical notes do not record the justification for commencing a subcutaneous infusion rather than continuing to administer drugs by the oral route. The equivalent dose of subcutaneous diamorphine is one third to one half of the total oral morphine dose received which would have equated to 15-23mg/24hr. Patient E was still in pain so a further 50% increase in dose was reasonable which would equate to about 35mg/24hr subcutaneous diamorphine. I would consider the dose of diamorphine infused was high but not unreasonably so, although careful monitoring of patient E's conscious level and respiratory rate was required.
16. The nursing and medical notes indicate patient E was in pain and distressed on 17 August and it was appropriate to continue to administer haloperidol via a syringe driver which was commenced on 18 August at an equivalent dose to that she had been receiving orally. On 16 August patient E received 6 mg oral haloperidol (section 2.10 report to Hampshire Constabulary) whilst at Royal Hospital Haslar. Patient E received one dose of haloperidol on 17 August after transfer back to Daedalus ward and the medical notes record she was in pain and distress. I consider the prescription of haloperidol 5mg/24hr by syringe driver on 17 August was reasonable as this equated to the total oral dose received on 16 August. The administration of diamorphine and haloperidol required careful monitoring because these drugs alone or in combination may produce coma and/or respiratory depression.

17. In my view it was appropriate to prescribe opioid analgesia for pain and haloperidol for distress and agitation on 18 August. The medical notes do not record a clear indication for using subcutaneous infusion rather than continuing oral administration. However the doses of morphine and haloperidol that were commenced by subcutaneous infusion on 18 August were in my view reasonable.
18. The medical notes provide no justification for the administration of midazolam to patient E on 18 August. It would have been appropriate to observe the response of patient E to the infusion of diamorphine and haloperidol. If patient E remained agitated and distressed and this was not thought to be due to pain it would have been appropriate to increase the dose of haloperidol infused to 10mg/24hr the upper limit of the haloperidol infusion dose range. If this did not relieve Patient E's symptoms it would have been appropriate to consider replacing the haloperidol with midazolam. However as outlined in my report to Hampshire Constabulary I consider the prescription and administration of midazolam with haloperidol and diamorphine in the doses prescribed to be inappropriate and highly risky because of the combined risk of these three drugs to produce respiratory depression and coma. If patient E had remained highly distressed on adequate doses of diamorphine analgesia and haloperidol and substitution of midazolam for haloperidol had not improved control of symptoms of distress and restlessness it would then have been reasonable to consider administering both haloperidol and midazolam to patient E with careful monitoring to ensure patient E's symptoms were controlled without unnecessary adverse effects.
19. [Code A] stated that she used midazolam in patient E as a muscle relaxant (section 2.27 report to Hampshire Constabulary). This is not an appropriate use. The medical and nursing notes at the time of the midazolam prescription and administration do not contain any record of an assessment of tone or muscle stiffness in patient E. In my opinion the dose range of subcutaneous midazolam prescribed by [Code A] was in excess of the recommended range. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-60mg/24hr. In an older frail patient an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The dose of 40mg/24hr that was administered was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr beyond that recommended. The prescribed dose range of midazolam prescribed particularly in conjunction with the diamorphine and haloperidol prescribed placed Patient E at high risk of developing life threatening complications.
20. I consider it likely that the diamorphine, midazolam and haloperidol infusions commenced on 18 August very likely produced respiratory depression and coma that led to her dying earlier than she would have done. However patient E required palliative care following her and was likely to die within a few days or weeks after her transfer back to Daedalus ward on 17 August and was likely to die within a short time period. The doses of subcutaneous diamorphine and haloperidol infusions administered were in my view appropriate but there was no justification in the medical notes for the prescription and administration of midazolam in addition to these drugs.

Summary of Conclusions

21. Patient E was a frail older lady with dementia who sustained a fractured neck of femur, which was successfully surgically treated but then complicated by dislocation and continuing pain following successful manipulation. She had a high risk of dying in hospital following these events. She was initially transferred to Daedalus ward with the aim of improving her

mobility before discharging her back to the nursing home she lived in. The information in the notes suggest there was inadequate assessment of patient E by [Code A] as the doctor responsible for the day to day medical care of the patient when transferred to Deadalus ward on 11 August 1998. The medical notes record no evidence of hip pain at this time and no justification was provided for the prescriptions of oramorphine and subcutaneous diamorphine and midazolam. The prescriptions of subcutaneous infusions of diamorphine and midazolam in the wide dose ranges used were highly risky.

22. Patient E deteriorated rapidly after dislocating her hip on 14 August and treatment with opioids and haloperidol was appropriate. The medical records do not provide any justification for the prescription of midazolam by subcutaneous infusion or its administration on 18 August until Patient E's death on 21 August. In my opinion the midazolam infusion at the dose infused very likely led to respiratory depression and shortened patient E's life although at this stage she required palliative care and was likely to die within a few days or weeks.
23. In my opinion, [Code A] in her care of Patient E failed to meet the requirements of good medical practice:
- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.

24. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
[Code A]

GMC and Code A
Report on Code A **(Patient E)**

Code A
Consultant Physician

19 April 2009

**GMC and Code A
Report on Patient E**

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient E, commenting on the care and treatment carried out by Code A in relation to this patient to assist the GMC Panel in determining whether Code A has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegations presented to the Fitness to Practice Panel that prescriptions by Code A on 11 August 1998 of diamorphine and midazolam were in too wide a dose range and created a situation whereby drugs could be administered to patient E which were excessive to her needs; that prescriptions of oramorphine, diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interests of Patient E.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I provided to Hampshire Constabulary dated 12 December 2001. In that report pages 4-13 I described the course of events relating to Patient E's admission to the Royal Hospital Haslar on 29 July 1998 subsequent care following her transfer to Daedalus ward, Gosport War Memorial Hospital on 11 August 1998 prior to her death on Code A 1998.

4. This report is based on my review of the following documents: medical records of Patient E; statements of Code A Code A Code A police statements of Code A; statement made by Code A in relation to patient E.

5. Course of events

I have described these in my report to Hampshire Constabulary dated 12 December 2001. I have no changes or corrections to make to my statement of the course of events as outlined in that report.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In the next section I list all drug therapy received providing more detail of Code A prescribing previously outlined in section 2.11 of my report to Hampshire Constabulary (12 December 2001).

Pages 62-All prescriptions written by Code A unless otherwise marked.

As required prescriptions

Oramorphine 10mg/5ml 2.5-5ml Prescribed 11 Aug	11 Aug 1115h 10mg 1145h 10mg 12 Aug 0615h 10mg 13 Aug 2050h 10mg 14 Aug 1150h 10mg 17 Aug 1300h 5mg ? 5mg 1645h 5mg 2030h 10mg 18 Aug 0230h 10mg ? 10mg
--	---

Diamorphine subcut via syringe driver 20-200mg/24hr Prescribed 11 Aug	None administered
---	-------------------

Hyoscine subcut via syringe driver 200-800 ucg/24hr Prescribed 11 Aug	19 Aug 1120h 200ucg/24hr ? 400 20 Aug 1045h 400ucg/24hr 21 Aug 1155h 40ucg/24hr
---	---

Midazolam subcut via syringe driver 20-80mg / 24 hr Prescribed 11 Aug	18 Aug 1145h 20mg/24hr 19 Aug 1120h 20mg/24hr 20 Aug 1045h 20mg/24hr 21 Aug 1155h 20mg/24hr
---	--

Regular prescriptions

Haloperidol 2mg/ml oral 0.5ml 'if noisy' Heading 'REGULAR PRESCRIPTION' crossed out and replaced with 'PRN' for this prescription	13 Aug One dose administered
---	------------------------------

Lactulose 10ml twice daily Prescribed 11 Aug	11-14 Aug 17 Aug then none administered
---	--

Haloperidol 2mg/ml, 1 mg twice daily Prescribed 11 Aug	11 -14 Aug 17 Aug then none administered
---	---

Oramorphine 10mg/5ml 2.5 ml four time daily Prescribed 12 Aug. Marked 'PRN'	None administered
---	-------------------

Oramorphine 10mg/5ml 5ml nocte Prescribed 12 Aug. Marked 'PRN'	None administered
--	-------------------

Diamorphine subcut via syringe driver 40-200mg/24hr Prescribed 17 Aug	18 Aug 1145h 40mg/24hr 19 Aug 1120h 40mg/24hr 20 Aug 1045h 40mg/24hr 21 Aug 1155h 40mg/24hr
---	--

Haloperidol subcut via syringe driver	18 Aug 1145h	5mg/24hr
5-10mg/24hr	19 Aug 1120h	5mg/24hr
Prescribed 17 Aug	20 Aug 1045h	5mg/24hr
	21 Aug 1155h	5mg/24hr

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to [Code A]'s prescribing. I have the following corrections to make to my report to Hampshire Constabulary:
- 2.26 line 11 '*The prescription by [Code A] on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate*' is incorrect as [Code A] had prescribed two sedative drugs diamorphine and midazolam on 11th August. In this report I comment on the initial prescription of the two drugs in this report and the prescription of haloperidol by subcutaneous infusion on 17 August.
 - 2.30 line 13 '*In the absence of post-mortem. Radiological data (chest Xray) or recordings of Mr _____ respiratory rate...*' should read '*In the absence of post-mortem. Radiological data (chest Xray) or recordings of Patient E's respiratory rate...*'.
8. Patient E was a frail elderly woman with dementia who was living in a nursing home prior to admission following a fractured hip secondary to a fall. Following assessment by [Code A] (page 24,26 letter summarising assessment) on 3 Aug 1998 she was transferred to Daedalus Ward, Gosport War Memorial Hospital with the aim to improve her mobility. Prior to her transfer to Daedalus ward the orthopaedic nursing team documented on the 10 August that she was fully weight bearing and walking with the aid of two nurses and a Zimmer Frame.
9. The medical notes record a limited assessment by [Code A] of patient E on 11 August following her admission to Daedalus ward but indicate she was '*not obviously in pain*'. The nursing records on 12 August also state that patient E did not appear to be in pain when she awoke from sleep very agitated. Prior to her transfer to Daedalus ward patient E had been taking cocodamol (paracetamol and codeine) as required. As I have previously commented (section 2.21 report to Hampshire Constabulary) I do not consider it was appropriate to prescribe oramorphine and a subcutaneous diamorphine infusion to patient E on 11 August. The medical records contain no information suggesting patient E's pain would not be controlled by as required or regular cocodamol which she had already been receiving.
10. The oramorphine patient E received between 11-13 August may have contributed to her confusion and agitation following admission to Daedalus ward and to her fall on 13 August leading to dislocation of the hip. However she had dementia, had been agitated prior to receiving the oramorphine and was also taking haloperidol, all of which increase the risk of falls and hip dislocation.
11. The prescription by [Code A] of diamorphine in the dose range 20-200mg/24hr was excessively wide and placed patient E at a high risk of developing respiratory depression and coma if a higher infusion rate had been commenced. In my opinion from the information available in the notes the prescriptions on 11 August of as required oramorphine and diamorphine by subcutaneous infusion by [Code A] were inappropriate and potentially hazardous to patient E. The recorded clinical assessment of patient E undertaken by [Code A] did not justify the prescription of powerful opioid drugs at this stage, and no

instructions were recorded in the medical or nursing records as to the circumstances under which oramorphine or diamorphine should be administered.

12. I can find no justification in the medical or nursing notes for the prescription and commencement of the midazolam infusion prescribed by [Code A] to patient E on 11 August. Patient E had intermittent episodes of agitation and regular haloperidol with additional as required doses was appropriate to manage these symptoms. Midazolam is indicated for terminal restlessness and is also indicated in the Wessex Protocol' for the management of anxiety in a palliative care setting for patients already receiving drugs through a syringe driver. None of these applied to patient E.
13. The dose of subcutaneous midazolam prescribed by [Code A] was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. In an older frail patient in whom a midazolam infusion as indicated an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 20mg/24hr was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr unacceptably high. The prescribed dose range of midazolam particularly in conjunction with the diamorphine prescribed placed Patient E at risk of developing life threatening complications if these doses were administered by nursing staff.
14. Following patient E's readmission to Daedalus ward on 17 August the medical and nursing notes document that Patient E had hip pain. I consider the administration of opioids at this point was reasonable and appropriate. The cause of the hip pain was unclear and it would have been good practice for [Code A] to discuss patient E with the responsible consultant and/or the orthopaedic team. However as no dislocation was present on the repeat XRay the focus would have been on the provision of effective pain relief. The medical and nursing notes Patient E was deteriorating rapidly at this stage. Hip fracture is often a pre-terminal event in frail patients with dementia. I would consider the focus of care was appropriately on palliating Patient E's symptoms of pain and agitation.
15. Oral morphine was initially used and a total of 45 mg morphine was administered to patient E between 17 August 1300h and 18 August 1145h when a diamorphine infusion was commenced. The medical notes do not record the justification for commencing a subcutaneous infusion rather than continuing to administer drugs by the oral route. The equivalent dose of subcutaneous diamorphine is one third to one half of the total oral morphine dose received which would have equated to 15-23mg/24hr. Patient E was still in pain so a further 50% increase in dose was reasonable which would equate to about 35mg/24hr subcutaneous diamorphine. I would consider the dose of diamorphine infused was high but not unreasonably so, although careful monitoring of patient E's conscious level and respiratory rate was required.
16. The nursing and medical notes indicate patient E was in pain and distressed on 17 August and it was appropriate to continue to administer haloperidol via a syringe driver which was commenced on 18 August at an equivalent dose to that she had been receiving orally. On 16 August patient E received 6 mg oral haloperidol (section 2.10 report to Hampshire Constabulary) whilst at Royal Hospital Haslar. Patient E received one dose of haloperidol on 17 August after transfer back to Daedalus ward and the medical notes record she was in pain and distress. I consider the prescription of haloperidol 5mg/24hr by syringe driver on 17 August was reasonable as this equated to the total oral dose received on 16 August. The

administration of diamorphine and haloperidol required careful monitoring because these drugs alone or in combination may produce coma and/or respiratory depression.

17. In my view it was appropriate to prescribe opioid analgesia for pain and haloperidol for distress and agitation on 18 August. The medical notes do not record a clear indication for using subcutaneous infusion rather than continuing oral administration. However the doses of morphine and haloperidol that were commenced by subcutaneous infusion on 18 August were in my view reasonable.
18. The medical notes provide no justification for the administration of midazolam to patient E on 18 August. It would have been appropriate to observe the response of patient E to the infusion of diamorphine and haloperidol. If patient E remained agitated and distressed and this was not thought to be due to pain it would have been appropriate to increase the dose of haloperidol infused to 10mg/24hr the upper limit of the haloperidol infusion dose range. If this did not relieve Patient E's symptoms it would have been appropriate to consider replacing the haloperidol with midazolam. However as outlined in my report to Hampshire Constabulary I consider the prescription and administration of midazolam with haloperidol and diamorphine in the doses prescribed to be inappropriate and highly risky because of the combined risk of these three drugs to produce respiratory depression and coma. If patient E had remained highly distressed on adequate doses of diamorphine analgesia and haloperidol and substitution of midazolam for haloperidol had not improved control of symptoms of distress and restlessness it would then have been reasonable to consider administering both haloperidol and midazolam to patient E with careful monitoring to ensure patient E's symptoms were controlled without unnecessary adverse effects.
19. [Code A] stated that she used midazolam in patient E as a muscle relaxant (section 2.27 report to Hampshire Constabulary). This is not an appropriate use. The medical and nursing notes at the time of the midazolam prescription and administration do not contain any record of an assessment of tone or muscle stiffness in patient E. In my opinion the dose range of subcutaneous midazolam prescribed by [Code A] was in excess of the recommended range. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-60mg/24hr. In an older frail patient an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The dose of 40mg/24hr that was administered was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr beyond that recommended. The prescribed dose range of midazolam prescribed particularly in conjunction with the diamorphine and haloperidol prescribed placed Patient E at high risk of developing life threatening complications.
20. I consider it likely that the diamorphine, midazolam and haloperidol infusions commenced on 18 August very likely produced respiratory depression and coma that led to her dying earlier than she would have done. However patient E required palliative care following her transfer and was likely to die within a few days or weeks after her transfer back to Daedalus ward on 17 August and was likely to die within a short time period. The doses of subcutaneous diamorphine and haloperidol infusions administered were in my view appropriate but there was no justification in the medical notes for the prescription and administration of midazolam in addition to these drugs.

Summary of Conclusions

21. Patient E was a frail older lady with dementia who sustained a fractured neck of femur, which was successfully surgically treated but then complicated by dislocation and continuing pain following successful manipulation. She had a high risk of dying in hospital following these events. She was initially transferred to Daedalus ward with the aim of improving her mobility before discharging her back to the nursing home she lived in. The information in the notes suggest there was inadequate assessment of patient E by **Code A** as the doctor responsible for the day to day medical care of the patient when transferred to Daedalus ward on 11 August 1998. The medical notes record no evidence of hip pain at this time and no justification was provided for the prescriptions of oramorphine and subcutaneous diamorphine and midazolam. The prescriptions of subcutaneous infusions of diamorphine and midazolam in the wide dose ranges used were highly risky.
22. Patient E deteriorated rapidly after dislocating her hip on 14 August and treatment with opioids and haloperidol was appropriate. The medical records do not provide any justification for the prescription of midazolam by subcutaneous infusion or its administration on 18 August until Patient E's death on **Code A**. In my opinion the midazolam infusion at the dose infused very likely led to respiratory depression and shortened patient E's life although at this stage she required palliative care and was likely to die within a few days or weeks.
23. In my opinion, **Code A** in her care of Patient E failed to meet the requirements of good medical practice:
- to provide an adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.

Declaration

24. I understand my duties as an expert, as set out at paragraph [] of my Generic Report.

Case A

**General Medical Council and Code A
Report on Code A (Patient F)**

**Code A
Consultant Physician**

21 April 2009

General Medical Council and **Code A**
Report on Patient F

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient F commenting on the care and treatment carried out by **Code A** in relation to this patient to assist the GMC Panel in determining whether **Code A** has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that the prescriptions by **Code A** on 18 August 1998 of oramorphine, and on 19 August 1998 of diamorphine and midazolam were inappropriate, potentially dangerous and not in the best interests of patient F.

2. **Code A**

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Patient F; statements of **Code A**
Code A statement by **Code A** in relation to **Code A**'s police interview 14 July 2005.

5. Course of events

5.1 Patient F was 84 years of age when she was admitted to Royal Hospital Haslar, Ward 3 on 5 August 1998 and transferred to Dryad ward, Gosport War Memorial Hospital on 18 August 1998. Patient F died on Dryad ward, Gosport War Memorial Hospital on 21 August 1998. Past medical history prior to this admission included inflammatory arthritis which had been considered to be possibly rheumatoid arthritis. When assessed by a consultant rheumatologist **Code A** in 1998 the diagnosis was thought to be CREST (Calcinosis, Raynauds, Eosphageal dysfunction, Scierodactyl, Telangiectasia) syndrome. Other past medical problems were gout, hypertension, renal impairment which had previously been assessed by **Code A** (p26-33). She had previous admissions for shortness of breath chest pain, atrial fibrillation and a myocardial infarction. In June 1998 she was admitted from home for a treatment of leg ulcers. The medical records state (p495) she had been 'mobile, independent and self caring' prior to admission on 5 August 1998.

5.2 Following a fall at home on 5 August 1998 Patient F was admitted to the accident and emergency department at Royal Hospital Haslar and found to have a fractured left neck of femur. She underwent surgery the same day with an insertion of left cemented hemiarthroplasty. A nursing transfer letter by a staff nurse dated 15 August 1998 (page 23-

- 25) summarises her course during her stay Royal Hospital Haslar prior to her transfer Dryad ward, Gosport War Memorial Hospital on 18 August. She had a slow recovery following surgery problems of angina and breathlessness. At the time of the transfer letter she was mobile with a Zimmer frame and supervision and could wash her top half independently. She had bilateral leg ulcers which were present prior to admission and a broken area on her left buttock that was improving. She had a urinary catheter in place, had been occasionally confused at night and her hearing aid had gone missing.
- 5.3 On 9 August the medical notes (p508) record *"slow progress, nausea, diarrhoea yesterday, poor mobilising, on examination pyrexial, pulse 80, wound fine, urine output good (illegible word) poor"*. On 10 August the medical notes (p509) record *"patient unwell, vomiting, diarrhoea, drowsy, denies pain, orientated in time and place o/e pulse 129 bpm irreg irreg BP 120/60 mmHg. Apyrexial chest clear, oxygen sats on air 94%, plan 1. ECG 2. continue IV fluid, rediscuss with SHO"*. An ECG was noted to show a sinus tachycardia (increased heart rate) ST depression in leads V5 and 6V. Blood tests including cardiac enzymes (p552) were taken at this stage showing a normal creatinine kinase (CK) at 68 (increased if a myocardial infarct occurs) and an elevated white cell count. An entry in the medical notes later that day by a medical SHO documents respiratory crackles in the left base and a possible diagnosis of a chest infection. A further note (p531) states by **Code A** **Code A** states *"for all necessary treatments and resuscitation..."*. A chest x-ray showed left-sided basal chest infection. Antibiotics were commenced.
- 5.4 On 12 August the medical notes record an entry by the registrar (page 514) *"much improved, has sat out today, not in failure, no further deterioration, developing sacral bed sore"*. A plan was to mobilise with physiotherapy, encourage oral fluid intake and stop antibiotics and intravenous fluids. On 13 August a referral was sent from the orthopaedic team to **Code A** **Code A** geriatrician, requesting assessment from the point of her future management. The referral notes her post-op recovery was slow with periods of confusion and pulmonary oedema and that she suffered vomiting, diarrhoea but that over the last 2 days she had been alert and well and the intention was to improve her immobilisation. The referral notes she lived in a ground floor house and was visited twice daily by the district nurse for the previous four weeks prior to admission.
- 5.5 On 13 August there is an entry from **Code A** (p516). She records that Patient F is a frail 85 year old who had problems of a left cemented hemiarthroplasty of the hip, left bundle branch block and left ventricular failure which was improving sick, sinus syndrome/atrial fibrillation, dehydration that was improving, bilateral buttock ulcers, bilateral leg ulcers, hypokalaemia (low blood potassium), normochromic anaemia, vomiting and diarrhoea ? cause. **Code A** suggested prescribing potassium supplements, hydrating orally and sending stool for culture and sensitivity if not already sent. **Code A** states *"It is difficult to know how much she will improve but I will take her to a NHS continuing care bed at Gosport War Memorial Hospital next week"*. There is a letter summarising her assessment dictated 14 August 1998 (p466).
- 5.6 On 15 August (p 518) an entry by a house officer in the medical notes documents left-sided chest pain *'since being manhandled'*. An electrocardiogram showed no new changes and there was response of the pain to due to GTN. The clinical impression was of a musculoskeletal pain although a pulmonary embolus (clot to the lung) or angina were considered as alternative diagnoses, and a comment was made that further investigation with spiral CT or VQ scanning might be necessary. Codeine phosphate was prescribed as an analgesic. On 17 August an entry in the medical notes (p519) by the SHO notes she is

well with no chest pain and was mobilising slowly and was awaiting transfer to Gosport War Memorial Hospital.

5.7 On 18 August Patient F was transferred to Dryad ward and an entry (p78) by **Code A** states "HPC fracture neck of femur left 05/08/98 past medical history angina, CCF (Congestive Cardiac Failure), catheterised, transferring with 2, needs some help with ADL (Activities Daily Living), Barthel 6. Get to know, gentle rehabilitation. I am happy for nursing staff to confirm death". There is one other entry in the medical notes on **Code A** by nursing staff confirming death at 1825h that evening (page 78).

5.8 Nursing notes on 18 August (page 394) record Patient F is "for slow mobilisation". There is no documentation of any pain or discomfort in the initial nursing assessment. Another entry on 18 August (p388) states "Settled and slept well from 2200 until midnight. Wake very distressed and anxious. Says she needs someone with her. Oramorph 10mg given 0015 with little effect. Very anxious during the night. Confused at times". An entry on the 19 August states "Comfortable night, settled well". Drowsy but rousable this am. Sips of oral fluid tolerated. Syringe driver satisfactory".

5.9 On 19 August the nursing notes (p394) state "1150 c/o chest pain. Not radiating down arm - no worse on exertion, pulse 96, grey around mouth. Oramorph 10mg/5ml given r notified". A further note states "pain only relieved for a short period, very anxious. Diamorphine 20mg Midazolam 20mg commenced via syringe driver". The next entry in the nursing summary on 20 August 1215h states "Condition appears to have deteriorated over night driver recharged 1010 diamorphine 20mg, midazolam 20mg, hyoscine 400ug. Family informed of condition. **Code A** present a time of report". An entry later that night states "General condition continued to deteriorated very "bubbly" suction attempted without success". An entry on 21 August in the nursing notes at 1855h (page 395) states "Condition continued to deteriorate slowly".

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

P358-359. All prescriptions written by **Code A** unless otherwise marked.

As required prescriptions

Temazepam 10-20mg not administered

Oramorph 10mg/5ml sc 2.5-5mg	18 Aug 1415h	5mg dose
	19 Aug 0015	10mg dose
	19 Aug 1150	10mg dose

Regular prescriptions

Digoxin 62.5ug od	18 -20 Aug
Slow K one tablet bd	18 -19 Aug
Bumetanide 1mg od	19 -20 Aug
Allopurinol 100mg od	18 -20Aug

Daily review prescriptions

Diamorphine sc via syringe driver	19 Aug 20mg/24 hr 1600h
20-200mg/24 hr	20 Aug 20mg/24hr
Prescribed (date unclear)	21 Aug 60mg/24 hr 0735hr

Hyoscine sc via syringe driver 200-800ug/24hr Prescribed (date unclear)	20 Aug 400ug/24hr 0915hr increased to 800ug/24hr 1050hr 21 Aug 800ug/24hr 0735hr
Midazolam sc via syringe driver 20-80mg/24hr Prescribed (date unclear)	19 Aug 20mg/24hr 1600hr 20 Aug 20mg/24hr 0915hr increased to 40mg/24hr 1015hr 21 Aug 60 mg/24hr 0735hr

Opinion on Patient Management

7. Patient F was making slow progress at Royal Hospital Haslar following her left hip hemiarthroplasty on 5 August. She had a number of episodes of chest pain. Investigation into these did not reveal any increase in her cardiac enzymes or change in her ECG. Therefore the most likely cause of her episodes of chest pain was angina or possibly musculoskeletal pain. At the time of her transfer she appeared to be stable the assessment by [Code A] on 13 August is comprehensive and notes a number of problems leading to [Code A] to include that the rate and level of final of improvement she would achieve following mobilisation was unclear. It is unclear from [Code A]'s assessment whether she thought there was a reasonable possibility she could improve sufficiently to return home. In my opinion from the description of her problems it was appropriate and reasonable to transfer her to an elderly care ward for continued assessment and rehabilitation with a view as to assessing whether she would regain mobility and sufficient independence to be able to return to her home.
8. The medical assessment by [Code A] on transfer to Dryad ward describes her past medical history and current function. There is no record of any physical examination being performed. It would be usual to expect a description of any current symptoms or complaints a patient had and for a physical examination to be performed on admission of a patient to rehabilitation ward to establish their baseline problems. [Code A]'s assessment failed to document episodes of chest pain or the problems with diarrhoea. An adequate assessment would have noted these and recorded current blood pressure and recent blood results. There is no documentation that Patient F had pain in this assessment. I find it of concern that there are no further entries in the medical records following this initial entry despite the deterioration in Patient F's condition. In my opinion there was a failure to maintain adequate medical records. [Code A] was responsible for day to day care of Patient F and this failure must be attributable to her.
9. The failure to document any problems of pain or other indication for opioids make it difficult to justify the prescription by [Code A] of "as required" oramorphine on 13 August. I would consider this prescription was not appropriate. Patient F was administered morphine later that night when she became distressed and anxious. I do not consider the administration of morphine was appropriate for these symptoms. The notes record that Patient F wished someone to be with her and a more appropriate response would have been for a nurse to sit with Patient F for a while and if her symptoms failed to improve to either to administer temazepam which had been prescribed or arrange for the prescription of another sedative such as a small dose of haloperidol.
10. The lack of clear instructions for the use of "as required" oramorphine may explain why the oramorphine was given for distress and anxiety by nursing staff. Although oramorphine is

used by some doctors to treat distress and anxiety in older people it is not an appropriate first line treatment for a patient who develops distress and anxiety shortly after admission to a rehabilitation ward. Although opiates usually more commonly produce drowsiness or sedation that may cause or exacerbate anxiety or distress in older people. The development of anxiety or distress in older people requires medical evaluation and assessment to determine the underlying cause before the administration of any drug but particularly opioids.

11. The prescription of diamorphine and midazolam and hyoscine (undated) by [Code A] was in my opinion not justified. There is no evidence recorded in the notes that she was experiencing significant pain or distress. The medical records do not record the indication for prescribing diamorphine and midazolam. It is possible this was prescribed as treatment for her chest pain which is recorded in the nursing notes as occurring on the morning of 19 August. An electrocardiogram was not obtained which might have found evidence of changes consistent with angina or a myocardial infarct. I can find no record of any observations of Patient F's pulse or heart rate or examination of her heart and lungs.
12. In my opinion there was an inadequate medical assessment of this problem. An adequate medical assessment would have sought to determine a diagnosis responsible for the chest pain and provided appropriate treatment. If it was musculoskeletal a mild or moderate analgesia therapy such as paracetamol or a non-steroidal anti-inflammatory drug would have been appropriate. If it was cardiac pain appropriate treatment would have been with a nitrate and possibly a dose of oral morphine if the pain failed to respond to nitrate therapy and there was clear evidence pain was cardiac in nature. A 10mg dose of oramorphine was administered at 1150h. No justification was given for the commencement of a continuous infusion by syringe driver with the combination of diamorphine and midazolam. On 19 August and 20 August Patient F was able to take oral medication as evidenced by the prescription chart recording the administration of oral bumetanide and allopurinol.
13. Patient F's condition deteriorated after the commencement of diamorphine and midazolam. This deterioration should have led to a full medical assessment. It is highly likely her deterioration was due to the combined sedative effects of diamorphine and midazolam and if the infusion had been discontinued her drowsiness may have resolved. However her deterioration was interpreted as requiring further sedative and drugs and the midazolam dose was increased twofold to 40mg over 24 hours and hyoscine was also commenced. These would have further contributed to Patient F's decline in my opinion. In my opinion there is no clear evidence presented to support the diagnosis of a myocardial infarct or cardiogenic shock as the cause of death in Patient F. It is much more likely she died from the sedative and depressant effects of the diamorphine and midazolam infusion that she received. There was no justification provided in the notes for the syringe driver as Patient F was able to swallow medication.

Summary of Conclusions

14. Patient F was a frail older lady who had a number of medical problems. Following her left hip fracture she was making slow progress. When transferred to Dryad ward she was medically stable. [Code A] was responsible for her day to day medical care there was inadequate medical assessment both when she was initially admitted and then a failure to adequately assess Patient F when she developed agitation and then chest pain. The prescription of opioids was in my opinion not justified and there was no justification provided for the prescription of diamorphine and midazolam by subcutaneous. The

prescription and administration of these drugs are the most likely cause of Patient F's subsequent deterioration and her death. There was a failure of adequate assessment by **Code A** **Code A** in particular when Patient F developed chest pain there should have been a physical examination and investigations undertaken and recorded in medical notes.

15. In my opinion **Code A** in her care of Patient F failed to meet the requirements of good medical practice to:

- Provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
- Consult colleagues
- Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
- Provide or arranging necessary investigations
- Prescribe only the treatment, drugs or appliances that serve patient's need

14. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
Code A

GMC and Code A
 Report on Code A

Code A
 Consultant Physician

4 April 2009

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Code A commenting on the care and treatment carried out by Code A in relation to this patient to assist the GMC Panel in determining whether Code A has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that the prescriptions of Oramorphine, Diamporphine and Midazolam were inappropriate, potentially dangerous and not in the best interest of Code A

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Code A statements of Code A statement by Code A in relation to Code A's police interview 14th July 2005.

5. Course of events

- 5.1 Code A was 84 years of age when she was admitted to Royal Haslar Hospital Ward 3 on 5th August 1998 and transferred to Dryad ward, Gosport War Memorial Hospital on 18th August 1998. Code A died on Dryad ward, Gosport War Memorial Hospital on Code A 1998. Past medical history prior to this admission included inflammatory arthritis which had been considered to be possibly rheumatoid arthritis or SLE. When assessed by a consultant rheumatologist Code A in 1998 the diagnosis was thought to be CREST syndrome. Other past medical problems were gout, hypertension, renal impairment which had previously been assessed by Code A (p26-33). She had previous admissions for shortness of breath chest pain, atrial fibrillation and a myocardial infarction. In June 1998 she was admitted from home for a treatment of leg ulcers. The medical records state (p495) she had been *'mobile, independent and self caring'* prior to admission on 5th August 1998.

5.2 Following a fall at home on 5th August 1998 [Code A] was admitted to the accident and emergency department at Royal Hospital Haslar and found to have a fractured left neck of femur. She underwent surgery the same day with an insertion of left cemented hemiarthroplasty. A nursing transfer letter by a staff nurse dated 15th August 1998 (page 23-25) summarises her course during her stay Royal Hospital Haslar prior to her transfer Dryad ward, Gosport War Memorial Hospital on 18th August 1998. She had a slow recovery following surgery problems of angina and breathlessness. At the time of the transfer letter she was mobile with a Zimmer frame and supervision and could wash her top half independently. She had bilateral leg ulcers which were present prior to admission and a broken area on her left buttock that was improving. She had a urinary catheter in place, had been occasionally confused at night and her hearing aid and gone missing.

5.3 On 9th August 1998 the medical notes (p508) record "slow progress, nausea, diarrhoea yesterday, poor mobilising, on examination pyrexial, pulse 80, wound fine, urine output good (illegible word) poor". On 10th August the medical notes (p509) record "patient unwell, vomiting, diarrhoea, drowsy, denies pain, orientated in time and place a/e pulse 129 bpm irreg irreg BP 120/60 mmHg Apyrexial chest clear, oxygen sats on air 94%, plan 1 ECG 2. continue IV fluid., rediscuss with SHO". An ECG is noted to show a sinus tachycardia (increased heart rate) ST depression in leads V5 and 6V. Blood tests including cardiac enzymes (p552) were taken at this stage showing a normal creatinine kinase (CK) at 68 (increased if a myocardial infarct occurs) and an elevated white cell count. An entry in the medical notes later that day by a medical SHO documents respiratory crackles in the left base and a possible diagnosis of a chest infection. A further note (p511) states by [Code A] [Code A] states "for all necessary treatments and resuscitation...". A chest x-ray showed left-sided basal chest infection. Antibiotics were commenced.

5.4 On 12th August 1998 the medical notes record an entry by the registrar (page 514) "much improved, has sat out today, not in failure, no further deterioration, developing sacral bed sore". A plan was to mobilise with physiotherapy, encourage oral fluid intake and stop antibiotics and intravenous fluids. On 13th August a referral was sent from the orthopaedic team to [Code A] geriatrician, requesting assessment from the point of her future management. The referral notes her post-op recovery was slow with periods of confusion and pulmonary oedema and that she suffered vomiting, diarrhoea but that over the last 2 days she had been alert and well and the intention was to improve her immobilisation. The referral notes she lived in a ground floor house and was visited twice daily by the district nurse for the previous four weeks prior to admission.

5.5 On 13th August 1998 there is an entry from [Code A] (p516). She records that [Code A] is a frail 85 year old who had problems of a left cemented hemiarthroplasty of the hip, left bundle branch block and left ventricular failure which was improving sick, sinus syndrome/atrial fibrillation, dehydration that was improving, bi lateral buttock ulcers, bilateral leg ulcers, hypokalaemia (low blood potassium), normochromic anaemia, vomiting and diarrhoea ? cause. [Code A] suggested prescribing potassium supplements, hydrating orally and sending stool for culture and sensitivity if not already sent. [Code A] states "It is difficult to know how much she will improve but I will take her to a NHS continuing care bed at Gosport War Memorial Hospital next week". There is a letter summarising her assessment dictated 14th August 1998 (p466).

5.6 On 15th August 1998 (p 518) an entry by a house officer in the medical notes documents left-sided chest pain 'since being manhandled'. An electrocardiogram showed no new changes

and there was response of the pain to due to GTN. The clinical impression was of a musculoskeletal pain although a pulmonary embolus (clot to the lung) or angina were considered as alternative diagnoses, and a comment was made that further investigation with spiral CT or VQ scanning might be necessary. Codeine phosphate was prescribed as an analgesic. On 17th August 1998 an entry in the medical notes (p519) by the SHO notes she is well with no chest pain and was mobilising slowly and was awaiting transfer to Gosport War Memorial Hospital.

5.7 On 18th August 1998 [Code A] was transferred to Dryad ward and an entry (p78) by Dr Barton states "HPC fracture neck of femur left 05/08/98 past medical history angina ,CCF (Congestive Cardiac Failure). catheterised, transferring with 2, needs some help with ADL (Activities Daily Living), Barthel 6. Get to know, gentle rehabilitation. I am happy for nursing staff to confirm death". There is one other entry in the medical notes on [Code A] by nursing staff confirming death at 1825h that evening (page 78).

5.8 Nursing notes on 18th August 1998 (page 394) record [Code A] is "for slow mobilisation". There is no documentation of any pain or discomfort in the initial nursing assessment. Another entry on 18th August 1998 (p388) states "Settled and slept well from 2200 until midnight. Woke very distressed and anxious. Says she needs someone with her. Oromorph 10mg given 0015 with little effect. Very anxious during the night. Confused at times". An entry on the 19th August states "Comfortable night. settled well". Drowsy but rousable this am. Sips of oral fluid tolerated. Syringe driver satisfactory".

5.9 On 19th August 1998 the nursing notes (p394) state "1150 c/o chest pain. Not radiating down arm - no worse on exertion, pulse 96, grey around mouth. Oramorph 10mg/5ml given r notified'. A further note states "pain only relieved for a short period, very anxious. Diamorphine 20mg Midazolam 20mg commenced via syringe driver". The next entry in the nursing summary on 20th August 1998 12:15 states 'Condition appears to have deteriorated over night driver recharged 1010 Diamorphine 20mg, Midazolam 20mg, Hyoscine 400ug Family informed of condition. [Code A] present a time of report'. An entry later that night states 'General condition continued to deteriorated very "bubbly" suction attempted without success'. An entry on 21st August 1998 in the nursing notes at 18:55 (page 395) states "Condition continued to deteriorate slowly".

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

P368–369. All prescriptions written by [Code A] unless otherwise marked.

As required prescriptions

Temazepam 10-20mg	not administered
Oramorph 10mg/5ml sc 2.5-5mg	18 Aug 1415h 5mg dose 19 Aug 0015 10mg dose 19 Aug 1150 10mg dose

Regular prescriptions

Digoxin 62.5ug od	18 -20 Aug
Slow K one tablet bd	18 -19 Aug
Bumetanide 1mg od	19 -20 Aug
Allopurinol 100mg od	18 -20Aug

Daily review prescriptions

Diamorphine sc via syringe driver	19 Aug 20mg/24 hr 1600h
Prescribed (date unclear)	20 Aug 20mg/24hr
20-200mg/24 hr	21 Aug 60mg/24 hr 0735hr
Hyoscine sc via syringe driver	20 Aug 400ug/24 hr 0915hr
Prescribed (date unclear)	increased to 800ug 1050hr
200-800ug/24 hr	21 Aug 800ug/ 24hr 0735hr
Midazolam sc via syringe driver	19 Aug 20ml/24 hr 1600hr
Prescribed (date unclear)	20 Aug 20mg/24hr 0915hr
20-80mg/24 hr	increased to 40mg/24hr 1015hr
	21 Aug 60 mg/24 hours 0735hr

Opinion on Patient Management**Management prior to admission to Dryad ward.**

7. Code A was making slow progress at Royal Hospital Haslar following her left hip hemiarthroplasty on 5th August. She had a number of episodes of chest pain. Investigation into these did not reveal any increase in her cardiac enzymes or change in her ECG. Therefore the most likely cause of her episodes of chest pain was angina or possibly musculoskeletal pain. At the time of her transfer she appeared to be stable the assessment by Code A on 13th August is comprehensive and notes a number of problems leading to Code A to include that the rate and level of final of improvement she would achieve following mobilisation was unclear. It is unclear from Code A's assessment whether she thought there was a reasonable possibility she could improve sufficiently to return home. In my opinion from the description of her problems it was appropriate and reasonable to transfer her to an elderly care ward for continued assessment and rehabilitation with a view as to assessing whether she would regain mobility and sufficient independence to be able to return to her home.
8. The medical assessment by Code A on transfer to Dryad ward describes her past medical history and current function. There is no record of any physical examination being performed. It would be usual to expect a description of any current symptoms or complaints a patient had and for a physical examination to be performed on admission of a patient to rehabilitation ward to establish their baseline problems. Code A's assessment failed to document episodes of chest pain or the problems with diarrhoea. An adequate assessment would have noted these and recorded current blood pressure and recent blood results. There is no documentation that Code A had pain in this assessment. I find it of concern that there are no further entries in the medical records following this initial entry despite the deterioration in Code A's condition. I consider there was a clear failure to maintain adequate medical records. Code A was responsible for day to day care of Code A and this failure must be attributable to her.
9. The failure to document any problems of pain or other indication for opioids make it difficult to justify the prescription by Code A of prn Oramorphine on 18th August. I would consider this prescription was not appropriate. Code A was administered morphine later that night when she became distressed and anxious. I do not consider the administration of morphine was appropriate for these symptoms. The notes record that Code A wished someone to be with her and a more appropriate response would have been for a nurse to sit

with [Code A] for a while and if her symptoms failed to improve to either to administer temazepam which had been prescribed or arrange for the prescription of another sedative such as a small dose of haloperidol. The lack of clear instructions for the use of Oramorphine may explain why the Oramorphine was given by the nursing staff. Although Oramorphine is used by some doctors to treat distress and anxiety in older people it is not an appropriate first line treatment for a patient who develops distress and anxiety shortly after admission to a rehabilitation ward. The development of anxiety or distress requires medical evaluation and assessment to determine the underlying cause before the administration of opioids in older people.

10. The prescription of Diamorphine and Midazolam and Hyoscine (undated) by [Code A] was in my opinion not justified. There is no evidence recorded in the notes that she was experiencing significant pain or distress. The medical records do not record the indication for prescribing Diamorphine and Midazolam. It is possible this was prescribed as treatment for her chest pain which is recorded in the nursing notes as occurring on the morning of 19th August. An electrocardiogram was not obtained which might have found evidence of changes consistent with angina or a myocardial infarct. I can find no record of any observations of [Code A]'s pulse or heart rate or examination of her heart and lungs. In my opinion there was an inadequate medical assessment of this problem. An adequate medical assessment would have sought to determine a diagnosis responsible for the chest pain and provided appropriate treatment. If it was musculoskeletal a mild or moderate analgesia therapy such as Paracetamol or a non-steroidal anti-inflammatory drug would have been appropriate. If it was cardiac pain appropriate treatment would have been with a nitrate and possibly a dose of oral morphine if the pain failed to respond to nitrate therapy and there was clear evidence pain was cardiac in nature. A 10mg dose of Oramorphine was administered at 11:50. No justification was given for the commencement of a continuous infusion by syringe driver with the combination of Diamorphine and Midazolam. On 19th and 20th August 1998 following day [Code A] was able to take oral medication as evidenced by the prescription chart recording the administration of oral Bumetanide and Allopurinol.
11. [Code A]'s condition deteriorated after the commencement of Diamorphine and Midazolam. This deterioration should have led to a full medical assessment. It is highly likely her deterioration was due to the combined sedative effects of Diamorphine and Midazolam and if the infusion had been discontinued her drowsiness may have resolved. However her deterioration was interpreted as requiring further sedative and drugs and the Midazolam dose was increased twofold to 40mg over 24 hours and Hyoscine was also commenced. These would have further contributed to [Code A]'s decline in my opinion. In my opinion there is no clear evidence presented to support the diagnosis of a myocardial infarct or cardiogenic shock as the cause of death in [Code A]. It is much more likely she died from the sedative and depressant effects of the Diamorphine and Midazolam infusion that she received. There was no justification provided in the notes for the syringe driver as [Code A] was able to swallow medication.

Summary of Conclusions

12. [Code A] was a frail older lady who had a number of medical problems. Following her left hip fracture she was making slow progress. When transferred to Dryad ward she was medically stable. [Code A] was responsible for her day to day medical care there was inadequate medical assessment both when she was initially admitted and then a failure to adequately assess [Code A] when she developed agitation and then chest pain. The prescription of opioids was in my opinion not justified there was no justification for the

prescription of Diamorphine and Midazolam by syringe driver. The prescription and administration of these drugs are the most likely cause of [Code A]'s subsequent deterioration and her death. There was a failure of adequate assessment by [Code A] in particular when [Code A] developed chest pain there should have been a physical examination and investigations undertaken and recorded in medical notes.

13. In my opinion [Code A] in her care of [Code A] failed to meet the requirements of good medical practice to:
- Provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
 - Consult colleagues
 - Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
 - Provide or arranging necessary investigations
 - Prescribe only the treatment, drugs or appliances that serve patient's need

Code A

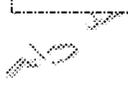
GMC and Code A
Report on Code A **(Patient G)**

Code A
Consultant Physician

21 April 2009

Code A

Code A



17-9.07

GMC and Code A
Patient G

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient G commenting on the care and treatment carried out by Code A in relation to this patient, to assist the GMC Panel in determining whether Code A has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that Code A prescribed diamorphine and midazolam subcutaneously over a 24 hour period in a dose range that was too wide, thereby creating a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs; that the prescribing of these drugs was inappropriate, potentially hazardous, not in the best interests of Patient G.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital, and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 14-20 of that report I describe the course of events relating to Patient G's admission to Dryad Ward, Gosport War Memorial Hospital on 21 September 1998 prior to his death on

Code A

4. This report is based on my review of the following documents; medical records of Patient G; witness statements of Code A
Code A
statement made by Code A in relation to Patient G; interview of Code A dated 21 April 2005.

Course of events

5. I have described these in my report to Hampshire Constabulary dated 12 December 2001. I have no major changes to make to that report. The statement in course of events "on 24 September Code A has written "Remains unwell. Code A has visited again today..." is incorrect. The entry in the medical notes on 24 September was by Code A (page 646). The entry I record by Code A in the medical notes on 21 September 1998 is correct except for the final sentence "analgesics prn" which on re-reading the medical notes I believe stated "prognosis poor". Otherwise I have no changes to make to the course of events as recorded in my report to Hampshire Constabulary.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In this section I list drug therapy received providing more detail of [Code A] prescribing in section 3.3 of my report to Hampshire Constabulary.

Pages 753-758 and page 831. All prescriptions written by [Code A] unless otherwise marked.

Regular Prescriptions

Diamorphine subcut via syringe driver	25 Sep	60mg/24hr	1015h
40-200mg/24hr	26 Sep	80mg/24hr	1150h
Prescribed 25 Sep			

Hyoscyne subcut via syringe driver	25 Sep	1200ucg/24hr	1015h
800ug-2mg/24hr	26 Sep	1200ucg/24hr	1150h
Prescribed 25 Sep			

Midazolam subcut via syringe driver	25 Sep	80mg/24hr	1015h
20-200mg/24hr	26 Sep	100mg/24hr	1150h
Prescribed 25 Sep			

As required prescription

Oramorph 2.5-10mg	21 Sep	1415h	5mg
Prescribed 21 Sep [Code A]	21 Sep	2015h	10mg

Actrapid Insulin sub-cut 10 units	None administered
Prescribed date unclear	

Daily Review Prescriptions (written as prn)

Diamorphine sc via syringe driver	21 Sep	20mg/24hr	2310h
10-200mg/24hr	22 Sep	20mg/24hr	2029h
Prescribed date unclear	23 Sep	20mg/24hr	0925h discarded
		20mg/24hr	2000h
	24 Sep	40mg/24hr	1055h
	24 Sep	60mg/24hr	time unclear

Midazolam sub-cut via syringe driver	21 Sep	20mg/24hr	2310h
10-80mg/24hr	22 Sep	20mg/24hr	2020h
Prescribed date unclear	23 Sep	20mg/24hr	0925h discarded
		60mg/24hr	2000h
	24 Sep	80mg/24hr	1055h

Hyoscyne sub-cut via syringe driver	23 Sep	400ug/24hr	0925h discarded
100-800ug/24hr		400ug/24hr	2000h
Prescribed date unclear	24 Sep	800ug/24hr	1055h

Opinion on Patient Management

7. I have provided an opinion on the management of Patient G in my report to Hampshire Constabulary. I have no changes to make to my opinions expressed in that report except to correct my statement 3.9 where I state "when [Code A] reviewed Patient G on 24 September...". This should state "when [Code A] reviewed Patient G on 24 September the notes implied that he was much worse than when he had been assessed by [Code A] three days earlier."
8. In the following sections I summarise my opinions on the management of Patient G by [Code A] and other staff and the actions taken particularly with respect to the prescribing of midazolam and diamorphine.
9. Although review of the notes suggests it was clear that Patient G was in pain from his sacral sore, there is little information in the medical and nursing notes that describes the location or severity of his pain. The initial assessment by [Code A] on 21 September is very brief. Although a reference is made to making Patient G comfortable there is no description of the cause of his pain or its severity. There had been clear instructions from [Code A] that Patient G was to receive oramorph "as required" for his pain. This *prn* ('*pro re nata*') as required instruction had been underlined by [Code A].
10. As I have previously outlined in my report to Hampshire Constabulary I consider the decision by [Code A] to prescribe and administer diamorphine in a very wide dose range (20-200mg/24hr) along with midazolam in a similarly wide dose range (20-80mg/24hr) was not justified by the information recorded in the medical records. The commencement of diamorphine and midazolam by subcutaneous infusion via syringe driver at 2310h on 21 September was in my opinion not justified and highly inappropriate. There is no evidence recorded in the notes that Patient G was unable to swallow oral medication. He had received only two doses of oramorphine which would be an inadequate number of doses over a very short time period to establish the total daily dose of opiates he would need over a 24 hour period to control his pain. Even if the decision had been made that Patient G required sustained administration of an opiate drug this could have been achieved through the prescribing of regular *prn* doses of morphine that had been prescribed by Dr Lord.
11. Although the nursing notes document that Patient G was agitated until 2330h there was no indication for prescribing subcutaneous midazolam by continuous infusion. Appropriate medication would have been either an oral benzodiazepine such as diazepam or an oral or intramuscular dose of a sedative such as haloperidol. The nursing notes during Patient G's admission are very limited but do not indicate any problem with swallowing. The nursing care plan of 21 September (page 869) states "*offer hot drink*" which suggests he was able to swallow on admission.
12. For reasons I have previously outlined in my report to Hampshire Constabulary the prescription of diamorphine at a dose of 20mg/24hr in conjunction with midazolam at a dose of 20mg/24hr was unnecessary and potentially highly dangerous in a frail elderly man such as Patient G because of the risk of the combination resulting in profound depression of respiration and/or conscious level. The subsequent deterioration of Patient G on 23 September was in my opinion most likely due to the combined effect of the diamorphine and midazolam infusions he had received. The nursing notes record that Patient G had become "chesty" and had possibly developed a chest infection.
13. The nursing notes also record that Patient G was seen by [Code A] but there was no evidence in the medical records that she undertook an examination of the patient and

considered that he may have developed a chest infection that required treatment with antibiotics, or that his deterioration was due to diamorphine and/or midazolam. The decision to increase the midazolam dose on 23 September at 2000h from 20mg/24hr to 60mg/24hr was not justified by any information recorded in the medical notes. The decision to increase the dose three fold appears to have been made by nursing staff as the nursing notes state the Patient G was agitated at 2300h and the syringe driver was boosted "with effect". In my opinion this increase in midazolam does was inappropriate and dangerous and in combination with continuing diamorphine infusion was the most likely cause of his subsequent deterioration.

14. The use of a syringe driver was challenged by relatives of Patient G on 23 September (page 362) and the nursing record records that the consultant would need to give permission for the syringe driver to be discontinued. Given the concerns expressed by relatives and that the commencement of the syringe driver had not been at the instruction of the Responsible **Code A** and indeed was against a specific direction that Patient G should receive prn analgesia, this should have led the nursing staff to contact **Code A** or **Code A** as the doctor responsible for Patient G's day to day care to discuss the management plan with **Code A**.
15. There is no information presented in the nursing or medical notes to justify the three-fold increase in the diamorphine infusion from 20mg/24hr to 60mg/24hr. The nursing records record that Patient G had pain when attended to, especially in his knees. In my opinion, the three-fold increase in diamorphine dose infused with the very high dose of midazolam infused inevitably led to the further deterioration documented on 26 September.
16. There were a number of time points between 21 and 23 September when the appropriateness of continuing the infusion of diamorphine and midazolam should have been questioned and discussed with the responsible consultant. In my view it is likely that Patient G died from midazolam and diamorphine induced respiratory depression in combination with bronchopneumonia. In my opinion it is very likely that the administration of midazolam and diamorphine at the doses used led to him dying earlier than would have been the case had he not received these drugs.

Summary of Conclusions

17. Patient G was a frail older man with multiple medical problems. He was admitted to Dryad Ward, Gosport War Memorial Hospital for treatment of his sacral sores. The medical and nursing notes following **Code A**'s assessment provide little detail but in my view it was reasonable to commence Patient G on as required oral morphine and then move subsequently to regular administration of an opiate drug to control his pain, at a dose that did not cause undue side effects. I consider the prescription and administration of diamorphine and midazolam by subcutaneous infusion was not justified, and that there was inadequate assessment of Patient G's pain and the cause of his subsequent deterioration by **Code A**. There was a failure to discuss the management and seek advice from **Code A** or another Consultant when Patient G deteriorated. In my view the doses of diamorphine and midazolam used were inappropriately high and were increased excessively without good cause. These prescriptions likely led to the shortening of Patient G's life.
18. In my opinion **Code A** in her care of Patient G failed to meet the requirements of good medical practice:

- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
- to consult colleagues;
- to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
- to prescribe only the treatment, drugs or appliances that serve patients' needs.

19. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
Code A

GMC and Code A
Report on Code A **(Patient G)**

Code A
Consultant Physician

13 April 2009

GMC and [Code A]
Patient G

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient G commenting on the care and treatment carried out by [Code A] in relation to this patient, to assist the GMC Panel in determining whether [Code A] has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that [Code A] prescribed diamorphine and midazolam subcutaneously over a 24 hour period in a dose range that was too wide, thereby creating a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs; that the prescribing of these drugs was inappropriate, potentially hazardous, not in the best interests of Patient G.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital, and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 14-20 of that report I describe the course of events relating to Patient G's admission to Dryad Ward, Gosport War Memorial Hospital on 21 September 1998 prior to his death on [Code A]
4. This report is based on my review of the following documents; medical records of Patient G; witness statements of [Code A]
[Code A]
statement made by [Code A] in relation to Patient G; interview of [Code A] dated 21 April 2005.

Course of events

5. I have described these in my report to Hampshire Constabulary dated 12 December 2001. I have no major changes to make to that report. The statement in course of events "on 24 September [Code A] has written "Remains unwell. [Code A] has visited again today..." is incorrect. The entry in the medical notes on 24 September was by [Code A] (page 646). The entry I record by [Code A] in the medical notes on 21 September 1998 is correct except for the final sentence "analgesics prn" which on re-reading the medical notes I believe stated "prognosis poor". Otherwise I have no changes to make to the course of events as recorded in my report to Hampshire Constabulary.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In this section I list drug therapy received providing more detail of [Code A]'s prescribing in section 3.3 of my report to Hampshire Constabulary.

Pages 753-758 and page 831. All prescriptions written by [Code A] unless otherwise marked.

As required prescription

Oramorph 2.5-10mg	21 Sept 14:15h 5mg
Prescribed 21 September 1998 [Code A]	21 Sept 20:15h 10mg

Actrapid insulin sub-cut 10 units	None administered
Prescribed date unclear	

Daily Review Prescriptions (written as prn)

Diamorphine sc via syringe driver	21 Sept 20mg/24h 23:10h
20-200mg/24h Prescribed date unclear	22 Sept 20mg/24h 20:29h
	23 Sept 20mg/24h 09:25h discarded
	23 Sept 20mg 20:00h
	24 Sept 40mg 10:55h
	24 Sept 60mg time unclear

Midazolam sub-cut via syringe driver	21 Sept 20mg/24h 23:10h
20-80mg/24h	22 Sept 20mg/24h 20:20h
Prescribed date unclear	23 Sept 20mg/24h 09:25h discarded
	23 Sept 60mg/24h 20:00h
	24 Sept 80mg/24h 10:55h

Hyoscine sub-cut via syringe driver	23 Sept 400ug/24h 09:25h discarded
200-800ug/24h	23 Sept 400ug/24h 20:00h
Prescribed date unclear	24 Sept 800ug/24h 10:55h

Opinion on Patient Management

- I have provided an opinion on the management of Patient G in my report to Hampshire Constabulary. I have no changes to make to my opinions expressed in that report except to correct my statement 3.9 where I state "when [Code A] reviewed Patient G on 24 September...". This should state "when [Code A] reviewed Patient G on 24 September the notes implied that he was much worse than when he had been assessed by [Code A] three days earlier."
- In the following sections I summarise my opinions on the management of Patient G by [Code A] and other staff and the actions taken particularly with respect to the prescribing of midazolam and diamorphine.
- Although review of the notes suggests it was clear that Patient G was in pain from his sacral sore, there is little information in the medical and nursing notes that describes the location or severity of his pain. The initial assessment by [Code A] on 21 September is very brief.

Although a reference is made to making Patient G comfortable there is no description of the cause of his pain or its severity. There had been clear instructions from [Code A] that Patient G was to receive oramorph as required for his pain. This prn as required instruction had been underlined by [Code A]

10. As I have previously outlined in my report to Hampshire Constabulary I consider the decision by [Code A] to prescribe and administer diamorphine in a very wide dose range (20-200mg/24h) along with midazolam in a similarly wide dose range (20-80mg/24h) to be very poor practice. The commencement of diamorphine and midazolam by subcutaneous infusion via syringe driver at 23:10h on 21 September 1998 was in my opinion not justified and highly inappropriate. No evidence is presented in the notes that Patient G was unable to swallow oral medication. He had received only two doses of oramorphine which would be an inadequate number of doses over a very short time period to establish the total daily dose of opiate he would need over a 24 hour period to control his pain. Even if the decision had been made that Patient G required sustained administration of an opiate drug this could have been achieved through the prescribing of regular prn doses of morphine that had been prescribed by [Code A]
11. Although the nursing notes document that Patient G was agitated until 23:30h there was no indication for prescribing subcutaneous midazolam by continuous infusion. Appropriate medication would have been either an oral benzodiazepine such as diazepam or an oral or intramuscular dose of a sedative such as haloperidol. The nursing notes during Patient G's admission are very limited but do not indicate any problem with swallowing. The nursing care plan of 21 September 1998 (page 869) states "offer hot drink" which suggests he was able to swallow on admission.
12. For reasons I have previously outlined in my report to Hampshire Constabulary the prescription of diamorphine at a dose of 20mg/24h in conjunction with midazolam at a dose of 20mg/24h was unnecessary and potentially highly dangerous in a frail elderly man such as Patient G because of the risk of the combination resulting in profound depression of respiration and/or conscious level. The subsequent deterioration of Patient G on 23 September 1998 was in my opinion most likely due to the combined effect of the diamorphine and midazolam infusions he had received. The nursing notes record that Patient G had become "chesty" and had possibly developed a chest infection. The nursing notes also record that Patient G was seen by [Code A] but there was no evidence that she undertook an examination of the patient and considered that he may have developed a chest infection that required treatment with antibiotics, or that his deterioration was due to diamorphine and/or midazolam. The decision to increase the midazolam dose on 23 September to 60mg/24h was in my opinion highly inappropriate and dangerous and in combination with continuing diamorphine infusion was the most likely cause of his subsequent deterioration.
13. The use of a syringe driver was challenged by relatives of Patient G on 23 September 1998 (page 862) and the nursing record records that the consultant would need to give permission for the syringe driver to be discontinued. Given the concerns expressed by relatives and that the commencement of the syringe driver had not been at the instruction of the Responsible [Code A] and indeed was against a specific direction that Patient G should receive prn analgesia, this should have led the nursing staff to contact [Code A] or [Code A] as the doctor responsible for Patient G's day to day care to discuss the management plan with [Code A]

14. There is no information presented in the nursing or medical notes to justify the three-fold increase in the diamorphine infusion from 20mg/24h to 60mg/24h. The nursing records record that Patient G had pain when attended to, especially in his knees. In my opinion, the three-fold increase in diamorphine dose infused with the very high dose of midazolam infused inevitably led to the further deterioration documented on 26 September 1998.
15. There were a number of time points between 21 and 25 September when the appropriateness of continuing the infusion of diamorphine and midazolam should have been questioned and discussed with the responsible consultant. In my view it is likely that Patient G died from midazolam and diamorphine induced respiratory depression in combination with bronco-pneumonia. In my opinion it is very likely that the administration of midazolam and diamorphine at the doses used led to him dying earlier than would have been the case had he not received these drugs.

Summary of Conclusions

16. Patient G was a frail older man with multiple medical problems. He was admitted to Dryad Ward, Gosport War Memorial Hospital for treatment of his sacral sores. The medical and nursing notes following [Code A] assessment provide little detail but in my view it was reasonable to commence Patient G on as required oral morphine and then move subsequently to regular administration of an opiate drug to control his pain, at a dose that did not cause undue side effects. I consider the prescription and administration of diamorphine and midazolam by subcutaneous infusion was not justified, and that there was inadequate assessment of Patient G's pain and the cause of his subsequent deterioration by [Code A]. There was a failure to discuss the management and seek advice from [Code A] or another Consultant when Patient G deteriorated. In my view the doses of diamorphine and midazolam used were inappropriately high and were increased excessively without good cause. These prescriptions likely led to the shortening of Patient G's life.
17. In my opinion [Code A] in her care of Patient G failed to meet the requirements of good medical practice:
 - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to consult colleagues;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.

Declaration

18. I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.
19. I have read and understood the Civil Procedure Rules Part 35 –Experts and Assessors.

SUMMARY OF CONCLUSIONS:

Code A a 79 year-old gentleman, suffers from long-standing Parkinson's disease with multiple complications followed by a fairly rapid decline in health leading to his first admission to the Gosport War Memorial Hospital on 21st July, 1998 and a final admission 21st September, 1998.

Code A receives terminal care including subcutaneous Diamorphine and Midazolam through a syringe driver and dies on Code A

The expert opinion is:

Code A is an example of a complex and challenging problems in geriatric medicine. He suffered from multiple chronic diseases and gradually deteriorated with increasing medical and physical dependency. It is always a challenge to clinicians to identify the point at which to stop trying to deal with each individual problem or crisis, to an acceptance the patient is dying and that symptom control is appropriate.

In my view, Code A was managed appropriately, including an appropriate decision to start a syringe driver for managing his symptoms and agitation as part of his terminal illness in September 1998.

My one concern is the increased dose of Diamorphine in the syringe driver on 25th and 26th September 1998, as I was unable to find any justification for this increase in dosage in either the nursing or the medical notes. In my view this increase in medication may have slightly shortened life for at most no more than a few hours to days, however, I am not able to find evidence to satisfy myself that this is to the standard of "beyond reasonable doubt".

1. INSTRUCTIONS

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

2. ISSUES

- 2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.
- 2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.

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

3. CURRICULUM VITAE

Code A

Code A

4. DOCUMENTATION

This Report is based on the following documents:

- [1] Full paper set of medical records of Code A
- [2] Full set of medical records of Code A on CD-ROM.
- [3] Operation Rochester Briefing Document Criminal Investigation Summary.
- [4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.
- [5] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).
- [7] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

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

- 5.1. During the 1980's Code A noted a tremor in his left hand and by 1987 a clinical diagnosis of Parkinson's disease had been made and he had been started on Sinemet a drug specifically for the treatment of Parkinson's disease (445). He then remains on Sinemet in one form or another for the rest of his life. In 1992 another drug called Selegiline is added to his Sinemet (445). His only previous problem had been a lumbar spinal fusion following a war accident (375) that left him with chronic back pain and foot drop.
- 5.2. In 1992 he had a percutaneous nephrolithotomy for kidney stones. (9). During that admission he was written up for Omnopon 10 – 20 mgs and received a dose of 20 mgs (12). There were no ill effects.

- 5.3. He was assessed in December 1994 (439 and 441) for declining mobility. He was noted to have a weight of 102 kgs, a mental test score of 10 out of 10, and a Waterlow score of 13 (391) suggesting some dependency. Code A had died in 1989 (439). His Barthel was 17 (433) some help needed was with dressing. The problems were assessed to be due to be Parkinson's disease, a weak leg from his war injury and obesity.
- 5.4. He was followed up in 1995 with a diet and change to his Sinemet regime in the Day Hospital. He was also treated with Ranitidine and Gaviscon, presumably for acid reflux (425) and was on regular Co-proxamol for pain (425). Subsequently Enalapril was started for hypertension (399 and 417). In March 1995 his weight was 99.4 kgs (407) and he was discharged shortly after from the Day Hospital (400).
- 5.5. In September 1997 the GP requests a domiciliary visit (379). He notes that he has been diagnosed with diabetes and was now losing weight (379). The GP refers to diabetes being diagnosed in 1986 when this should have been 1995 (555). His Parkinson's disease has deteriorated and he is now getting dystonic movements. Dystonic movements are writhing and jumpy movement that occur as a side effect of drug therapy in people who have had Parkinson's disease for many years. These movements often occurs at times of peak drug levels and may alternate with periods of severe stiffness and immobility at times of low drug levels. It was also noted that he had lost some lower body strength (379). He was now spending most of his time in his chair (379). His drugs included the regular analgesia, Solpadol (381).
- 5.6. An assessment in September 1997 (375, 377) finds he has weak lower limbs and has difficulty in transfers. He can walk indoors slowly with sticks. He has a poor appetite and daily home care. He is documented to have very weak flexion and extension of the left hip, wasting of the left quadriceps and left foot drop (377). It is suggested that he comes to the Day Hospital for physiotherapy. His weight in October 1987 (629) is 84 kgs. However in November 1987 he cancels further appointments (355). In September 1997 his white cell count is 4.0 and his platelet count is 112. It is likely that his haematological abnormalities date from this time.
- 5.7. In March 1998 he is seen again in outpatients with new episodes of shortness of breath (139 – 141). The diagnosis is not clear but was thought possibly to be cardiac in nature. However a chest x-ray (519) was normal. There is no further investigation of this problem. One note suggests that he had just moved to a nursing home (141).
- 5.8. In June 1998 he is seen at the Merlin Park Residential Home by Code A following a GP request (345). He is noted to have significant weight loss, is transferring very unsteadily, is occasionally breathless and has had two falls in the home. He remains on a five times a day dose of his Sinemet and is

also on a hypertensive drug Amlodipine, Diazepam and drugs for constipation. Examination (349) finds that he has markedly dystonic movements and records that the home had noticed visual hallucinations after he moved in. Code A feels that he is on too much Levodopa (the main drug in Sinemet). She feels the Sinemet is causing his dystonic movements, too low a blood pressure on standing leading to falls, and his hallucinations. The notes state that Code A never agreed with this diagnosis. Code A also feels that he is depressed (349).

- 5.9. On 22nd June 1998 he is brought to the Gosport War Memorial Hospital by Social Services as he was refusing to stay at Merlin Park (349). He is described as a difficult and unhappy man (59). No acute health problems are found (343). Social Services place him in the Alvestoke Nursing Home (341).
- 5.10. On 6th July 1998 he is seen again at the Gosport War Memorial Hospital (339) and is noted to have decreased mobility and his weight has now decreased to 68.7 kgs. He is not happy with his new nursing home placement. His functional status has declined and his Barthel is 9/20 (334). His blood count that day shows a normal haemoglobin but a white cell count of 2.7, platelets of 103 (650). The reduced white count particularly his neutrophil count and reduced platelets count is thought to be due to "likely myelodysplasia known since February 1997" (68). This was never confirmed with specialist haematologist investigation.
- 5.11. On 8th July he is seen by Code A a psychiatrist and is thought to be depressed (117). Other problems including his Parkinson's disease and his myeloproliferative disorder are noted (115).
- 5.12. On 20th July his care is discussed with Code A in the Day Hospital (111 and 113). It is thought his Parkinson's disease is stable but because of concern about his weight loss, he is referred for a speech and language assessment, which subsequently occurs on 27th July (101). This finds he has difficulty in initiating swallow but there is no aspiration. This likely to be a complication of his Parkinson's disease.
- 5.13. On 21st July he is admitted to Mulberry Ward with depression (323) his weight is 65.5 kgs (303) a bed sore is now noted (293) he is thought to have dementia (67) and there is a documented mental test score in June of 23 out of 29 on the Folstein Mini Mental State Examination (343). He is found to be constipated (289) is restless and demanding at night (271) (269), nursing notes comment that he can be awkward and difficult (242). Waterlow scores are recorded on a number of occasions, all between 19 and 20 suggesting very high risk of further pressure sore development (309 and 310). He is documented to have various urine tract infections including proteus (207) and enterococcus on two occasions (211) (205). On

admission his white cell count is 2.9 neutrophil count 1.4 and platelet count of 97 (201). On 12th August his white count is 3.5 his neutrophil count 1.8 and platelets 135. The blood form states "known myelodysplasia" (193). On admission his albumin is 26 (185) his urea is 6 and his creatinine 59, his prostatic-specific antigen is 6.4 (179) normal is less than 4. This raised level is not investigated any further, it might represent either benign prostate disease or early prostatic cancer.

- 5.14. During his admission to Mulberry ward he has a fall on the 24th July (70). He is described as quite demanding, wanting staff to come and see him every few minutes (70), he is depressed and tearful on 24th July (71), he is rude and abusive to a member of staff on 26th July (72) and apologises later in the day (73). Code A sees him on 27th July (74) and finds that there were no particular new problems. He is still low in mood on 3rd August (79) calling out for assistance quite a lot (80). He needs a lot more assistance on 10th August (83). On 17th August he became noisy, shouting for help and very abusive, refusing medication (85). He is assessed for a further move to the Thalassa Nursing Home on 17th August (86). He is again confused in the middle of the night on 18th August (87). On 25th August it is noted that he has not passed much urine (90). Blood tests carried out on 26th August (175) find a Sodium 134, Potassium 5.1, Urea 28 and Creatinine 301. He has gone into acute renal failure and is examined and found to have a large palpable bladder (90). He is catheterised. On 28th August there is a significant improvement in his renal function, Sodium 140, Potassium 4.1, Urea 15.6, Creatinine 144 (173). By the time of his discharge to his current usual medication of Sinemet, pain killers and anti-hypertensive drugs; Mirtazapine (an anti-depressant), Carbamazepine 100 mgs nocte, Triclofos 20 mgs nocte and Risperidone 0.5 mgs early evening, have all been started as psychotropic medication to help control his mood and agitation (161 and 163).
- 5.15. He is seen by Code A on Mulberry Ward on 27th August the day before his discharge, the day after he has had a catheter put in. She finds him much better in mood and eating better with a weight of 89.7 kgs (327). There were 2 litres of urine passed after he was catheterised (91). He cannot wheel himself but Code A is happy for him to be discharged to the Thalassa Nursing home with a follow up in the Day Hospital on 14th September. He is then discharged to the Thalassa Nursing Home on 28th August.
- 5.16. On 11th September (99) he is seen by the Community Psychiatric Nurse who says that he has settled well into the Thalassa Nursing Home and his mood seems good.
- 5.17. On 14th September he is seen in the Gosport War Memorial Day Hospital his weight is 88.6 kgs (323), brighter and says he is eating not too badly (459). His blood pressure is a little low at 108/58 and his pulse is 90 (323).

5.23.23rd September (668) it is recorded that he is chesly overnight and Hyoscine is added. The **Code A** are angry that a syringe driver was commenced and the nurses "explain it was to control pain". He is agitated

5.22. The nursing notes are more detailed on 21st September. He is admitted (667) but at 20.30pm is noted to have remained agitated and was pulling off his dressing (680). Syringe driver is commenced "as requested" and he is peaceful. On 22nd September **Code A** is told that the Diamorphine pump has been "started for pain relief and to allay his anxiety". His Barthel is 0/20 (673) and Waterlow 20, suggesting high risk. The patient is recorded as stating he had HIV disease" and trying to remove his catheter.

5.21.25th September **Code A** writes, "remains very poorly on syringe driver saying "death certificate discussed with **Code A** 1 - Bronchopneumonia, 2 - Parkinson's Disease, Sacral Ulcer".

at 23.25 on **Code A** and the final medical note is on 25th September for TLC. There is then a nursing note on 25th September, the patient died (644) on 24th September, states, "remains very poorly, **Code A** has visited staff to confirm death". The next medical note (which is out of sequence comfortable, give adequate analgesia and that "I am happy for the nursing

6.20. He is taken to Dryad Ward (645) and seen by **Code A** who says to make again today and is aware of how unwell he is. Analgesia is controlling pain just. I am happy for the nursing staff to confirm death".

6.19. On 21st September (642) he is again seen in the Day Hospital by **Code A** notes relating to this.

admission on Monday when reviewed again. I have not found any medical notes state that he is seen by **Code A** (909) who thinks he may need was refusing to eat or drink and expressing a wish to die. The nursing not comply with dressings and then would not wake up after bed rest. He sore is exuding markedly. During this session it is recorded that he would September (909). He is recorded to be very frail with his tablets not swallowed and in his mouth. He has a very offensive large necrotic sacral ulcer. His weight is 69 kgs (642). A care plan is made by **Code A** (643) to stop unneeded drugs, to admit to hospital for treatment of the sacral ulcer, to nurse on the side, for a high protein diet and for Oramorph pm for pain. The notes state the nursing home should keep the bed open for the next three weeks at least) and the prognosis is poor (643).

There is no comment on his pressure sore although, he is subsequently given a prescription for Meltronidazole from "a swab to the sores on your bottom" (317). He is presumably still catheterised.

5.18. He appears to have a routine appointment at the Day Hospital on 17th September (908) for therapist assessment. It is noticed that the pressure sore is exuding markedly. During this session it is recorded that he would not comply with dressings and then would not wake up after bed rest. He was refusing to eat or drink and expressing a wish to die. The nursing notes state that he is seen by **Code A** (909) who thinks he may need admission on Monday when reviewed again. I have not found any medical notes relating to this.

at night that evening (876).

5.24. On 24th September the night staff and the day staff report pain and in the notes his Midazolam is increased to 80 mgs a day and his Diamorphine to 40 mgs. The nursing notes record that Code A saw Code A confirming the medical notes (643).

5.25. On Code A Midazolam is continued at 80, he is on Diamorphine 60 mgs and is recorded as being peaceful (876). Finally on 26th September the notes record his Diamorphine is increased to 80 mgs and Midazolam to 100 mgs.

5.26. Drug Chart Analysis:

His original drug chart on admission to the ward on 21st September (752) prescribes Dramorphine 2.5 – 10 mgs orally 4 hourly, he receives 5 mgs at 14.50pm on 21st and 10 mgs at 20.15pm. He is also written up (753) for all his current anti-Parkinsonian and anti-psychotic medication but the notes demonstrate that on some dates the drugs are missing and on almost all occasions he is too ill to be able to take the medication on 21st – 24th September.

5.27. Diamorphine is 20 – 200 mgs subcutaneously in 24 hours is written up on 21st September (756) and on the 21st at 23.10pm, 20 mgs is started. On 22nd September 20.29pm, 20 mgs is started and on 23rd September at 9.25am, 20 mgs is started. On 24th 40 mgs is started in the syringe driver at 10.55am, on 25th 60mgs is in the syringe driver (837) and on 26th 80 mgs.

5.28. Midazolam 20 – 80 mgs is written up on 21st September (756) and 20 mgs is given on 21st, 22nd and 23rd. On the 23rd though, this is increased to 60 mgs, 80 mgs on the 24th. He receives another 80 mgs on 25th and 100 mgs written up in 24 hours on 26th (837).

5.29. Hyoscine 200 – 800 micrograms sub cut in 24 hours is written up 400 micrograms are given on 22nd and 23rd September and 800 micrograms on 24th. This is then re-prescribed. Hyoscine 80 – 2 grams sub cut in 24 hours (837) and he receives 1,200 micrograms on 25th and 26th.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

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

negligently or trivially contributed to death.

- 6.2. Code A's two main problems were lumbar spinal fusion as a result of a war injury, which left him his weakness in his lower legs and his progressive neurological disease, Parkinson's disease. Parkinson's disease is a degenerative disease of the central nervous system, which causes tremor, body rigidity and akinesia (stiffness in movement). It was first noted in 1980 presenting with a tremor, he was certainly on treatment by 1987. The natural history is often a good response to treatment over 5 years and then gradual increasing problems. Late Parkinson's disease becomes increasingly difficult to control with drugs; the patients get difficulty in swallowing, severe constipation, and often in later stages a dementing illness.
- 6.3. There are complications with the drugs as the disease progresses, as the drugs are harder to keep in an effective therapeutic range. Too much and the patients get marked writhing or shaking movements call dystonias, too little and the patient may cease up completely. The longer-term side effects of the drugs also include postural hypotension (loss of blood pressure when standing, leading to falls) and mental state deterioration, including hallucinations. To try and combat this, complex regimes are used with multiple doses at different times of days, sometimes combined with other drugs. There is no cure for the condition.
- 6.4. In 1992 he is troubled with kidney stones but has an uneventful operation.
- 6.5. In 1994 he has a decline in his conditions with reduced mobility. This is a multiple factorial problem caused by his Parkinson's disease, weak legs as a result of his war injury and his obesity of 102 kgs. He is now living alone as Code A. He uses an electric wheelchair effectively and his Barthel is 17 but most of the help he currently needs is with dressing.
- 6.6. Further problems occur include hypertension, which is treated in 1995, and diabetes mellitus (high blood sugar), which is diagnosed later in the year.
- 6.7. By September 1987 he is getting considerable problems in managing his mobility as well as his Parkinsonian drug regime with significant dystonic movements. He is now on multiple drugs to treat his various medical conditions. He is referred to the Day Hospital for more physiotherapy to try and support him and to change his drug regime but he cancels further appointments in November 1997 (355).

- 6.8. By March 1998 (141) when he is seen in the Day Hospital within the Outpatients it mentions that he was now in Solent Cliff Nursing Home, though when seen in June 1998 (345) he has moved to the Merlin Park Residential Home. Throughout this gentleman's last illness there is a pattern of him being persistently dissatisfied with the care he receives, either in hospital or in the various homes he is cared for in, leading to multiple moves. This often complicates assessment as one institution never gets entirely used to him, his management and his behaviour.
- 6.9. By June 1998 there is now a very marked change in his health. There has been massive weight loss from 102 kgs in 1994 (441), 84 kgs in October 1997 (629) to 68.7 kgs documented by July 1998 (339). He is walking very unsteadily, is having falls in the home, having hallucinations at night, he is depressed and has marked dystonic movements. He is not happy with the suggestion that he actually needs less medication rather than more to help manage his condition.
- 6.10. Whether the result of genuine unhappiness with the home or depression on top of what is now probably becoming an early dementing illness (his mental test score on 22nd June (343) was 23/29), he refuses to stay at Merlin Park. Social Services become involved and he is seen in the Day Hospital when no new acute problems on top of his known chronic problems are detected. Social Services manage to place him in the Alvestoke Nursing Home (341).
- 6.11. However, he is not happy at all with this placement when he is seen in the Day Hospital on 6th July 1998 (339). The plan is to investigate his weight loss and to reduce his Sinemet treatment. His Barthel is now 9/20. A further medical complication that has developed, probably since early 1997 (68), is that he has an abnormality of his full blood count with a reduced white cell count and a reduced platelet count. This suggests a problem with his bone marrow. Although the blood film say this is likely to be myelodysplasia (a pre-malignant condition of the bone marrow where there is partial bone marrow failure, but it has not progressed to Leukaemia) no definitive haematological investigations appear to have been undertaken. The main effect of this condition is he is likely to be much more susceptible to infections.
- 6.12. He is seen by the psychiatric team on 8th July (117) and then is admitted to hospital on 21st July to Mulberry Ward with a primary diagnosis of depression, probably on top of an underlying mild dementing illness (67). For the first time a bed-sore is noted in the nursing notes (293) although this is not commented on in the thorough medical clerking that was undertaken on admission (66).

- 6.13. There is no doubt that there has been a very significant decline in this gentleman's general health. He has now lost over 40 kgs of weight, including 25% of his body weight in the last year. He had rapidly declining mobility, an early bedsore, he has started to develop mental impairment and his Parkinson's disease has become increasingly difficult to manage.
- 6.14. Admission is characterised by descriptions of restless and demanding behaviour and occasionally aggression. I suspect he has a low-grade delirium (delirium is acute confusion on top of, in this case, an early underlying dementing illness). Probably being caused by a combination of his drugs and the urinary tract infections that are documented on serial urine samples. He is started on drugs for his (understandable) depressive illness, which in themselves may complicate his drug regime. Finally he is treated with major tranquillisers to try and control his moods and behaviours.
- 6.15. The outcome of this admission is that he is now on multiple medications to try and control multiple symptoms. Yet there is very little improvement or change in his behaviour, as noted in the nursing cardex.
- 6.16. He is planned to the Thalassa Nursing home on 28th August as his 4th residential move of the year. However, on the 25th August he is noted to be passing less urine and a blood test on 26th August shows that he has gone into quite significant acute renal failure. On examination he is found to be in retention of urine and is catheterised and two litres of urine is passed (91).
- 6.17. The retention of urine in itself is likely to have had multi-factorial causes, including the drugs he was on, his proven urinary tract infections and he may also have had an undiagnosed prostatic problems based on a raised PSA (179). However, he responds well to catheterisation and his renal function is dramatically improved by 28th when he is discharged, with a Urea of 15.6 and a Creatinine of 144 (173).
- 6.18. Following discharge things appear to go not too badly, the CPN seeing him on 11th September (99) states that his mood seems good and he is settled well. On 14th September when he is seen in the Day Hospital, his weight remains unchanged on 68.6 kgs (323) "he is brighter and says eating not too badly" (459). However, his blood pressure is rather low on 14th September at 108/58 (323) and the pressure sore must be causing concern as a swab is sent (317).
- 6.19. He then has a routine review, for a therapist assessment on 17th September. The nursing notes give a clue that he is quite unwell that day (908 and 909), they refer to the pressure sore now exuding

markedly, he would not comply with his dressings, he would not wake up after bed rest and was refusing to eat or drink. He was apparently expressing a wish to die. This suggests to me he was acutely delirious again and the underlying aetiology could well be sepsis from pressure sore or sepsis (which is very common) from his urinary tract after a recent catheterisation. The nursing notes say that he is seen by the consultant but I was not able to find any medical notes. The nursing notes suggest that [Code A] considered that she needed to review him on 21st and might need admission at this stage. It is below normal acceptable good medical practice to not make a record when seeing a patient, particularly if there has been a significant change in their condition.

6.20 [Code A] is reviewed again on 21st September (642) when he has rapidly deteriorated, is very ill and very frail. He has an offensive large necrotic sacral ulcer and is not able to swallow with tablets in his mouth. He is admitted to hospital appropriately. [Code A] asked for a management plan, including nursing him on his side, a high protein diet, Oramorph PRN for pain and writes to the nursing home to keep the bed open for three weeks at least, the prognosis is poor.

6.21. This gentleman is very seriously ill, with multiple problems and has been in decline for at least three months. The consultant has to make a judgement whether these are easily reversible problems, which would need intensive therapy, including drips and surgery to the pressure sore in an acute hospital environment or whether this is likely to be the terminal event of a progressive physical decline.

6.22. In my view the combination of acute problems on top of his known progressive chronic problems, including the large necrotic pressure ulcer would mean that active treatment in an acute DGH was very likely to be futile and therefore inappropriate. It was appropriate to admit him into a caring environment for pain relief and to observe and provide symptomatic support. In my experience it is unusual for a consultant to write "poor prognosis" in the notes unless they believe the patient is terminally ill and death is likely to be imminent.

6.23. He is admitted to the ward, [Code A] sees him and writes, "make comfortable" in the notes (645). As the patient has just been seen and examined by a consultant who has made a care plan, I think it is reasonable for no further clerking or examination to have been carried out, although many doctors would automatically do that, if briefly, so that they know the baseline of the patient. As suggested Oramorphine is written up and [Code A] receives two doses on 21st.

6.24. However, a syringe driver has also been written up on admission (756) for Diamorphine and Midazolam. There is nothing in the medical notes that specifically explain why was it written up, when the drugs should be started or what dose. It would be normal medical practice to write a comment on such management plan in the notes, but it is not negligent by itself, to fail to do so.

6.25. The nursing notes state that he remains agitated, pulling off his dressings later in the day (880). A decision is made, with the drugs written up (who decides?) to start him on Diamorphine 20 mgs with 20 mgs of Midazolam in a syringe driver.

6.26. The dose of Diamorphine is within an acceptable starting range for patients in pain. Midazolam is also widely used for terminal restlessness; the dose prescribed is from 5 – 80 mgs per 24 hours. The starting dose is within the range of 5 – 20 mgs per 24 hours that is acceptable for older patients (Palliative Care, Chapter 23 in Brocklehurst's Text Book of Geriatric Medicine 6th Edition 2003). Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. As the patient was terminally ill and restless, despite his previous doses of Omnopon, I think this was a reasonable management decision.

6.27. By 29th he is clearly delirious and is now totally dependent with a Barthel of 0/20. There does not appear to have been very good communication with the Code A as anxieties are raised about his management (868). The dose of Diamorphine and Midazolam remain unchanged on 22nd and 23rd, although he is a little agitated at night on 23rd (876) and both day and night staff report pain on 24th (869). At this stage Diamorphine is increased to 40m mgs and the Midazolam to 80 mgs. In my view, the dose of Diamorphine prescribed was appropriate, however the four-fold increase in Midazolam 20 mgs on the 23rd to 80 mgs on the 24th appears excessive.

6.28. After the pain on 24th there is no further distress noted in either the medical notes (845) or the nursing notes (889). Despite this, the Diamorphine is increased to 60 mgs a day on 25th and 80 mgs on the 26th and the Midazolam is put up to 100 mgs a day on the 26th. In my view it was reasonable to increase the palliative care regime of Diamorphine and Midazolam on both 23rd and 24th September. He was in pain and he was agitated. It might well have been better to increase the Diamorphine (as pain does seem to be a major issue here with the bed-sore) rather than the Midazolam to ensure that this dying man was symptom free and did not require an increase in medication on the 24th.

6.29. The dose of Diamorphine is then increased on both the 25th and 26th to 60 then 80 mgs (637) and Midazolam is increased again on 26th September to 100 mgs. There is no justification given for this in either the nursing or the medical notes, nor at any stage is it possible to tell from the notes whether the decision to change the drug dosages was a medical or a nursing decision or which doctor or nurse made that decision.

6.30. In my view the dose of Diamorphine and Midazolam was excessive on 25th and 26th and the medication may have slightly shortened life. However, I cannot find evidence to satisfy myself to the standard of "beyond reasonable doubt". I would have expected a difference of at most, no more than a few hours to days if a lower dose of either or both of the drugs had been used instead during the last few days.

7. OPINION

7.1. Code A is an example of a complex and challenging problems in geriatric medicine. He suffered from multiple chronic diseases and gradually deteriorated with increasing medical and physical dependency. It is always a challenge to clinicians to identify the point to stop trying to deal with each individual problem or crisis, to an acceptance the patient is now dying and that symptom control is appropriate.

7.2. In my view Code A was managed appropriately, including an appropriate decision to start a syringe driver for managing his symptoms and agitation as part of his terminal illness in September 1998.

7.3. My one concern is the increased dose of Diamorphine in the syringe driver on 25th and 26th September 1998, as I was unable to find any justification for this increase in dosage in either the nursing or the medical notes. In my view this increase in medication may have slightly shortened life for at most no more than a few hours to days, however, I am not able to find evidence to satisfy myself that this is to the standard of "beyond reasonable doubt".

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.

5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002;1:129
6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.

9. EXPERTS' DECLARATION

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

10. STATEMENT OF TRUTH

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

Version 2 of complete report 11th July 2005 - Code A

Signature: _____ Code A _____ Date: 12/8/08

Code A

Code A

GMC and Code A
Report on Code A **(Patient H)**

Code A

Consultant Physician

21 April 2009

GMC and Code A
Report on Patient H

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient H commenting on the care and treatment carried out by Code A in relation to this patient to assist the GMC Panel in determining whether Code A has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that Patient H was not properly assessed upon admission; that the prescription of oramorphine was inappropriate, potentially hazardous and likely to lead to serious and harmful consequences for Patient H and not in his best interests; that the prescription of diamorphine was in too wide a dose range that created a situation whereby drugs could be administered to Patient H which were excessive to his needs; that the prescriptions of oramorphine, diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interests of Patient H.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 25-29 of that report I describe the course of events relating to Patient H's admission to the Queen Alexandra Hospital on 22 September 1998 and following transfer to Dryad Ward at Gosport War Memorial Hospital on 14 October 1998 prior to his death on Code A
Code A

4. This report is based on my review of the following documents; medical records of Patient H; statements of Code A
Code A statement made by Code A in relation to Patient H.

5. Course of events

I have described these in my report to Hampshire Constabulary dated 12 December 2001 and have no changes or corrections to make or add to my statement in that report. In this report I comment on the potential influence of the past diagnosis of alcoholic liver disease on the prescribing of opioid drugs to Patient H, which I did not include in my report to Hampshire Constabulary. The recorded cause of death was congestive cardiac failure, renal failure and liver failure.

	18 Oct 1450h 60mg/24 hr
Hyoscine subcut via syringe driver	16 Oct 1610 400ug / 24 hr
200-800ug/24hr	17 Oct 0515 600ug / 24 hrs
Prescription date unclear	1550h Increased to 800ug/24hr
Midazolam subcut via syringe driver	17 Oct 1550h 20 mg/24hr
20-80mg/24hr	18 Oct 1450h 40 mg/24hr
Prescription date unclear	
Hyoscine subcut 1200ug/24hr	18 Oct 1450 1200ug / 24 hours
Verbal prescription Code A	18 Oct

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to **Code A**'s assessment and prescribing.
8. Patient H had a history of alcohol problems and had previously presented with ascites and had signs of chronic liver disease suggesting he had cirrhosis due to alcoholic liver disease (admission in January 1997). Ultrasound of the abdomen produced at that time (page153) had shown a smallish bright liver consistent with cirrhosis. Reduced dose of opioid analgesics is recommended in patients with hepatic and renal impairment with recommendations to avoid if severe hepatic impairment is present (BNF 55 page 229). Opioid analgesics may precipitate hepatic encephalopathy and come in patients with cirrhosis. However when patients are in severe pain it may still be necessary to use opiates. In older people a lower dose should be used and patients need to be carefully monitored.
9. In 1997 Patient H had a low albumin indicating he had at least moderately severe liver disease. Prior to Patient H's admission to Dryad Ward he was receiving paracetamol 1g qds for analgesia and the transfer letter (page 81) notes he still had a lot of pain from the fractured left humerus. He had been receiving a combination of paracetamol and dihydrocodeine as codydramol until the 30 September when this was changed to paracetamol alone. After **Code A** had assessed Patient H on 14 October she prescribed paracetamol four hourly prn and oramorphine 2.5-5mg four hourly.
10. **Code A** does not provide any justification in the medical records for moving from paracetamol to the use of a strong opioid morphine, although the prescription of "as required" oral morphine controlled Patient H's pain without undue adverse effects initially on the 14 October. A more appropriate response to manage his continuing arm pain would have been to prescribe paracetamol with a mild opioid such as codeine or dihydrocodeine which he had previously been prescribed. He was prescribed 5-10mg morphine prn and then administered two doses of 10mg morphine. Given his age and chronic liver disease a lower 5mg dose would have been a more appropriate cautious response if opioid drugs were needed. The nursing notes report on 15 October that he had slept well.
11. On 15 October **Code A** prescribed regular oramorphine at a dose of 10mg 4 times daily and 20mg nocte (60mg morphine daily). This was a high dose of morphine for an elderly man with chronic liver disease. **Code A** had not undertaken a physical examination of

Patient H when transferred to Dryad Ward on 14 October and may not have been aware of his diagnosis of chronic liver disease, as this was not described in his recent medical notes, or taken into consideration the potential impact of this on his response to opiate drugs.

12. The nursing notes suggested he had had symptomatic improvement and control of his pain with the previous pm doses of morphine (20mg received over the 12 hour period) without any obvious problems. Although a more cautious and appropriate response would have been to increase his opiate dose to 40mg oral morphine over 24 hours, the prescription of regular tramorphine at the doses prescribed (60 mg/24hr) after he had experienced pain control from pm doses of morphine equate to a 50% increase in the 24 hour dose equivalent, would have been reasonable if Patient H did not have liver disease and he was monitored for adverse effects of opioids. However this is a large increase in an older patient with chronic liver disease who has only received two "as required" doses of morphine, and there was a significant risk the increased dose of morphine could precipitate liver failure.
13. On 16 October there was a clear deterioration after Patient H had received three 10mg doses and a 20mg night-time dose (total 50mg) of morphine. **Code A** who assessed Patient H appears not to have considered that the deterioration in conscious level could have been secondary to the oral morphine he had received and nursing staff administered further doses of oral morphine at 0600h, 1000h and 1400h on 16 October. It would have been appropriate for **Code A** to discuss Patient H's deterioration with a senior colleague.
14. Later that afternoon on 16 October, **Code A** prescribed diamorphine by subcutaneous infusion to a syringe driver with a dose range of 20-200mg with midazolam in the dose range of 20-80mg and hyoscine in the dose range of 200-800ug per 24 hours. There is no evidence in the medical records that **Code A** examined Patient H at this stage. **Code A** was presumably informed of Patient H's deterioration and did not appear to have considered that the oral morphine he had received was the likely cause of the deterioration due to both its depressive effects on conscious level and ability to precipitate a hepatic encephalopathy in patients with chronic liver disease.
15. At this stage as Patient H was unresponsive it is likely he was unable to take oral medication and this may explain the decision of **Code A** to prescribe opioids and other drugs by subcutaneous route. However, the lack of medical assessment and failure to consider that Patient H's deterioration was secondary to the morphine he had received was not consistent with good medical practice. If **Code A** was uncertain as to the cause of Patient H's deterioration she should have discussed this with the responsible medical consultant. If **Code A** was aware Patient H had chronic liver disease it would have been particularly important for her to assess Patient H to determine if he had developed liver failure secondary to morphine. If **Code A** had taken a full history from Patient H when he was admitted she might have obtained a history of ascites and chronic liver disease from Patient H.
16. The prescription of diamorphine and midazolam was inappropriate and not justified by any information presented in the notes. There is no evidence at this stage that Patient H was in pain. When his conscious level deteriorated an appropriate response would have been to discontinue opiates, and assess the cause of his deterioration. I can find no evidence of any symptoms which required the prescription of the midazolam, which can precipitate hepatic encephalopathy in patients with chronic liver disease. The dose range prescribed was highly inappropriate and potentially dangerous given Patient H's age, clinical condition with a

depressed conscious level and presence of chronic liver disease. The subsequent escalation of diamorphine and midazolam dose on 17 October inevitably led to his further deterioration and in my view contributed to his death through depression of his conscious level and respiration. The nursing notes of 15 October record no symptoms of pain and no justification is given for the prescribing of diamorphine and midazolam or the escalation in dose to diamorphine 60 mg/24hr and midazolam 40mg/24hr.

Summary of conclusions

17. Patient H was a frail older man with depression, alcoholic liver disease and a painful fracture of the left humerus transferred to Dryad ward for rehabilitation. Oral opioid drugs were an appropriate treatment for Patient H if his pain had been uncontrolled on mild opioid drugs and paracetamol but this combination was not first prescribed. **Code A** failed to undertake or record an adequate clinical assessment of Patient H when he was admitted to Dryad ward or adequately assess his subsequent deterioration. The prescription by **Code A** of subcutaneous diamorphine and midazolam infusions was not justified and the dose ranges used were inappropriately wide. The subsequent increase in diamorphine and midazolam doses that were infused were not justified. In my opinion the doses of diamorphine and midazolam received by Patient H led to his subsequent deterioration and most likely led to Patient H's death through producing respiratory depression.
18. In my opinion **Code A** in her care of Patient H failed to meet the requirements of good medical practice:
- * to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - * to consult colleagues;
 - * to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - * to prescribe only the treatment, drugs or appliances that serve patients' needs.
19. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

Code A

GMC and Code A
Report on Code A **(Patient H)**

Code A
Consultant Physician

13 April 2009

GMC and Code A Report on Patient H

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient H commenting on the care and treatment carried out by Code A in relation to this patient to assist the GMC Panel in determining whether Code A has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that Patient H was not properly assessed upon admission; that the prescription of oramorphine was inappropriate, potentially hazardous and likely to lead to serious and harmful consequences for Patient H and not in his best interests; that the prescription of diamorphine was in too wide a dose range that created a situation whereby drugs could be administered to Patient H which were excessive to his needs; that the prescriptions of oramorphine, diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interests of Patient H.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 25-29 of that report I describe the course of events relating to Patient H's admission to the Queen Alexandra Hospital on 22 September 1998 and following transfer to Dryad Ward at Gosport War Memorial Hospital on 14 October 1998 prior to his death on Code A Code A
4. This report is based on my review of the following documents; medical records of Patient H; statements of Code A Code A statement made by Code A in relation to Patient H.

5. Course of events

I have described these in my report to Hampshire Constabulary dated 12 December 2001 and have no changes or corrections to make or add to my statement in that report. In this report I comment on the potential influence of the past diagnosis of alcoholic liver disease on the prescribing of opioid drugs to Patient H, which I did not include in my report to Hampshire Constabulary. The recorded cause of death was congestive cardiac failure, renal failure and liver failure

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In this section I list all drug therapy received providing more detail of [Code A]'s prescribing in section 5.4 and 5.5 of my report to Hampshire Constabulary (12 December 2001).

Pages 258 - 263. All prescriptions written by: [Code A] unless otherwise marked.

As required prescriptions

Paracetamol 1g 4 hourly None administered
Prescribed 14 October 1998

Hyoscine subcut 600ug / 24 hours None administered
Prescribed by another doctor

Regular prescriptions

Frusemide 80mg once daily 15 / 16 October 1 dose
Prescribed 14 October 1998

Spironolactone 50mg bd 14 October 1 dose
Prescribed 14 October 1998 15 October 2 doses then discontinued

Bendrofluzide 2.5mg od 15 October 1 dose
Prescribed 14 October 1998 16 October 1 dose then discontinued

Trazodone 50mg once daily 14 October 1 dose
Prescribed 14 October 1998 15 October 1 dose then discontinued

Thiamine 100mg once daily 15 October then discontinued
Prescribed 14 October 1998

Multivitamins 1 tablet 15 October then discontinued
Prescribed 14 October 1998

Magnesium hydroxide 1 tablet bd 14 October 1 dose
Prescribed 14 October 15 October 2 doses then discontinued

Senna 2 tablets once daily 14 October 2 tablets then discontinued
Prescribed 14 October 1998

Oramorph 10mg / 5mls 15 October 3 doses 1000h, 1400h, 1800h
10mg 4 times daily 16 October 3 doses 0600h, 1000h, 1400h
prescribed 15 October 1998

Oramorph 10mg / 5mls 15 October 1 dose 2200h then discontinued
20mg nocte prescribed 15 October 1998
Illegible prescription by another doctor

Daily review prescriptions

REGULAR PRESCRIPTION CROSSED OUT AND REPLACED WITH PRN

Oramorph 10mg / 5mls 14 October 1445h 10mg
2.5-5mls 4 hourly 14 October 2245h 10mg

Prescription date unclear

Diamorphine subcut via syringe driver	16 October 1610h 20mg/24 hr
20–200mg / 24hrs	17 October 0515h 20mg/24 hr
Prescription date unclear	17 October 1550h increased to 40mg/24hr
	18 October 1450h 60mg/24 hr
Hyoscine subcut via syringe driver	16 October 1610 400ug / 24 hr
200-800ug / 24hr	17 October 0515 600ug / 24 hrs
Prescription date unclear	17 October 1550h increased to 800ug/24hr
Midazolam subcut via syringe driver	17 October 1550h 20 mg/24hr
20-80mg / 24hrs	18 October 1450h 40 mg/24hr
Hyoscine subcut 1200ug / 24hrs	18 October 1450 1200ug / 24 hours

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to [Code A]'s assessment and prescribing.
8. Patient H had a history of alcohol problems and had previously presented with ascites and had signs of chronic liver disease suggesting he had cirrhosis due to alcoholic liver disease (admission in January 1997). Ultrasound of the abdomen produced at that time (page153) had shown a smallish bright liver consistent with cirrhosis. Reduced dose of opioid analgesics is recommended in patients with hepatic and renal impairment with recommendations to avoid if severe hepatic impairment is present (BNF 55 page 229). Opioid analgesics may precipitate hepatic encephalopathy and coma in patients with cirrhosis. However when patients are in severe pain it may still be necessary to use opiates. In older people a lower dose should be used and patients need to be carefully monitored.
9. In 1997 Patient H had a low albumin indicating he had at least moderately severe liver disease. Prior to Patient H's admission to Dryad Ward he was receiving paracetamol 1g qds for analgesia and the transfer letter (page 81) notes he still had a lot of pain from the fractured left humerus. He had been receiving a combination of paracetamol and dihydrocodeine as co-dydramol until the 30 September when this was changed to paracetamol alone. After [Code A] had assessed Patient H on 14 October she prescribed paracetamol four hourly prn and oramorphine 2.5-5mg four hourly.
10. [Code A] does not provide any justification in the medical records for moving from paracetamol to the use of a strong opioid morphine, although the prescription of prn oral morphine controlled Patient H's pain without undue adverse effects initially on the 14 October. A more appropriate response to manage his continuing arm pain would have been to prescribe paracetamol with a mild opioid such as codeine or dihydrocodeine which he had previously been prescribed. He was administered two doses of 10mg morphine given his age and liver disease a lower 5mg dose would have been more appropriate cautious response. The nursing notes report on 15 October that he had slept well.

11. The following day [Code A] prescribed regular oramorphine at a dose of 10mg 4 times daily and 20mg nocte (60mg morphine daily). This was a high dose of morphine for an elderly man with chronic liver disease. [Code A] had not undertaken a physical examination of Patient H when transferred to Dryad Ward on 14 October and may not have been aware of his diagnosis of chronic liver disease, as this was not described in his recent medical notes, or taken into consideration the potential impact of this on his response to opiate drugs. However the death certificate, not signed by [Code A] records liver failure as a contributory cause suggesting [Code A] was aware of this diagnosis.
12. The nursing notes suggested he had had symptomatic improvement and control of his pain with the previous prn doses of morphine (20mg received over the 12 hour period) without any obvious problems. Although a more cautious and appropriate response would have been to increase his opiate dose to 40mg oral morphine over 24 hours, the prescription of regular oramorphine at the doses prescribed (60 mg/24hr) after he had experienced pain control from prn doses of morphine, was not in my view unreasonable if Patient H was carefully monitored for adverse effects of opioids.
13. On 16 October there was a clear deterioration after Patient H had received three 10mg doses and a 20mg night-time dose (total 50mg) of morphine. [Code A] who assessed [Code A] [Code A] appears not to have considered that the deterioration in conscious level could have been secondary to the oral morphine he had received and nursing staff administered further doses of oral morphine at 0600h, 1000h and 1400h on 16 October. It would have been appropriate for [Code A] to discuss Patient H's deterioration with a senior colleague.
14. Later that afternoon on 16 October, [Code A] prescribed diamorphine by subcutaneous infusion to a syringe driver with a dose range of 20-200mg with midazolam in the dose range of 20-80mg and hyoscine in the dose range of 200-800ug per 24 hours. There is no evidence in the medical records that [Code A] examined Patient H at this stage. [Code A] was presumably informed of Patient H's deterioration and did not appear to have considered that the oral morphine he had received was the likely cause of the deterioration due to both its depressive effects on conscious level and ability to precipitate a hepatic encephalopathy in patients with chronic liver disease.
15. At this stage as Patient H was unresponsive it is likely he was unable to take oral medication and this may explain the decision of [Code A] to prescribe opioids and other drugs by subcutaneous route. However, the lack of medical assessment and failure to consider that Patient H's deterioration was secondary to the morphine he had received was not consistent with good medical practice. If [Code A] was uncertain as to the cause of Patient H's deterioration she should have discussed this with the responsible medical consultant.
16. The prescription of diamorphine and midazolam was inappropriate and not justified by any information presented in the notes. There is no evidence at this stage that Patient H was in pain. When his conscious level deteriorated an appropriate response would have been to discontinue opiates, and assess the cause of his deterioration. I can find no evidence of any symptoms which required the prescription of the sedative midazolam, which can precipitate hepatic encephalopathy in patients with chronic liver disease. The dose range prescribed was highly inappropriate and potentially dangerous given Patient H's age, clinical condition with a depressed conscious level and presence of chronic liver disease. The subsequent escalation of diamorphine and midazolam dose on 17 October inevitably led to his further deterioration and in my view contributed to his death through depression of his conscious level and respiration. The nursing notes of 15 October 1998 record no symptoms of pain

and no justification is given for the prescribing of diamorphine and midazolam or the escalation in dose to diamorphine/ 60 mg/24 hours and 40mg midazolam 40mg/24 hours.

Summary of conclusions

17. Patient H was a frail older man with depression, alcoholic liver disease and a painful fracture of the left humerus transferred to Dryad ward for rehabilitation. Oral opioid drugs were an appropriate treatment for Patient H if his pain had been uncontrolled on mild opioid drugs and paracetamol but this combination was not first prescribed. [Code A] failed to undertake or record an adequate clinical assessment of Patient H when he was admitted to Dryad ward or adequately assess his subsequent deterioration. The prescription by [Code A] of subcutaneous diamorphine and midazolam infusions was not justified and the dose ranges used were inappropriately wide. The subsequent increase in diamorphine and midazolam doses that were infused were not justified. In my opinion the doses of diamorphine and midazolam received by Patient H led to his subsequent deterioration and most likely led to Patient H's death through producing respiratory depression.
18. In my opinion [Code A] in her care of Patient H failed to meet the requirements of good medical practice:
- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to consult colleagues;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.

Declaration

19. I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.
20. I have read and understood the Civil Procedure Rules Part 35 –Experts and Assessors.

Code A

General Information

Surname <u>WILSON</u>	Date of Birth		
Forenames <u>ROBERT</u>	Day	Month	Year
Likes to be known as	<u>8</u>	<u>3</u>	<u>23</u>
Address <u>5 ADDISON ROAD</u>	Religion		
<u>SARISBURY GREEN</u>	Ethnic Origin		
<u>01489 583816</u>	Allergies		
Tel No:	Post code		

Next of Kin		Carer/Contact/Confidante	
Surname <u>WILSON</u>	Forenames <u>GILLIAN</u>	Surname	Forenames
Address <u>S/A</u>	Relationship <u>WIFE</u>	Address <u>S/A</u>	Relationship <u>WIFE</u>
Post code	Tel Nos: Home <u>01489 583816</u>	Post code	Tel Nos: Home
Relationship	Work	Post code	Work

Useful Information

Hospital Information		Community Information	
Hospital: <u>GNHH</u>	Tel No:	District Nurse:	Tel No:
Hospital No: <u>Q519459</u>	Named nurse: <u>SHIRLEY HALLMAN</u>	G.P.: <u>DR DURRANT</u>	Tel No:
Ward: <u>DRYAD</u>	Ward: <u>DRYAD</u>	Bank Holiday	Tel No:
Consultant: <u>DR LORD</u>	Weekends:	Weekends:	Tel No:
Manager: <u>GILL HAMBLIN</u>	Consultant: <u>DR LORD</u>	Twilight Nurse:	Tel No:
Tel No:	Manager: <u>GILL HAMBLIN</u>	Twilight Nurse:	Tel No:
Patient code		Manager:	
Tel No:		Tel No:	
Patient code			
Code			

Code A

Code A

Code A

General Medical Council and Code A
Report on Code A (Patient I)

Code A
Consultant Physician

21 April 2009

General Medical Council and Code A
Report on Patient I

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient I, commenting on the care and treatment carried out by Code A in relation to this patient to assist the GMC Panel in determining whether Code A has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegation presented to the Fitness to Practice Panel that the assessment of Patient I on admission was inadequate and not in her best interests, that the prescriptions of midazolam and diamorphine were in too wide a dose range and created a situation whereby drugs could be administered to Patient I that were excessive to her needs, and that actions in prescribing these drugs were inappropriate and potentially hazardous; and that the prescription of 80mg of diamorphine and 20mg of midazolam over 24 hours was excessive to Patient I's needs and was inappropriate, potentially hazardous and not in her best interests.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents: medical records of Patient I; witness statements of Code A; Code A statement made by Code A in relation to Patient I; interview of Code A dated 15 September 2005.
5. Course of events
- 5.1 Patient I was 92 years of age when she was admitted to Royal Hospital Haslar on 19 March 1999 following a fall, was transferred to Dryad Ward, Gosport War Memorial Hospital on 20 March 1999. Patient I died on Dryad Ward, Gosport War Memorial Hospital on Code A. Code A Prior to her admission on 19 March the admission notes to the orthopaedic service at Royal Hospital Haslar state *"lives alone, self caring, independent"* (page 356). There were no significant problems in her past medical history. A letter by Code A Physician in Geriatrics on 26 March states *"Before her fall, Patient I had been very active and had been in good health"* (page 464).
- 5.2 The orthopaedic medical notes record Patient I had sustained a right sub-trochanteric femur fracture (page 356) which had occurred after she had been pulled over by her dog and landed on her right hip. The notes record she underwent an anaesthetic pre-operative assessment on 20 March at 1200 hours (page 358) and was given Voltarol (diclofenac) 15mg

and paracetamol 1gm for analgesia. A further entry at 1400 hours (page 359) indicates she had been given intravenous fluids, cyclizine 50mg and morphine 2mg IV. Following the 2mg morphine she had had hallucinations and the notes by an SHO anaesthetist state "nil further opiates".

- 5.3 She underwent surgery under spinal anaesthesia on 20 March 1999 with insertion of a right dynamic hip screw. An entry by an SHO post-operative review on 20 March 1999 at 2130 hours (page 359) notes "oozing from the wound with swelling of the right thigh." The impression was of a potential bleeding vessel in the wound with risk of a compartment syndrome and hypovolaemia developing. She was monitored and received a blood transfusion. On 21 March 1999 at 2300h (page 371) the notes record a review by [Code A] records "R hip painful +++ no ooze but thigh enlarged. Possible bleed into thigh but no evidence of hypovolaemia. Monitor".
- 5.4 On 22 March the notes record a ward round and comment that she has poor oral fluid intake and required her haemoglobin to be checked. Her haemoglobin was 11.1 when checked. The next entry in the medical notes 24 March notes "her skin is very thin and fragile on the lower legs" and that Patient I would benefit from assessment by [Code A] with a view to rehabilitation. The referral to [Code A] notes that she was transfused with 3 units of blood but was otherwise making an unremarkable post-operative recovery (page 373). The referral letter stated "was proving difficult to mobilise her and that the skin on her legs was at risk of breaking down". The referral states [Code A] would appreciate advice regarding her rehabilitation and consideration for a place at Gosport War Memorial Hospital (page 374).
- 5.5 An entry in the notes by [Code A] in Elderly Medicine is dated 23 March states "a delightful 92 year old lady, previously well, with sub-trochanteric fracture right femur. She is still in a lot of pain which is the main barrier to mobilisation at present. Could her analgesia be reviewed? I'd be happy to take her to GWMH provided you are satisfied that orthopaedically all is well with the right hip. Please let me know."
- 5.6 The drug charts (pages 326-331) at Royal Hospital Haslar indicate Patient I had received 2mg of morphine intravenously on 20 March, diclofenac 50mg once only on 19 March, paracetamol 1g seven doses between 19-25 March, and three doses of 5mg morphine on 20 March and on two doses of 5mg morphine on 21 March. I can find no record of other analgesia being administered during her admission at Royal Hospital Haslar.
- 5.7 A transfer letter (undated) (page 23) indicates that at a time prior transfer to Dryad Ward, Patient I was mobile, walking short distances with a zimmer frame, that she required the assistance of two nurses to transfer from bed to chair, that she was continent during the day but incontinent at night. Her only medication on transfer was paracetamol. On 26 March Patient I was transferred to Dryad Ward, Gosport War Memorial Hospital. An entry by [Code A] (page 27) states "transfer to Dryad Ward HPC fracture neck of femur right 19.3.1999. PMH nil of significance, Barthel, no weight bearing, tissue paper skin, not continent, plan sort out analgesia."
- 5.8 The next entry in the medical notes is dated 7 April by [Code A] and states "still in a lot of pain and very apprehensive. MST increased to 20mg bd yesterday. Try adding flupenthixol jar x-ray right hip as movement still quite painful also about 2 inch shortening right leg". The next entry following this is dated 12 April again by [Code A] and states "now v drowsy (since diamorphine infusion established) reduced to 40mg/24 hours. If pain recurs increase to

50mg. Able to move legs without pain but patient not rousable." The final entry in the medical notes is [Code A] at 0115 hours stating the patient died peacefully and death had been confirmed by nursing staff.

- 5.9 The nursing notes relating to admission to Dryad Ward note on 20 March that Patient I required assistance to settle for the night (page 89) and that she had pain in her hips (page 91). The nursing care plan (page 95) states "..... is experiencing a lot of pain on movement". On 27 March state "is having regular oramorph but still in pain". On 28 March "has been vomiting with oramorph, advised by [Code A] to stop oramorph. is now having metoclopramide tds and co-dydramol. Vomited this afternoon after using commode". An entry in the nursing notes dated 29 March (page 97) states "please review pain relief this morning". The next entry on 31 March states "now commence on 10mg MST bd. Walked with physiotherapist this am but in a lot of pain". A further entry on 3 April states "MST 10mg bd continued. Still continues to complain of pain on movement". On 8 April "MST increased to 20mg bd".
- 5.10 The nursing summary relating to Patient I's admission to Dryad Ward states on 26 March 1999 (page 132) "admitted to Dryad Ward for rehabilitation and gentle mobilisation. In Hastar she was mobile with a zimmer frame and two nurses for short distances and apparently transferring satisfactorily. However, transfer has been difficult here since admission. She has complained a lot of pain for which she is receiving oramorph regularly now, with effect". An entry on 6 April 1999 states "seen by [Code A] MST increased to 20mg. [Code A] has visited. If necessary once [Code A] is discharged home (as she is adamant about not going to a nursing home) he will employ someone to live in".
- 5.11 An entry on 11 April (page 134) states "[Code A] telephoned at 1910 hours as [Code A]'s condition has deteriorated during this afternoon. She is very drowsy, unrousable at times and refusing food and drink and asking to be left alone. Asked about her pain, [Code A] denies pain when left alone but complaining when moved at all. Syringe driver possibility discussed with nephew who is anxious that be kept as comfortable as possible. Seen by [Code A] to commence syringe driver". An entry on 12 April (page 136) states "seen by [Code A] Diamorphine to be reduced to 40mg over 24 hours. If pain recurs the dose can be gradually increased as and when necessary".
6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Pages 157-179. All prescriptions written by [Code A] unless otherwise marked.

As required prescriptions

Oramorph 10mg/5ml sc 2.5-5mg	31 Mar	2.5mg
Prescribed 26 March	11 Apr	2.5mg

Regular prescriptions

Oramorph 10mg/5ml, 2.5mg four x day	26 Mar	3 doses received
	27 Mar	1 dose 0600h then discontinued
Oramorph 10mg/5ml, 5mg nocte	26 Mar	1 dose then discontinued
Oramorph 10mg/5mls, 5mg four x day	27 Mar	2 doses received 1800h dose not administered
	28 Mar	2 doses received then discontinued
Oramorph 10mg/5mls, 10mg nocte	27 Mar	1 dose

	28 Mar	not administered
Codydramol 2 tablets 4 x day Prescribed 27 March 1999	28 Mar – 31 Mar	
Metoclopramide 10mg tds Prescription date unclear pp [Code A] and then counter-signed by [Code A]	28 Mar	2 doses
	29-30 Mar	3 doses per day
	31 Mar	1 dose
	1-6 Apr	None administered
	7/8 Apr	2 doses
	9-11 Apr	3 doses per day
Morphine MST 10mg bd Prescribed 31 Mar	6 Apr	1 dose received then discontinued
Morphine MST 20mg bd Prescribed 6 Apr	6 Apr	1 dose administered
	7-11 Apr	2 doses daily
Diamorphine sc via syringe driver 20-200mg /24 hr Prescribed 12 Apr	12 Apr	80mg / 24hr 0800h
Hyoscine subcut via syringe driver 200-800 ucg/24hr Prescribed 12 Apr. Marked PRN		Not administered
Midazolam subcut via syringe driver 20-80mg/24hr Prescribed 12 Apr	12 Apr	80mg/24hr 0900h
Cyclizine sc via syringe driver 50-7600mg (unclear) per 24 hours Prescribed 12 Apr. Marked PRN		Not administered
Ciprofloxacin 100mg bd	7-11 Apr	
Metronidazole 400mg bd	7-11 Apr	
Lactulose 10mls bd	28 Mar-11 Apr	
Senna 2 tablets once daily	29 Mar-10 Apr	2 tablets
	11/12 April	Not administered

Opinion on Patient Management

7. Patient 1 was an elderly independent lady with no active medical problems prior to admission with a hip fracture. This was repaired surgically on 19 March and over the following seven days she made slow progress with mobilisation but was walking with a zimmer frame prior to her transfer. She was referred to the Geriatrics Team for further rehabilitation and following assessment by [Code A] transferred to Dryad Ward on 26 March.
8. The medical assessment by [Code A] on 26 March following admission to Dryad Ward is very limited. It describes her having a fractured neck of femur and no significant past

medical history. There is no record of a physical examination. There is no record of her having any pain although there is a comment that she is not weight bearing. As the transfer letter from Royal Hospital Haslar had indicated she was mobilising this would suggest there had been a change in her mobility and functional and a physical examination particularly of the right hip was indicated. There should have been an assessment of whether the right hip was causing any pain at this stage. There is no record of the drug she is taking at this stage but there is a comment "*sort out analgesia*" which I would take to indicate [Code A] considered she had pain which was not controlled. The nursing notes record on a number of occasions that Patient I had hip pain.

9. [Code A] prescribed oramorphine on an as required basis on 26 March 1999 but no regular analgesia until the 27 March when codydramol (dihydrocodeine and paracetamol) was prescribed. This was signed as a pp signature suggesting this was commenced as a telephone order and subsequently counter-signed by [Code A]. I would consider the prescription of codydramol was appropriate as an initial analgesic. Initially prescribing a regular combination of paracetamol and mild opioid drugs would have been appropriate before prescribing oramorphine. If pain was uncontrolled on the codydramol which appears to have been the case, the subsequent regular prescription of regular morphine (initially as oral morphine and then as sustained release preparation morphine MST) was reasonable and appropriate. However, there are no medical notes from [Code A] which record her assessment or reasons for prescribing the drugs she did during this period. In this respect I would consider the medical notes are inadequate and [Code A] failed to maintain adequate medical records as the doctor responsible for the day to day care of Patient I.
10. As Patient I's pain was not controlled on either mild or regular prescriptions of morphine there should have been re-examination of her hip to ascertain the cause of the hip pain and an x-ray of the hip should have been arranged to determine whether there was any mechanical problem with the dynamic hip screw which might account for the pain. It would not be usual for a patient to have severe pain at this stage following a hip fracture if there was no mechanical or other complication.
11. On 6 April [Code A] increased the dose of morphine (MST) to 20mg twice daily after [Code A] records this and suggested adding flupenthixol but I can find no record that this was prescribed. However as the main problem appeared to be pain I think it was appropriate to first increase her analgesia. His assessment suggested there may have been a problem with the right hip dynamic hip screw as the right leg was 2 inches shorter and he requested an x-ray of the right hip be arranged. I can find no record of this x-ray of the right hip being requested by [Code A] or any reason why it was not requested. I would consider the failure to arrange an x-ray of the hip when this had been recommended by [Code A] was a failure of [Code A] to provide and arrange a necessary investigation for Patient I.
12. On 11 April Patient I became very drowsy. This is likely to have been due to the increased dose of oral morphine (40mg daily) that she was receiving. The nursing notes indicate she was not in pain when left alone but complained of pain when moved. I consider the prescription of diamorphine in the dose range 20-200mg/24 hr was inappropriate and reckless. The 40mg oral morphine Patient I was receiving every 24 hr would be equivalent to approximately 15-20 mg diamorphine administered by subcutaneous infusion over 24 hours. Patient I was already drowsy so increasing the opioid dose would have been expected to produce further depression in her conscious level. However as she was still in pain when being moved it would have been reasonable to consider an increase of 50% in the dose and monitor Patient I closely. An appropriate dose of diamorphine to prescribe over 24

hours would therefore have been 20-30mg/24hr. The prescription of 20-200mg was dangerous because if a dose greater than 30mg/24 hr was administered it was highly likely to produce coma and respiratory depression. In the event an infusion was commenced at 80mg/24hr four times greater than the equivalent dose received orally in the previous 24 hours.

13. In my opinion the additional prescription of midazolam 20-80mg/24hr was also reckless and inappropriate. No justification was given in the medical notes by [Code A] for the prescription of midazolam. The 20mg/24hr midazolam infusion further contributed to respiratory depression and depressed conscious level. I consider the diamorphine and midazolam infusions directly contributed to Patient I's death on [Code A]. The reduction in dose by [Code A] on 12 March was not sufficient to prevent the toxicity of these drugs and it would have been more appropriate to temporarily discontinue both the diamorphine and midazolam infusions

Summary of Conclusions

14. Patient I was an elderly independent lady who sustained a fractured hip who underwent surgery and was referred for rehabilitation. Patient I experienced persistent pain in the right hip after transfer to Dryad Ward, Gosport War Memorial Hospital. Good medical practice required appropriate investigation to determine the cause of the hip pain and the administration and monitoring of analgesia. There was inadequate investigation of patient I's hip pain. Specifically there is no record of an adequate examination of the hip by [Code A] as the doctor responsible for her day to day care, and an X-ray of the right hip was not obtained. In my opinion the prescriptions of diamorphine and midazolam by [Code A] were dangerous and reckless and the administration of these drugs by subcutaneous infusion at the doses used led to depression of her conscious level and respiration and most likely contributed to her death.
15. In my opinion, [Code A] in her care of Patient I failed to meet the requirements of good medical practice to:
- provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
 - keep clear accurate contemporaneous patient records to support the relevant clinical findings, decisions made, information given to patients and any drugs or other treatments prescribed
 - prescribe only the treatment drugs or appliances that serve the patient's needs.
16. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
[Code A]

GMC and [Code A]
Report on [Code A]

[Code A]
Consultant Physician

5 April 2009

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of [Code A], commenting on the care and treatment carried out by [Code A] in relation to this patient to assist the GMC Panel in determining whether [Code A] has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegation presented to the Fitness to Practice Panel that the assessment of [Code A] on admission was inadequate and not in her best interests, that the prescriptions of midazolam and diamorphine were in too wide a dose range and created a situation whereby drugs could be administered to [Code A] that were excessive to her needs, and that actions in prescribing these drugs were inappropriate and potentially hazardous; and that the prescription of 80mg of diamorphine and 20mg of midazolam over 24 hours was excessive to [Code A]'s needs and was inappropriate, potentially hazardous and not in her best interests.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of [Code A] [Code A] witness statements of [Code A] [Code A] statement made by [Code A] in relation to [Code A] [Code A] interview of [Code A] dated 15 September 2005.

5. Course of events

- 5.1 [Code A] was 92 years of age when she was admitted to Royal Hospital Haslar on 19 March 1999 following a fall, was transferred to Dryad Ward, Gosport War Memorial Hospital on 20 March 1999. [Code A] died on Dryad Ward, Gosport War Memorial Hospital on [Code A] [Code A]. Prior to her admission on 19 March 1999 the admission notes to the orthopaedic service at Royal Hospital Haslar state "*lives alone, self caring, independent*" (page 356). There were no significant problems in her past medical history. A letter by [Code A]

Consultant Physician in Geriatrics on 26 March 1999 states *"Before her fall, [Code A] had been very active and had been in good health"* (page 464).

- 5.2 The orthopaedic medical notes record [Code A] had sustained a right sub-trochanteric femur fracture (page 356) which had occurred after she had been pulled over by her dog and landed on her right hip. The notes record she underwent an anaesthetic pre-operative assessment on 20 March 1999 at 1200 hours (page 358) and was given Voltarol (diclofenac) 15mg and paracetamol 1gm for analgesia. A further entry at 1400 hours (page 359) indicates she had been given intravenous fluids, cyclizine 50mg and morphine 2mg IV. Following the 2mg morphine she had had hallucinations and the notes by an SHO anaesthetist state *"nil further opiates"*.
- 5.3 She underwent surgery under spinal anaesthesia on 20 March 1999 with insertion of a right dynamic hip screw. An entry by an SHO post-operative review on 20 March 1999 at 2130 hours (page 359) notes *"oozing from the wound with swelling of the right thigh."* The impression was of a potential bleeding vessel in the wound with risk of a compartment syndrome and hypovolaemia developing. She was monitored and received a blood transfusion. On 21 March 1999 at 2300h (page 371) the notes record a review by [Code A] records *"R hip painful +++ no ooze but thigh enlarged. Possible bleed into thigh but no evidence of hypovolaemia. Monitor"*.
- 5.4 On 22 March 1999 the notes record a ward round and comment that she has poor oral fluid intake and required her haemoglobin to be checked. Her haemoglobin was 11.1 when checked. The next entry in the medical notes 24 March 1999 notes *"her skin is very thin and fragile on the lower legs"* and that [Code A] would benefit from assessment by [Code A] with a view to rehabilitation. The referral to [Code A] notes that she was transfused with 3 units of blood but was otherwise making an unremarkable post-operative recovery (page 373). The referral letter stated *"was proving difficult to mobilise her and that the skin on her legs was at risk of breaking down"*. The referral states [Code A] would appreciate advice regarding her rehabilitation and consideration for a place at Gosport War Memorial Hospital (page 374). An entry in the notes by [Code A] in Elderly Medicine is dated 23 March 1999 states *"a delightful 92 year old lady, previously well, with sub-trochanteric fracture right femur. She is still in a lot of pain which is the main barrier to mobilisation at present. Could her analgesia be reviewed? I'd be happy to take her to GWMH provided you are satisfied that orthopaedically all is well with the right hip. Please let me know."*
- 5.5 The drug charts (pages 326-331) at Royal Hospital Haslar indicate [Code A] had received 2mg of morphine intravenously on 20 March 1999. Diclofenac 50mg once only on 19 March. Paracetamol 1g, seven doses, between 19-25 March and three doses of morphine 5mg on 20 March and on two occasions on 21 March 1999. I can find no record of other analgesia being administered during her admission at Royal Hospital Haslar.
- 5.6 A transfer letter (undated) (page 23) indicates that at a time prior transfer to Dryad Ward, [Code A] was mobile, walking short distances with a zimmer frame, that she required the assistance of two nurses to transfer from bed to chair, that she was continent during the day but incontinent at night. Her only medication on transfer was paracetamol. On 26 March 1999 [Code A] was transferred to Dryad Ward, Gosport War Memorial Hospital. An entry by [Code A] (page 27) states *"transfer to Dryad Ward HPC fracture neck of femur right 19.3.1999. PMH nil of significance, Barthel, no weight bearing, tissue paper skin, not continent, plan sort out analgesia."*

- 5.7 The next entry in the medical notes is dated 7 April 1999 by [Code A] and states *"still in a lot of pain and very apprehensive. MST increased to 20mg bd yesterday. Try adding flupenthixol for x-ray right hip as movement still quite painful also about 2 inch shortening right leg"*. The next entry following this is dated 12 April 1999 again by [Code A] and states *"now v drowsy (since diamorphine infusion established) reduced to 40mg/24 hours. If pain recurs increase to 60mg. Able to move legs without pain but patient not rousable."* The final entry in the medical notes is [Code A] at 0115 hours stating the patient died peacefully and death had been confirmed by nursing staff.
- 5.8 The nursing notes relating to admission to Dryad Ward note on 20 March that [Code A] required assistance to settle for the night (page 89) and that she had pain in her hips (page 91). The nursing care plan (page 95) states [Code A] *"is experiencing a lot of pain on movement"*. On 27 March state *"is having regular oramorph but still in pain"*. On 28 March *"has been vomiting with oramorph, advised by [Code A] to stop oramorph. Is now having metoclopramide tds and co-dydramol. Vomited this afternoon after using commode"*. An entry in the nursing notes dated 29 March 1999 (page 97) states *"please review pain relief this morning"*. The next entry on 31 March 1999 states *"now commence on 10mg MST bd. Walked with physiotherapist this am but in a lot of pain"*. A further entry on 3 April 1999 states *"MST 10mg bd continued. Still continues to complain of pain on movement"*. On 8 April 1999 *"MST increased to 20mg bd"*.
- 5.9 The nursing summary relating to [Code A]s admission to Dryad Ward states on 26 March 1999 (page 132) *"admitted to Dryad Ward for rehabilitation and gentle mobilisation. In Haslar she was mobile with a zimmer frame and two nurses for short distances and apparently transferring satisfactorily. However, transfer has been difficult here since admission. She has complained a lot of pain for which she is receiving oramorph regularly now, with effect"*. An entry on 6 April 1999 states *"seen by [Code A] MST increased to 20mg. [Code A] has visited. If necessary once [Code A] is discharged home (as she is adamant about not going to a nursing home) he will employ someone to live in"*.
- 5.10 An entry on 11 April 1999 (page 134) states [Code A] *"telephoned at 1910 hours as [Code A]s condition has deteriorated during this afternoon. She is very drowsy, unrousable at times and refusing food and drink and asking to be left alone. Asked about her pain, [Code A] denies pain when left alone but complaining when moved at all. Syringe driver possibility discussed with nephew who is anxious that [Code A] be kept as comfortable as possible. Seen by [Code A] to commence syringe driver"*. An entry on 12 April 1999 (page 136) states *"seen by [Code A] Diamorphine to be reduced to 40mg over 24 hours. If pain recurs the dose can be gradually increased as and when necessary"*.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Pages 157-179. All prescriptions written by [Code A] unless otherwise marked.

As required prescriptions

Oramorph 10mg/5ml sc 2.5-5mg	31 March 1999	2.5mg
prescribed 26 March 1999	11 April 1999	2.5mg

Regular prescriptions

Oramorph 10mg/5ml, 2.5mg four x day	26 March 1999	3 doses received
	27 March 1999	1 dose 0600 then discontinued

Oramorph 10mg/5ml, 5mg nocte	26 March 1999	1 dose then discontinued
Oramorph 10mg/5mls, 5mg four x day	27 March	2 doses received 1800 dose not administered
	28 March	2 doses received then discontinued
Oramorph 10mg/5mls, 10mg nocte	27 March	1 dose
	28 March	not administered
Co-dydramol 2 tablets 4 x day Prescribed 27 March 1999	28 March – 31 March	
Metoclopramide 10mg tds	28 March	2 doses
Prescription date unclear	29-30 March	3 doses per day
pp [Code A] and then	31 March	1 dose
counter-signed by [Code A]	1-6 April	None administered
	7/8 April	2 doses
	9-11 April	3 doses per day
Morphine MST 10mg bd Prescribed 31 March	6 April	1 dose received then discontinued
Morphine MST 20mg bd Prescribed 6 April	6 April	1 dose administered
	7 – 11 April	2 doses daily
Diamorphine sc via syringe driver 20-200mg / 24 hours Prescribed 12 April 1999	12 April 80mg / 24 hours 0800 hours	
Hyoscine sc via syringe driver 200-800 ug / 24 hours Prescribed 12 April 1999. Marked PRN	Not administered	
Midazolam sc via syringe driver 20-80mg per 24 hours Prescribed 12 April 1999	12 April 30mg/24 hrs 0900h	
Cyclizine sc via syringe driver 50-?600mg (unclear) per 24 hours Prescribed 12 April. Marked PRN	Not administered	
Ciprofloxacin 100mg bd	7 – 11 April	
Metronidazole 400mg bd	7 – 11 April	
Lactulose 10mls bd	26 March – 11 April	
Senna 2 tablets once daily	29 March – 10 April 2 tablets	
	11/12 April	Not administered

Opinion on Patient Management

Management prior to admission to Dryad ward.

7. [Code A] was an elderly independent lady with no active medical problems prior to admission with a hip fracture. This was repaired surgically on 19 March 1999 and over the following seven days she made slow progress with mobilisation but was walking with a zimmer frame prior to her transfer. She was referred to the Geriatrics Team for further rehabilitation and following assessment by [Code A] transferred to Dryad Ward on 26 March 1999.

Management following admission to Dryad ward.

8. The medical assessment by [Code A] on 26 March 1999 following admission to Dryad Ward is very limited. It describes her having a fractured neck of femur and no significant past medical history. There is no record of a physical examination. There is no record of her having any pain although there is a comment that she is not weight bearing. As the transfer letter from Royal Hospital Haslar had indicated she was mobilising this would suggest there had been a change in her mobility and functional and a physical examination particularly of the right hip was indicated. There should have been an assessment of whether the right hip was causing any pain at this stage. There is no record of the drug she is taking at this stage but there is a comment "sort out analgesia" which I would take to indicate [Code A] considered she had pain which was not controlled. The nursing notes record on a number of occasions that [Code A] had hip pain.
9. [Code A] prescribed oromorphine on an as required basis on 26 March 1999 but no regular analgesia until the 27 March 1999 when co-dydramol (dihydrocodeine and paracetamol) was prescribed. This was signed as a pp signature suggesting this was commenced as a telephone order and subsequently counter-signed by [Code A] I would consider the prescription of co-dydramol was appropriate as an initial analgesic. Initially prescribing a regular combination of paracetamol and mild opioid drugs would have been appropriate before prescribing oramorphine. If pain was uncontrolled on the co-dydramol which appears to have been the case, the subsequent regular prescription of regular morphine (initially as oral morphine and then as sustained release preparation morphine MST) was reasonable and appropriate. However, there are no medical notes from [Code A] which record her assessment or reasons for prescribing the drugs she did during this period. In this respect I would consider the medical notes are inadequate and [Code A] failed to maintain adequate medical records as the doctor responsible for the day to day care of [Code A]
10. As [Code A]'s pain was not controlled on either mild or regular prescriptions of morphine there should have been re-examination of her hip to ascertain the cause of the hip pain and an x-ray of the hip should have been arranged to determine whether there was any mechanical problem with the dynamic hip screw which might account for the pain. It would not be usual for a patient to have severe pain at this stage following a hip fracture if there was no mechanical or other complication.
11. On 6 April 1999 [Code A] increased the dose of morphine (MST) to 20mg twice daily after [Code A] records this and suggested adding flupenthixol but I can find no record that this was prescribed. However as the main problem appeared to be pain I think it was appropriate to first increase her analgesia. His assessment suggested there may have been a problem with the right hip dynamic hip screw as the right leg was 2 inches shorter and he requested an x-ray of the right hip be arranged. I can find no record of this x-ray of the right hip being requested by [Code A] or any reason why it was not requested. I would consider the failure to arrange an x-ray of the hip when this had been recommended by [Code A] was a failure of [Code A] to provide and arrange a necessary investigation for [Code A]

12. On 11 April 1999 [Code A] became very drowsy. This is likely to have been due to the increased dose of oral morphine (40mg daily) that she was receiving. The nursing notes indicate she was not in pain when left alone but complained of pain when moved. I consider the prescription of diamorphine in the dose range 20-200mg/24 hr was inappropriate and reckless. The 40mg oral morphine [Code A] was receiving every 24 hr would be equivalent to approximately 15 mg diamorphine administered by subcutaneous infusion over 24 hours. [Code A] as already drowsy so increasing the opioid dose would have been expected to produce further depression in her conscious level. However as she was still in pain when being moved it would have been reasonable to consider an increase of 50% in the dose and monitor [Code A] closely. An appropriate dose of diamorphine to prescribe over 24 hours would therefore have been around 20mg. The prescription of 20-200mg was dangerous because if a dose greater than 20mg/24 hr was administered it was highly likely to produce coma and respiratory depression. In the event an infusion was commenced at 8mg/24 hr give times greater than the equivalent dose received orally in the previous 24 hours.
13. The additional prescription of Midazolam 20-80mg/24 hr was also reckless and inappropriate. No justification was given in the medical notes by [Code A] for the prescription of Midazolam. The 20mg/24hr Midazolam infusion further contributed to respiratory depression and depressed conscious level. I consider the diamorphine and midazolam infusions directly contributed to [Code A]'s death on [Code A]. The reduction in dose by [Code A] on 12 March 1999 was not sufficient to prevent the toxicity of these drugs and it would have been more appropriate to temporarily discontinue both the diamorphine and midazolam infusions

Summary of Conclusions

14. [Code A] was an elderly independent lady who sustained a fractured hip who underwent surgery and was referred for rehabilitation. [Code A] experienced persistent pain in the Right hip after transfer to Dryad Ward, Gosport War Memorial Hospital. Good medical practice required appropriate investigation to determine the cause of the hip pain and the administration and monitoring of analgesia. There was inadequate investigation of [Code A]'s hip pain. Specifically there is no record of an adequate examination of the hip by [Code A] as the doctor responsible for her day to day care, and an Xray of the Right hip was not obtained. In my opinion the prescriptions of diamorphine and midazolam by [Code A] were dangerous and reckless and the administration of these drugs by subcutaneous infusion at the doses used led to depression of her conscious level and respiration and most likely contributed to her death.
15. In my opinion, [Code A] in her care of [Code A] failed to meet the requirements of good medical practice to:
- provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - keep clear accurate contemporaneous patient records to support the relevant clinical findings, decisions made, information given to patients and any drugs or other treatments prescribed;
 - prescribe only the treatment drugs or appliances that serve the patient's needs.

Declaration

J. M. M. M.

General Medical Council and Code A
Report on Code A **(Patient J)**

Code A
Consultant Physician

21 April 2009

General Medical Council and Code A
Report on Patient J

1. This report is provided at the instruction of Field Fisher Waterhouse solicitors. I have been asked to prepare a report on the medical care of the above patient and comment upon the care and treatment carried out by Code A in relation to patient J to assist the GMC panel in determining whether Code A has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the panel that: the verbal prescribing of diamorphine, prescriptions of diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interest of patient J; that the failure to obtain medical advice and/or undertake further investigation on 26 August was inappropriate and not in the best interests of Patient J.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. Documents reviewed this report is based on my review of the following documents: medical records of patient J, statements of Code A
Code A statement made by Code A in relation to patient J, interview of Code A dated 17 November 2005, interview of Code A dated 6 April 2006.
5. Course of Events

- 5.1 Patient J was 67 years old when admitted to Dryad Ward on 23 August 1999. In July 1999 he was seen at the out-patient clinic of Code A Consultant Dermatologist (describe him having bilateral severe leg oedema (swelling) secondary to venous hypertension and secondary skin problems (p30). His wife describes him as having being overweight for many years and his legs being a 'constant problem to him' because of weeping fluid (p2 BP1).
- 5.2 On 6 August he had a fall at home and was admitted to the Accident and Emergency department by his general practitioner (p43). The notes in A&E indicate problems of bilateral leg oedema, obesity and not coping. He was admitted to Anne Ward which I assume was a general medical ward.
- 5.3 The admission clerking on 6 August by a Senior House Officer describes the primary problem as decreased mobility (p44) with problems of obesity and bilateral lower

leg oedema with ulcers and erythema (redness) in the groin. Other medical problems listed were hypertension and arthritis. Drug therapy on admission was doxazosin, bendrofluzide and felodipine (all blood pressure lowering drugs). On examination there was a slight temperature, pulse was 80 irregular, BP was 128/81 mm Hg, erythema was seen in both groins, bilateral swelling of both legs. The left lower leg was noted to be swollen and erythematous. The examination notes nursing staff had reported blistering on buttocks. Problems were considered to be: bilateral leg oedema, cellulitis of the groin and left lower leg, decreased mobility due to obesity/oedema/infection and atrial fibrillation.

- 5.4 A number of investigations were performed at this stage. An ECG confirmed the presence of atrial fibrillation (irregular heart beat). A Chest X-ray, blood tests and swabs from the groin and leg ulcers were obtained. Blood tests showed a normal haemoglobin (Hb 15.7 g/dl) and an elevated white cell count 25.7 consistent with a bacterial skin infection in the groin and legs. Intravenous antibiotics were commenced to treat infection and diuretics were changed from bendrofluzide to frusemide.
- 5.5 Patient J was reviewed later the same afternoon by a Registrar, [Code A] who agreed with the diagnoses and suggested stopping felodipine and doxazosin since they could be exacerbating his oedema. He indicated an echocardiogram might be obtained to assess his cardiac function. A separate note (signature unclear) at the bottom of the page (p47) states *'In view of premorbid state and multiple medical problems not for CPR in event of arrest'*.
- 5.6 The following day 7 August, there is an entry from a different registrar (name unclear) (p48) noting that the patient has been seen by [Code A] (I would assume this was the responsible consultant physician). The notes record he has 'morbid obesity' (the nursing notes record his weight was 148.6 Kg p108) and says Patient J reported *'walking till about a week before'*. The recorded plan was to obtain a good history from the next of kin, continue intravenous antibiotics over the weekend and considered his problems were mainly nursing. Renal impairment (creatinine 173) was also noted. There is a comment "Agree not for 555" (meaning not for attempted resuscitation).
- 5.7 On the 9 August the medical notes record the cellulitis of the left leg was improving and he should be switched to oral antibiotics. On the 11 August the notes record he was well and the cellulitis improved and physiotherapy should continue. On the 12 August a further entry states *'continue nursing care and try to mobilise'*. The felodipine was stopped to try and improve his oedema. Again a note is made *'Not for 555'*. On the 13 August the medical notes document the white cell count has fallen to 12.4 and the Hb is 13.5. Antibiotics were to continue for a total of 10 days and there is a comment to *'Transfer to Dryad ward on 16 August 1999'*. On the 16 August the notes state *'Dryad when bed available'*. On 18 August the medical notes record antibiotics were to be stopped the following day. A further entry on 18 August is by [Code A] Geriatrician, states *'P sores extensive, feed himself, not mobilising, black stool overnight - nil says bowels looser than usual, no pain. Abdomen soft, BS /, PR - normal brown stool. Check Hb R/O bleed. ? antibiotic related diarrhoea stool chart.'*

- 5.8 On 20 August the medical notes record 'no further black motion, nausea or epigastric pain, epigastric tenderness, BP 140/80 m Hg'. The full blood count was checked with no significant change in Hb at 12.9. The notes record transfer to Gosport Hospital was to take place on 23 August (p54).
- 5.9 On Monday 23 August the medical notes (doctors name unclear) record problems of obesity, arthritis bilateral knees, immobility, pressure sores and note he is on a high protein diet and '? Melasna 13/8/99 Hb stable, alb 29'. There is a further note 'MTS very good'. Clinical examination records a normal cardiovascular and respiratory systems, obese, legs slightly, chronic skin disease, ulcers dressed yesterday. Needs review later this week'. MTS is an abbreviation for Mental Test Score and the comment indicates he had no significant cognitive impairment. There is a note that Haemoglobin (Hb) and other blood tests are to be repeated on Friday.
- 5.10 On Wednesday 25 August the nursing notes (p63) record 'Passing fresh blood PR ?Cleaxane'. Verbal message from [Code A] to withhold 1500 dose and review with [Code A] mane. Lunch also vomiting -- metoclopramide 10 mg given im at 1755h. Good effect.'
- 5.11 On 26 August the nursing notes state 'Fairly good morning no further vomiting, [Code A] contacted re Cleaxane, advised to discontinue and repeat Hb today and tomorrow. Not for resuscitation. Unwell at lunchtime, colour poor, c/o feeling unwell. Seen by [Code A] this afternoon, await results of Hb, Further deterioration c/o indigestion -- pain in throat not radiating -- vomited again this evening. Verbal order from [Code A] Diamorphine 10 mg stat -- same given at 1800. Metoclopramide 10mg given im.' A blood sample was sent on 26 August. The notes include a laboratory report that the Hb was 7.7 g/dl (p210) and there is a comment on the report 'Many attempts were made to phone these results, no answer from Gosport War Memorial Hospital switchboard'. The previous Haemoglobin was 12.0 g/dl from a sample taken on 24 August and analysed on the 25 August.
- 5.12 There is an entry in the medical notes on 26 August by [Code A] which states 'Called to see. Pale, clammy, unwell. Suggests ?MI treat stat diamorph and oramorph overnight. Alternative possibility GI bleed but no haematemesis. Not well enough to transfer to acute unit, keep comfortable. I am happy for nursing staff to confirm death.' I can find no records of any pulse, BP observations in the notes at this point or at any time relating to Patient J's admission on Dryed ward. A further entry in the nursing notes on 26h August 1900 (p83) states [Code A] here. For Gramorph 4 hourly. [Code A] seen by [Code A] explained Patient Js condition and medication used.'
- 5.13 On the 27 August the nursing notes state 'Some marked improvement since yesterday'. Seen by [Code A] this am -- to continue Diamorph 4 hourly same given tolerated well. Some discomfort this afternoon -- especially when dressings being done'. The next entry in the medical notes is on 28 August from [Code A] and state 'remains poorly, but uncomfortable, please continue opiates over weekend.'
- 5.14 On 30 August the nursing notes state 'condition remains poor. Syringe driver commenced at 1445 Diamorphine 40mg, midazolam 20mg no further complaints of abdominal pain. Very small amount diet taken.'

5.15 On 1 September there is an entry from the [Code A] Geriatrician, which states 'Rather drowsy, but comfortable. Passing melena stools. Abdomen huge but quite soft. Pressure sores over buttock and across the posterior aspects of both thighs. Remains confused. For T.L.C - stop frusemide and doxazosin. [Code A] aware of poor prognosis'. Death was confirmed on [Code A] at 1350h. I understand the death certificate stated he died from myocardial infarction.

Drug therapy received at Gosport War Memorial Hospital

6. Pages 167-172. All prescriptions written by [Code A] unless otherwise marked.

Once only drugs

Diamorphine im 10mg 26 Aug 1800h
Verbal message, subsequent prescription by [Code A] date unclear

As required prescriptions

Gaviscon 10ml 25 Aug 1200h
Prescription date unclear (Doctor other than Dr Barton)

Temazepam 10-20mg 24 Aug 2210h 10mg
Prescribed 24 Aug 25 Aug 2205h 20mg

Regular prescriptions

Doxazosin 4mg od 24 Aug -31 Aug
Frusemide 80mg od 24 Aug -31 Aug
Clexane 40mg sc bd 24 Aug -25 Aug (morning dose only received 25 Aug)
Paracetamol 1 g qds 23 Aug -26 Aug
None of above 4 drugs prescribed by [Code A]

Daily review prescriptions

Metoclopramide 10 mg im 8hrly 25 Aug 1755h
Verbal order 25 Aug Dr Beasley 26 Aug 1740h

Oramorph 10mg 4hrly None administered
Prescribed 26 Aug

Oramorph 10mg/5ml (10-20mg) qds 26 Aug 20 mg nocte
Oramorph 10 mg/5ml 20mg nocte 27 Aug 4 doses administered unclear if 10 or 20 mg
Prescribed 26 Aug 20 mg nocte
28 Aug 4 doses administered unclear if 10 or 20 mg
20 mg nocte
29 Aug 4 doses administered unclear if 10 or 20 mg
20 mg nocte
30 Aug 2 doses administered unclear if 10 or 20 mg

Diamorphine sc via syringe driver 30 Aug 1445h 40mg/24hr
40-200mg/24hr 31 Aug 1545h 40mg/24hr
Prescription date not written 1 Sep 1545h 40mg/24hr
1915h increased to 60mg/24hr
2 Sep 1540h 90mg/24hr

Midazolam subcut via syringe driver	30 Aug 1445h	20 mg/24hr
20-80mg/24hr	31 Aug 1540h	20 mg/24hr
Prescription date not written	1 Sep 1545h	40 mg/24hr
	1915h	increased to 60 mg/24hr
	2 Sep 1540h	80mg/24hr
Hyoscine subcut via syringe driver	No doses administered	
800-2000ucg/24hr		
Prescribed 2 Sep		

Opinion on Patient Management

7. The initial assessment and management of patient J during his admission to Anne Ward was in my view competent. The information in the medical records suggests appropriate clinical assessments were undertaken, investigations obtained and management initiated. The main initial problem was cellulitis (skin infection) of the groin and legs in the setting of chronic leg swelling. Secondary skin infections are a common problem in patients with chronic leg oedema. He responded to antibiotics and was commenced on subcutaneous heparin (Clexane) to reduce his risk of developing a deep vein thrombosis. There was a clear plan to mobilise patient J with the intention of him then being able to return home.
8. [Code A] assessed patient J presumably at the request of the responsible medical team. She identified a possible episode of melaena (black stool due to bleeding from the gut). It is not uncommon for nursing staff to see dark stools and for it to be unclear if these are due to melaena. [Code A] examined patient J and performed a rectal examination to see if there was any evidence of bleeding from the gut. She gave clear instructions to check the haemoglobin and rule out a gastro intestinal bleed. This was done prior to his transfer to Dryad ward. I consider the management on Anne ward and [Code A]'s assessment were competent.
9. The one aspect of his management on Anne Ward that could be questioned was the decision to make patient J not for attempted resuscitation without this being discussed with him or his next of kin and without a clear statement of the level of medical intervention that was appropriate. The decision that patient J was not for attempted resuscitation appears to have influenced subsequent management decisions on Dryad ward. The decision was not necessarily inappropriate since if he had experienced a cardiac or respiratory arrest he would have been unlikely to survive this.
10. Current medical practice is for decisions about resuscitation status to be discussed with patients or their next of kin. In 1999 such decisions were not always discussed with older patients or their relatives. There is no evidence from the medical notes or relative statements that patient J expressed any wishes that he did not want any medical intervention that might prolong his life. A very important principle in the medical care of patients, particularly for older people, is that the decision not for attempted resuscitation is separate from other decisions about other medical interventions. The majority of patients where a decision has been made that attempted resuscitation should not be undertaken in cardiac or respiratory arrest occurs still receive active medical treatment including surgery, antibiotic and other medical treatments.
11. A key principle of decision making about active treatment is that that treatments should be given that serve the patients needs. Therefore unless patients express or have expressed a

wish not to receive certain treatments, these should be provided by doctors unless other barriers, such as resource limitations prevent this. In the case of patient J there are no entries in the medical records to suggest that the medical team or [Code A] intended patient J should not receive treatment that might prevent early death or further disability. [Code A] [Code A]'s assessment and investigation of patient J suggest if he had been identified to have a gastrointestinal bleed he would have received further investigation (such as gastroscopy), treatment with blood transfusion and to be considered for surgery.

12. Primary responsibility for the medical care of patient J whilst he was on Dryad ward lay with [Code A] the consultant responsible of his care. Day to day medical care was the responsibility of [Code A] as [Code A] and during out of hours period on call medical staff. Ward nursing staff were responsible for assessing, monitoring, and administering treatment to patient J and informing medical staff of any significant deterioration.
13. I consider there are many aspects of patient J's management that were of concern. Review of the medical and nursing notes indicates that patient J died from massive gastrointestinal haemorrhage most likely contributed to in part by the Clexane (enoxaparin) he received to reduce his risk of developing a deep vein thrombosis, and possibly opiate and sedative induced respiratory depression. There was no evidence to support a diagnosis of myocardial infarction (such as ECG changes, cardiac enzyme changes) which was given as the cause of his death.
14. Had patient J been readmitted to an acute hospital unit alternative actions would have been taken including blood transfusion and possibly therapeutic endoscopy (if available) or surgery and he might have survived the gastrointestinal bleed. Although his severe obesity would be expected to place him at risk of a number of complications, he was not dying or expected to die prior to his deterioration on Dryad ward on 26 August. His pressure sores were treatable and there was a reasonable possibility that he might regain limited mobility. The available evidence suggests patient J's had a reasonable quality of life and would wish to be treated. Patient J's [Code A] states that they were told patient J was to be transferred to Gosport War Memorial Hospital for recuperation and rehabilitation (p4 BP/1).
15. [Code A] as the doctor responsible for the day to day management of patient J had a responsibility to obtain, review and act upon the results of blood tests. The medical notes on 23 August indicated repeat blood tests were to be performed. The nursing notes indicate the haemoglobin result was to be reviewed by [Code A]. On 26 August [Code A] was called to see patient J as he was unwell and she had recognised that patient J might have had a gastrointestinal bleed. Had this result been obtained it would have indicated that patient J had experienced a large bleed and required blood transfusion and transfer to an acute medical unit for further care. I find the comment by [Code A] that patient J was too unwell to transfer to an acute unit difficult to understand when at no point had it been suggested that patient J was for palliative care. On the contrary it was clear he was too unwell to be safely investigated and managed at Gosport War Memorial Hospital. This decision was not appropriately made by a clinical assistant without discussion with a consultant colleague and [Code A] should have discussed patient J with a consultant Geriatrician or the on call Acute Medical Team.
16. The medical notes suggest the medical assessment of patient J by [Code A] on 26 August were in my view inadequate. The standard of note keeping falls below the expected level of documentation on a continuing care of rehabilitation ward. [Code A] describes patient J as being clammy and unwell but does not appear to have performed a physical examination of

his chest and abdomen, recorded the results of any examination and did not instruct nurses or obtain herself his pulse rate and blood pressure. She did not obtain appropriate further investigations such as an electrocardiogram and blood tests to obtain further information supporting a diagnosis of a myocardial infarct. Had she done this and discussed the results with a consultant colleague it is likely patient J would have been transferred to an acute medical unit at another hospital. [Code A]'s own provisional diagnosis of a myocardial infarct should have prompted her to discuss transferring patient J to a coronary care unit or acute medical unit so that he could be assessed and be in an appropriate environment where complications of a myocardial infarct such as cardiac arrhythmias could be monitored and treated. For these reasons I consider [Code A] failed to provide appropriate medical care to patient J.

17. The verbal message by [Code A] to administer diamorphine to patient J on 26 August before she had seen and assessed patient J was inappropriate as no medical assessment was undertaken and no clear diagnosis had been made. If the pain was considered severe enough to require diamorphine patient J should have been assessed immediately by [Code A] or another doctor to establish whether he had experienced a myocardial infarction or other serious problem.
18. The rationale for commencement of regular oral morphine is not recorded in the medical notes on 26 August by [Code A]. On the 28 August [Code A] records that patient J is uncomfortable but does not record the site of pain or justification for continuing morphine. There is no record in the medical notes explaining why diamorphine and midazolam were administered by syringe driver on 30 August or why the doses of diamorphine were increased from 40mg/24hr to 90mg/24hr and midazolam from 20mg/24hr to 80mg/24hr between 31 and 2 September.
19. The medical records contain no information indicating why patient J required midazolam as neither the medical or nursing notes record that he had symptoms of restlessness or agitation requiring administration of a sedative drug. [Code A] did not record the reasons why the diamorphine and midazolam doses were increased on the 1 and 2 September.
20. The dose ranges of diamorphine and midazolam prescribed were inappropriate and hazardous. After the commencement of diamorphine and midazolam patient J became drowsy. There are no records of his respiratory rate or detailed assessments of his conscious level but the progressive increase in diamorphine and midazolam doses after 1 September may have led to respiratory depression and contributed to his death, although his primary cause of death appears to be due to massive gastrointestinal haemorrhage. The medical records do not contain a record of an adequate medical assessment by [Code A] or record the reasons for her treatment decisions. In my opinion the prescriptions of oramorphine, diamorphine and midazolam were inappropriate and hazardous.
21. [Code A] assessed patient J on 1 September. At this stage it was clear patient J had bleeding from the gut and was drowsy. The notes suggest [Code A] did not review the full blood count results and did not consider the possibility that his drowsiness and confusion might be secondary to the diamorphine infusion. The notes suggest [Code A] did not consider transferring patient J to an acute medical unit. This was possibly because [Code A] considered Patient J would inevitably die whatever actions were taken.

Summary of Conclusions

22. Patient J was a man with severe obesity and long standing leg oedema who was admitted to hospital because of mobility problems and difficulties managing at home. He was transferred to Dryad ward for rehabilitation. Shortly after transfer he deteriorated on the 26 August 1999 and died on [Code A] from gastrointestinal bleeding and possibly diamorphine and midazolam induced respiratory depression. In my opinion the information in the medical records indicates an adequate medical assessment was not performed by [Code A] when patient J deteriorated on 26 August and the verbal order to administer diamorphine before a medical assessment was not justified. The prescriptions of diamorphine and midazolam and the reasons for increasing the doses infused were not justified by the information in the medical records.
23. In my opinion [Code A] in her care of patient J failed to meet the requirements of good medical practice to:
- Provide an adequate assessment of the patients condition based on the history and clinical findings and including where necessary an appropriate examination
 - Consult colleagues
 - Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
 - Provide or arranging necessary investigations
 - Prescribe only the treatment, drugs or appliances that serve patient's need
20. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
[Code A]

GMC and [Code A]
Report on [Code A]

[Code A]
Consultant Physician

2 April 2009

1. This report is provided at the instruction of Field Fisher Waterhouse solicitors. I have been asked to prepare a report on the medical care of the above patient and comment upon the care and treatment carried out by [Code A] in relation to [Code A] to assist the GMC panel in determining whether [Code A] has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the panel are that the prescribing of Diamporphine, Oramorphine and midazolam were inappropriate, potentially hazardous and not in the best interest of [Code A] [Code A]
2. My curriculum vitae is separately attached.
3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. Documents reviewed this report is based on my review of the following documents; medical records of [Code A], statements of [Code A] [Code A] statement made by [Code A] in relation to [Code A] Interview of [Code A] dated 17 November 2005, interview of [Code A] dated 6 April 2006.
5. **Course of Events**
 - 5.1 [Code A] was 67 years old when admitted to Dryad Ward on 23 August 1999. In July 1999 he was seen at the out-patient clinic of [Code A] Dermatologist describe him having bilateral severe leg oedema (swelling) secondary to venous hypertension and secondary skin problems (p30). [Code A] describes him as having being overweight for many years and his legs being a '*constant problem to him*' because of weeping fluid (p2 BP1).
 - 5.2 On 6 August 1999 he had a fall at home and was admitted to the Accident and Emergency department by his general practitioner (p43). The notes in A&E indicate problems of bilateral leg oedema, obesity and not coping. He was admitted to Anne Ward which I assume was a general medical ward.
 - 5.3 The admission clerking on 6 August 1999 by a Senior House Officer describes the primary problem as decreased mobility (p44) with problems of obesity and bilateral lower leg oedema with ulcers and erythema (redness) in the groin. Other medical problems listed were hypertension and arthritis. Drug therapy on admission was doxazosin, bendrofluazide and felodipine (all blood pressure lowering drugs). On

examination there was a slight temperature, pulse was 80 irregular, BP was 128/81 mm Hg, erythema was seen in both groins, bilateral swelling of both legs. The left lower leg was noted to be swollen and erythematous. The examination notes nursing staff had reported blistering on buttocks. Problems were considered to be: bilateral leg oedema, cellulitis of the groin and left lower leg, decreased mobility due to obesity/oedema/infection and atrial fibrillation.

- 5.4 A number of investigations were performed at this stage. An ECG confirmed the presence of atrial fibrillation (irregular heart beat). A Chest Xray, blood tests and swabs from the groin and leg ulcers were obtained. Blood tests showed a normal haemoglobin (Hb 15.7 g/dl) and an elevated white cell count 25.7 consistent with a bacterial skin infection in the groin and legs. Intravenous antibiotics were commenced to treat infection and diuretics were changed from bendrofluzide to frusemide.
- 5.5 [Code A] was reviewed later the same afternoon by a Registrar, [Code A] who agreed with the diagnoses and suggested stopping felodipine and doxazosin since they could be exacerbating his oedema. He indicated an echocardiogram might be obtained to assess his cardiac function. A separate note (signature unclear) at the bottom of the page (p47) states *'In view of premorbid state and multiple medical problems not for CPR in event of arrest'*.
- 5.6 The following day 7th August 1999, there is an entry from a different registrar (name unclear) (p48) noting that the patient has been seen by [Code A] (I would assume this was the responsible consultant physician). The notes record he has 'morbid obesity' (the nursing notes record his weight was 148.6 Kg p108) and says [Code A] reported *'walking till about a week before'*. The recorded plan was to obtain a good history from the next of kin, continue intravenous antibiotics over the weekend and considered his problems were mainly nursing. Renal impairment (creatinine 173) was also noted. There is a comment *"Agree not for 555"* (meaning not for attempted resuscitation).
- 5.7 On the 9th August the medical notes record the cellulitis of the left leg was improving and he should be switched to oral antibiotics. On the 11th August the notes record he was well and the cellulitis improved and physiotherapy should continue. On the 12th August a further entry states *'continue nursing care and try to mobilise'*. The felodipine was stopped to try and improve his oedema. Again a note is made *'Not for 555'*. On the 13th August the medical notes document the white cell count has fallen to 12.4 and the Hb is 13.5. Antibiotics were to continue for a total of 10 days and there is a comment to *'Transfer to Dryad ward on 16th August 1999'*. On the 16th August the notes state *'Dryad when bed available'*. On 18th August the medical notes record antibiotics were to be stopped the following day. A further entry on 18th August is by [Code A] Geriatrician, states *'P sores extensive, feed himself, not mobilising, black stool overnight – nil says bowels looser than usual, no pain. Abdomen soft, BS /, PR – normal brown stool. Check Hb R/O bleed. ? antibiotic related diarrhoea 'stool chart.'*
- 5.8 On 20th August the medical notes record *'no further black motion, nausea or epigastric pain, epigastric tenderness, BP 140/80 m Hg'*. The full blood count was checked with no significant change in Hb at 12.9. The notes record transfer to Gosport Hospital was to take place on 23rd August (p54).

- 5.9 On Monday 23rd August the medical notes (doctors name unclear) record problems of obesity, arthritis bilateral knees, immobility, pressure sores and note he is on a high protein diet and '*? Melaena 13/8/99 Hb stable, alb 29*'. There is a further note '*MTS very good*'. *Clinical examination records a normal cardiovascular and respiratory systems , obese, legs slightly, chronic skin disease, ulcers dressed yesterday. Needs review later this week*'. MTS is an abbreviation for Mental Test Score and the comment indicates he had no significant cognitive impairment. There is a note that Haemoglobin (Hb) and other blood tests are to be repeated on Friday.
- 5.10 On Wednesday 25th August the nursing notes (p63) record '*Passing fresh blood PR ?Clexane*'. *Verbal message from [Code A] to withhold 1500 dose and review with [Code A] mane. Lunch also vomiting – metoclopramide 10 mg given im at 1755h. Good effect.*'
- 5.11 On 26th August the nursing notes state '*Fairly good morning no further vomiting, Dr Rabi contacted re Cleaxane, advised to discontinue and repeat Hb today and tomorrow. Not for resuscitation. Unwell at lunchtime, colour poor, c/o feeling unwell. Seen by [Code A] this afternoon, await results of Hb, Further deterioration c/o indigestion – pain in throat not radiating – vomited again this evening. Verbal order from [Code A] Diamorphine 10 mg stat – same given at 1800. Metoclopramide 10mg given im.*' A blood sample was sent on 26th August. The notes include a laboratory report that the Hb was 7.7 g/dl (p210) and there is a comment on the report '*Many attempts were made to phone these results, no answer from Gosport War Memorial Hospital switchboard*'. The previous Haemoglobin was 12.0 g/dl from a sample taken on 24 August and analysed on the 25th August.
- 5.12 There is an entry in the medical notes on 26th August by [Code A] which states '*Called to see. Pale, clammy, unwell. Suggests ?MI treat stat diamorph and oromorph overnight. Alternative possibility GI bleed but no haematemesis. Not well enough to transfer to acute unit, keep comfortable. I am happy for nursing staff to confirm death.*' I can find no records of any pulse, BP observations in the notes at this point or at any time relating to [Code A]'s admission on Dryad ward. A further entry in the nursing notes on 26^h August 1900 (p63) states [Code A] *here. For Oramorph 4 hourly. [Code A] seen by [Code A] explained [Code A]'s condition and medication used.*'
- 5.13 On the 27th August the nursing notes state '*Some marked improvement since yesterday*'. *Seen by [Code A] this am – to continue Diamorph 4 hourly same given tolerated well. Some discomfort this afternoon – especially when dressings being done.*' The next entry in the medical notes is on 28th August from [Code A] and state '*remains poorly, but uncomfortable, please continue opiates over weekend.*'
- 5.14 On 30th August the nursing notes state '*condition remains poor. Syringe driver commenced at 1445 Diamorphine 40mg, midazolam 20mg no further complaints of abdominal pain. Very small amount diet taken.*'
- 5.15 On 1 September there is an entry from the [Code A] Geriatrician, which states '*Rather drowsy, but comfortable. Passing melaena stools. Abdomen huge but quite soft. Pressure sores over buttock and across the posterior aspects of both*

thighs. Remains confused. For T.L.C – stop frusemide and doxazosin, [Code A] aware of poor prognosis'. Death was confirmed on [Code A] at 1350h. I understand the death certificate stated he died from Myocardial Infarction.

6. Drug therapy received at Gosport War Memorial Hospital

Doxazosin 4mg od	24 Aug – 31 Aug
Frusemide 80mg od	24 Aug – 31 Aug
Clexane 40mg sc bd	24 Aug – 25 Aug
Paracetamol 1 g qds	23 Aug – 26 Aug
Metoclopramide 10 mg im	25 Aug 1755h 26 Aug 1740h
Diamorphine 10mg im	26 Aug 1800h (verbal message)
Oramorph 10mg 4hrly (Oral morphine)	Prescription 26 Aug no doses administered
Oramorph 10mg/5ml (10-20mg) qds	26 Aug 20 mg nocte
Oramorph 10 mg/5ml 20mg nocte	27 Aug 4 doses administered unclear if 10 or 20 mg 20 mg nocte
	28 Aug 4 doses administered unclear if 10 or 20 mg 20 mg nocte
	29 Aug 4 doses administered unclear if 10 or 20 mg 20 mg nocte
	30 Aug 2 doses administered unclear if 10 or 20 mg
Diamorphine sc via syringe driver	30 Aug 40mg/24hr
Prescribed 40-200mg/24hr	31 Aug 40mg/24hr
	1 Sep 40mg/24hr increased to 60mg/24hr 1915h
	2 Sep 90mg/24hr
Midazolam sc via syringe driver	30 Aug 20 mg/24hr
Prescribed 20-80mg/24hr	31 Aug 20 mg/24hr
	1 Sep 40 mg/24hr increased to 60 mg/24hr 1915h
	2 Sep 80mg/24hr
Hyoscine 800ucg – 2gm / 24hr sc	Prescription 2 Sep no doses administered

Opinion on Patient Management

7. Management prior to admission to Dryad Ward.

The initial assessment and management of [Code A] during his admission to Anne Ward was in my view competent. My review of the medical records suggests appropriate clinical assessments were undertaken, investigations obtained and management initiated. The main initial problem was cellulitis (skin infection) of the groin and legs in the setting of chronic leg swelling. Secondary skin infections are a common problem in patients with chronic leg oedema. He responded to antibiotics and was commenced on subcutaneous heparin

(Clexane) to reduce his risk of developing a deep vein thrombosis. There was a clear plan to mobilise [Code A] with the intention of him then being able to return home.

8. [Code A] assessed [Code A] presumably at the request of the responsible medical team. She identified a possible episode of melaena (black stool due to bleeding from the gut). It is not uncommon for nursing staff to see dark stools and for it to be unclear if these are due to melaena. [Code A] examined [Code A] and performed a rectal examination to see if there was any evidence of bleeding from the gut. She gave clear instructions to check the haemoglobin and rule out a gastro intestinal bleed. This was done prior to his transfer to Dryad ward. I consider the management on Anne ward and [Code A]'s assessment were competent.
9. The one aspect of his management on Anne Ward that could be questioned was the decision to make [Code A] not for attempted resuscitation without this being discussed with him or his next of kin and without a clear statement of the level of medical intervention that was appropriate. The decision that [Code A] was not for attempted resuscitation appears to have influenced subsequent management decisions on Dryad ward. The decision was not necessarily inappropriate since if he had experienced a cardiac or respiratory arrest he would have been unlikely to survive this. Now such a decision would be discussed with the patient or his next of kin. In 1999 such decisions were not always discussed with older patients or their relatives in all hospitals. There is no evidence from the medical notes or relative statements that [Code A] expressed any wishes that he did not want any medical intervention that might prolong his life. A very important principle in the medical care of patients, particularly for older people, is that the decision not for attempted resuscitation is separate from other decisions about other medical interventions. The majority of patients where a decision has been made that attempted resuscitation should not be undertaken in cardiac or respiratory arrest occurs still receive active medical treatment including surgery, antibiotic and other medical treatments.
10. A key principle of decision making about active treatment is that treatments should be given that serve the patients needs. Therefore unless patients express or have expressed a wish not to receive certain treatments, these should be provided by doctors unless other barriers, such as resource limitations prevent this. In the case of [Code A] there are no entries in the medical records to suggest that the medical team or [Code A] intended [Code A] [Code A] should not receive treatments that might prevent early death or further disability. [Code A]'s assessment and investigation of [Code A] suggest if he had been identified to have a gastrointestinal bleed he would have received further investigation (such as gastroscopy), treatment with blood transfusion and to be considered for surgery.

Management on Dryad Ward.

11. Primary responsibility for the medical care of [Code A] whilst he was on Dryad ward lay with [Code A] the [Code A] responsible of his care. Day to day medical care was the responsibility of [Code A] as [Code A] and during out of hours period on call medical staff. Ward nursing staff were responsible for assessing, monitoring, and administering treatment to [Code A] and informing medical staff of any significant deterioration.
12. I consider there are many aspects of [Code A]'s management that were of considerable concern. Review of the medical and nursing notes indicates that [Code A] died from massive gastrointestinal haemorrhage most likely contributed to in part by the Clexane (enoxaparin) he received to reduce his risk of developing a deep vein thrombosis, and

possibly opiate and sedative induced respiratory depression. There was no evidence to support a diagnosis of myocardial infarction (such as ECG changes, cardiac enzyme changes) which was given as the cause of his death. Had [Code A] been readmitted to an acute hospital unit alternative actions would have been taken including blood transfusion and possibly therapeutic endoscopy (if available) and he might have survived the gastrointestinal bleed. Although his severe obesity would be expected to place him at risk of a number of complications, he was not dying or expected to die prior to his deterioration on Dryad ward on 26th August. His pressure sores were treatable and there was a reasonable possibility that he might regain limited mobility. The available evidence suggests [Code A]'s had a reasonable quality of life and would wish to be treated. [Code A] states that they were told [Code A] was to be transferred to Gosport War Memorial Hospital for recuperation and rehabilitation (p4 BP/1).

13. [Code A] as the doctor responsible for the day to day management of [Code A] had a responsibility to obtain, review and act upon the results of blood tests. The medical notes on 23rd August 1999 indicated repeat blood tests were to be performed. The nursing notes indicate the Hb results was to be reviewed by [Code A]. On 26th August 1999 [Code A] was called to see [Code A] as he was unwell and she had recognised that [Code A] might have had a gastrointestinal bleed. Had this result been obtained it would have indicated that [Code A] had experienced a larger bleed and required blood transfusion and transfer to an acute medical unit for further care. I find the comment by [Code A] that [Code A] [Code A] was too unwell to transfer to an acute unit difficult to understand when at no point had it been suggested that [Code A] was for palliative care. On the contrary it was clear he was too unwell to be safely investigated and managed at Gosport War Memorial Hospital. This decision was not appropriately made by a [Code A] without discussion with a consultant colleague and [Code A] should have discussed [Code A] with a consultant Geriatrician or the on call Acute Medical Team.
14. The medical notes and medical assessment of [Code A] by [Code A] on 26th August 1999 were in my view inadequate. The standard of note keeping falls below the expected level of documentation on a continuing care of rehabilitation ward. [Code A] describes [Code A] [Code A] as being clammy and unwell but does not appear to have performed a physical examination of his chest and abdomen, recorded the results of any examination and did not instruct nurses or obtain herself his pulse rate and blood pressure. She did not obtain appropriate further investigations such as an electrocardiogram and blood tests to obtain further information supporting a diagnosis of a myocardial infarct. Had she done this and discussed the results with a consultant colleague it is likely [Code A] would have been transferred to an acute medical unit at another hospital. [Code A]'s won provisional diagnosis of a myocardial infarct should have prompted her to discuss transferring [Code A] [Code A] to a coronary care unit or acute medical unit so that he could be assessed and be in an appropriate environment where complications of a myocardial infarct such as cardiac arrhythmias could be monitored and treated. For these reasons I consider [Code A] failed to provide appropriate medical care to [Code A].
15. The verbal message by [Code A] to administer diamorphine to [Code A] on 26 August 1999 before she had seen and assessed [Code A] was inappropriate as no medical assessment was undertaken and no clear diagnosis had been made. If the pain was considered severe enough to require diamorphine [Code A] should have been assessed immediately by [Code A] or another doctor to establish whether he had experienced a myocardial infarction or other serious problem.

16. The rationale for commencement of regular oral morphine is not recorded in the medical notes on 26th August 1999 by [Code A]. On the 28th August 1999 [Code A] records that [Code A] [Code A] is uncomfortable but does not record the site of pain or justification for continuing morphine. There is no record in the medical notes explaining why diamorphine and midazolam were administered by syringe driver on 30th August 1999. In particular there is no record as to why [Code A] required midazolam as neither the medical or nursing notes record that he had symptoms of restlessness or agitation requiring administration of a sedative drug. [Code A] did not record the reasons why the diamorphine and midazolam doses were increased on the 1st and 2nd September 1999. The dose range of diamorphine and midazolam prescribed were inappropriate and hazardous. After the commencement of diamorphine and midazolam [Code A] became drowsy. There are no records of his respiratory rate or detailed assessments of his conscious level but the progressive increase in diamorphine and midazolam doses after 1st September 1999 may have led to respiratory depression and contributed to his death, although his primary cause of death appears to be due to massive GI haemorrhage. Because [Code A] did not perform appropriate clinical assessments or keep accurate medical records explaining the reasons for these treatment decisions I consider the prescriptions of diamorphine, diamorphine and midazolam were inappropriate and hazardous and may have contributed to his death.
17. I consider the assessment by [Code A] of [Code A] on 1st September 1999 can also be criticised. At this stage it was clear [Code A] had bleeding from the gut. He was drowsy. [Code A] did not review the full blood count results and did not consider the possibility that his drowsiness and confusion might be secondary to the diamorphine infusion. [Code A] did not consider transferring [Code A] to an acute medical unit. At this stage [Code A] was very unwell but this would still have been appropriate to consider.

Summary of Conclusions

18. [Code A] was a man with severe obesity and long standing leg oedema who was admitted to hospital because of mobility problems and difficulties managing at home. He was transferred to Dryad ward for rehabilitation. Shortly after transfer he deteriorated on the 26th August 1999 and died on [Code A] from gastrointestinal bleeding and possibly diamorphine and midazolam induced respiratory depression. In my opinion the medical assessment and management of [Code A] by [Code A] did not reach the standard expected.
19. In my opinion [Code A] in her care of [Code A] failed to meet the requirements of good medical practice to:
- Provide an adequate assessment of the patients condition based on the history and clinical findings and including where necessary an appropriate examination
 - Consult colleagues
 - Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
 - Provide or arranging necessary investigations
 - Prescribe only the treatment, drugs or appliances that serve patient's need

Declaration

? Standard declaration for GMC

20.

Code A

GMC and Code A
Report on Code A **Patient K)**

Code A
Consultant Physician

21 April 2009

GMC and **Code A**
Patient K

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient K commenting on the care and treatment carried out by **Code A** in relation to this patient, to assist the GMC Panel in determining whether **Code A** has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that the prescription by **Code A** of morphine solution was not justified by the patient's presenting symptoms; that the prescription of diamorphine and midazolam by subcutaneous infusion was in too wide a dose range and created a situation whereby drugs could be excessive to the patient's need; that the prescription of morphine solution, fentanyl 25 patch and diamorphine with midazolam infusions were inappropriate, potentially hazardous and not in the best interests of Patient K.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Patient K; statements of **Code A**
Code A
Code A statement made by **Code A**
in relation to Patient K; interview of **Code A** dated 4 November 2004 (three transcripts).

5. Course of events

- 5.1 Patient K was an 88 year old lady who was admitted to Queen Alexandra Hospital, Ward 3 on 9 October 1999 with an episode of acute confusion. Some of the medical records relating to this admission appear not to be in the copy of medical notes provided to me but a letter by **Code A** in Old Age Psychiatry summarises Patient K's problems at this time (page 29, 30). **Code A** saw Patient K on behalf of **Code A** Consultant in Old Age Psychiatry, at the request of the responsible Consultant Physician, **Code A**. Prior to her admission, **Code A** indicated Patient K had been wandering and aggressive.

5.2 Patient K remained confused following admission to the Ward, had tried to get out of windows and was possibly hallucinating. Her behaviour had settled but she remained confused and disorientated. Until January 1999 Patient K had been able to look after herself but her family had noticed a decline in her memory since that time and she was no longer able to cook. She had background medical problems of hypothyroidism, treated with thyroxine, chronic renal failure and an IgA paraprotein. A bone marrow biopsy had shown a 8% plasma cell infiltrate. On assessment in June 1999 by [Code A] Consultant Haematologist (page 63) she did not consider there was sufficient evidence to make diagnosis of myeloma. Patient K also had a diagnosis of nephrotic syndrome (renal impairment with loss of protein through the kidneys). Examination of Patient K's skeletal system in May 1999 (page 75) had not shown any bone lesions due to plasma cell infiltration.

5.3 [Code A]s letter indicated that Patient K's [Code A] was currently unable to provide support to [Code A] due to other [Code A]. On the ward Patient K was mobile, able to wash with prompting and independent in her self-care but did tend to get lost on the ward. At this time Patient K was sleeping well and settled during the day but had been aggressive at times towards [Code A]. [Code A] found Patient K had hearing difficulties and scored low (9/30) on the mini-mental state examination – an assessment of cognitive function. [Code A] considered Patient K had a diagnosis of dementia and that she would not be able to return home and recommended referring her to Social Services for consideration for residential care in a home with experience dealing with memory problems. As her behaviour was settled, [Code A] did not think she required an EMI (Elderly Mental Infirm) home.

5.4 On 15 October the notes record a discussion with [Code A] Patient K's GP, and a plan to transfer her to St Christopher's. This appears to have been planned as a temporary transfer prior to placement in a suitable home in the community. A referral was made to [Code A] Consultant Geriatrician who saw Patient K on 19 October and stated in the notes that she was suitable for rehabilitation and had arranged a transfer to Gosport War Memorial Hospital (page 169). A letter relating to that assessment dated 20 October (page 21) stated she was alert, could stand but was unsteady on walking. A transfer letter dated 20 October 1999 summarises Patient K's admission prior to transfer to Gosport War Memorial Hospital and states "Patient admitted with increasing confusion ?UTI. Originally was at times aggressive but this has resolved now she knows us better. Due to her crp (C reactive protein) we treated her for a UTI and apart from needing guidance and reassurance is self-caring. Her social circumstances have changed drastically and now she needs temporary placement with you until a permanent place is..."

5.5 The medical notes record Patient K's transfer to Dryad Ward on 21 October and an entry by [Code A] states "transfer to Dryad Ward, continuing care. HPC acute confusion, admitted to Mulberry → Dryad. Past medical history dementia, myeloma, hypothyroidism, Barthel transfers with one. So far continent. Needs some help with ADL MMSE 9/30. Barthel 8. Plan get to know. Assess rehab potential probably for rest home in due course".

5.6 The next entry in the medical notes is by [Code A] Geriatrician on 25 October. This states "mobile unaided. Washes with supervision. Dresses self. Continent. Mildly confused. BP 110/70. Normochromic anaemia-chronic renal failure. Was living with [Code A] [Code A] Need to find out more [illegible] etc". A further entry by [Code A] on 1 November states "physically independent but needs supervision with W and D help with bathing, continent. Quite

confused and disorientated e.g. wandering during the day. Unlikely to get much social support at home therefore try home visit to see if functions better in own home".

5.7 There is a further unsigned entry in the medical notes dated 15 November indicating Patient K had been aggressive at times and restless and that needed thioridazine. She was on treatment for a urinary tract infection after a urine specimen had shown blood and protein. Examination at this time showed Patient K was apyrexial, had some peripheral oedema but had a clear chest. The notes state that a request would go to **Code A** to review Patient K.

5.8 There is then an entry by **Code A** dated 16 November which states "Dear **Code A** Thank you so much for seeing Patient K. I gather she is well known to you. Her confusional state has increased in the last few days to the point where we are using thioridazine. Her renal function is decreasing. Her MSU showed no growth. Can you help? Many thanks."

5.9 Patient K was seen by **Code A** on 18 November. The medical notes record "this lady has deteriorated and has become more restless and aggressive again. She is refusing medication and not eating well. She doesn't seem to be depressed and her physical condition is stable. I will arrange for her to go on the waiting list for Mulberry Ward". The next entry is on 19 November 1999 by **Code A** and records "marked deterioration overnight. Confused aggressive, creatinine 300, fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs so analgesia with midazolam. **Code A** aware of condition and prognosis. Please keep comfortable. I am happy for nursing staff to confirm death". A final entry in the medical notes on **Code A** records Patient K had died at 2030h (page 157).

5.10 The nursing summary notes (page 223) record on 21 October 1999 Patient K was admitted with increasing confusion and aggression which had resolved. The notes state "a very pleasant lady. Her appetite on the whole is not good and can be a little unsteady on her feet". An entry on 19 November which is difficult to read states "Extremely aggressive.... Two staff to special. Syringe driver commenced at 0925h diamorphine 40mg + midazolam 40m. fentanyl patch removed". The nursing notes record Patient K was seen by **Code A** at 1300h (page 224). An entry on 21 November records that her condition had continued to deteriorate slowly. I can find no record in the nursing notes indicating Patient K was at any time in pain.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 279 -281. All prescriptions written by **Code A** unless otherwise marked.

Once only drugs

Chlorpromazine 50mg im Date unclear November 0830h

Regular prescriptions

Thyroxine 100ug od	22 Oct-17 Nov. Not administered 2 Nov or 18 Nov onwards
Prescribed 21 Oct	
Furosemide 40mg od	22 Oct – 17 Nov. Not administered 18 Nov onwards
Prescribed 21 Oct	
Amloride 5 mg od	2 Nov-18 Nov. Not administered 19 Nov onwards
Prescribed 1 Nov	
Trimethoprim 200mg bd	11 Nov – 15 Nov. Then discontinued

Prescribed 11 Nov	
Fentanyl 25ug skin (every three days)	18 Nov 0915h
Prescribed 18 Nov	
Diamorphine subcut via syringe driver	19 Nov 40mg/24hr
40-80mg/24hr	20 Nov 40mg/24hr
Prescribed 19 Nov	21 Nov 40mg/24hr
Midazolam subcut via syringe driver	19 Nov 40mg/24hr
40-80mg/24hr	20 Nov 40mg/24hr
Prescribed 19 Nov	21 Nov 40mg/24hr
<i>As required prescriptions</i>	
Temazepam 10mg nocte	11 Nov
Prescribed 21 October 1999	
Oramorph 10mg/5ml 2.5-5ml	None administered
Prescribed 21 Oct	
Thiordiazine 10mg tds	11 Nov 0830h
Prescribed 11 Nov	12 Nov 1320h
	13 Nov 0825h, 1800h
	14 Nov 0825h, 1945h
	15 Nov 0830h, 2130h
	16 Nov 0845h
	17 Nov 1740h

Opinion on Patient Management

7. Patient K was an elderly woman with dementia who prior to admission to hospital in October 1999 had been living at home with increasing difficulties and was likely to move into a residential care home. She had been admitted to Queen Alexandra Hospital after being found wandering and aggressive and continued to exhibit some behavioural difficulties. These were not judged sufficiently severe to merit moving into an Elderly Mental Infirm home rather than a residential home. She was referred to Gosport War Memorial Hospital for temporary placement prior to a suitable residential home being found for her to move into.
8. Following transfer to Dryad ward [Code A] had suggested Patient K be taken on a home visit to see if she functioned better in her own home than on the ward. This is common and good practice in elderly care medicine as some patients function better in their own homes than when observed in a ward environment. Observation of the patient in their own home allows a decision to be made as to whether they can continue to manage at home and what level of support services might be required to support this. At this point Patient K was independently mobile, continent, able to wash with supervision and dress herself. It was reasonable to consider the possibility that Patient K might be able to manage to live in the community with support from her family and social services.
9. Patient K was intermittently aggressive on the ward. Aggression is a well recognised and troublesome symptom in some patients with dementia and is often worse when patients are in a new environment such as a hospital ward. It can also be precipitated or worsened by

other medical problems particularly chest or urinary tract infections. Thioridazine had been prescribed on 11 November. Neuroleptic drugs such as thioridazine are commonly used to try and improve symptoms of aggressions in people with dementia. I would consider this was an appropriate treatment approach.

10. When her aggressive behaviour persisted a request for consultation was sent to [Code A] Consultant Old Age Psychiatrist who had previously assessed Patient K. This was appropriate and good medical practice. [Code A] a member of [Code A]'s team assessed Patient K and noted she was refusing medication and not eating well. [Code A] made plans to transfer her to an Old Age Psychiatry ward for further assessment and management. This suggests that [Code A] considered Patient K's main problems were related to her dementia and she had no other significant active medical problems.
11. On 18 November when [Code A] saw Patient K [Code A] prescribed a fentanyl patch to Patient K. [Code A]'s entry in the medical records on 19 November indicates Patient K deteriorated the day before. The medical and nursing notes contain no evidence that Patient K was in pain and the indication for prescribing the fentanyl patch is not recorded. Good medical practice requires the reasons for commencement of any drug but particularly a controlled drug such as an opiate to be recorded in the medical notes. If Patient K was in pain the details of the pain should have been recorded in the medical notes and a physical examination should have been performed to further assess the pain. Patients with dementia may not always communicate they are in pain, but may become confused and aggressive because of pain. Examination may reveal a patient has a musculoskeletal injury, such as a hip fracture, or other problem such as a distended bladder or other acute painful condition which require specific treatments.
12. Nursing and medical review of Patient K was indicated when she deteriorated on the 18 November. There is no evidence in the medical and nursing notes that [Code A] examined Patient K. In my opinion the prescription of fentanyl by [Code A] was not justified as there is no evidence Patient K was in pain. I consider [Code A] failed to meet the requirements of good medical practice to adequately assess Patient K, keep contemporaneous patient records and provide appropriate treatment.
13. A medical assessment was also indicated when she became very aggressive, which appears to have been on the 19 November but could have been on the 18 November. The nursing and medical notes lack sufficient information to be clear when she became aggressive. [Code A] [Code A]'s notes document that Patient K deteriorated overnight but she does not record what the cause of this deterioration in her condition was due to. One key issue that should have been considered at this stage was that Patient K's further deterioration and aggression might have been related in part to adverse effects of the fentanyl patch that had been commenced. Opioid drugs commonly cause sedation but can precipitate confusion and aggression in some older people.
14. When Patient K deteriorated [Code A]'s notes document an increased blood creatinine concentration suggesting her renal function had deteriorated. This was possibly due to dehydration but could have been also due to a urinary tract or other infection. There is also a comment that Patient K needed subcutaneous analgesia with midazolam but her notes do not record why. The specific reference to analgesia suggests [Code A] considered Patient K was in pain but neither the medical or nursing notes record any information suggesting she was in pain. As Patient K was not able to swallow use of the transdermal or subcutaneous

route to administer analgesia and/or sedation if she required this would have been appropriate if these treatments were indicated.

15. The prescription of subcutaneous diamorphine by [Code A] on 19 November was in my opinion not appropriate or justified as there was no evidence she was in pain. The dose prescribed was also in my opinion excessively high if she had been in pain. In an older frail patient an appropriate dose would have been 10mg/24hr or 20mg/24 hr particularly when midazolam was also prescribed. The prescription of diamorphine 40-80mg/24hr placed Patient K at risk of developing respiratory depression and coma.
16. The prescription of subcutaneous midazolam by [Code A] on 19 November was in my opinion not justified by the information recorded in the medical records. The Wessex Protocols list midazolam by subcutaneous infusion as a treatment option for agitation (10 mg im stat then 10-100mg/24hr) in patients receiving palliative care who have a syringe driver for other reasons. The notes indicate patient K was extremely aggressive. In my opinion midazolam by subcutaneous infusion was not the optimal initial treatment for her aggression. She had previously been receiving thioridazine until 17 November and it would have been appropriate to administer thioridazine by intramuscular injection or use an alternative neuroleptic drug such as haloperidol.
17. In patients who are very aggressive single doses of drugs, repeated as necessary if aggression continues without significant adverse effects from the drugs administered, are a more appropriate approach to controlling symptoms. This is rationale for the Wessex Protocols recommend an initial loading dose by intramuscular midazolam to treat agitation. Commencing a midazolam infusion without an initial loading dose leads to the maximal effect of the drug not being observed until 'steady state' concentrations are reached which may be more than 24 hours later. Therefore the initial response may be inadequate and there may be adverse effects that occur much later as the drug accumulates in the patient.
18. If [Code A] considered Patient K was terminally ill her medical records do not indicate why this was the case. Given that the day before the plan had been to transfer Patient K for further assessment on an Old Age Psychiatry ward it would have been appropriate for [Code A] [Code A] as the doctor responsible for Patient K's day to day care, to discuss the sudden deterioration in Patient K with [Code A] the responsible consultant or another senior colleague.
19. The dose of subcutaneous midazolam prescribed by [Code A] was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-100mg/24hr. In an older frail patient an appropriate dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 40mg/24hr was therefore inappropriately high. The prescribed dose range of midazolam with an upper limit of 80mg/24hr particularly in conjunction with the diamorphine prescribed placed patient K at high risk of developing life threatening complications.
20. In my opinion the subsequent deterioration in Patient K after 19 November until her death on [Code A] was very likely due to diamorphine and midazolam leading to respiratory depression and coma.

Summary of Conclusions

21. Patient K was an elderly lady with dementia who developed aggressive behavioural problems whilst on Dryad ward and awaiting transfer to an Old Age Psychiatry ward. The notes do not suggest that [Code A] conducted an adequate assessment of patient K before prescribing the opiate fentanyl and then subcutaneous infusions of diamorphine and midazolam. In my opinion fentanyl and diamorphine were not indicated. The prescription of a midazolam infusion without an initial loading dose was not in my view optimal management, but if this had been administered alone without diamorphine would not in my opinion have been a breach of a duty of care if there had been an adequate clinical assessment. The doses of diamorphine and midazolam prescribed by [Code A] were excessive, dangerous and reckless. In my opinion the administration of these drugs by subcutaneous infusion at the doses used led to depression of her conscious level and respiration and most likely contributed to her death.
22. In my opinion [Code A] in her care of Patient K failed to meet the requirements of good medical practice:
- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to consult colleagues;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.
23. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
[Code A]

GMC and Code A
Report on: Code A **(Patient K)**

Code A
Consultant Physician

14 April 2009

GMC and Code A
Patient K

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient K commenting on the care and treatment carried out by Code A in relation to this patient, to assist the GMC Panel in determining whether Code A has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that the prescription by Code A of morphine solution was not justified by the patient's presenting symptoms; that the prescription of diamorphine and midazolam by subcutaneous infusion was in too wide a dose range and created a situation whereby drugs could be excessive to the patient's need; that the prescription of morphine solution, fentanyl 25 patch and diamorphine with midazolam infusions were inappropriate, potentially hazardous and not in the best interests of Patient K.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Patient K; statements of Code A
Code A
Code A statement made by Code A
in relation to Patient K; interview of Code A dated 4 November 2004 (three transcripts).

5. Course of events

- 5.1 Patient K was an 88 year old lady who was admitted to Queen Alexandra Hospital, Ward 3 on 9 October 1999 with an episode of acute confusion. Some of the medical records relating to this admission appear not to be in the copy of medical notes provided to me but a letter by Code A in Old Age Psychiatry summarises Patient K's problems at this time (page 29, 30). Code A saw Patient K on behalf of Code A Consultant in Old Age Psychiatry, at the request of the responsible Consultant Physician, Code A. Prior to her admission, Code A indicated Patient K had been wandering and aggressive.

- 5.2 Patient K remained confused following admission to the Ward, had tried to get out of windows and was possibly hallucinating. Her behaviour had settled but she remained confused and disorientated. Until January 1999 Patient K had been able to look after herself but her family had noticed a decline in her memory since that time and she was no longer able to cook. She had background medical problems of hypothyroidism, treated with thyroxine, chronic renal failure and an IgA paraprotein. A bone marrow biopsy had shown a 6% plasma cell infiltrate. On assessment in June 1999 by [Code A] Consultant Haematologist (page 63) she did not consider there was sufficient evidence to make diagnosis of myeloma. Patient K also had a diagnosis of nephrotic syndrome (renal impairment with loss of protein through the kidneys). On examination of Patient K's skeletal system in May 1999 (page 75) had not shown any bone lesions due to plasma cell infiltration.
- 5.3 [Code A] s letter indicated that Patient K's [Code A] was currently unable to provide support to her mother due to other family illness. On the ward Patient K was mobile, able to wash with prompting and independent in her self-care but did tend to get lost on the ward. At this time Patient K was sleeping well and settled during the day but had been aggressive at times towards [Code A] found Patient K had hearing difficulties and scored low (9/30) on the mini-mental state examination – an assessment of cognitive function. [Code A] considered Patient K had a diagnosis of dementia and that she would not be able to return home and recommended referring her to Social Services for consideration for residential care in a home with experience dealing with memory problems. As her behaviour was settled, [Code A] did not think she required an EMI (Elderly Mental Infirm) home.
- 5.4 On 15 October 1999 the notes record a discussion with [Code A] Patient K's GP, and a plan to transfer her to St Christopher's. This appears to have been planned as a temporary transfer prior to placement in a suitable home in the community. A referral was made to [Code A] Consultant Geriatrician who saw Patient K on 19 October and stated in the notes that she was suitable for rehabilitation and had arranged a transfer to Gosport War Memorial Hospital (page 169). A letter relating to that assessment dated 20 October (page 21) stated she was alert, could stand but was unsteady on walking. A transfer letter dated 20 October 1999 summarises Patient K's admission prior to transfer to Gosport War Memorial Hospital and states *"Patient admitted with increasing confusion ?UTI. Originally was at times aggressive but this has resolved now she knows us better. Due to her crp (C reactive protein) we treated her for a UTI and apart from needing guidance and reassurance is self-caring. Her social circumstances have changed drastically and now she needs temporary placement with you until a permanent place is..."*
- 5.5 The medical notes record Patient K's transfer to Dryad Ward on 21 October 1999 and an entry by [Code A] states *"transfer to Dryad Ward, continuing care. HPC acute confusion, admitted to Mulberry → Dryad. Past medical history dementia, myeloma, hypothyroidism, Barthel transfers with one. So far continent. Needs some [illegible] MMSE 9/30. Barthel 8. Plan get to know. Assess rehab potential probably for rest home in due course"*.
- 5.6 The next entry in the medical notes is by [Code A] Geriatrician dated 25 October 1999. This states *"mobile unaided. Washes with supervision. Dresses self. Continent. Mildly confused. BP 110/70. Normochromic anaemia-chronic renal failure. Was living with [Code A] [Code A] Need to find out more [illegible] etc"*. A further entry by [Code A] on 1 November 1999 states *"physically independent in [illegible] needs supervision with..... help with bathing, continent. Quite*

Trimethoprim 200mg bd Prescribed 11 November 1999	11 Nov – 15 Nov. Then discontinued
Fentanyl 25ug skin (every three days) Prescribed 18 November 1999	18 Nov 0915h
Diamorphine subcut via syringe driver 40-80mg/24hr Prescribed 19 November 1999	19 Nov 40mg/24 hours 20 Nov 40mg/24 hours 21 Nov 40mg/24 hours
Midazolam subcut via syringe driver 40-80mg/24h Prescribed 19 Nov 1999	19 Nov 40mg/24hr 20 Nov 40mg/24hr 21 Nov 40mg/24hr
<i>As required prescriptions</i>	
Temazepam 10mg nocte Prescribed 21 October 1999	11 Nov
Oramorph 10mg/5ml 2.5-5ml Prescribed 21 October 1999	None administered
Thiordiazine 10mg tds Prescribed 11 November 1999	11 Nov 0830h 12 Nov 1320h 13 Nov 0825h, 1800h 14 Nov 0825h, 1945h 15 Nov 0830h, 2130h 16 Nov 0845h 17 Nov 1740h

Opinion on Patient Management

7. Patient K was an elderly woman with dementia who prior to admission to hospital in October 1999 had been living at home with increasing difficulties and was likely to move into a residential care home. She had been admitted to Queen Alexandra Hospital after being found wandering and aggressive and continued to exhibit some behavioural difficulties. These were not judged sufficiently severe to merit moving into an Elderly Mental Infirm home rather than a residential home. She was referred to Gosport War Memorial Hospital for temporary placement prior to a suitable residential home being found for her to move into.
8. Following transfer to Dryad ward [Code A] had suggested Patient K be taken on a home visit to see if she functioned better in her own home than on the ward. This is common and good practice in elderly care medicine as some patients function better in their own homes than when observed in a ward environment. Observation of the patient in their own home allows a decision to be made as to whether they can continue to manage at home and what level of support services might be required to support this. At this point Patient K was independently mobile, continent, able to wash with supervision and dress herself. It was reasonable to consider the possibility that Patient K might be able to manage to live in the community with support from her family and social services.

9. Patient K was intermittently aggressive on the ward. Aggression is a well recognised and troublesome symptom in some patients with dementia and is often worse when patients are in a new environment such as a hospital ward. It can also be precipitated or worsened by other medical problems particularly chest or urinary tract infections. Thioridazine had been prescribed on 11 November 1999. Neuroleptic drugs such as thioridazine are commonly used to try and improve symptoms of aggressions in people with dementia. I would consider this was an appropriate treatment approach.
10. When her aggressive behaviour persisted a request for consultation was sent to [Code A] Consultant Old Age Psychiatrist who had previously assessed Patient K. This was appropriate and good medical practice. [Code A] a member of [Code A]'s team assessed Patient K and noted she was refusing medication and not eating well. [Code A] made plans to transfer her to an Old Age Psychiatry ward for further assessment and management. This suggests that [Code A] considered Patient K's main problems were related to her dementia and she had no other significant active medical problems.
11. On 18 November when [Code A] saw Patient K [Code A] prescribed a fentanyl patch to Patient K. [Code A]'s entry in the medical records on 1st November indicates Patient K deteriorated the day before. The medical and nursing notes contain no evidence that Patient K was in pain and the indication for prescribing the fentanyl patch is not recorded. Good medical practice requires the reasons for commencement of any drug but particularly a controlled drug such as an opiate to be recorded in the medical notes. If Patient K was in pain the details of the pain and should have been recorded in the medical notes and a physical examination should have been performed to further assess the pain. Patients with dementia may not always communicate they are in pain, but may become confused and aggressive because of pain. Examination may reveal a patient has a musculoskeletal injury, such as a hip fracture, or other problem such as a distended bladder or other acute painful condition which require specific treatments.
12. Nursing and medical review of Patient K was indicated when she deteriorated on the 18 November. There is no evidence in the medical and nursing notes that [Code A] examined Patient K. In my opinion the prescription of fentanyl by [Code A] was not justified as there is no evidence Patient K was in pain. I consider [Code A] failed to meet the requirements of good medical practice to adequately assess Patient K, keep contemporaneous patient records and provide appropriate treatment.
13. A medical assessment was also indicated when she became very aggressive, which appears to have been on the 19 November but could have been on the 18 November. The nursing and medical notes lack sufficient information to be clear when she became aggressive. [Code A] [Code A]'s notes document that Patient K deteriorated overnight but she does not record what the cause of this deterioration in her condition was due to. [Code A]. One key issue that should have been considered at this stage was that Patient K's further deterioration and aggression might have been related in part to adverse effects of the fentanyl patch that had been commenced. Opioid drugs commonly cause sedation but can precipitate confusion and aggression in some older people.
14. When Patient K deteriorated [Code A]'s notes document an increased blood creatinine concentration suggesting her renal function had deteriorated. This was possibly due to dehydration but could have been also due to a urinary tract or other infection. There is also a comment that Patient K needed subcutaneous analgesia with midazolam but her notes do not record why. The specific reference to analgesia suggests [Code A]

considered Patient K was in pain but neither the medical or nursing notes record any information suggesting she was in pain. As Patient K was not able to swallow use of the transdermal or subcutaneous route to administer analgesia and/or sedation if she required this would have been appropriate if these treatments were indicated.

15. The prescription of subcutaneous diamorphine by [Code A] on 19 November was in my opinion not appropriate or justified as there was no evidence she was in pain. The dose prescribed was also in my opinion excessively high if she had been in pain. In an older frail patient an appropriate dose would have been 10mg/24hr or 20mg/24 hr particularly when midazolam was also prescribed. The prescription of diamorphine 40-80mg/24hr placed Patient K at risk of developing respiratory depression and coma. It is not clear from the notes whether the fentanyl patch was removed on 19 November before the diamorphine infusion was commenced. If it had not been this would have placed Patient K at even higher risk of developing life threatening complications.
16. The prescription of subcutaneous midazolam by [Code A] on 19 November was in my opinion not justified. The Wessex Protocols list midazolam by subcutaneous infusion as a treatment option for agitation (10 mg im stat then 10-100mg/24hr) in patients receiving palliative care who have a syringe driver for other reasons. The notes indicate patient K was extremely aggressive. In my opinion midazolam by subcutaneous infusion was not the optimal initial treatment for her aggression. She had previously been receiving thioridazine until 17 November and it would have been appropriate to administer thioridazine by intramuscular injection or use an alternative neuroleptic drug such as haloperidol.
17. In patients who are very aggressive single doses of drugs, repeated as necessary if aggression continues without significant adverse effects from the drugs administered, are a more appropriate approach to controlling symptoms. This is rationale for the Wessex Protocols recommend an initial loading dose by intramuscular midazolam to treat agitation. Commencing a midazolam infusion without an initial loading dose leads to the maximal effect of the drug not being observed until 'steady state' concentrations are reached which may be more than 24 hours later. Therefore the initial response may be inadequate and there may be adverse effects that occur much later as the drug accumulates in the patient.
18. If [Code A] considered Patient K was terminally ill her medical records do not indicate why this was the case. Given that the day before the plan had been to transfer Patient K for further assessment on an Old Age Psychiatry ward it would have been appropriate for [Code A] [Code A] as the doctor responsible for Patient K's day to day care, to discuss the sudden deterioration in Patient K with [Code A] the responsible [Code A] or another senior colleague.
19. The dose of subcutaneous midazolam prescribed by [Code A] was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-100mg/24hr. In an older frail patient an appropriate dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 40mg/24hr was therefore inappropriately high. The prescribed dose range of midazolam with an upper limit of 80mg/24hr particularly in conjunction with the diamorphine prescribed placed patient K at high risk of developing life threatening complications.

20. In my opinion the subsequent deterioration in Patient K after 19 November until her death on [Code A] was very likely due to diamorphine and midazolam leading to respiratory depression and coma.

Summary of Conclusions

21. Patient K was an elderly lady with dementia who developed aggressive behavioural problems whilst on Dryad ward and awaiting transfer to an Old Age Psychiatry ward. The notes do not suggest that [Code A] conducted an adequate assessment of patient K before prescribing the opiate fentanyl and then subcutaneous infusions of diamorphine and midazolam. In my opinion fentanyl and diamorphine were not indicated. The prescription of a midazolam infusion without an initial loading dose was not in my view optimal management, but if this had been administered alone without diamorphine would not in my opinion have been a breach of a duty of care if there had been an adequate clinical assessment. The doses of diamorphine and midazolam prescribed by [Code A] were excessive, dangerous and reckless. In my opinion the administration of these drugs by subcutaneous infusion at the doses used led to depression of her conscious level and respiration and most likely contributed to her death.
22. In my opinion [Code A] in her care of Patient B failed to meet the requirements of good medical practice:
- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to consult colleagues;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.

Declaration

23. I understand my duties as an expert, as set out at paragraph [] of my Generic Report.

Code A

General Medical Council and Code A
Report on Code A (Patient L)

Code A
Consultant Physician

21 April 2009

GMC and **Code A**
Patient L

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient L commenting on the care and treatment carried out by **Code A** in relation to this patient, to assist the GMC Panel in determining whether **Code A** has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that; **Code A** did not properly assess patient L on admission; the prescriptions by **Code A** of diamorphine, diacetylmorphine and midazolam were not clinically justified and created a situation whereby drugs could be administered which were excessive to patient L's need; that the prescriptions were inappropriate, potentially hazardous and not in the best interests of Patient L.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Patient L; statements of **Code A** and various nurse statements.
5. Course of events

- 5.1 Patient L was a 73 years old when admitted to Royal Hospital Haslar on 26 April 1999 after experiencing chest pain and then collapsed at home after developing left arm and leg weakness. She was transferred to Daedalus ward, Gosport War Memorial Hospital on 20 May and died on that ward on **Code A**. Prior to this admission she was living at home with **Code A**. Her past medical history (page 174) included ischaemic heart disease and previous myocardial infarction, atrial fibrillation, asthma and chronic airways disease, and surgery for diverticular disease and a stricture. She had problems with recurrent lower abdominal pain thought to be due to adhesions (page 129) or irritable bowel syndrome (page 125). She had rated her health as poor in October 1997 (page 150).

- 5.2 The admission clerking to Royal Hospital Haslar documents she had developed new left face, arm and leg weakness and slurred speech. She was complaining of a headache and was thought to have had a stroke. A CT brain scan was obtained on 26 April (page 177) and demonstrated infarction in the right parietal lobe indicating she had a stroke due to cerebral infarction (blocked blood vessel). The notes state that an ECG showed atrial

fibrillation and ischaemic changes. Cardiac enzymes were elevated (CKMB 65) suggesting she had possibly sustained a myocardial infarction as the cause of her chest pain.

5.3 The notes record on 27 April (page 178) that she was alert and had left sided neglect. A nasogastric tube was placed to commence feeding as to swallow was unsafe. On 28 April the notes record she was experiencing continuing chest pain thought to be due to angina (page 180). An ECG showed ST elevation and she was transferred to the coronary care unit (CCU) and treated with a nitrate infusion (page 182). An entry in the medical notes on 30 April states that ECGs had confirmed she had experienced an anterior myocardial infarct. Later that day she developed increasing shortness of breath (page 183). The notes record she was hypoxic (low oxygen in the blood) and had signs on examination suggesting she had either a chest infection or pulmonary oedema due to fluid overload. A chest XRay found the nasogastric tube was not in the stomach and feed had been passed into the nasopharynx suggesting she had developed an aspiration pneumonia. Antibiotics were commenced (Page 184).

5.4 On 5 May 1999 the notes record patient L was able to start taking food (page 190). A referral was made by the medical team to [Code A] Consultant Geriatrician (page 190) stating that she was improving and requesting [Code A]'s opinion on the provision of rehabilitation. Later that day the notes record she was less well (page 191) and was in respiratory failure. She was treated with oxygen and small doses of diamorphine. The notes record patient L had a reasonable quality of life prior to her stroke (page 192). After discussion with the family a decision was made that she was for active treatment but not for ventilation if she deteriorated. An entry in the notes the following day records a discussion with the consultant and a decision that she was not for resuscitation.

5.5 [Code A] assessed patient L on 6 May (page 194). [Code A] records in the notes that patient L was extremely unwell with problems of a dense left hemiparesis due to stroke, myocardial infarction, atrial fibrillation, and aspiration pneumonia. The notes document she was 'chesty, flushed and tachypnoeic'. [Code A]'s assessment was that she was not well enough to transfer to Gosport War Memorial Hospital and she thought she was unlikely to survive. She recommended patient L be given intravenous fluids, salbutamol nebulisers, and diamorphine if distressed. [Code A] states 'if stable early next week for transfer to slow stream stroke care GWMH later in the week'.

5.6 On 10 May the notes record patient L was improving and nasogastric feeding was recommenced. [Code A] consultant Geriatrician reviewed patient L on 10 May (page 196-198) and noted that she was experiencing chest pain and had an elevated blood sodium (Na 165). [Code A] states 'if... (illegible) will take to GWMH. Please normalise Na+(has had 5% dextrose). Rule out MI ensure angina reasonable 'stable'. Make sure tolerating ng. if above OK, please transfer to GWMH next week'. A letter dated 12 May also summarises her assessment (page 66)

5.7 Later on 10 May the notes record patient L had a further episode of central chest pain which was relieved by GTN spray and her pain settled. On 12 May the notes record [Code A] spoke to patient L's family and explained her poor prognosis and the rationale for making her not for resuscitation or care on an intensive care unit if she deteriorated (p200). On 14 May she was reviewed by an orthopaedic specialist as it was thought she might have dislocated her left shoulder. This was found to be subluxation of the shoulder and no active intervention was needed (page 202). On 18 May the notes record the medical team liaised with Gosport War Memorial Hospital (page 204) and that she was tolerating her

- nasogastric feeding, was recovering from her aspiration pneumonia and showing improvement in her orientation, speech and strength, but was faecally incontinent and had a urinary catheter in place. The transfer note states that patient L was for rehabilitation (p70). On transfer she was taking prescribed aspirin, enalapril, digoxin, isosorbide mononitrate (Imdur) and "as required" subcutaneous diamorphine 5mg.
- 5.8 Patient L was transferred to Daedalus ward on 20 May. The medical records do not state the time patient L arrived on Daedalus ward. The first timed entry is at 1340h in the nursing summary. The medical notes (Vol 3 page 20) contain an entry from [Code A] which states 'Transfer to Daedalus ward S.S.S.R (Slow Stream Stroke Rehabilitation) HPC. R CVA 26-4-99. Dense L Heml. Aspiration pneumonia and MI 28-4-99. P.M.H. IHD MI x 2. AF, COPD asthma, sigmoid resection due to diverticular disease. Barthel needs help c ADL, catheterised, ng tube in situ, transfer with hoist, Barthel 0.' There are no further medical entries in the notes. The notes record in an entry by staff nurse Tubbritt that patient L died at 2230h on [Code A]
- 5.9 [Code A] states in his statement of 5 April 2008 that [Code A] did not see patient L whilst at Gosport War Memorial Hospital. In his statement dated 16 April 2004 [Code A] states he arrived on Daedalus Ward at 1830h on 20 May and had to wait to see patient L as the nurses were attending to her.
- 5.10 The nursing note summary on 20 May records '... Appears quite alert and aware of surroundings'. The notes do not record that patient L appeared distressed or in pain (vol 3 page 26). However the nursing records record 'c/o abdo pain. Due to Hx bowel problems. Gramorph given o/a (on arrival)' (Vol 3 page 28). An entry in the nursing night care plan on 20 May (Vol 3 page 60) states 'pramorph 2.5 ml given as per kardex. c/o pain in stomach and arm. Condition poor'. On 21 May the nursing records state that isosorbide was discontinued and patient L was to have GTN spray "as required". A separate entry that day states 'now on regular (4 hourly) Dramorph 10mg/5ml'.
- 5.11 At 1800h on 21 May the nursing records (Vol 3 page 34) state 'uncomfortable throughout afternoon despite 4hrly oramorph. [Code A] seen and care discussed. Very upset. Agreed to commence syringe driver for pain at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medications given should not shorten her life.' An entry at 1945h records a syringe driver was commenced at 1945h with 20mg oramorphine and 20mg midazolam over 24 hours. On 22 May 0800h the nursing notes state 'condition has deteriorated. Very bubbly. 800mcg hyoscine, 20 mg diamorphine, 20 mg midazolam commenced via syringe driver at 8am'. A further entry at 1020h states [Code A] contacted and verbal order to increase hyoscine to 1600mcg.'
6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 64 - 69. All prescriptions written by [Code A] unless otherwise marked.

Regular prescriptions

Digoxin elixir 1.2 ml od	21 May 1 dose
Prescribed 20 May	
Enalapril 5mg od	21 May 1 dose
Prescribed 20 May	
Aspirin 75mg od	21 May 1 dose
Prescribed 20 May	

Isosorbide Mononitrate 60mg Prescribed 20 May	None administered. Discontinued (date unclear)
Suby C Prescribed 20 May	None administered
GTN spray 2 puffs (pm) Prescribed 21 May	None administered
Hyoscine subcut via syringe driver 1600ucg/24hr Prescribed 22 May (verbal message)	22 May 1030h 1600mcg/24hr Code A
Oramorph 10mg/5ml 10 mg 4 times a day Prescribed 21 May	21 May 2 doses 1000h, 1400h
Oramorph 10mg/5ml 20mg nocte Prescribed 21 May	None administered
<i>Daily review prescriptions</i>	
Liquid? ng tube 4mg qds No prescription date	None administered
<i>As required prescriptions</i>	
Oramorphine 10mg/5ml 2.5-5ml Prescribed 20 May	20 May 1430h 5mg 1830h 2.5mg 2245h 2.5mg 21 May 0735h 2.5mg
Diamorphine subcut via syringe driver 20-200mg/24hr Prescribed 20 May	21 May 1920h 20mg/24hr 22 May 0800h 20mg/24hr 22 May 1030h 20mg/24hr
Hyoscine subcut via syringe driver 200-800 ucg/24hr Prescribed 20 May	22 May 0800h 800ucg/24hr
Midazolam subcut via syringe driver 20-80mg/24 hr Prescribed 20 May	21 May 1920h 20mg/24hr 22 May 0800h 20mg/24hr 22 May 1030h 20mg/24hr

Opinion on Patient Management

7. Patient L was a 73 year old woman with pre-existing cardiac disease and chronic abdominal pain who was living at home independently prior to being admitted with cardiac chest pain and a stroke in April 1999. Her stroke was severe leaving her with significant problems of left sided weakness, swallowing difficulties and inattention, which would almost certainly have left her with long term disabilities requiring care and support, either at home with the support of **Code A** and carers or in a nursing home. Following her admission she had continuing problems from a myocardial infarction, aspiration pneumonia and hypernatraemia (high blood sodium). Her problems were clearly summarised by **Code A** following her assessment 10 days after admission. She considered patient L was unlikely to

survive and I agree with this assessment. A patient aged over 70 years of age with a severe stroke, myocardial infarction and these complications would have a high likelihood of dying from these problems.

8. [Code A] recommended a treatment plan for patient L including diamorphine if distressed. I consider this was an appropriate recommendation. Patient L had cardiac chest pain and evidence of pulmonary odema both of which are appropriately treated with diamorphine. I have been unable to find the prescription chart in the medical records during her admission to Royal Hospital Haslar to determine the amount of opioid analgesia patient L received during this admission. Despite her poor state at this time [Code A] recognised that patient L might improve and indicated that if she became medically stable she would be suitable to transfer to slow stream stroke care at Gosport War Memorial Hospital. In my opinion this was an appropriate plan.
9. Slow stream stroke care or rehabilitation is a commonly used term used to describe a period of rehabilitation over a few months required for patients with severe strokes, who are often elderly and/or have other medical complications, such as in the case of patient L. Such rehabilitation often takes place in rehabilitation wards that are not on acute hospital sites. It is important that patients are medically stable before transfer to such units which usually do not have a resident on site doctor or facilities to investigate patients if they develop new medical problems.
10. Patient L was still very unwell when seen four days later on 10 May by [Code A] who summarised the ongoing medical problems that needed to be stabilised before transfer to Gosport War Memorial Hospital could be considered. One week later patient L had improved and her ongoing medical problems had stabilised with normalisation of her blood sodium, stabilisation of her chest pain and her pneumonia was resolving. She was judged to be sufficiently stable for her to be transferred to Daedalus ward for rehabilitation. At this point she had an ongoing prescription for 5mg diamorphine "as required" but I have not been able to establish how many doses she had received. From the information available in the medical notes I consider patient L was sufficiently stable on 20 May for her to be transferred to Daedalus ward, although she was at risk of developing further medical complications.
11. The nursing notes state that patient L was complaining of abdominal pain and was administered oramorphine on arrival at Daedalus ward. The drug chart indicates that the first dose of oramorphine was administered at 1430h. I would estimate that patient L arrived at Daedalus ward shortly around 1300h as the first entry on the nursing notes was timed at 1340h. [Code A] was the doctor responsible for the initial assessment of patient L. She prescribed oral morphine to patient L which was administered shortly after patient L's arrival. I would expect the nurse who initially assessed patient L and documented she had abdominal pain on arrival at the ward would have informed [Code A] of this. It is routine practice for nursing staff to admit and assess a patient before the admitting doctor sees a patient arriving on a ward. Even if the nurse had not informed [Code A] that patient L was complaining of abdominal pain I would have expected [Code A] to assess patient L as a new patient arriving on the ward, and note any current symptoms and examine the patient L. Given the medical problems patient L had recently experienced it would be particularly important that [Code A] undertook such an assessment of patient L.
12. [Code A]'s entry on 20 May makes no mention of patient L being in pain and contains no record of a physical examination of patient L. As patient L was complaining of abdominal

pain, it would have been appropriate for [Code A] to have recorded the patient's account of pain if she was able to give such an account, or that the nursing staff had noted she was in pain. The medical notes suggest abdominal pain was a new complaint of patient L's since her admission to hospital although she had a history of chronic abdominal pain. It would have been appropriate for [Code A] to undertake a clinical assessment of patient L including examining her abdomen. There is no evidence in the notes that [Code A] undertook such a clinical assessment. The information recorded by [Code A] could have been obtained entirely from the information contained in the Royal Hospital Haslar notes and transfer letter, and from the nursing assessment. In my opinion the information available in the notes suggests [Code A] failed to undertake an adequate clinical assessment of patient L after she arrived on the ward on 20 May.

13. On 20 May [Code A] prescribed oramorphine and also subcutaneous infusions of diamorphine, hyoscine and midazolam. It is not clear if the last three prescriptions for subcutaneous drug infusions were written at the same time as the oramorphine. [Code A] did not record in the records why she prescribed oramorphine to patient L. It is unclear if this was to replace the diamorphine "as required" prescription that was in place or was commenced for the treatment of the abdominal pain patient L was complaining of on admission to Daedalus ward.
14. I consider the prescription by [Code A] of oramorphine to replace the "as required" diamorphine for chest pain or distress related to pulmonary oedema if this occurred in patient L would not be optimal because when patient are acutely unwell with such symptoms the oral route for administering opiates leads to slower absorption and patients may be too unwell or nauseated to take oral medication. It would have been preferable to continue the prn subcutaneous diamorphine prescription which had been in place for patient L at Royal Hospital Haslar. The "as required" prescription for oramorphine should have specified the symptoms that [Code A] intended the oramorphine be given for. In my opinion the prescription of oramorphine was not optimal practice if it was a replacement for the diamorphine prescription.
15. However if [Code A] had given clear written instructions to nursing staff, in either the drug chart or in the medical notes I would not consider such an action constituted a failure of good medical practice. If [Code A] had given clear verbal instructions to the nursing staff that the oramorphine was replacing the "as required" diamorphine prescription and the circumstances under which it should be administered there would be a risk of nursing staff misunderstanding the reasons oramorphine was prescribed. The nursing records state that the initial dose of oramorphine was given to patient L for abdominal pain. On the basis of the information available in the medical records [Code A] failed to either record or inform the nursing staff that the oramorphine was replacing the "as required" diamorphine and the circumstances under which the oramorphine should be given if this had been her intention. Therefore if the oramorphine was intended to replace the diamorphine prescription I consider the oramorphine prescription was not appropriately prescribed and potentially hazardous, as the oramorphine could have been given for other symptoms for which it was not intended such as abdominal pain.
16. If [Code A] prescribed the "as required" oramorphine to relieve abdominal pain in patient L, I consider this was inappropriate and potentially hazardous, since there is no record in the medical notes that [Code A] performed a clinical assessment, or considered whether any investigations, such as an abdominal Xray and blood tests were required, or discussion with a senior colleague was required. If as seems possible the abdominal pain was a recurrence

of her chronic abdominal pain, opioids were not an appropriate treatment. Opioid drugs had not been prescribed to patient L for abdominal pain in the past when patient L had been assessed by consultant specialists. In my opinion from the information available in the notes the prescription on 20 May of "as required" oramorphine by [Code A] was inappropriate and potentially hazardous to patient L, as the oramorphine was administered for abdominal pain and there had not been an adequate clinical assessment of patient L undertaken by [Code A] and no instructions had been given as to the circumstances under which oramorphine should be administered.

17. It is unclear who made the decision that diamorphine and midazolam infusions should be administered to patient L on 21 May. The nursing notes record this was discussed with patient L's [Code A] that evening and the infusion commenced at 1945h. The notes do not record if the decision to commence these infusions was discussed with [Code A] or another member of medical staff. The nursing notes suggest that these were commenced because patient L was uncomfortable despite 4 hourly oramorphine. [Code A] had commenced regular oramorphine the morning of 21 May, although the notes do not record the symptoms being treated or the underlying diagnosis considered responsible for the pain. Before prescribing a diamorphine infusion there should have been a clinical assessment of the cause of the pain and response to oramorphine and the reasons why a subcutaneous infusion was necessary, but there is no evidence in the notes that this took place.
18. Patient L was able to receive oramorphine through the nasogastric tube she was being fed through. This had been pulled out on the morning of 20 May. If the nasogastric tube was not in place and patient L was unable to swallow oral medication, this might have been a reason to consider administering opioids by a subcutaneous infusion if they were indicated. The nursing notes do not record there was a problem with administering oramorphine and she had received two doses at 1000h and 1400h before the diamorphine infusion was commenced at 1920h.
19. In the preceding 24 hours patient L had received 27.5 mg oramorphine (2.5+2.5+25+10+10). An equivalent dose of subcutaneous diamorphine would be one third to a half of the dose of morphine received i.e. 9mg-14mg over 24 hours. The diamorphine infusion was commenced at 20mg/24hr was within an acceptable starting dose if continuing opioid drugs by using a subcutaneous infusion as appropriate and patient L's pain was uncontrolled on the oramorphine and this would be 50% greater than the equivalent dose. The prescription by [Code A] of diamorphine in the dose range 20-200mg/24hr was excessively wide and placed patient L at risk of developing respiratory depression and coma if a higher infusion rate had been commenced.
20. I can find no justification in the medical or nursing notes for the prescription and commencement of the midazolam infusion. Patient L was medically stable and transferred for rehabilitation on 20 May when [Code A] wrote the prescription for midazolam. Midazolam is indicated for terminal restlessness and is also indicated in the Wessex Protocol' for the management of anxiety in a palliative care setting for patients already receiving drugs through a syringe driver. The notes contain no information which suggests patient L was restless or agitated. If patient L had been agitated or restless a clinical assessment was indicated to establish the cause, but there is no evidence in the notes that this occurred.
21. The dose of subcutaneous midazolam prescribed by [Code A] was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of

developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-60mg/24hr. In an older patient an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 20mg/24hr was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr beyond that recommended. The prescribed dose range of midazolam prescribed particularly in conjunction with the diamorphine prescribed placed Patient L at high risk of developing life threatening complications.

22. On the morning of 22 May, a Saturday, the on call doctor [Code A] was contacted because patient L had deteriorated and was experiencing increasing secretions from her chest and airways. Ideally a clinical assessment should have taken place at this time point and the cause of the deterioration and possible contributory role of the drugs she was receiving considered. However if [Code A] had been told by ward nursing staff that patient L had been assessed by the medical team and was terminally ill, and for palliative care I would not consider there was a duty of care for [Code A] to visit Daedalus ward and assess patient L unless the nursing staff had very clearly requested this.
23. In my opinion the subsequent deterioration in Patient L on 21 May until her death [Code A] [Code A] was very likely due to diamorphine and midazolam leading to respiratory depression and coma. However because of the limited detail in the nursing and medical notes and lack of a clinical assessment I cannot exclude the possibility that patient L died from another undiagnosed problem that developed immediately after she was transferred to Daedalus ward.
24. Although patient L had been seriously ill and was not expected to survive 10-14 days prior to her transfer this was not the case when she was transferred to Daedalus ward. Patient L and was not expected to die within a few days or weeks from a progressive non curable condition. I cannot determine from the medical records whether [Code A] considered patient L had deteriorated and was dying, but if this was her view she should have assessed patient L and discussed the change in her status with the responsible consultant or another senior colleague.
25. Patient L was transferred from Royal Hospital Haslar for rehabilitation and was considered medically stable on the morning of 20 May. Within 24 hours of transfer she was receiving diamorphine and midazolam infusions and died within 48 hours of transfer. This dramatic change in her condition should have led to a detailed medical assessment by [Code A] discussion with the consultant responsible for Daedalus ward and the referring medical team but there is no evidence in the notes that any of these took place. The reference in the nursing records to patient L's husband not wishing the medications should shorten her life also indicates he wished appropriate active measures to be taken to enable her to survive.

Summary of Conclusions

26. Patient L was a 73 year old woman with a disabling stroke and recent myocardial infarct transferred to Daedalus ward for stroke rehabilitation. She was considered medically stable for transfer and was not expected to die within a few days unless new complications developed. The information in the notes suggest there was inadequate assessment of patient L by [Code A] as the doctor responsible for the day to day medical care of the patient with no clinical findings recorded of an assessment of patient L's abdominal pain, or justification for the prescriptions of oramorphine and subcutaneous diamorphine and

midazolam. The prescriptions of subcutaneous infusions of diamorphine and midazolam in the wide dose ranges used were highly risky.

27. In my opinion the combination of diamorphine and midazolam very likely shorten Patient L's life. However the very limited content of the medical notes make it difficult to exclude the possibility that patient L developed a new medical problem on transfer to Daedalus ward that led to her deterioration and death.

28. In my opinion Code A in her care of Patient L failed to meet the requirements of good medical practice:

- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
- to consult colleagues;
- to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
- to prescribe only the treatment, drugs or appliances that serve patients' needs.

29. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
Code A

GMC and Code A
Report on Code A (Patient L)

Code A
Consultant Physician

19 April 2009

GMC and [Code A]
Patient L

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient L commenting on the care and treatment carried out by [Code A] in relation to this patient, to assist the GMC Panel in determining whether [Code A] has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that; [Code A] did not properly assess patient L on admission; the prescriptions by [Code A] of oramorphine, diamorphine and midazolam were not clinically justified and created a situation whereby drugs could be administered which were excessive to patient L's need; that the prescriptions were inappropriate, potentially hazardous and not in the best interests of Patient L.

2.

Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.
4. This report is based on my review of the following documents; medical records of Patient L; statements of [Code A] and various nurse statements.

5. Course of events

5.1 Patient L was a 73 years old when admitted to Royal Hospital Haslar on 26 April 1999 after experiencing chest pain and then collapsed at home after developing left arm and leg weakness. She was transferred to Daedalus ward, Gosport War Memorial Hospital on 20 May 1999 and died on that ward on [Code A] Prior to this admission she was living at home with [Code A] Her past medical history (page 174) included ischaemic heart disease and previous myocardial infarction, atrial fibrillation, asthma and chronic airways disease, and surgery for diverticular disease and a stricture. She had problems with recurrent lower abdominal pain thought to be due to adhesions (page 129) or irritable bowel syndrome (page 125). She had rated her health as poor in October 1997 (page 150).

5.2 The admission clerking to Royal Hospital Haslar documents she had developed new left face, arm and leg weakness and slurred speech. She was complaining of a headache and was thought to have had a stroke. A CT brain scan was obtained on 26 April 1999 (page 177) and demonstrated infarction in the right parietal lobe indicating she had a stroke due to cerebral infarction (blocked blood vessel). The notes state that an ECG showed atrial

fibrillation and ischaemic changes. Cardiac enzymes were elevated (CKMB 65) suggesting she had possibly sustained a myocardial infarction as the cause of her chest pain.

5.3 The notes record on 27 April 1999 (page 178) that she was alert and had left sided neglect. A nasogastric tube was paced to commence feeding as he swallow was unsafe. On 28 April 1999 the notes record she was experiencing continuing chest pain thought to be due to angina (page 180). An ECG showed ST elevation and she was transferred to the coronary care unit (CCU) and treated with a nitrate infusion (page 182). An entry in the medical notes on 30 April states that ECGs had confirmed she had experienced an anterior myocardial infarct. Later that day she developed increasing shortness of breath (page 183). The notes record she was hypoxic (low oxygen in the blood) and had signs on examination suggesting she had either a chest infection or pulmonary oedema due to fluid overload. A chest X Ray found the nasogastric tube was not in the stomach and feed had been passed into the nasopharynx suggesting she had developed an aspiration pneumonia. Antibiotics were commenced (Page 184).

5.4 On 5 May 1999 the notes record patient L was able to start taking food (page 190). A referral was made by the medical team to [Code A] Geriatrician (page 190) stating that she was improving and requesting [Code A]'s opinion on the provision of rehabilitation. Later that day the notes record she was less well (page 191) and was in respiratory failure. She was treated with oxygen and small doses of diamorphine. The notes record patient L had a reasonable quality of life prior to her stroke (page 192). After discussion with the family a decision was made that she was for active treatment bit not for ventilation if she deteriorated. An entry in the notes the following day record a discussion with the consultant and a decision that she was not for resuscitation.

5.5 [Code A] assessed patient L on 6 May 1999 (page 194). [Code A] records in the notes that patient L was extremely unwell with problems of a dense left hemiparesis due to stroke, myocardial infarction, atrial fibrillation, and aspiration pneumonia. The notes document she was *'chesty, flushed and tachypnoeic'*. [Code A]'s assessment was that she was not well enough to transfer to Gosport War Memorial Hospital and she thought she was unlikely to survive. She recommended patient L be given intravenous fluids, salbutamol nebulisers, and diamorphine if distressed. [Code A] states *'If stable early next week for transfer to slow stream stroke care GWMH later in the week'*.

5.6 On 10 May 1999 the notes record patient L was improving and nasogastric feeding was recommenced. [Code A] Geriatrician reviewed patient L on 10 May 1999 (page 196-198) and note that she was experiencing chest pain and had an elevated blood sodium (Na 165). [Code A] states *'If... (illegible) will take to GWMH. Please normalise Na+(has had 5% dextrose). Rule out MI ensure angina reasonable 'sable'. Make sure tolerating ng. If above OK, please transfer to GWMH next week'*. A letter dated 12th May also summarises her assessment (page 68)

5.7 Later on 10 May the notes record patient L had a further episode of central chest pain which was relieved by GTN spray and her pain settled. On 12 May the notes record [Code A] spoke to patient L's family and explained her poor prognosis and the rationale for making her not for resuscitation or are on an intensive care unit if she deteriorated (p200). On 14 May she was reviewed by an orthopaedic specialist as it was thought she might have dislocated he let shoulder. This was found to be subluxation of the shoulder and no active intervention was needed (page 202). On 18 May the notes record the medical team liaised with Gosport War Memorial Hospital (page 204) and that she was tolerating her

nasogastric feeding, was recovering from her aspiration pneumonia and showing improvement in her orientation, speech and strength, but was faecally incontinent and had a urinary catheter in place. The transfer note states that patient L was for rehabilitation (p70). On transfer she was taking prescribed aspirin, enalapril, digoxin, isosorbide mononitrate (Imdur) and as required subcutaneous diamorphine 5mg.

5.8 Patient L was transferred to Daedalus ward on 20 May 1999. The medical records do not state the time patient L arrived on Daedalus ward. The first timed entry is at 1340h in the nursing summary. The medical notes (Vol 3 page 20) contain an entry from [Code A] which states *'Transfer to Daedalus ward S.S.S.R (Slow Stream Stroke Rehabilitation) HPC. R CVA 26-4-99. Dense L Hemi. Aspiration pneumonia and MI 28-4-99. P.M.H. IHD MI x 2. AF, COPD asthma, sigmoid resection due to diverticular disease. Barthel needs help c ADL, catheterised, ng tube in situ, transfer with hoist, Barthel 0.'* There are no further medical entries in the notes. The notes record in an entry by staff nurse [Code A] that patient L died at 2230h on [Code A]

5.9 [Code A] states in his statement of 5 April 2008 that [Code A] did not see patient L whilst at Gosport War Memorial Hospital. In his statement dated 16 April 2004 [Code A] states he arrived on Daedalus Ward at 1330h on 20 May and had to wait to see patient L as the nurses were attending to her.

5.10 The nursing note summary on 20 May records *'... Appears quite alert and aware of surroundings'*. The notes do not record that patient L appeared distressed or in pain (vol 3 page 26). However the nursing records record *'c/o abdo pain. Due to Hx bowel problems. Oramorph given o/a (on arrival)'* (Vol 3 page 28). An entry in the nursing night care plan on 20 May Vol 3 page 60) states *'oramorph 2.5 ml given as per kardex. c/o pain in stomach and arm. Condition poor'*. On 21 May the nursing records state that isosorbide was discontinued and patient L was to have GTN spray as required. A separate entry that day states *'now on regular (4 hourly) Oramorph 10mg/5ml'*.

5.11 At 1800h on 21 May the nursing records (Vol 3 page 34) state *'uncomfortable throughout afternoon despite 4hrly oramorph. [Code A] seen and care discussed. Very upset. Agreed to commence syringe driver for pain at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medications given should not shorten her life.'* An entry at 1945h records a syringe driver was commenced at 1945h with 20mg oramorphine and 20mg midazolam over 24 hours. On 22 May at 0800h the nursing notes state *'condition has deteriorated. Very bubbly. 800mcg hyoscine, 20 mg diamorphine, 20 mg midazolam commenced via syringe driver at 8am'*. A further entry at 1020h states [Code A] *'contacted and verbal order to increase hyoscine to 1600mcg.'*

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 64 - 69. All prescriptions written by [Code A] unless otherwise marked.

Regular prescriptions

Digoxin elixir 1.2 ml od	21 May 1 dose
Prescribed 20 May	
Enalapril 5mg od	21 May 1 dose
Prescribed 20 May	
Aspirin 75mg od	21 May 1 dose
Prescribed 20 May	

Isosorbide Mononitrate 60mg Prescribed 20 May	None administered. Discontinued (date unclear)
Suby C Prescribed 20 May	None administered
GTN spray 2 puffs (prn) Prescribed 21 May	None administered
Hyoscine subcut via syringe driver 1600ucg/24hr Prescribed 22 May (verbal message: Code A)	22 May 1030h 1600mcg/24hr
Oramorph 10mg/5ml 10 mg 4 times a day Prescribed 21 May	21 May 2 doses 1000h, 1400h
Oramorph 10mg/5ml 20mg nocte Prescribed 21 May	None administered
Daily review prescriptions	
Liquid? ng tube 4mg qds No prescription date	None administered
As required prescriptions	
Oramorphine 10mg/5ml 2.5-5ml Prescribed 20 May	20 May 1430h 5mg 1830h 2.5mg 2245h 2.5mg 21 May 0735h 2.5mg
Diamorphine subcut via syringe driver 20-200mg/24hr Prescribed 20 May	21 May 1920h 20mg/24hr 22 May 0800h 20mg/24hr 22 May 1030h 20mg/24hr
Hyoscine subcut via syringe driver 200-800 ucg/24hr Prescribed 20 May	22 May 0800h 800ucg/24hr
Midazolam subcut via syringe driver 20-80mg / 24 hr Prescribed 20 May	21 May 1920h 20mg/24hr 22 May 0800h 20mg/24hr 22 May 1030h 20mg/24hr

Opinion on Patient Management

7. Patient L was a 73 year old woman with pre-existing cardiac disease and chronic abdominal pain who was living at home independently prior to being admitted with cardiac chest pain and a stroke in April 1999. Her stroke was severe leaving her with significant problems of left sided weakness, swallowing difficulties and inattention, which would almost certainly have left her with long term disabilities requiring care and support, either at home with the support of Code A and carers or in a nursing home. Following her admission she had continuing problems from a myocardial infarction, aspiration pneumonia and hypernatraemia (high blood sodium). Her problems were clearly summarised by Code A following her assessment 10 days after admission. She considered patient L was unlikely to survive and I agree with this assessment. A patient aged over 70 years of age with a severe

stroke, myocardial infarction and these complications would have a high likelihood of dying from these problems.

8. [Code A] recommended a treatment plan for patient L including diamorphine if distressed. I consider this was an appropriate recommendation. Patient L had cardiac chest pain and evidence of pulmonary odema both of which are appropriately treated with diamorphine. I have been unable to find the prescription chart in the medical records during her admission to Royal Hospital Haslar to determine the amount of opioid analgesia patient L received during this admission. Despite her poor state at this time [Code A] recognised that patient L might improve and indicated that if she became medically stable she would be suitable to transfer to slow stream stroke care at Gosport War Memorial Hospital. In my opinion this was an appropriate plan.
9. Slow stream stroke care or rehabilitation is a commonly used term used to describe a period of rehabilitation over a few months required for patients with severe strokes, who are often elderly and/or have other medical complications, such as in the case of patient L. Such rehabilitation often takes place in rehabilitation wards that are not on acute hospital sites. It is important that patients are medically stable before transfer to such units which usually do not have a resident on site doctor or facilities to investigate patients if they develop new medical problems.
10. Patient L was still very unwell when seen four days later on 10 May by [Code A] who summarised the ongoing medical problems that needed to be stabilised before transfer to Gosport War Memorial Hospital could be considered. One week later patient L had improved and her ongoing medical problems had stabilised with normalisation of her blood sodium, stabilisation of her chest pain and her pneumonia was resolving. She was judged to be sufficiently stable for her to be transferred to Daedalus ward for rehabilitation. At this point she had an ongoing prescription for 5mg diamorphine as required but I have not been able to establish how many doses she had received. From the information available in the medical notes I consider patient L was sufficiently stable on 20 May for her to be transferred to Daedalus ward, although she was at risk of developing further medical complications.
11. The nursing notes state that patient L was complaining of abdominal pain and was administered oramorphine on arrival at Daedalus ward. The drug chart indicate that the first dose of oramorphine was administered at 1430h. I would estimate that patient L arrived at Daedalus ward shortly around 1300h as the first entry on the nursing notes was timed at 1340h. [Code A] was the doctor responsible for the initial assessment of patient L. She prescribed oral morphine to patient L which was administered shortly after patient L's arrival. I would expect the nurse who initially assessed patient L and documented she had abdominal pain on arrival at the ward would have informed [Code A] of this. It is routine practice for nursing staff to admit and assess a patient before the admitting doctor sees a patient arriving on a ward. Even if the nurse had not informed [Code A] that patient L was complaining of abdominal pain I would have expected [Code A] to assess patient L as a new patient arriving on the ward, and note any current symptoms and examine the patient L. Given the medical problems patient L had recently experienced it would be particularly important that [Code A] undertook such an assessment of patient L.
12. [Code A]'s entry on 20 May makes no mention of patient L being in pain and contains no record of a physical examination of patient L. As patient L was complaining of abdominal pain, it would have been appropriate for [Code A] to have recorded the patient's account of pain if she was able to give such an account, or that the nursing staff had noted she was in

pain. The medical notes suggest abdominal pain was a new complaint of patient L's since her admission to hospital although she had a history of chronic abdominal pain. It would have been appropriate for [Code A] to undertake a clinical assessment of patient L including examining her abdomen. There is no evidence in the notes that [Code A] undertook such a clinical assessment. The information recorded by [Code A] could have been obtained entirely from the information contained in the Royal Hospital Haslar notes and transfer letter, and from the nursing assessment. In my opinion the information available in the notes suggests [Code A] failed to undertake an adequate clinical assessment of patient L after she arrived on the ward on 20 May 1999.

13. On 20 May [Code A] prescribed oramorphine and also subcutaneous infusions of diamorphine, hyoscine and midazolam. It is not clear if the last three prescriptions for subcutaneous drug infusions were written at the same time as the oramorphine. [Code A] did not record in the records why she prescribed oramorphine to patient L. It is unclear if this was to replace the diamorphine as required prescription that was in place or was commenced for the treatment of the abdominal pain patient L was complaining of on admission to Daedalus ward.
14. I consider the prescription by [Code A] of oramorphine to replace the as required diamorphine for chest pain or distress related to pulmonary oedema if this occurred in patient L would not be optimal because when patient are acutely unwell with such symptoms the oral route for administering opiates leads to slower absorption and patients may be too unwell or nauseated to take oral medication. It would have been preferable to continue the prn subcutaneous diamorphine prescription which had been in place for patient L at Royal Hospital Haslar. The as required prescription for oramorphine should have specified the symptoms that [Code A] intended the oramorphine be given for. In my opinion the prescription of oramorphine was not optimal practice if it was a replacement for the diamorphine prescription.
15. However if [Code A] had given clear written instructions to nursing staff, in either the drug chart or in the medical notes I would not consider such an action constituted a failure of good medical practice. If [Code A] had given clear verbal instructions to the nursing staff that the oramorphine was replacing the as required diamorphine prescription and the circumstances under which it should be administered there would be a risk of nursing staff misunderstanding the reasons oramorphine was prescribed. The nursing records state that the initial dose of oramorphine was given to patient L for abdominal pain. On the basis of the information available in the medical records [Code A] failed to either record or inform the nursing staff that the oramorphine was replacing the as required diamorphine and the circumstances under which the oramorphine should be given if this had been her intention. Therefore if the oramorphine was intended to replace the diamorphine prescription I consider the oramorphine prescription was not appropriately prescribed and potentially hazardous, as the oramorphine could have been given for other symptoms for which it was not intended such as abdominal pain.
16. If [Code A] prescribed the as required oramorphine to relieve abdominal pain in patient L, I consider this was inappropriate and potentially hazardous, since there is no record in the medical notes that [Code A] performed a clinical assessment, or considered whether any investigations, such as an abdominal Xray and blood tests were required, or discussion with a senior colleague was required. If as seems possible the abdominal pain was a recurrence of her chronic abdominal pain, opioids were not an appropriate treatment. Opioid drugs had not been prescribed to patient L for abdominal pain in the past when patient L had been

assessed by consultant specialists. In my opinion from the information available in the notes the prescription on 20 May 1990 of as required oramorphine by [Code A] was inappropriate and potentially hazardous to patient L, as the oramorphine was administered for abdominal pain and there had not been an adequate clinical assessment of patient L undertaken by [Code A] and no instructions had been given as to the circumstances under which oramorphine should be administered.

17. It is unclear who made the decision that diamorphine and midazolam infusions should be administered to patient L on 21 May. The nursing notes record this was discussed with patient L's [Code A] that evening and the infusion commenced at 1945h. The notes do not record if the decision to commence these infusions was discussed with [Code A] or another member of medical staff. The nursing notes suggest that these were commenced because patient L was uncomfortable despite 4 hourly oramorphine. [Code A] had commenced regular oramorphine the morning of 21 May, although the notes do not record the symptoms being treated or the underlying diagnosis considered responsible for the pain. Before prescribing a diamorphine infusion there should have been a clinical assessment of the cause of the pain and response to oramorphine and the reasons why a subcutaneous infusion was necessary, but there is no evidence in the notes that this took place.
18. Patient L was able to receive oramorphine through the nasogastric tube she was being fed through. This had been pulled out on the morning of 20 May. If the nasogastric tube was not in place and patient L was unable to swallow oral medication, this might have been a reason to consider administering opioids by a subcutaneous infusion if they were indicated. The nursing notes do not record there was a problem with administering oramorphine and she had received two doses at 1000h and 1400h before the diamorphine infusion was commenced at 1920h.
19. In the preceding 24 hours patient L had received 27.5 mg oramorphine (2.5+2.5+25+10+10). An equivalent dose of subcutaneous diamorphine would be one third to a half of the dose of morphine received i.e. 9mg-14mg over 24 hours. The diamorphine infusion was commenced at 20mg/24hr was within an acceptable starting dose if continuing opioid drugs by using a subcutaneous infusion as appropriate and patient L's pain was uncontrolled on the oramorphine and this would be 50% greater than the equivalent dose. The prescription by [Code A] of diamorphine in the dose range 20-200mg/24hr was excessively wide and placed patient L at risk of developing respiratory depression and coma if a higher infusion rate had been commenced.
20. I can find no justification in the medical or nursing notes for the prescription and commencement of the midazolam infusion. Patient L was medically stable and transferred for rehabilitation on 20 May 1999 when [Code A] wrote the prescription for midazolam. Midazolam is indicated for terminal restlessness and is also indicated in the Wessex Protocol for the management of anxiety in a palliative care setting for patients already receiving drugs through a syringe driver. The notes contain no information which suggests patient L was restless or agitated. If patient L had been agitated or restless a clinical assessment was indicated to establish the cause, but there is no evidence in the notes that this occurred.
21. The dose of subcutaneous midazolam prescribed by [Code A] was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-60mg/24hr. In an older patient an appropriate starting

dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 20mg/24hr was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr beyond that recommended. The prescribed dose range of midazolam prescribed particularly in conjunction with the diamorphine prescribed placed Patient L at high risk of developing life threatening complications.

22. On the morning of 22 May 1999, a Saturday, the on call doctor [Code A] was contacted because patient L had deteriorated and was experiencing increasing secretions from her chest and airways. Ideally a clinical assessment should have taken place at this time point and the cause of the deterioration and possible contributory role of the drugs she was receiving considered. However if [Code A] had been told by ward nursing staff that patient L had been assessed by the medical team and was terminally ill, and for palliative care I would not consider there was a duty of care for [Code A] to visit Daedalus ward and assess patient L unless the nursing staff had very clearly requested this.
23. In my opinion the subsequent deterioration in Patient L on 21 May until her death [Code A] [Code A] was very likely due to diamorphine and midazolam leading to respiratory depression and coma. However because of the limited detail in the nursing and medical notes and lack of a clinical assessment I cannot exclude the possibility that patient L died from another undiagnosed problem that developed immediately after she was transferred to Daedalus ward.
24. Although patient L had been seriously ill and was not expected to survive 10-14 days prior to her transfer this was not the case when she was transferred to Daedalus ward. Patient L and was not expected to die within a few days or weeks from a progressive non curable condition. I cannot determine from the medical records whether [Code A] considered patient L had deteriorated and was dying, but if this was her view she should have assessed patient L and discussed the change in her status with the responsible consultant or another senior colleague.
25. Patient L was transferred from Royal Hospital Haslar for rehabilitation and was considered medically stable on the morning of 20 May 1999. Within 24 hours of transfer she was receiving diamorphine and midazolam infusions and died within [Code A] of transfer. This dramatic change in her condition should have led to a detailed medical assessment by [Code A] [Code A] discussion with the consultant responsible for Daedalus ward and the referring medical team but there is no evidence in the notes that any of these took place. The reference in the nursing records to patient L's [Code A] not wishing the medications should shorten her life also indicates he wished appropriate active measures to be taken to enable her to survive.

Summary of Conclusions

26. Patient L was a 73 year old woman with a disabling stroke and recent myocardial infarct transferred to Daedalus ward for stroke rehabilitation. She was considered medically stable for transfer and was not expected to die within a few days unless new complications developed. The information in the notes suggest there was inadequate assessment of patient L by [Code A] as the doctor responsible for the day to day medical care of the patient with no clinical findings recorded of an assessment of patient L's abdominal pain, or justification for the prescriptions of oramorphine and subcutaneous diamorphine and

midazolam. The prescriptions of subcutaneous infusions of diamorphine and midazolam in the wide dose ranges used were highly risky.

27. In my opinion the combination of diamorphine and midazolam very likely shorten Patient L's life. However the very limited content of the medical notes make it difficult to exclude the possibility that patient L developed a new medical problem on transfer to Daedalus ward that led to her deterioration and death.
28. In my opinion [Code A] in her care of Patient L failed to meet the requirements of good medical practice:
- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
 - to consult colleagues;
 - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
 - to prescribe only the treatment, drugs or appliances that serve patients' needs.

Declaration

29. I understand my duties as an expert, as set out at paragraph [] of my Generic Report.