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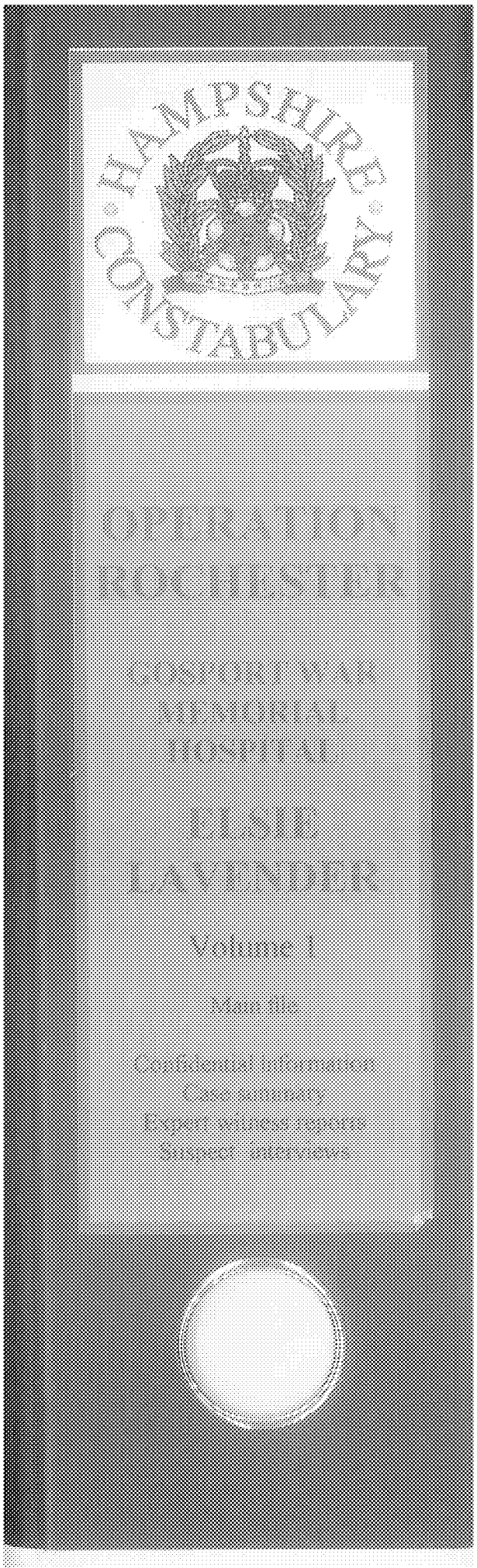

Volume 1

Tab 43

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4. Generic Case File (exhibits)
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Operation ROCHESTER

Elsie LAVENDER.

KEYPOINTS May 2005.

Elsie Hester LAVENDER Born 04.11.1912.

Diabetic and insulin dependant since the 1940's when she was 53.

Generally strong healthy and independent, other than poor eyesight and recorded high blood pressure in 1986.

February 1996 suffered a fall at her Gosport home address from the top to the bottom of the stairs, suffering head lacerations found by her home help.

She was admitted to Haslar Hospital on 5th February 1996.

Following admission noted to suffer pain in her shoulders, she received regular analgesia comprising Co-Proximal and Dihydrocodeine.

Examined by Doctor LORD on 13th February 1996, who confirms bilateral weakness of both legs.

Transpired that she had suffered a brain stem stroke, made excellent progress towards recovery and being prepared for release, walking with a frame, talking coherently (according to next of kin her son)

On 22nd February 1996 transferred to Daedelus Ward, Gosport War Memorial Hospital for rehabilitation.

Noted that Mrs LAVENDER suffering severe incontinence and leg ulcers.
Is catheterised throughout, suffering bed sores assessed as grossly dependent, mental test score normal.

On 24th February Nursing records report a meeting with Mrs LAVENDERS son, comment that' son is happy to make Mrs LAVENDER comfortable, and syringe driver explained'. Slow release morphine 10mgs was commenced.

In response to a question from Mrs LAVENDERS son about the timing of her release, DR BARTON allegedly told him 'you can get rid of the cat , you do know that your mother has come here to die'.

On 26th February it is noted on medical records that the patient is 'not so well', Oral morphine is increased to 20mgs.

On 27th February the nursing plan first mentions significant pain, describes pain on most days until 5th March when pain is uncontrolled and the patient is distressed.

On the 4th March Oramorph increased to 30mg and administered.

On 5th March notes indicate that the patient has deteriorated further and to start syringe driver analgesia. 100-200mgs with 40mgs of midazolam (pro-actively prescribed).

Mrs LAVENDER died on 6th March 1996.

Cause of death recorded and certified by Dr BARTON as 'cerebral-vascular accident diabetes mellitus.'

Case assessed by multidisciplinary key clinical team 2004.

Elsie LAVENDER. 83. 22nd February 1996 – 6th March 1996. Head Injury or brain - stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. It was possibly musculoskeletal pain from a fall downstairs. Other forms of analgesia such as anti-inflammatory drugs or hot/cold packs might have worked. The most worrying aspect is the large dose escalation when converting Morphine to Diamorphine via syringe driver (Five fold increase). The cause of death is unclear and the dose escalation might have contributed.

Dr Jane BARTON. From Caution interview with Police 24th March 2005.

Workplace demands were substantial and a choice had to be made between detailed note making or spending more time with patients.

Felt obliged to adopt a policy of pro-active prescribing given constraints/demands on her time.

Consultant Geriatrician DR TANDY had recorded in a letter on 16th February that Mrs LAVENDER had most likely suffered a brain stem stroke leading to the fall. Dr TANDY confirmed atrial fibrillation on examination but heard no murmurs. Made mention of iron deficiency anaemia and stroke and agreed to take the patient to Daedalus Ward for rehabilitation as soon as possible.

Dr BARTON entered on the transfer assessment of 22nd February details of the fall, head laceration, leg ulcers, sever incontinence needing a catheter, urine incontinence, needing help to dress and feed, she adds that the patient was profoundly dependent.

The prognosis for the patient was not good her being blind, diabetic, with brain stem stroke, and immobile. The hope was for rehabilitation.

Prescribed for congestive cardiac failure, diabetes, anaemia, asthma, and dihydrocodeine for pain relief.

The following day prescribed for a urinary tract infection.

On 24th prescribed morphine sulphate in addition to dihydrocodeine for pain relief.

Increased dosage for pain relief on 26th February, her bottom was very sore, Pegasus mattress arranged for pressure sores.

No recollection of meeting with the son of the patient on the 26th February.

The circumstances of the fall with pre-existing illness can have a serious and deleterious effect on health leading to death. May have mentioned to son that his mother was dying, believe would have discussed options for pain relief.

Might have explained that administration of proper pain relieving medication might have the incidental and undesired effect of hastening death.

Following discussion with son wrote up a proactive prescription for further pain relief for diamorphine, would have anticipated that the nursing staff would contact her so that she could authorise administration as necessary within the dosing range.

Saw the patient on 29th February and 1st March, to review condition which was slowly deteriorating.

Next saw on 4th March Oramorph slow release increased.

Reviewed again on 5th March, pain relief clearly inadequate, Mrs LAVENDER had had a poor night and was distressed, diamorphine and midazolam authorised via syringe driver, considered doses appropriate in view of uncontrolled pain.

On 6th March Mrs LAVENDER comfortable and peaceful, medication successful in relieving the significant pain and distress, Dr BARTON aware that she was dying, and content for a nurse to confirm death.

Expert Dr Andrew WILCOCK (Palliative medicine and Medical Oncology) comments:-

- Notes inadequate.
- Cause and treatment of Mrs LAVENDER'S urinary tract infection not properly assessed/treated.
- Morphine may have been inappropriate or excessive to the type of pain experienced and the possible role this played in her deterioration was not considered.
- Treatments were continued that may have aggravated her condition ie the diuretic.
- Excessive doses of diamorphine/midazolam from 26th February 1996.
- Blood tests of 27th February 1996 revealed low platelet count and deteriorating kidney function, not reflected in the notes and no action taken, not discussed with a consultant or specialist advice.
- On 29th February 1996 no mention of high blood sugar requiring high doses of insulin. No mention of pain in medical notes therefore inconsistent with nursing notes.
- No pain assessment recorded against increase in morphine of 4th March 1996.
- The reported deterioration mentioned in the notes of 5th March is not explained.
- There is reasonable doubt that Mrs LAVENDER had reached her terminal phase. Causes of her decline may have been reversible with appropriate treatment.
- Ultimately excessive doses of diamorphine and midazolam could have contributed more than minimally trivially or negligibly towards her death, Dr BARTON leaves herself open to the accusation of gross negligence.
- Cause of death registered as cerebrovascular accident, validity difficult to comment upon but final deterioration does not seem typical of cerebrovascular accident, more likely immobility from fall leading to infection.

Expert Dr David BLACK (Geriatrics) reports that Mrs LAVENDER represents the most complex and challenging problems of geriatric medicine.

- Patient suffered long standing multiple medical problems, after admission found to be doubly incontinent, totally dependent, suffering constant pain to shoulders and arms and found to have serious abnormalities in various blood tests.
- Increasing physical dependency and increased patient distress.
- Doctors and consultants failed to make adequate medical assessment and diagnosis of her condition.
- Dr BLACK believes Mrs LAVENDER was misdiagnosed and had suffered a quadriplegia from a high cervical spinal cord injury secondary to her fall.

- Abnormal blood tests could have represented systemic illness such as cancer of the bone marrow, the test should have been commented upon by the doctor in charge of the case as to their relevance.
- The lack of examination and comment on abnormal blood tests make it impossible to assess the care as sub optimal, negligent or criminally culpable.
- Likely she had several serious illnesses and entering the terminal phase of her life.
- Mrs LAVENDER received a negligent medical assessment both at Haslar and Gosport War Memorial Hospital, in particular not examined on admission to Gosport. No medical diagnosis made for pain, which would fit with spinal cord fracture. Without appropriate assessment impossible to plan appropriate management.
- The two options were to either get further specialist opinion or provide palliative care. Would have been wise to obtain specialist opinion, probably from the consultant in charge of the case. There is no evidence that this was done.
- Unusually large dose of diamorphine written up on 26th February 1996, and subsequent excessive dose reported on 5th March 1996, together with high dose of Midazolam likely to cause excessive sedation and respiratory depression.
- Cannot say beyond all reasonable doubt that life was shortened.

Evidence of other key witnesses.

Alan William LAVENDER Son of the deceased. Spoke of his mother making an excellent recovery at Haslar Hospital following her fall, and the occupational therapist speaking of preparing her to return home. Mother coherent, and walking with the assistance of a frame. Within a couple of days of admission to Gosport War Memorial Hospital DR BARTON told him that 'his mother has come here to die', she deteriorated rapidly, he was not aware that his mother was being administered syringe driver diamorphine until the day prior to death.

Dr Althea LORD Community Geriatrician responsible for the ward rounds at Daedalus Ward of Gosport War Memorial Hospital. Was on annual leave from 23rd February 1996 – 18th March 1996 as a consequence had no input into the treatment or care of the patient Elsie LAVENDER. No formal arrangements in place for arranging locum cover, although this may be done in respect of long periods of absence (There is no evidence of Consultant supervision of this patient)

Sheelagh JOINES Registered Nurse GWMH Daedalus Ward, 1973-1997.. consisted of 8 stroke beds and 14 geriatric long stay beds, working to consultant Dr LORD and clinical assistant DR BARTON. Only Doctors authorised syringe drivers, which did not accelerate the process of dying. In 4 years at Daedalus only one family denied syringe driver treatment. It was agreed by Dr BARTON, DR LORD and Nurse JOINES that prescriptions would be written up in advance (pro-active prescribing) to enable use on a patient need basis. Ms JOINES wrote in notes that Dr BARTON had discussed Elsie LAVENDERS prognosis and the issue of syringe driver with the

son's wife, and that pain was not being controlled by DF 118 and as a result DDR BARTON prescribed further pain relief.

Yvonne ASTRIDGE Senior Staff Nurse made various entries onto the nursing care plan referring to condition of the patient and nursing care afforded. On 6th March 1996 wrote on medical notes that 'medication other than through syringe driver discontinued as patient un-rousable'

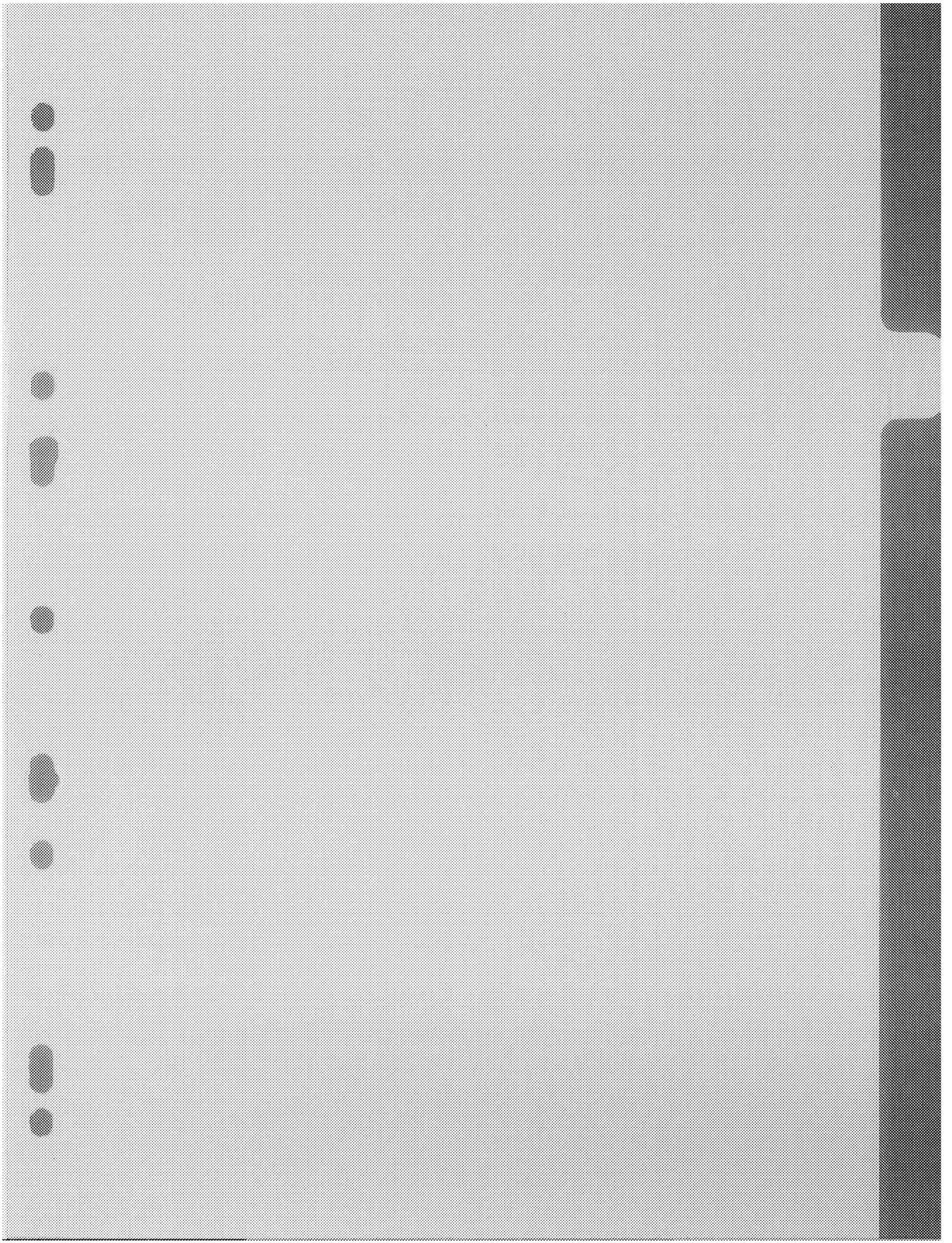
Christine JOICE Registered Nurse noted requirement for increased analgesia following Physio- exercises on 4th March 1996, Morphine sulphate tablets/Oramorph increased in dosage as a result.

Patricia WILKINS Registered Nurse delivered nursing care, bed bath, catheter and dressings.

Margaret COUCHMAN Registered Nurse entered on medical notes 1.3.1996 that patient 'complaining of pain in shoulders' this nurse commenced syringe driver diamorphine 100mg and midazolam 40mg on 5th March 1996 she explained that she had been informed by overnight staff that the patient had suffered a poor night distressed with uncontrolled pain, and had conformed to DR BARTON and Sister JOINES written instructions to commence syringe driver analgesia. Administered as the lowest amounts written up by Dr BARTON.

Irene DORRINGTON Registered Nurse, nursing note entries regarding general nursing care.

Catherine MARJORAM Senior Staff Nurse, has written on notes 6th March 1996 'Death Verified', explains that she would have checked heart and breathing before verifying. Given that there was no 24hr doctor, it was common for nurses to verify death.



OPERATION ROCHESTER

Investigation Overview 1998-2006.

Background.

Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed during much of the period under investigation by the Fareham and Gosport Primary Care Trust. The hospital fell under the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002 when services were transferred to the local Primary Care Trust.

The hospital operates on a day-to-day basis by nursing and support staff employed by the PCT. Clinical expertise was provided by way of visiting general practitioners and clinical assistants, consultant cover being provided in the same way.

Elderly patients were generally admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who in 1988 took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000.

Police Investigations.

Operation ROCHESTER was an investigation by Hampshire Police into the deaths of elderly patients at GWMH following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at levels or under circumstances that hastened or caused death. There were

further concerns raised by families of the deceased that the general standard of care afforded to patients was often sub-optimal and potentially negligent.

Most of the allegations involved a particular General Practitioner directly responsible for patient care Doctor Jane BARTON.

Two allegations (SPURGIN and PACKMAN) were pursued in respect of a consultant Dr Richard REID.

Of 945 death certificates issued in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Doctor BARTON.

The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Dr BARTON.

The General Medical Council also heard evidence during Interim Order Committee Hearings to determine whether the registration of Dr BARTON to continue to practice should be withdrawn. On each of the three occasions that the matter was heard the GMC was satisfied that there was no requirement for such an order and Dr BARTON continued to practice under voluntary restrictions in respect of the administration of Opiate drugs.

<u>The First Police investigation.</u>

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS aged 91 years.

Mrs. Richards died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs. Richards two of her daughters, Mrs. MACKENZIE and Mrs. LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs. MACKENZIE contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

The Reviewing CPS Lawyer determined that on the evidence available he did not consider a criminal prosecution to be justified.

Mrs. MACKENZIE then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs. MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

Hampshire Police commenced a re-investigation into the death of Gladys RICHARDS on Monday 17th April 2000.

Professor Brian LIVESLEY an elected member of the academy of experts provided medical opinion through a report dated 9th November 2000 making the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys RICHARDS in a manner as to cause her death."

- "Mr. Philip James BEED, Ms. Margaret COUCHMAN and Ms. Christine JOICE were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs. RICHARDS was unlawfully killed."

A meeting took place on 19th June 2001 between senior police officers, the CPS caseworker Paul CLOSE, Treasury Counsel and Professor LIVESLEY.

Treasury Counsel took the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs. RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

Professor LIVESLEY provided a second report dated 10th July, 2001 where he essentially underpinned his earlier findings commenting:-

- "It is my opinion that as a result of being given these drugs Mrs RICHARDS death occurred earlier than it would have done from natural causes."

In August 2001 the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH as a result four more cases were randomly selected for review.

Expert opinions were sought of a further two medical professors FORD and MUNDY who were each provided with copies of the medical records of the four cases in addition to the medical records of Gladys RICHARDS.

The reports from Professor FORD and Professor MUNDY were reviewed by the Police and a decision was taken not to forward them to the CPS as they were all of a similar nature to

the RICHARDS case and would therefore attract a similar response as the earlier advice from counsel. A decision was then made by the Police that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October 2001 the Commission for Health Improvement (CHI) launched an investigation into the management provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible at GWMH interviewing 59 staff in the process.

A report of the CHI investigation findings was published in May 2002 concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality patient care.

The CHI further reported that the Trust post investigation had adequate policies and guidelines in place that were being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer Sir Liam DONALDSON commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Professor BAKER. Immediately following the meeting nurse Anita TUBBRITT (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

The documents were copies of memos letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including :-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol).
- Particular concerns regarding the conduct of Dr BARTON in respect of prescription and administration of Diamorphine.

Nurse TUBRITT'S disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19th September 2002 the following decisions being made:-

- Examine the new documentation and investigate the events of 1991.
- Review existing evidence and new material in order to identify any additional viable lines of enquiry.
- Submit the new material to experts and subsequently to CPS.
- Examine individual and corporate liability.

A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

On 23rd September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients that had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns (including the five original cases)

In addition Professor Richard BAKER during his statistical review of mortality rates at GWMH identified 16 cases which were of concern to him in respect of pain management.

14 further cases were raised for investigation through ongoing complaints by family members between 2002 and 2006.

A total of 92 cases were investigated by police during the third phase of the investigation.

A team of medical experts (key clinical team) were appointed to review the 92 cases completing this work between September 2003 and August 2006.

The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

The terms of reference for the team were to examine patient notes initially independently and to assess the quality of care provided to each patient according to the expert's professional discipline.

The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1- Optimal care.
Category 2- Sub optimal care.
Category 3- Negligent care.

The cases were screened in batches of twenty then following this process the experts met to discuss findings and reach a consensus score.

Each expert was briefed regarding the requirement to retain and preserve their notations and findings for possible disclosure to interested parties.

All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN to further confirm the decision that there was no basis for further criminal investigation.

Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly were referred to the General Medical Council and Nursing and Midwifery Council for their information and attention.

Fourteen Category 3 cases were therefore referred for further investigation by police. Of the fourteen cases, four presented as matters that although potentially negligent in terms of standard of care were cases where the cause of death was assessed as entirely natural. Under these circumstances the essential element of causation could never be proven to sustain a criminal prosecution for homicide.

Notwithstanding that the four cases could not be prosecuted through the criminal court they were reviewed from an evidential perspective by an expert consultant Geriatrician Dr David BLACK who confirmed that the patients were in terminal end stage of life and that in his opinion death was through natural causes.

Accordingly the four cases ...Were released from police investigation in June 2006:-

- Clifford HOUGHTON.
- Thomas JARMAN.
- Edwin CARTER.
- Norma WINDSOR

The final ten cases were subjected to full criminal investigation upon the basis that they had been assessed by the key clinical team as cases of 'negligent care that is to day outside the bounds of acceptable clinical practice, and cause of death unclear.'

The investigation parameters included taking statements from all relevant healthcare staff involved in care of the patient, of family members and the commissioning of medical experts to provide opinion in terms of causation and standard of care.

The expert witnesses, principally Dr Andrew WILCOCK (Palliative care) and Dr David BLACK (Geriatrics) were provided guidance from the Crown Prosecution Service to ensure that their statements addressed the relevant legal issues in terms of potential homicide.

The experts completed their statements following review of medical records, all witness statements and transcripts of interviews of Dr Reid and Dr Barton the

healthcare professionals in jeopardy. They were also provided with the relevant documents required to put the circumstances of care into 'time context' The reviews were conducted by the experts independently.

Supplementary expert medical evidence was obtained to clarify particular medical conditions beyond the immediate sphere of knowledge of Dr's BLACK and WILCOCK.

A common denominator in respect of the ten cases was that the attending clinical assistant was Dr Jane BARTON who was responsible for the initial and continuing care of the patients including the prescription and administration of opiate and other drugs via syringe driver.

Dr BARTON was interviewed under caution in respect of the allegations.

The interviews were conducted in two phases. The initial phase was designed to obtain an account from Dr BARTON in respect of care delivered to individual patients. Dr BARTON responded during these interviews through provision of prepared statements and exercising her right of silence in respect of questions asked.

During the second interview challenge phase (following provision of expert witness reports to the investigation team) Dr BARTON exercised her right of silence refusing to answer any questions.

Consultant Dr Richard REID was interviewed in respect of 2 cases (PACKMAN and SPURGIN) following concerns raised by expert witnesses. Dr REID answered all questions put.

Full files of evidence were incrementally submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.

- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

Additional evidence was forwarded to the CPS through the compilation of generic healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

The ten category three cases were:-

1. Elsie DEVINE 88yrs. Admitted to GWMH 21st October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died 21st November 1999, 32 days after admission cause of death recorded as Bronchopnuemonia and Glomerulonephritis.

2. Elsie LAVENDER 83yrs. Admitted to GWMH 22nd February 1996 with head injury /brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Died 6th March 1996, 14 days after admission cause of death recorded as Cerebrovascular accident.

3. Sheila GREGORY 91yrs. Admitted to GWMH 3rd September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died 22nd November 1999, 81 days after admission cause of death Bronchopnuemonia.

4. Robert WILSON. 74 yrs. Admitted to GWMH 14th October 1998 with fractured left humerus and alcoholic hepatitis. Died 18th October 1998 4 days after admission cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Enid SPURGIN 92 yrs. Admitted to GWMH 26th March 1999 with a fractured neck of the femur. Died 13th April 1999 18 days after admission cause of death recorded as cerebrovascular accident.

6. Ruby LAKE 84 yrs. Admitted to GWMH 18th August 1998 with a fractured neck of the femur, diarrhea atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Died 21st August 1998 3 days after admission cause of death recorded as bronchopneumonia.

7. Leslie PITTOCK 82 yrs. Admitted to GWMH 5th January 1996 with Parkinsons disease he was physically and mentally frail immobile suffering depression. Died 24th January 1996 15 days after admission cause of death recorded as bronchopneumonia.

8. Helena SERVICE 99 yrs. Admitted to GWMH 3rd June 1997 with many medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died 5th June 1997 2 days after admission cause of death recorded as congestive cardiac failure.

9. Geoffrey PACKMAN 66yrs. Admitted to GWMH 23rd August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died 3rd September 1999 13 days after admission cause of death recorded as myocardial infarction.

10. Arthur CUNNINGHAM 79 yrs. Admitted to GWMH 21st September 1998 with Parkinson's disease and dementia. Died 26th September 1998 5 days after admission cause of death recorded as bronchopneumonia.

Dr David WILCOCK provided extensive evidence in respect of patient care concluding with particular themes 'of concern' in respect of the final 10 category ten cases including:-

- *'Failure to keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues Including:-*

  Enid Spurgin – orthopaedic surgeon, microbiologist

  Geoffrey Packman – general physician, gastroenterologist

  Helena Service – general physician, cardiologist

  Elsie Lavender – haematologist

  Sheila Gregory – psychogeriatrician

  Leslie Pittock – general physician/palliative care physician

  Arthur Cunningham – palliative care physician.

Many of the concerns raised by Dr WILCOCK were reflected by expert Geriatrician Dr David BLACK and other experts commissioned, the full details being contained within their reports.

There was however little consensus between the two principal experts Drs BLACK and WILCOCK as to whether the category 3 patients were in irreversible end stage terminal decline, and little consensus as to whether negligence more than minimally contributed towards the patient death.

As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that Doctors were negligent to criminal standard.

Whilst the medical evidence obtained by police was detailed and complex it did not prove that drugs contributed substantially towards death.

Even if causation could be proved there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of conviction.

Family group members of the deceased and stakeholders were informed of the decision in December 2006 and the police investigation other than referral of case papers to interested parties and general administration was closed.

David WILLIAMS.
Detective Superintendent 7227
Senior Investigating Officer.
16th January 2007.

SUMMARY OF EVIDENCE

CASE OF ELSIE LAVENDER

Background/Family Observations

Elsie Hester LAVENDER nee BRYANT was born on 4th November 1912. She married at the age of 22 and had one child Alan William LAVENDER. She became a widow in 1989 and had one brother who died in 1993/4. She continued to live alone in the family home in Gosport until she died at the Gosport War Memorial Hospital on 6th March 1996 at the age of 84 years.

Mrs LAVENDER was diagnosed as suffering with diabetes in 1982 and was insulin dependant; her only other medical conditions were that she had slight rheumatism and was partially blind due to the diabetes. Apart from this she was a strong, healthy and independent woman who coped with her housework, washing and was very family orientated. She did have a home help and a nurse would assist with her insulin regime twice a day. She had been admitted to hospital on a couple of occasions when she became 'hypo' but the hospital would stabilise her and send her home.

In February 1996 Mrs LAVENDER had a fall at home and was found by her home help, Frances DOHINI, and was taken to Haslar Hospital. It was several days later before the family was informed she had suffered a brain stem stroke, although she was sat up in bed from the start. Mrs LAVENDER was in pain not only from the stroke but from the fall as well albeit she had not fractured any bones but had cut her head.

Mrs LAVENDER remained in Haslar for two or three weeks and made excellent progress so much so that her Occupational Therapist and physiotherapist were preparing her for home. She had learned to walk with the assistance of a frame and an adjustable walking stick was being arranged. She was talking to others coherently and understanding what was being said to her.

Mrs LAVENDER was transferred to Daedelus Ward at Gosport War Memorial Hospital for rehabilitation and was placed in a room on her own. She easily passed a mental test conducted by a nurse just after she arrived.

Her son Adam LAVENDER and his wife visited daily and after two or three days spoke with Dr BARTON. Adam LAVENDER asked Dr BARTON when his mother would be going home as he would have to get rid of the cat if she was going to get a warden controlled flat.

Dr BARTON replied, "You can get rid of the flat" and added, "You do know that your mother has come here to die".

Mr LAVENDER was stunned as he believed his mother was at the War Memorial Hospital for rehabilitation and he could not believe the cold and callous way Dr BARTON had broken the news to him. He felt as if his mother's death had been predetermined.

Shortly after this conversation Mrs LAVENDER was placed on a syringe driver and her health quickly deteriorated. On one occasion she appeared unconscious and smelt awful.

On 6th March 1996 Mr LAVENDER received a call from the Gosport War Memorial Hospital informing him that his mother had died. Her death certificate was certified by J A BARTON BM and gave the cause of death as cerebralvascular accident diabetes mellitus.

Mrs LAVENDER was an elderly lady and at that time was one of the longest standing insulin dependant people. She appeared to be making a full recovery from the stroke, was alert, lucid and only had a little pain in her shoulder. It was not until her final day that Mr LAVENDER was told that diamorphine was being administered through the syringe driver.

Police Investigation

Following the publicity in respect of the Police investigation of the case of Gladys RICHARDS who died at the Gosport War Memorial hospital in, a number of relatives of other patients who died at the same hospital reported to the Police that they had concerns in respect of the medical treatment of their relatives and requested Police investigations. Amongst these relatives were those of Mrs LAVENDER.

The medical records of Mrs LAVENDER were obtained by the Police, copied and submitted to the key clinical team for review. The key clinical team considered that Mrs LAVENDER'S treatment at the Gosport War Memorial hospital was negligent and the cause of death was unclear.

As a result of the key clinical team's findings the medical records of Mrs LAVENDER have been examined by Police in order to identify all persons who were concerned in her medical and nursing treatment. All medical and nursing staff identified have made statements explaining those entries, in the medical records of Mrs LAVENDER, made by them or to which they made some contribution.

Case papers and the medical records of Mrs LAVENDER have been analysed by a further set of independent experts, Dr's WILCOCK and BLACK.

Medical history of Elsie LAVENDER.

(The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes, 'M' in front are the microfilm notes).

The Gosport notes record that Mrs LAVENDER was an insulin dependent diabetes mellitus since the1940's (53). She is referred to the Diabetic Service because of more troublesome hypoglycaemia in 1984 (65). In 1985 she is known to have a mild peripheral neuropathy (73).

By 1988 she has very poor eyesight (47M). She is also documented to have high blood pressure in 1986 (29).

Elsie LAVENDER was admitted to Haslar hospital on 5th February 1996 through A&E having had a fall at home (H15, H16). She is recorded as having right shoulder tenderness (H25) is moving all four limbs and her cervical spine is thought to be normal, written as (CX spine√) (H16). The notes record that x-rays were taken of her skull and both shoulders (H24). In a subsequent neurological examination, she is noted to have reduced power 3/5, cannot move her right fingers and has an extensor right plantar (H24). A Barthel on the 5th (H631) is recorded as 5/20.

Her past medical history is noted as insulin dependent, diabetes mellitus for 54 years (age 29) appendicectomy and a hysterectomy. She is noted to have previous collapses in the past (H47) but without weakness, although her clerking in 1995 (H48) suggested that she might have had some sensory loss and a mild diabetic peripheral neuropathy. Her Barthel in 1995 was 14/20 (H495) and she was able to mobilise at that stage with a walking stick (H497). She had diabetes, eye disease, was registered blind in 1988 (H 97). She had hypoglycaemic episodes going back many years (H 71) and pneumonia in 1985 (H317).

On transfer to the ward, both her legs are noted to be weak 4/5 (H35) no sensory loss is noted. The notes also state she does not normally go upstairs and her bed is downstairs (H29). However, her son stated that a large pool of blood was found at the top of the stairs (H37). She apparently goes out once a week with her son is forgetful but not confused (H39).

Following admission, she is seen by a physiotherapist (157) who notes pain in both shoulders, can only stand with two people and is now having to be fed, washed and dressed, when previously independent.

No further neurological examination is recorded by the Haslar medical team and she is referred to Dr Lord on 13th February (H159). Dr Lord sees her and confirms that she still has bilateral weakness of both arms and legs (H163) and finds that her left plantar is extensor (H163) confirmed in his letter (H253) but is not sure about the right plantar which has previously been found to be extensor.

The importance of this finding is that it suggests that she has a bilateral neurological event in the brain or brain stem somewhere above the lumbar spine.

Dr LORD records "probable brain stem CVA"..... "she has had her neck x-rayed, I assume it was normal" (H167).

Dr LORD notes her mild anaemia of 9.7 with an MCV of 76.5 (H17) and says that she will consider investigation into anaemia later (H164). Abnormal blood tests are also available in the notes on 9th February (H609) an albumin of 32, a Gamma GT 128 and Alkaline Phosphatase of 362. No investigations are done to determine whether these are a hepatic effect of her diabetes or a mixture of problems with the raised alkaline phosphatase potentially coming from a fracture.

On the 20th February Mrs LAVENDER is again seen by a physiotherapist (H165), her bilateral shoulder pain is again documented and she needs two to transfer. Reviewing her drug charts (H684 and H690) she receives regular analgesia comprising Co-proxamol and Dihydrocodeine all through her admission.

Events at Gosport War Memorial Hospital.

The medical notes in Gosport (45M) 22nd February 1996 state that she "fell at home from the top to the bottom of the stairs and had lacerations on her head". It also states that she has severe incontinence and leg ulcers. Once in Gosport there is no rigorous clerking of the patient and no examination recorded. In some of the nursing cardex there is a series of assessments confirming that this lady is highly dependent. She has no mobility and bed rest is maintained all through her stay (100 -101). She has leg ulcers both legs (107 - 109). She is catheterised throughout, although there is no suggestion that she had a catheter prior to her admission to hospital (111). She has a sacral bed sore noted; "a red and broken sacrum on 21st February" (115) and this progresses to a black and blistered bed sore on the 27th February (115). She is thought to be constipated on an assessment, and then continually leaks faeces throughout her admission (119).

Barthel is documented at 4/20 on 22nd February (165) (i.e. grossly dependent). Her mental test score is normal 10/10 on the same date (165). Lift handling score (171) also confirms high dependency.

Investigation tests reported on 23rd February 1996 find that she has a normal haemoglobin of 12.9 with a slightly reduced mean cell volume of 75.6 and gross thrombocytopenia (a low platelet count) of 36,000 (57M). The report on the film (58M) shows that this is a highly abnormal full blood count with distorted red blood cells and polychromasia. A repeat blood film is suggested. This is repeated on 27th February (57M) and thrombocytopenia is now even lower at 22,000. The urea is normal at 7.1 on 23rd February but has increased and is abnormal at 14.6 on 27th February (187). Her alkaline phosphatase is 572 (over 5 times the upper limit of normal) her albumin is low at 32 (187). No comment is made on

any of these significantly abnormal blood tests in any of the Gosport notes, though the low platelet count is noted in nursing summary on 23rd February (151). The platelet count had been normal at 161 on admission to the Haslar (H17).

An MSU (59M) sent on 5th February showed a heavy growth of strep faecalis there are no other MSU or other blood culture results in the notes.

Medical progression (documented on pages 45M and 46M) is of catheterisation and treatment for a possible U.T.I on 23rd February. On 26th February, a statement that the patient is not so well and the family were seen regarding progress. Nursing cardex reports (153) a meeting with the son occurred on the 24th February and state "son is happy for us just to make Mrs Lavender comfortable". "Syringe driver explained".

The medical notes on 5th March say deteriorated further, in some pain, therefore start subcutaneous analgesia. On 6th March "analgesia commenced, comfortable overnight I am happy for the night staff to confirm death". It is then confirmed at 21.28 hours on 6th March.

The nursing care plan first mentions significant pain on 27th February (95) and describes pain on most days up until 5th March where the pain is uncontrolled and the patient is distressed, at which point a syringe driver is commenced (97).
Morphine slow release (MST) (67M) was started at 10 mgs bd on the 24th February and is given until 26th February when MST 20 mgs bd (145) is started, this continues until the 3rd March. On 4th March Oramorph 30 mgs bd is written up and given during 4th March (139). On 5th March Diamorphine is written up 100 – 200 mgs subcut in 24 hours (137). 100 mgs is prescribed and started at 08.30 in the morning, together with Midazolam 40 mgs (137) (61M). Midazolam had been written up at 40 – 80 mgs subcut in 24 hours. Diamorphine and Midazolam pump is filled at 09.45 hours (61M) on 6th March together with another 40 mgs of Midazolam.

The notes document (for example page 65M) Dr Lord was the consultant responsible for this patient although the patient only appears to have been seen medically at any stage by Dr Barton, and a different consultant Dr Tandy saw the patient in the Haslar Hospital.

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Elsie DEVINE was a Clinical Assistant, Dr Jane BARTON. As such her role in caring for patients is governed by Standards of Practice and Care as outlined by the General Medical Council. This advice is sent to all doctors on a yearly basis and includes the following statements

Good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination.

In providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed.

Good clinical care must include – taking suitable and prompt action necessary.

Referring the patient to another practitioner, when indicated.

In providing care you must – recognise and work within the limits of your professional competence...

Prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patient's health and medical needs.

In reviewing the medical records of Mrs LAVENDER it is apparent that Dr BARTON has not made entries in the medical records when she has visited her patient. There is lack of explanation as to the treatment being offered to Mrs LAVENDER and the reasoning behind the various prescriptions of drugs. Ranges of drugs are prescribed which appear to fall outside recognised parameters.

Expert analysis

Dr Andrew WILCOCK

The medical records were examined by two independent experts. Dr Andrew WILCOCK in his review of the standard of care afforded to Mrs LAVENDER reported specifically:-

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

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

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

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

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

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

vii) On the 29th February 1996 there is no mention in the medical notes that Mrs LAVENDER's blood sugars were high requiring additional doses of insulin. The fact that this could have been due to an untreated infection does not appear to have been considered. Despite entries in the nursing care plan and summary sheets relating to Mrs LAVENDER's pain there is no mention of this in the medical notes.

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

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

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

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

Dr David BLACK

Dr BLACK is an expert in Geriatric medicine. His review of the standard of care afforded to Mrs LAVENDER reported specifically:-

i) Mrs Elsie LAVENDER provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.

ii) The major problems in this lady's case are the apparent lack of medical assessment and the lack of documentation. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical care must include – taking suitable and prompt action necessary"... "referring the patient to another practitioner, when indicated"..... "in providing care you must – recognise and work within the limits of your professional competence...."..... "prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs". The major gaps in the written notes, as documented in my report, represent poor clinical practice to the standards set by the General Medical Council. In this case, I believe that the overall medical care received between Haslar and Gosport Hospital was negligent in that an inadequate assessment and diagnosis of this lady's conditions was made. If it was, it was never recorded. The lack of any examination at Gosport, the lack of any comment on the abnormal blood test make it impossible to decide if the care she subsequently received was sub optimal, negligent or criminally culpable. It seems likely to me that she had several serious illnesses, which were probably unlikely to be reversible, and therefore, she was entering the terminal phase of her life at the point of admission to Gosport Hospital. However, without proper assessment or documentation this is impossible to prove either way.

iii) The initial symptomatic management of her terminal illness was appropriate. The prescription of the Diamorphine on the 26th February (never given) and the excessive doses of medication used in the final 36 hours was, in my view, sub optimal drug management. These may have been given with the intention of shortening life at the final phase of her terminal illness. However, I am unable to prove beyond reasonable doubt this did hasten death by anything other than a short period of time (hours to a few days).

Interview of Dr Jane BARTON

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified as a registered medical practitioner in 1972. In addition to her GP duties she took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 24th March 2005 Dr BARTON, in company with her solicitor, Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Elsie LAVENDER at the Gosport War Memorial hospital. The interviewing officers were DC Christopher YATES and Code A

The interview commenced at 0917hrs and lasted for 22 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/4.

This statement dealt with the specific issues surrounding the care and treatment of Elsie LAVENDER.

Expert response to statements of Dr BARTON

REPORT

regarding

ELSIE LAVENDER (BJC/30)

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

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

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

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

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

be an inappropriate and excessive use of medication due to a lack of sufficient knowledge. However, in my opinion, based on the medical and nursing records, there is reasonable doubt that Mrs Lavender had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lavender by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lavender by not carefully assessing the possible causes of her decline that may have been reversible with appropriate treatment (e.g. antibiotics for an infection, stopping the diuretics, reducing the dose of morphine) and unnecessarily exposing her to possibly inappropriate and excessive doses of morphine and ultimately excessive doses of diamorphine and midazolam that could have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton leaves herself open to the accusation of gross negligence.

2. INSTRUCTIONS

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

3. ISSUES

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

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

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

4. BRIEF CURRICULUM VITAE

Code A

5. DOCUMENTATION

This Report is based on the following documents:

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

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

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

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

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

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

[7] Portsmouth Health Care NHS Trust Policies:

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

ii) Prescription Writing Policy (July 2000).

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

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

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

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

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

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

Elderly (March 1995).

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

6. CHRONOLOGY/CASE ABSTRACT

Events at the Royal Naval Hospital

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

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

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

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

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

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

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

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

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

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

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

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

Events at Gosport War Memorial Hospital

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Syringe drivers, diamorphine and midazolam

A syringe driver is a small portable battery-driven pump used to deliver medication subcutaneously (SC) via a syringe, over 24hours. Indications for its use include swallowing difficulties or a comatose patient. In the United Kingdom, it is commonly used in patients with cancer in their terminal phase in order to continue to deliver analgesic medication. Other medication required for the control other symptoms, e.g. delirium, nausea and vomiting can also be added to the pump.

Diamorphine is a strong opioid that is ultimately converted to morphine in the body. In the United Kingdom, it is used in preference to morphine in syringe drivers as it is more soluble, allowing large doses to be given in very small volumes. It is indicated for the relief of pain, breathlessness and cough. The initial daily dose of diamorphine is usually determined by dividing the daily dose of oral morphine by 3 (BNF number 29 (March 1995)). Others sometimes suggested dividing by 2 or 3 depending on circumstance (Wessex protocol). Hence, 60mg of morphine taken orally a day could equate to a daily dose of 20 or 30mg of diamorphine SC. It is usual to prescribe additional doses for use 'as required' in case symptoms such as pain breakthrough. The dose is usually 1/6th of the 24hour dose. Hence for someone receiving 30mg of diamorphine in a syringe driver over 24hours, a breakthrough dose would be 5mg. One would expect it to have a 2–4 hour duration of effect, but the dose is often prescribed to be given hourly if required. As the active metabolites of morphine are excreted by the kidneys, caution is required in patients with impaired kidney function.

Midazolam is a benzodiazepine, a diazepam like drug. It is commonly used in syringe drivers as a sedative in patients with terminal agitation. Sedation can be defined as the production of a restful state of mind. Drugs that sedate will have a calming effect, relieving anxiety and tension. Although drowsiness is a common effect of sedative drugs, a patient can be sedated without being drowsy. Most practitioners caring for patients with cancer in their terminal phase would generally aim to find a dose that improves the patient's symptoms rather than to render them unresponsive. In some patients however, symptoms will only be relieved with doses that make the patient unresponsive. A typical starting dose for an adult is 30mg a day. A

smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The Wessex protocol suggests a range with the lowest dose of 5mg a day. The regular dose would then be titrated every 24hours if the sedative effect is inadequate. This is generally in the region of a 33–50% increase in total dose, but would be guided by the severity of the patients symptoms and the need for additional 'as required' doses. These are generally equivalent to 1/6th of the regular dose, e.g. for midazolam 30mg in a syringe driver over 24hours, the 'as required' dose would be 5mg given as a stat SC injection. The duration of effect is generally no more than 4hours, and it may need to be given more frequently. As an active metabolite of midazolam is excreted by the kidneys, caution is required in patients with impaired kidney function.

ii) The principle of double effect.

The principle of double effect states that:

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

This is a universal principle without which the practice of medicine would be impossible, given that every kind of treatment has an inherent risk. Many discussions on the principle of double effect have however, involved the use of morphine in the terminally ill. This gives a false impression that the use of morphine in this circumstance is a high risk strategy. When correctly used (i.e. in a dose appropriate to a patient's need) morphine does not appear to shorten life or hasten the dying process in patients with cancer. Although a greater risk is acceptable in more extreme circumstances, it is obvious that effective measures which carry less risk to

life will normally be used. Thus, in an extreme situation, although it may occasionally be necessary (and acceptable) to render a patient unconscious, it remains unacceptable (and unnecessary) to cause death deliberately. As a universal principle, it is also obvious that the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care.

8. OPINION

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

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

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

Events at Gosport War Memorial Hospital

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

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

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

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

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

The medical care provided by Dr Barton to Mrs Lavender following her transfer to Gosport War Memorial Hospital, Daedalus Ward is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (General Medical Council, Good Medical Practice, October 1995, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination; providing or arranging investigations or treatment where necessary; taking suitable and prompt action when necessary; referring the patient to another practitioner when indicated
- in providing care you must keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs or appliances that serve the patients' needs.

Specifically:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If there were concerns that a patient may experience, for example, episodes of pain or anxiety, it would be much more usual, and indeed seen as good practice, to prescribe appropriate doses of morphine/diamorphine, or diazepam/midazolam respectively that could be given intermittently 'as required' orally or SC. This allows a patient to receive what they need, when they need it, and guides the doctor in deciding if a regular dose is required, the appropriate starting dose and subsequent dose titration.

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

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

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

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

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

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

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

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

In patients with cancer, the use of diamorphine and midazolam when appropriate for the patients needs does not appear to hasten the dying process. This has not been examined in patients dying from other illnesses to my knowledge, but one would have no reason to suppose it would be any different. The key issue is whether the use and the dose of diamorphine and midazolam are *appropriate* to the patients needs. In situations where they are inappropriate or excessive to the patients needs, it would be difficult to exclude

with any certainty that they did not contribute more than minimally, negligibly or trivially to the death of the patient.

Although the principle of double effect could be invoked here (see technical issues), it remains that a doctor has a duty to apply effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose of strong opioid that was *appropriate* and not excessive for a patient's needs.

If it were that Mrs Lavender had naturally entered the terminal phase of her life, at best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mrs Lavender a peaceful death, albeit with what appears to be an inappropriate and excessive use of medication due to a lack of sufficient knowledge.

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

9. LITERATURE/REFERENCES

British National Formulary 29 (March 1995).

Prescribing in Terminal Care, pages 12–15.

British National Formulary 47 (March 2004).

Palliative Care Handbook, Guidelines on Clinical Management, Third Edition

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

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

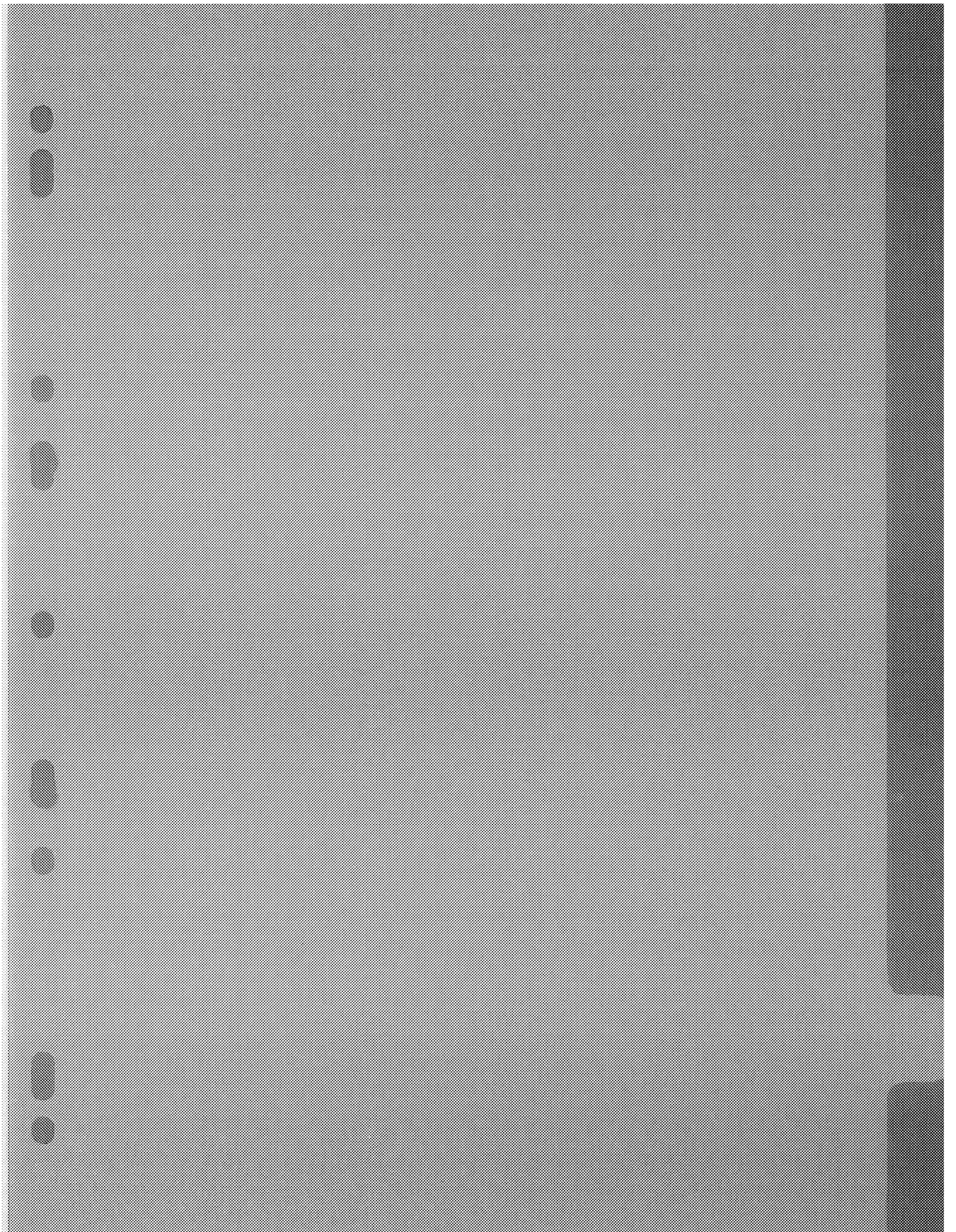
10. EXPERTS' DECLARATION

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

11. STATEMENT OF TRUTH

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

Signature: Code A Date: 1.5.05



SUMMARY OF CONCLUSIONS

Mrs Elsie Lavender was an 84 year-old lady admitted to the Haslar Hospital on 5th February 1996 following a fall and then transferred to Gosport War Memorial Hospital on 26th February 1996. She had long-standing problems with diabetes, a peripheral neuropathy, poor eyesight and registered blind. After admission she is found to be doubly incontinent, totally dependent with a probable quadriplegia, constant pains down her shoulders and arms and is found to have serious and unexplained abnormalities in various blood tests.

In the Gosport War Memorial Hospital, she fails to make any improvement, deteriorates with a bed sore that eventually becomes black and blistered. She receives pain relief and palliation for her deteriorating physical condition including subcutaneous Diamorphine and Midazolam and dies on 6th March 1996.

The expert opinion is:

> Mrs Elsie Lavender provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.
>
> The major problems in this lady's case are the apparent lack of medical assessment and the lack of documentation. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical care must include – taking suitable and prompt action necessary"... "referring the patient to another practitioner, when indicated"..... "in providing care you must – recognise and work within the limits of your professional competence...."..... "prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs". The major gaps in the written notes, as documented in my report, represent poor clinical practice to the standards set by the General Medical Council. In this case, I believe that the overall episode of medical care provided between Haslar and Gosport Hospital was negligent in that an inadequate assessment and diagnosis of this lady's conditions was made. If it was, it was never recorded. The lack of any examination at Gosport, the lack of any comment on the abnormal blood test make it impossible to decide if the care she subsequently received was sub optimal, negligent or criminally culpable. It seems likely to me that she had several serious illnesses, which were probably unlikely to be reversible, and therefore, she was entering the terminal phase of her life at the point of admission to Gosport Hospital.

However, without proper assessment or documentation this is impossible to prove either way.

The initial symptomatic management of her terminal illness was appropriate. The prescription of the Diamorphine on the 26th February (never given) and the excessive doses of medication used in the final 36 hours was, in my view, sub optimal drug management. These may have been given with the intention of shortening life at the final phase of her terminal illness. However, I am unable to satisfy myself beyond reasonable doubt this did hasten death by anything other than a short period of time (hours to a few days).

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.

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

3. CURRICULUM VITAE

Code A

Version 4 of complete report 19th March 2005 – Elsie Lavender

Code A

Code A

Version 4 of complete report 19th March 2005 – Elsie Lavender

Code A

Code A

Code A

Code A

Version 4 of complete report 19th March 2005 – Elsie Lavender

Code A

BOOK

Code A

RECENT SIGNIFICANT PRESENTATIONS

Code A

Code A

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Elsie Lavender

[2] Full set of medical records of Elsie Lavender on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

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

[5] Hampshire Constabulary Summary of Care of Elsie Lavender

[6] 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.'

[8] Medical report prepared by Dr James Gillespie

5 CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes, 'M' in front are the microfilm notes).

5.1. The Gosport notes record that Mrs Lavender was a insulin dependent diabetes mellitus since the1940's (53). She is referred to the Diabetic Service because of more troublesome hypoglycaemia in 1984 (65). In 1985 she is known to have a mild peripheral neuropathy (73). Her weight in 1988 is 85 kgs (73) and in 1987 her weight is 89 kgs (77). By 1988 she has very poor eyesight (47M). She is also documented to have high blood pressure in 1986 (29).

5.2. Elsie Lavender was admitted to Haslar hospital on 5th February 1996 through A&E having had a fall at home (H15, H16). She is recorded as having right shoulder tenderness (H25) is moving all four limbs and her cervical spine is thought to be normal, written as (CX spine√) (H16). The notes record that x-rays were taken of her skull and both shoulders (H24). In a subsequent neurological examination, she is noted to have reduced power 3/5, cannot move her right fingers and has an extensor right plantar (H24). A Barthel on the 5th (H631) is recorded as 5/20.

Her past medical history is noted as insulin dependent, diabetes mellitus for 54 years (age 29) appendicectomy and a hysterectomy. She is noted to have previous collapses in the past (H47) but without weakness, although her clerking in 1995 (H48) suggested that she might have had some sensory loss and a mild diabetic peripheral neuropathy. Her Barthel in 1995 was 14/20 (H495) and she was able to mobilise at that stage with a walking stick (H497). She had diabetes, eye disease, was registered blind in 1988 (H 97). She had hypoglycaemic episodes going back many years (H 71) and pneumonia in 1985 (H317).

On transfer to the ward, both her legs are noted to be weak 4/5 (H35) no sensory loss is noted. The notes also state she does not normally go upstairs and her bed is downstairs (H29). However, her son stated that a large pool of blood was found at the top of the stairs (H37). She apparently goes out once a week with her son is forgetful but not confused (H39).

Following admission, she is seen by a physiotherapist (157) who notes pain in both shoulders, can only stand with two people and is now having to be fed, washed and dressed, when previously independent.

No further neurological examination is recorded by the Haslar medical team and she is referred to Dr Lord on 13th February (H159). Dr Lord sees her and confirms that she still has bilateral weakness of both arms and legs (H163) and finds that her left plantar is extensor (H163) confirmed in his letter (H253) but is not sure about the right plantar which has previously been found to be extensor.

The importance of this finding is that it suggests that she has a bilateral neurological event in the brain, brain stem or spinal cord somewhere above the thoracic spine.

Dr Lord records "probable brain stem CVA"..... "she has had her neck x-rayed, I assume it was normal" (H167).
I was unable to find any x-ray request recorded in the notes for a cervical spine, nor any reports of an x-ray of a cervical spine or indeed reports on the x-rays that were recorded as being requested (i.e. the skull and shoulder x-rays).

Dr Lord notes her mild anaemia of 9.7 with an MCV of 76.5 (H17) and says that he will consider investigation into anaemia later (H164). Abnormal blood tests are also available in the notes on 9th February (H609) an albumin of 32, a Gamma GT 128 and Alkaline Phosphatase of 362. No investigations are done to determine whether these are a hepatic effect of her diabetes or a mixture of problems with the a raised alkaline phosphatase potentially coming from a fracture.

On the 20th February Mrs Lavender is again seen by a physiotherapist (H165), her bilateral shoulder pain is again documented and she needs two to transfer. Reviewing her drug charts (H684 and H690) she receives regular analgesia comprising Co-proxamol and Dihydrocodeine all through her admission.

5.3. The medical notes in Gosport (45M) 22nd February 1996 state that she "fell at home from the top to the bottom of the stairs and had lacerations on her head". It also states that she has severe incontinence and leg ulcers. Once in Gosport there is no rigorous clerking of the patient and no examination recorded. In some of the nursing cardex there is a series of assessments confirming that this lady is highly dependent. She has no mobility and bed rest is maintained all through her stay (100 -101). She has leg ulcers both legs (107 - 109). She is catheterised throughout, although there is no suggestion that she had a catheter prior to her admission to hospital (111). She has a sacral bed sore noted; "a red and broken sacrum on 21st February" (115) and this progresses to a black and blistered bed sore on the 27th February (115). She is thought to be constipated on a assessment, then continually leaks faeces throughout her admission (119).

5.4. Barthel is documented at 4/20 on 22nd February (165) (i.e. grossly dependent). Her mental test score is normal 10/10 on the same date (165). Lift handling score (171) also confirms high dependency.

5.5. Investigation tests reported on 23rd February 1996 find that she has a normal haemoglobin of 12.9 with a slightly reduced mean cell volume of 75.6 and gross thrombocytopenia (a low platelet count) of 36,000 (57M). The report on the film (58M) shows that this is a highly abnormal full blood count with distorted red blood cells and polychromasia. A repeat blood film is suggested. This is repeated on 27th February (57M) and thrombocytopenia is now even lower at 22,000. The urea is normal at 7.1 on 23rd February but has increased and is abnormal at 14.6 on 27th February (187). Her alkaline phosphatase is 572 (over 5 times the upper limit of normal) her albumin is low at 32 (187). No comment is made on any of these significantly abnormal blood tests in any of the Gosport notes, though the low platelet count is noted in nursing summary on 23rd February (151). The platelet count had been normal at 161 on admission to the Haslar (H17).

5.6. An MSU (59M) sent on 5th February showed a heavy growth of strep faecalis there are no other MSU or other blood culture results in the notes.

5.7. Medical progression (documented on pages 45M and 46M) is of catheterisation and treatment for a possible U.T.I on 23rd February. On 26th February, a statement that the patient is not so well and the family were seen regarding progress. Nursing cardex reports (153) a meeting with the son occurred on the 24th February and state "son is

happy for us just to make Mrs Lavender comfortable". "Syringe driver explained".

5.8. The medical notes on 5th March say deteriorated further, in some pain, therefore start subcutaneous analgesia. On 6th March "analgesia commenced, comfortable overnight I am happy for the night staff to confirm death". It is then confirmed at 21.28 hours on 6th March.

5.9. The nursing care plan first mentions significant pain on 27th February (95) and describes pain on most days up until 5th March where the pain is uncontrolled and the patient is distressed, at which point a syringe driver is commenced (97). On 6th March pain is controlled.

5.10. **Drug management in Gosport.** I shall concentrate on the use of analgesia. Throughout the patient received appropriate doses of insulin, Co-amilofruse (a diuretic), Digoxin, Iron and steroid inhalers up unto the last twelve hours. She also received a course of Trimethoprim (an antibiotic) between 23rd and 27th February.

5.11. Morphine slow release (MST) (67M)was started at 10 mgs bd on the 24th February and is given until 26th February when MST 20 mgs bd (145)is started, this continues until the 3rd March. On 4th March Oramorph 30 mgs bd is written up and given during 4th March (139). On 5th March Diamorphine is written up 100 – 200 mgs subcut in 24 hours (137). 100 mgs is prescribed and started at 08.30 in the morning, together with Midazolam 40 mgs (137) (61M). Midazolam had been written up at 40 – 80 mgs subcut in 24 hours. Diamorphine and Midazolam pump is filled at 09.45 hours (61M) on 6th March together with another 40 mgs of Midazolam.

5.12. When admitted into hospital Dihydrocodeine PRN for pain had been written up together Hyoscine. Diamorphine 80 – 160 mgs subcut in 24 hours was written up on 26th February together with Midazolam 40 – 80 mgs in 24 hours subcut, but these drugs were never prescribed (141).

5.13. The notes document (for example page 65M) Dr Lord was the consultant responsible for this patient although the patient only appears to have been seen medically at any stage by Dr Barton, and a different consultant Dr Tandy saw the patient in the Haslar Hospital.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

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

6.2. In particular I have discussed:
a) Her medical conditions
b) Whether she had become terminally ill during her admission
c) Whether the treatment that was then provided was appropriate.

6.3. Mrs Lavender had a number of serious underlying medical conditions. The most serious of which was her insulin dependent diabetes mellitus going back to the 1940's complicated by hypoglycaemia's, which had led, to falls on previous occasions, peripheral neuropathy which may also contribute to falls and with a combination of diabetes and other processes she had become registered blind. She also had documented frailty prior to admission, for example, already having moved her bed downstairs with an exercise tolerance of 10 yards with a stick. Her son was documented to do her shopping (11). However, she was still living alone, was only documented to have stress incontinence (11) and was cognitively intact (MTS 10/10) (165).

6.4. She was then admitted to Haslar Hospital having had a fall, which was from the top to the bottom of the stairs. No explanation is given as to how she was at the top of the stairs, if she was already set up with her bed downstairs at home. Following this she is documented both at the assessment at Haslar Hospital and then on admission to Gosport Hospital as being severely dependent. She cannot use her arms properly, her hands and wrists are noted to be weak and she cannot stand and walk, she is so incontinent she needs a catheter and she has continual faecal leakage. Barthel is 4/10. I believe this lady was misdiagnosed and had quadriplegia from a high cervical Spinal cord injury secondary to her fall. This diagnosis appears to have been missed by all the doctors who saw her. Although the A&E notes in Haslar state "cervical spine normal" (H18), presumably on clinical, not x-ray, grounds. Also Dr Tandy mistakenly believes she had her neck x-rayed and it was normal (H163). No-one checks this statement is correct.

6.5. Other on-going serious medical problems have also not been explained. She has a documented low platelet count on admission to Gosport, which on repeat is extremely low and at a level that makes life threatening bleeding at any time quite probable. The blood film is also highly abnormal which suggests that there is now some systemic illness going on, probably involving this lady's bone marrow. In the absence of infection or a likely drug culprit, then cancer involving the bone marrow would be a possibility. She also has a very rapidly rising alkaline phosphatase, which suggests either liver, or bone pathology. No other information is now available that would help me clarify this further.

I would have expected that these very abnormal blood tests would have been reviewed and commented on by the doctor in charge of the case. There is no point in undertaking investigations if the results are ignored. The blood results appear to be complex to interpret and I would have expected a clinical assistant or General Practitioner to have taken advice from the consultant in charge of the case as to their relevance and whether further action was required. If further discussion did take place or the results were properly looked at, this is simply not recorded in the notes.

6.6. Other evidence that this lady was frail and ill is provided by the pressure sore which appears to deteriorate during admission and a low albumin documented on admission.

6.7. In my view this lady received a negligent medical assessment in both Haslar and Gosport. In particular she was not examined on admission to Gosport, or if she was it was not documented in the notes. Thus no medical explanation beyond the "possible brain stem CVA" is made. This would not explain all her physical symptoms, or her profound neurological deficit. Also no medical diagnosis was made for pain that she continually complained of down her arms, which again would fit with a high cervical Spinal cord fracture or similar injury. Also, no attempt was made to determine why this lady had a very low platelet count and rising alkaline phosphatase. Without making an adequate medical assessment it is impossible to plan appropriate management. The lack of an adequate medical assessment and adequate documentation make it very difficult to be certain as to what treatment should normally have been given.

Good medical practice (GMC, 2001) states that "good clinical care must include an adequate assessment of the patient's

condition, based on the history and symptoms, and if necessary, an appropriate investigation".... "In providing care you must , keep clear, accurate, legible and contemporaneous patient records, which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". The major gaps in the written notes as described above represents poor clinical practice to the standard set by the General Medical Council.

6.8. There can be no doubt though that the family, Dr Barton and the nursing staff all recognised this lady was seriously ill. Although the doctors fail to come to a diagnosis and therefore could not determine whether there was any treatable underlying problem. Evidence for this is that there was already discussion, within 2 days of admission, with the family about prognosis for recovery and how best to manage her illness. A syringe driver was already being discussed with the family on 24th February. Indeed all the markers of illness I have found, suggest this lady was very seriously ill.

6.9. Even if a high cervical Spinal cord fracture had been diagnosed, the potential for neurosurgical intervention in an elderly lady with diabetes is low and treatment with prolonged immobilisation has a very high mortality rate in itself. The unexplained low platelet count also suggests other significant serious pathology, which was never diagnosed, and on top of this we have somebody who needs all care and has leg ulcers and pressure sores. In my view, there were only two options open at this stage, **a)** to get a further specialist opinion or **b)** treat symptomatically and provide palliative care.

6.10. In view of the complexity of the medical problems, it would have been wise and appropriate to have obtained a further specialist opinion, probably from the consultant in charge of the case before deciding this lady was definitely terminally ill. I can see no evidence in the notes that this was considered.

If there was a failure to obtain further specialist opinion I believe this would be poor clinical practice to the standards set by the General Medical Council.

It was appropriate though to provide pain relief for someone who was both apparently in pain and distressed with loss of totally bodily function. To start MST at a normal low dose on the 24th February was appropriate.

6.11. If the pain was not resolved, increasing the dose to 20 mgs bd on both the 26th February adding the Oramorph 30 mgs bd on 4th March were all appropriate symptomatic responses.

6.12. An unusually large dose of Diamorphine (80 – 160 mgs subcut in 24 hours) is written up on the 26th February on the PRN (as required prescriptions) section of the drug chart. Midazolam 80 mgs subcut is also written up PRN. Although never prescribed, there is no justification in the notes for why such an apparently large dose of Diamorphine was written to be given if needed.

6.13. I have little doubt this lady was moving to a terminal phase of her illness by the 5th March. There had been no improvement in her quadriplegia, she remained faecally incontinent, the nursing cardex documents increasing pain, her platelet count has fallen further and her urea has doubled to 14.6 (187). At this stage a decision to start Diamorphine 100 mgs once a day subcutaneously and 40 mgs once a day Midazolam is made.

6.14. Midazolam is widely used subcutaneously in doses from 5 – 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 40 mgs for 24 hours, which is within current guidance, although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours. (Palliative Care. Chapter 23 in Brocklehurst Text Book of Geriatric Medicine, 6th Edition 2003).

6.15. The Diamorphine was specifically prescribed for pain and is commonly used for pain in terminal care, Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. The dose of Diamorphine actually prescribed was 100 mgs in 24 hours. At that time Mrs Lavender was receiving 60 mgs a day of Oramorphine. Diamorphine subcutaneously is usually given at a maximum ratio of 1:2 (i.e. up to 30 mgs of Diamorphine in 24 hours for 60 mgs of Oramorphine). (Wessex Guidelines). However her pain was not controlled and it would be appropriate to give a higher dose of the Diamorphine. Conventionally this would be 50% greater than the previous days; (Wessex Guidelines) some people might give up to 100%. Thus a starting dose of Diamorphine of 45 – 60 mgs in 24 hours would seem appropriate. Mrs Lavender actually was prescribed a minimum dose of 100 mgs of Diamorphine, in my view excessive.

6.16. Diamorphine is compatible with Midazolam and can be used in the same syringe driver. It is documented above though that she

received a high dose of Midazolam and an excessive, and in my view, inappropriately large dose of Diamorphine. Together these drugs are likely to have caused excessive sedation and respiratory depression. However there is no evidence in the notes to prove these complications occurred.

6.17. Mrs Lavender is documented to be comfortable on the 6th and dies approximately 36 hours after the Midazolam and Diamorphine pumps were started.

The prediction of how long a terminally ill patient will live is virtually impossible and even Palliative Care experts show enormous variation (Higginson I J and Costantini M. Accuracy of Prognosis Estimates by 4 Palliative Care teams: A prospective cohort study. BMC Palliative Care 2002 1:1.)

6.18. The doses of Midazolam and Diamorphine used were in my opinion excessively high and may have been prescribed with the intention of deliberately shortening the terminal phase of her life. However, I can not find evidence to satisfy myself the standard of "beyond reasonable doubt", they had the definite effect of shortening her life in more than a minor fashion of a few hours to a few days.

7. OPINION

7.1. Mrs Elsie Lavender provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.

7.2. The major problems in this lady's case are the apparent lack of medical assessment and the lack of documentation. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical care must include – taking suitable and prompt action necessary"... "referring the patient to another practitioner, when indicated"..... "in providing care you must – recognise and work within the limits of your professional competence...."..... "prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs". The major gaps in the written notes, as

documented in my report, represent poor clinical practice to the standards set by the General Medical Council. In this case, I believe that the overall episode of medical care provided between Haslar and Gosport Hospital was negligent in that an inadequate assessment and diagnosis of this lady's conditions was made. If it was, it was never recorded. The lack of any examination at Gosport, the lack of any comment on the abnormal blood test make it impossible to decide if the care she subsequently received was sub optimal, negligent or criminally culpable. It seems likely to me that she had several serious illnesses, which were probably unlikely to be reversible, and therefore, she was entering the terminal phase of her life at the point of admission to Gosport Hospital. However, without proper assessment or documentation this is impossible to prove either way.

7.3. The initial symptomatic management of her terminal illness was appropriate. The prescription of the Diamorphine on the 26th February (never given) and the excessive doses of medication used in the final 36 hours was, in my view, sub optimal drug management. These may have been given with the intention of shortening life at the final phase of her terminal illness. However, I am unable to satisfy myself beyond reasonable doubt this did hasten death by anything other than a short period of time (hours to a few days).

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
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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.

Signature: _____ Date: _____

Form MG15(T)

RESTRICTED

RECORD OF INTERVIEW

Number: Y20F

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

Person interviewed: BARTON, JANE ANN

Place of interview: FRAUD SQUAD, NETLEY

Date of interview: 24/03/2005

Time commenced: 0917 Time concluded: 0939

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

Interviewer(s): Code A

Other persons present: MR BARKER SOLICITOR

Police Exhibit No: CSY/JAB/5A Number of Pages: 19

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This interview is being tape recorded, I'm Code A Code A my colleague is -
	I Code A
	I'm interviewing Doctor Jane BARTON. Doctor would you please give your full name and your date of birth.
BARTON	Jane Anne BARTON, 19/10/48 (19/10/1948).
Code A	Thank you. Also present is Mr BARKER who is Doctor BARTON'S Solicitor, can you please introduce yourself.

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Code A

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

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

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

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

BARTON

Yes thank you.

Code A

And you're happy to go on at the moment. Also point out that you've attended freely, completely voluntarily, your not under arrest so as you've come here of your own free will if at any time you feel you want leave then your free to do so. Do you understand that? Okay. I've also got to tell you though that you do not have to say anything but it may harm your defence if you do not mention when questioned

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something, which you later rely on in Court. Anything you do say maybe given in evidence. And that's what's called a Caution. Do you understand that Caution?

BARTON — Yes.

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

BARTON — Thank you.

Code A — Yeah.

SOLICITOR — (Inaudible...).

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

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

SOLICITOR Yes that is correct.

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

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

BARTON — I am Doctor Jane BARTON of the Forton.

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

BARTON — I have. I have a prepared statement.

Code A — Yeah fine we again, did you make the statement yourself?

BARTON — I did.

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

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

Code A — Yeah.

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

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

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BARTON

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

have authorised administration as necessary within that dose range.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Code A — You can do yeah. Do you want to

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

BARTON — Sign each page.

Code A — It doesn't, it doesn't necessarily matter.

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

DC BARTON — Handed to Code A

Code A — Please yes.

Do you mind counter signing that Mr BARKER.

SOLICITOR — Not at all.

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

BARTON — No.

Code A — Is there anything you wish to clarify at the moment.

BARTON — No.

Code A — Is there anything you wish to add.

BARTON — No.

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Code A

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

STATEMENT OF DR JANE BARTON - RE: ELSIE LAVENDER

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

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

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

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

5. Mrs Lavender aged 83 was transferred to Daedalus Ward at GWMH on 22nd February 1996 under the care of consultant Geriatrician Dr Althea Lord. Her Past Medical history was of diabetes for over 40 years, and she had been registered blind since 1988. She had apparently lived alone since the death of her husband and had a son living in Warsash who would do her shopping. She had fallen down the stairs at home two weeks previously and been admitted to a medical bed in Royal Naval Hospital Haslar with general weakness and immobility. She was referred to Dr Jane Tandy consultant Geriatrician at Portsmouth Healthcare Trust by her consultant physician, Surgeon Commander Taylor although I do not have the benefit of the referral letter nor any of her Haslar notes. Dr Tandy had seen her on ward A4 at Haslar and dictated a letter to Surgeon Commander Taylor on 16th February 1996.

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

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

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

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

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

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

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

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

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

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

"23-2-96 Catheterised last night 500ml residue
blood & protein Trimethoprim"

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

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

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

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

17. I would have reviewed Mrs Lavender's condition again on the Monday morning, 26th February. In view of the fact that the previous dosage of Morphine Sulphate had become insufficient for Mrs Lavender's pain, I increased the dose to 20mgs twice a day, again with the Dihydrocodeine continuing. I believe Mrs Lavender's bottom was very sore, and I was concerned that she should have a Pegasus mattress in the hope of reducing pressure sores. I was probably made aware of the fact that Mrs Lavender's son wanted to see me and arranged to return to GWMH at 2pm for that purpose.

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

19. Sadly it is the case that in elderly frail people with pre-existing illness, such as Mrs Lavender, significant events such as a major fall with transfer to one

hospital and then another can in themselves have a very serious deleterious effect on their health, leading to death.

20. It may be the case that in the circumstances I indicated to Mrs Lavender's son that his mother might be dying, this simply being a feature of what can happen to elderly people in such circumstances, with the trauma of stroke, a major fall, and transfer to one hospital and then another. I believe I would have discussed the options for pain relief with Mrs Lavender's son and probably explained that it might become necessary to use a syringe driver and administer Diamorphine if the pain continued to be inadequately controlled. I think I would have explained that it was possible the administration of proper pain relieving medication might have the incidental and undesired effect of hastening death.

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

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

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

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

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

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

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

27. Unfortunately, Mrs Lavender was again suffering in pain by 4th March. The drug chart and the nursing notes show that I therefore increased the Morphine Sulphate, in the form of Oramorph slow release tablets, to 30mgs twice a day. I think the Dihydrocodeine was still continued at this stage.

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

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

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

30. My note on this occasion in Mrs Lavender's medical records reads as follows:

> "5-3-96 Has deteriorated over last few days
> not eating or drinking
> In some pain ∴ start sc analgesia
> Let family know"

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

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

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

33. As indicated, Mrs Lavender was now comfortable and peaceful. It was apparent that the medication had been successful in relieving the significant pain and distress which she had suffered. Aware that she was dying, I indicated that I was happy for nursing staff to confirm death and that it

would not be necessary for a duty doctor to be asked to attend for this purpose.

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

Ingrid handed to Code A 24-3-05

Code A

Code A