FFW/133/01

HAMPSHIRE CONSTABULARY

OPERATION ROCHESTER

GOSPORT WAR MEMORIAL HOSPITAL

Code A

Volume 1

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Operation ROCHESTER.

Code A

KEYPOINTS May 2005.

Code A Born Hemel Hempstead Code A

Suffered depression/ attempted suicide between 60's and 90's.

During the 2 months prior to death suffered, depression, suicidal, poor mobility shuffling gait, diarrhoea, chest infection, poor fluid/food intake, hypoproteinaemia. He may have been developing cerebrovascular disease and Parkinsons.

1993-1996 Knowle hospital for depression, discharged to Hazledene rest home, then to Gosport War memorial Hospital where he died 24.01 1996. Cause of death Bronchopnemonia.

Medical records examined by Key Clinical team who assessed the care delivered prior to death as negligent and cause of death unclear.

4th January 1996 (20 days before death) Consultant Geriatrician Code A notes severe depression, total dependency, catheterisation, lateral hip pressure sores, and hypoproteinaemia, recommending move to long stay bed at Gosport War Memorial Hospital.(Code A comments reflects that Code A probably terminally ill).

5th January 1996 transferred for long term care TO Gosport War Memorial Hospital.

9th January Code A suggests Opiates may be appropriate response to physical and mental condition.

10th January medical notes Code A record that 'TLC' is to be administered and Oramorph prescribed.

15th January syringe driver Diamorphine commenced.

16th January Haloperidol (antipsychotic) added to the syringe driver.

18th January Nozinan administered, the dosage doubled on 20th January.

20th January Code A increased Nozinam and discontinued Haloperidol

21st January patient reported as 'settled'.

24th January 1996 - death.

Case assessed by multidisciplinary key clinical team. 2004.

Code A 82. 5th January 1996 – 24th January 1996. Gosport War Memorial Hospital. He was physically and mentally frail, deteriorating on a mental health ward. Medical notes state pain in flexed right hand. Nursing notes state generalised pain. Arthrotec tried plus oramorph. Syringe driver started five days later with a large dose increase when converting from oramorph to diamorphine. Notes on the 21st January 1996 record a respiratory rate of 6 per minute, likely as a reflection of the dose of opiates ie he was probably opiate toxic but the dose was not reduced. Cause of death unclear, although he was very frail, but opiates could have contributed.

Code A From caution interview with police 3.3.2005.

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

Due to demands of work adopted a policy of pro-active prescribing.

Code A noted Code A poor prognosis of Code A on 5th January 1996 and believed that Code A felt that Code A was unlikely to get better and that he was not likely to live for a significant period.

Following admission to GWMH on 5th Jan 1996 Code A placed under the care of Code A. Assessed by Code A.

Would have seen Code A every week day Monday to Friday.

Code A made the note of 9th January 1996, prescribed arthrotec for pain in the hand.

Code A seen by Code A and Code A on 10th January.. Code A noted dementia etc, and wrote that he was for TLC. This indicated to Code A that Code A Code A agreed with Code A assessment and felt Code A was not appropriate for attempts at rehabilitation but for appropriate nursing care and treatment only. Discussed with Code A who agreed.

Code A prescribed Oramorph no doubt as a consequence of liaison with Code A Code A. This was for relief from pain anxiety and distress. Also proactively wrote prescription for diamorphine upon the basis that Oramorph may be insufficient, and that further medication should be available should he need it.

On Monday 15th January 1996 Code A would have reviewed all of the patients in the usual way including Code A Believes she may have been told that his condition had deteriorated over the weekend experienced marked agitation and restlessness and significant pain and distress. Believe assessment was that Code A Code A in terminal decline.

Tried to judge medication as necessary to provide appropriate relief whilst not excessive.

Dosages effectively increased appropriate to increased pain/ distress of patient.

Code A examined patient on 20th January, few modifications to drug regime so therefore presumably not inappropriate.

Code A examined on 21st January Code A settled. With quiet breathing not distressed.. drug treatment continued therefore not inappropriate.

Expert Code A (Palliative medicine and Medical Oncology) comments..

- Notes inadequate.
- Pain not appropriately assessed.
- Opioids not appropriate as administered to alleviate anxiety and agitation.
- Not necessary to use syringe driver (unless patient unwilling or unable to take medicines orally)
- Doses of diamorphine 40-120mgs excessive to needs of the patient (far exceeding appropriate starting dose)
- Appropriate dose would be 10-15mgs.
- Little doubt that Code A was naturally coming to the end of his life.
- At best Code A had attempted to allow a peaceful death, albeit with excessive use of diamorphine.
- Opinion that Code A breached her duty of care, by failing to provide treatment with skill and care, difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs may have contributed more than minimally negligibly or trivially to his death. Code A leaves herself open to the accusation of gross negligence.
- Given the nature of Code A decline, Bronchopneumonia appears to be the most likely cause of death.

In his assessment of Code A prepared statement Code A comments that:-

- According to Code A job description she should take part in weekly consultant ward rounds.
- Consultants were responsible for patient care and should have been available to discuss complex patient issues.

- Given patient numbers 44, and admission numbers Code A should have been able to satisfactory manage in a half post as clinical assistant with regular consultant supervision.
- It is completely unacceptable for the trust to have left Code A with continuing medical responsibilities without consultant supervision and regular ward rounds, to fail to do so would be a serious failure of responsibility by the trust in its governance of patients.

Expert Code A (Geriatrics) reports that Code A was extremely frail and dependent, and at the end of a chronic disease process of depression and drug related side effects spanning 20 or more years.

- Problem in assessing care due to lack of documentation.
- Lack of notes represents poor clinical practice, no written justification for high doses of Diamorphine and Midazolam.
- Drug management afforded to patient is sub-optimal.
- Starting dose of 80mgs of diamorphine is approximately 3 times the dose that conventionally applied.
- Combination of higher than standard doses of drugs, Diamorphine, and Midazolam combined with Nozinan likely to have caused excessive sedation and may have shortened life by a short period of time, hours to days.
- Whilst care is sub-optimal cannot prove to be negligent or criminally culpable.
- Predictions of how long terminally ill patients live are impossible, even palliative care experts show enormous variation.
- Medication likely to have shortened life but not beyond all reasonable doubt.

Other key witnesses.

Code A (also a retired registered metal nurse) understood that Code A Code A was transferred to GWMH for terminal care. She watched Code A die through self neglect. He had become extremely frail and had lost the will to live. She was not alarmed that Code A was given morphine, she considered it appropriate care.

Code A, comments that he suffered chronic intractable depression for which he received continual treatment. It was apparent that in the 5 months prior to his death his physical condition has begun to deteriorate.

Code A employed as Consultant Geriatrician at GWMH, Queen Alexandra Hospital and St Mary's Hospital Portsmouth between March 1992 and June 2004. Consultant for all patients over 65yrs requiring specialist care for their physical health. Assessed Code A prognosis as poor (ie patients chances of survival were slim and unlikely to survive for long) on 4th January 1996, transfer to GWMH

Dryad ward in order to address patients physical and psychiatric needs. Not intended to be a comprehensive care plan.

Code A employed by East Hants Primary Care trust as Consultant Geriatrician in elderly medicine since 1994, covered Dryad ward until late 1996. On 10th January 1996 Code A had overall medical responsibility of the ward. Dryad was a long term care ward containing frail and elderly patients difficult to manage due to medical or nursing requirements. There was no resident doctor on the ward which was covered by local GP Code A responsibilities included a ward round once fortnightly. No requirement for a GP to notify Code A of every change to drugs prescribed to patients, unless her advice was sought by the GP, this occurred infrequently.
On 10th January 1996, Code A conducted a ward round with Code A and Code A and prescribed 5mg Oramorph to alleviate pain and distress. Thereafter Code A recites the drugs prescribed by Code A, and comments that she would have used lower dosage of Diamorphine and Midazalam (than prescribed by Code A her practice was to use the lowest dose to achieve the desired outcome diminishing adverse effects. There was no resident doctor to review the medication.

Code A a Gosport general practitioner. On 20th January 1996 responding to nursing concerns as to the patients clinical response to Haloperidol, Code A stopped the dose and increased dose of Nozinan. He did not see the patient at the time but visited later.

Code A Consultants attended once fortnightly on Mondays unless on leave when it would be monthly. Her practice was to challenge Code A if she did not feel levels of drugs prescribed were appropriate. Syringe drivers used once a patient becomes incapable of swallowing. The term TLC means that a patient was very likely to die. Code A commenced the syringe driver diamorphine on 15.1.1996., and an increased dosage on 18.01.1996. There no policy or protocol regarding the use of syringe drivers prior to 2000.

Code A administered Diamorphine to Code A on the 16th and 23rd January 1996.

Code A administered Diamorphine to Code A 17.1.1996.

Code A in accordance with policy witnessed the accurate recording of Diamorphine prescribed, and recorded on drug charts.

Code A re - charged the syringe driver with Diamorphine on 21.1.1996, and witnesses and recorded the withdrawal of Diamorphine for the patient on 4 other occasions.

Code A witnesses withdrawal of drugs for Code A on 3 occasions.

Code A variously administered ORAMORPH and verified the death of Code A
Code A

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.

Code A 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 Code A.

Two allegations (Code A) were pursued in respect of a consultant Code A Code A

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

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 Code A

The General Medical Council also heard evidence during Interim Order Committee Hearings to determine whether the registration of Code A 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 Code A 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 Code A Code A aged 91 years.

Code A 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 Code A two of Code A Code A complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Code A contacted Gosport police on 27th September, 1998 and alleged that Code A 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.

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

The complaint made by Code A 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 Code A on Monday 17th April 2000.

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

- "Code A prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Code A in a manner as to cause her death."

- "Code A were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Code A was unlawfully killed."

A meeting took place on 19th June 2001 between senior police officers, the CPS caseworker Code A, Treasury Counsel and Code A

Treasury Counsel took the view that Code A report on the medical aspects of the case, and his assertions that Code A 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.

Code A 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 Code A 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 Code A 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 Code A who were each provided with copies of the medical records of the four cases in addition to the medical records of Code A

The reports from Code A 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 Code A 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 Code A 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 Code A commissioned Code A 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 Code A Immediately following the meeting nurse Code A (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 Code A in respect of prescription and administration of Diamorphine.

Code A 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 Code A 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, **Code A** 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 Code A 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:-

- Code A

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 Code A (Palliative care) and Code A (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 Code A 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 Code A Code A

A common denominator in respect of the ten cases was that the attending clinical assistant was Code A 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.

Code A 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 Code A in respect of care delivered to individual patients. Code A 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) Code A exercised her right of silence refusing to answer any questions.

Consultant Code A was interviewed in respect of 2 cases (Code A Code A) following concerns raised by expert witnesses. Code A 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. Code A 88yrs. Admitted to GWMH 21st October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Code A Code A cause of death recorded as Bronchopnuemonia and Glomerulonephritis.

2. Code A 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. Code A cause of death recorded as Cerebrovascular accident.

3. Code A 91yrs. Admitted to GWMH 3rd September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Code A Code A cause of death Bronchopnuemonia.

4. Code A 74 yrs. Admitted to GWMH 14th October 1998 with fractured left humerus and alcoholic hepatitis. Code A cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Code A 92 yrs. Admitted to GWMH 26th March 1999 with a fractured neck of the femur. Died Code A cause of death recorded as cerebrovascular accident.

6. Code A 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 Code A cause of death recorded as bronchopneumonia.

7. Code A 82 yrs. Admitted to GWMH 5th January 1996 with Parkinsons disease he was physically and mentally frail immobile suffering depression. Died Code A Code A cause of death recorded as bronchopneumonia.

8. Code A 99 yrs. Admitted to GWMH 3rd June 1997 with many medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died Code A Code A 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 Code A Code A cause of death recorded as myocardial infarction.

10. Code A 79 yrs. Admitted to GWMH 21st September 1998 with Parkinson's disease and dementia. Died Code A Code A cause of death recorded as bronchopneumonia.

Code A 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:-*

  Code A *– orthopaedic surgeon, microbiologist*

  Code A *– general physician, gastroenterologist*

  Code A *– general physician, cardiologist*

  Code A *– haematologist*

  Code A *– psychogeriatrician*

  Code A *– general physician/palliative care physician*

  Code A *– palliative care physician.*

Many of the concerns raised by Code A were reflected by expert Geriatrician Code A and other experts commissioned, the full details being contained within their reports.

There was however little consensus between the two principal experts Code A Code A 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.

Code A

16th January 2007.

SUMMARY OF EVIDENCE

CASE OF Code A

Background/Family Observations

Code A was born in Hemel Hempstead on Code A He was a sub-mariner in the Royal Navy and met his wife in Canada. They had three children and settled in England in 1947.

Code A suffered depression for a great deal of his life end even attempted suicide on a number of occasions. He was admitted to Knowle Hospital a number times throughout the 60's, 70's and 80's. He returned from the Navy after 22 years service and worked as a Nautical Instructor on the River Hamble. He loved sailing but when the Nautical Training School closed he lost his purpose in life and withdrew into himself. Code A died in 2001.

In about 1993/1994 Code A was admitted again to Knowle Hospital with depression. This time when he was discharged, due to the strain of caring for him at home he was discharged to Hazledene Rest Home where he lived until he died at the Gosport War Memorial Hospital on 24th January 1996.

Whilst at the Rest Home Code A became progressively worse, not socialising, refusing to eat or drink. He was then admitted to Mulberry Ward, a psychiatric ward at Gosport War Memorial Hospital. Again here he continued to deteriorate and didn't respond to treatment. Code A contracted a chest infection and was moved to Dryad Ward for terminal care. He was refusing to eat or drink. He became extremely frail and lost the will to live.

Code A was turned regularly by the nursing staff to prevent bed sores as his skin was breaking down. This caused him pain. He was therefore given morphine via a syringe driver to relieve this pain when turned. The family consider this treatment to be totally appropriate.

Code A died on Code A his death was certified by Code A, the cause of death given as bronchopneumonia.

Police Investigation

Following the publicity in respect of the Police investigation of the case of Code A Code A 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 Code A.

The medical records of Code A were obtained by the Police, copied and submitted to the key clinical team for review. The key clinical team considered that Code A Code A 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 Code A 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 Code A, made by them or to which they made some contribution.

Case papers and the medical records of Code A have been analysed by a further set of independent experts, Code A

Medical history of Code A

(References to page numbers are in respect of the file of medical records reviewed by the key clinical team and the set of independent experts.)

Code A had a very long history of depression as clearly set out in a summary (13). In 1959 he had reactive depression, it occurred again in 1967. In

1979 he had agitation and in 1988 agitated depression.

He had a further long admission with agitated depression in 1992 (8) complicated by an episode of cellulitis (30). This culminated in an admission to long-term residential care in January 1993 (34). He had further admissions to hospital under the care of the psychiatric team including June 1993 (37) when some impaired cognition was noted. In 1995 there was a home visit for further psychiatric problems (42).

In 1995 (44) there was a change in behaviour; loss of weight and increased frailty was noted. He was falling at the residential home. He was expressing grief, frustrations and aggression. At this time his psychiatric medications included Diazepam, Temazepam, Thioridazine, Sertraline, Lithium, and Codanthrusate for constipation. His other problems were hypothyroidism and Parkinsonism with a tremor. (Note: this was not Parkinson's disease but tremor, rigidity and akinesia which occurs similar to Parkinson's disease but as a result of long-term anti-psychotic medication).

On 29th November 1995 he was admitted under the psychiatrist Code A (46) to Gosport War Memorial Elderly Mental Health beds. His mental test score was documented at 8/10 (50). He was discharged back to residential home on 24th October (46) with a continued diagnosis of depression (56). However, his very poor mobility and shuffling gate was noted (57).

On 13th December 1995 he was re-admitted (62) to mental health beds at the Gosport War Memorial under Code A stating "everything is horrible". He was verbally aggressive to the staff and was not mobilising and staying in bed all day. He felt hopeless and suicidal. (62).

On 22nd December, diarrhoea started and he also had chest symptoms. It was thought he had a chest infection, and was treated with Erythromycin (64). On 27th December he was "chesty, not himself", and his bowels were causing concern. The physiotherapist noted that he had signs in his chest (65). A second course of a different antibiotic (Cephalosporin) was prescribed (81). The nursing cardex documents that he started becoming faecally incontinent on 20th December and then had further episodes of diarrhoea (140). It is also noted that by 1st January (147) he was drowsy with very poor fluid intake.

On 2nd January 1996 Code A consultant geriatrician was asked to see (66) and on 3rd January he was noted to be clinically deteriorating with poor food intake (66), albumin of 27 (67). An abdominal x-ray on 27th December describes possible "pseudo-obstruction" (116). This is a condition when the large bowel fails to work and starts to dilate, usually in patients who have multiple illnesses including Parkinsonism, electrolyte imbalance, infections, antibiotics and other drugs. Prognosis is often poor and depends on resolving the underlying causes.

On 4th January 1996 Code A is seen by Code A, Consultant Geriatrician who noted severe depression, total dependency, catheterisation, lateral hip pressure sores

and hypoproteinaemia. (67) He states that the patient should be moved to a long-stay bed at the Gosport War Memorial Hospital and that his residential home place should be given up as he was unlikely to return. On 5th January he is transferred to Dryad Ward for "long-term care" (151). Code A also states (5M) "Code A is aware of the poor prognosis".

Gosport War Memorial Hospital

On 5th January a basic summary of the transfer is recorded, on the 9th January increasing anxiety and agitation is noted and the possibility of needing opiods is raised. The nurses cardex on 9th said that he is sweaty and has "generalised pain" (25M). On 10th January a medical decision is recorded "for TLC". In the medical discussion (13M) with Code A also apparently agrees "for TLC". I am not sure of the signature of 10th January in the medical notes (13M). The nursing cardex records they commenced Oramorph and that Code A is aware of the poor outcome (25M).

The 15th January the nursing notes document that a syringe driver has been commenced (25M) and by the evening the patient is unresponsive (26M). However on 16th January there is some agitation when being attended to and Haloperidol is added to the syringe driver (26M). On the 17th the patient remains tense and agitated, (27M) the nursing cardex states that Code A attended, reviewed and altered the dosage of medication. The syringe driver is removed at 15.30 hours and the notes say "two drivers" (27M).

The next medical note is on 18th January, eight days after previous note on 10th January. This states further deterioration, subcut analgesia continues..... try Nozinan.

On 20th January the nursing notes state that Code A was contacted regarding the drug regime and there was a verbal order to double the Nozinan and omit the Haloperidol (28M). This is confirmed in the medical notes on 20th January (15M).

On 21st January the nursing notes state "much more settled", respiratory rate of 6 per minute, not distressed.

On 24th January the date of death is verified by Code A in the medical notes at 0145hrs. (15M).

Code A

The doctor responsible on a day to day basis for the treatment and care of Code A was a Clinical Assistant, Code A. 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 patients condition, based on the history and clinical signs and, if necessary, an appropriate examination
- 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 patient's needs.

In reviewing the medical records of Code A it is apparent that Code A 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 Code A and the reasoning behind the various prescriptions of drugs. Ranges of drugs are prescribed which appear to fall outside recognised parameters.

Expert analysis

Code A

Code A is an expert in Palliative Medicine and Medical Oncology. He has produced two reports in respect of the cases of Code A. His first report comments on the standard of care afforded to Code A and his second report comments on the first statement of Code A (referred to later).

Code A in his review of Code A care of Code A reported specifically:-

i) The notes relating to Code A transfer to Dryad Ward are inadequate. On transfer from one service to another, a patient is usually reclerked highlighting in particular the relevant history, examination findings and any planned investigations to be carried out.

ii) Pain is the most likely reason for prescribing the non-steroidal anti-inflammatory drug (Arthrotec). However, pain was not documented in the notes, nor was any pain assessed.

iii) Code A painful right hand held in flexion does not appear to have been appropriately assessed. From its description it may have been tetany causing carpopedal spasm and the common causes of this should have been considered, e.g. a low serum calcium or magnesium deficiency. Less likely is a dystonia but given that some of his medications could cause extrapyramidal effects (see technical background) this possibility should also have been considered. As hypocalcaemia is reported to cause mood disturbance such as anxiety and agitation, it would have been particularly relevant to consider.

iv) It should be clarified why Code A felt Code A needed opioids. From the medical notes, it appears to relate to his increasing anxiety and agitation. This is not an appropriate indication for the use of opioids. If opioids were being suggested for his painful hand, this would also be inappropriate. The medical notes state no other pain. The nursing notes do state he had generalised pain, but the lack of a full pain assessment makes it difficult to

know what pain this represented; for example, was it related to muscle and/or joint stiffness from immobility, his pressure sores or abdomen?

v) It is not clear from the medical notes the indication for which the morphine was commenced. If it was for pain then this should have been documented and assessed. It was a reasonable starting dose for someone of his age and morphine is used in palliative care for generalised pain related to muscle or joint stiffness due to immobility or painful pressure sores.

vi) It is not clear what the indications were for prescribing the syringe driver on the 10th January 1996 and for the medications it contained. It is not usually necessary to utilise the SC route unless a patient is unwilling or unable or to take medications orally (e.g. difficulty swallowing, nausea and vomiting). From the drug chart Code A did not appear to have these problems (page 18 of 49). No instructions were given on the drug chart on when the syringe driver should be commenced, how this would be decided and by whom. The dose of diamorphine was initially written as a dose range of 40–80mg, only to be subsequently rewritten the next day as 80–120mg without explanation of why a higher dose range was necessary. Based on Code A existing opioid dose, all of the doses of diamorphine are likely to be excessive for his needs. Given his total dose of oramorph (morphine solution) of 30mg in 24hours, an appropriate dose of diamorphine using a 1:2 or the more usual 1:3 dose conversion ratio, would have been 10–15mg in 24hours. There is no justification given for this in the medical notes. Similarly, the

indications for including the hyoscine hydrobromide and midazolam should have been documented. The dose range of midazolam of 40–80mg would generally be seen as excessive for someone of Code A age. However, taking into account he was a long term user of benzodiazepines, a higher than usual starting dose would likely be necessary.

vii) The dose of diazepam was increased on the 11th January 1996 with no mention of this in the medical notes.

viii) The sertraline and lithium carbonate were discontinued on the 12th January 1996 with no mention of this in the medical notes. It was unclear if this was on the advice of the psycho geriatricians or not; my understanding is that sertraline should not be discontinued abruptly as this is associated with a withdrawal syndrome that can include anxiety, agitation and delirium. A gradual withdrawal of lithium is also advised (BNF).

ix) A syringe driver was ultimately commenced on the 15th January 1996. It is not documented why it had become necessary to give these medications via a syringe driver. Code A appeared to have been taking his oral medications and the medical entry noted that he 'will eat and drink'. There was no mention in the medical or nursing notes of pain, retained secretions, agitation or anxiety that day. If he was more drowsy and unable to take his medication it would have been reasonable, particularly if he required morphine for pain relief. However, taking into account Code A dose of morphine, the starting dose of diamorphine (80mg) was likely to be excessive for his needs as detailed above. The reasons for including the

hyoscine hydrobromide (400microgram) and midazolam (60mg) over 24hours was not documented. The dose of midazolam of 60mg over 24hours is an above average starting dose for somebody of Code A age (see technical issues). He had however, been on long term benzodiazepines and in these patients a larger than usual starting dose may be necessary.

x) On the 16th January 1996 the nursing notes reported some agitation when Code A Code A was being attended to. Haloperidol 5mg SC over 24hours was added to the syringe driver. Haloperidol is a reasonable part of the approach to treating delirium or terminal agitation in someone of Code A age. It should be given with caution, given Code A parkinsonism, as it can cause extrapyramidal effects (see technical issues). However, it is not clear from the notes that his agitation had been assessed and hence the possible underlying causes of the agitation considered. Drugs (or their withdrawal) are one of the common causes of agitation or terminal restlessness. Of particular relevance to Code A these would include the use of opioids, particularly in inappropriate and excessive doses, hyoscine hydrobromide and benzodiazepines (Wessex Protocol, pages 30, 34). It is possible that a reduction in the dose of diamorphine may have helped Code A agitation.

xi) On the 17th January 1996 the dose of diamorphine was increased to 120mg and the midazolam to 80mg SC over 24hours with no reason given in the notes. The nursing notes suggest that Code A remained tense and agitated.

There is no documentation that a medical assessment was undertaken to determine whether his being 'tense' related to muscle and joint stiffness, possible extrapyramidal effects from the haloperidol or that other causes of agitation had been considered. Again, rather than increase the diamorphine, a reduction may have been more appropriate. Similarly, the discontinuation or reduction in the dose of haloperidol, or substitution for an antipsychotic with a lower risk of causing extrapyramidal effects, e.g. levomepromazine, may have been appropriate.

The nursing notes suggest that Code A was 'bubbly' due to retained secretions and this appears to be the reason for the hyoscine hydrobromide dose being increased twice in one day from 400 to 600 microgram then to 1200microgram SC over 24hours.

xii) The medical notes entry on the 18th January 1996 suggested that Code A Code A symptoms were difficult to control but did not document which symptoms. Levomepromazine 50mg SC over 24hours was commenced. This is an appropriate drug to use for terminal agitation when haloperidol is insufficient. The dose is in keeping with that recommended by the BNF and the Wessex Protocol. However, it would have been usual to substitute it for the haloperidol rather than use it concurrently.

Code A

Code A is an expert in Geriatric medicine. His reporting comments on the standard of care afforded to Code A and his expert opinion reports specifically:-

> Code A was an extremely ill, frail and dependent gentleman on his admission to Gosport War Memorial Hospital and was at the end point of a chronic disease process of depression and drug related side effects that had gone back for very many years.
>
> The major problem in assessing Code A care is 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 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 other drugs or other treatments prescribed". The major gaps in the written notes, the lack of evidence of appropriate examinations, use of unusual drug regimes without adequate documentation in the medical notes, changes in

prescription without proper documentation, all represent poor clinical practice clinical practice to the standards set by the General Medical Council. However, by itself, these do not prove that the medical or nursing care provided to Code A was sub-optimal, negligent or criminally culpable.

In my view the drug management as Gosport was sub-optimal. There was no written justification at any stage for the high doses of Diamorphine and Midazolam written up in the drug charts and subsequently prescribed to Code A The notes and the drug charts leave confusion as to whether at one stage there may have been three syringe drivers being used. The dose of Nozinan may have been prescribed by verbal prescription and not written up in the drug chart. Combinations of the higher than standard doses of Diamorphine and Midazolam, together with the Nozinan were very likely to have caused excessive sedation and may have shortened his life by a short period of time, that in my view would have been no more than hours to days. However, this was a dying man, the family appeared to have been appropriately involved and the patient did eventually die without distress on 24th January. While his care is sub-optimal I cannot prove it beyond reasonable doubt to be negligent or criminally culpable.

Interview of Code A

Code A has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified 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 3rd March 2005 Code A in company with her solicitor, Code A Code A voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Code A Code A at the Gosport War Memorial hospital. The interviewing officers were Code A Code A.

The interview commenced at 0915 and lasted for 25 minutes. During this interview Code A Code A read a prepared statement, later produced as JB/PS/3. This statement dealt with the specific issues surrounding the care and treatment of Code A

Expert response to statement of Code A

The statement of Code A regarding her care and treatment of Code A was provided to Code A on completion of his initial report on the case. He is currently reviewing the statements of Code A against his report. Although not fully completed and therefore subject to change his first draft highlights the following points.

i) Code A was admitted to Mulberry ward on 14th September 1995 and not 29th November 1995 as stated in his report (para 5.4). Code A also assumed incorrectly that Code A was a male referring to him as 'him' (para 6.9).

ii) Paragraph 13 does imply that an external examination of Code A pressure area's may have been undertaken. However as in Code A report (para 6.10) no general physical examination is otherwise recorded to have taken place.

The statement of Code A regarding her care and treatment of Code A was also provided to Code A on completion of his initial report on the case. Although not completed and therefore subject to change his draft highlights the following points.

Code A admits to poor note keeping and proactive prescribing due to time pressures in 1996. Even with significant episodes in Code A care however, no entry was made. Having read Code A statement regarding Code A, I believe that the main issues raised in my report (BJC 71), dated 24th April 2005, remain valid and have not yet been satisfactorily addressed due to a lack of clarity regarding:

- the nature of Code A pain and its possible cause(s)
- the justification for the proactive prescribing of a syringe driver containing diamorphine, hyoscine and midazolam 'just in case he needed it'
- the lack of use of 'as required' doses of the above drugs instead of, or subsequently, alongside the syringe driver
- the basis for Code A use of diamorphine specifically for the relief of agitation
- the lack of assessment of the possible cause(s) of Code A agitation
- how the dose of diamorphine Code A ultimately received (80mg) was calculated in a way that can be clearly related to his existing dose of opioid
- given the difficulty of controlling the symptoms, whether Code A sought advice.

As some of the above points relate directly to Code A knowledge of the management of pain and other symptoms in a palliative care setting it would

be helpful if she could state what specific training she had received in relation to this. In particular, where she obtained her understanding from with regards to the indications for the use of morphine/diamorphine, the phenomenon of tolerance to opioids, the methods of determining an appropriate dose of diamorphine given a patients oral morphine dose and what prescribing guidelines she was aware of and/or followed.

Code A (BJC/71) April 25th 2005

REPORT

regarding

Code A (BJC/71)

PREPARED BY: Code A MB ChB FRCP DM
Reader in Palliative Medicine and Medical Oncology

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

Code A was a frail 82 year old man admitted to Mulberry Ward, Gosport War Memorial Hospital due to depression. He was withdrawn, agitated and irritable and required the help of two others to mobilise. Despite the admission and a reduction or discontinuation in some of his medication, his low mood and poor mobility persisted. He developed a chest infection and urinary retention. After about three weeks in hospital, his condition remained poor and he started to develop pressure sores. Code A was referred to Code A Code A Consultant Geriatrician, for a medical review and was subsequently transferred to Dryad Ward.

During this admission, the medical care provided by Code A fell short of a good standard of clinical care as defined by the General Medical Council that included the lack of clear note keeping, adequate assessment of the patient and providing treatment that was excessive to a patients' needs. The reason for the prescription of drugs was not clear. If pain was a problem, it was not recorded or assessed. Most significantly, the dose range of diamorphine prescribed for the 'as required' syringe driver, and the dose finally administered (80mg), far exceeded that generally considered to be an appropriate starting dose (10–15mg) based on Code A existing opioid usage.

Code A was described as tense and agitated several times following the syringe driver being commenced. In this regard the use of midazolam, haloperidol and levomepromazine could be seen as justified. However, an assessment of the possible causes of his agitation should have been carried out. This would have included considering if drugs, such as the diamorphine, were a possible contributing factor to his agitation. At the very least, given that

diamorphine in a dose that is excessive to a patients needs can cause agitation and confusion, it should have prompted a review of the appropriateness of Code A dose of diamorphine.

There appears little doubt that Code A was 'naturally' coming to the end of his life. At best, Code A could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Code A a peaceful death, albeit with what appears to be an excessive use of diamorphine due to a lack of sufficient knowledge.

It is my opinion however, that given the lack of documentation to the contrary, Code A could be seen as a doctor who breached the duty of care she owed to Code A by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Code A by unnecessarily exposing him to excessive doses of diamorphine that could have resulted in a worsening of his agitation. Code A response to this was to further increase Code A dose of diamorphine. Despite the fact that Code A Code A was dying 'naturally', it is difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death. As a result Code A 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 his 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 his 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 Reader in Palliative Medicine and Medical Oncology, University of Nottingham and Honorary Consultant Physician, Nottingham City Hospital NHS Trust.

Trained in general medicine, including experience in health care of the elderly (acute medicine and rehabilitation) prior to specialising in Palliative Medicine, working in Specialist Palliative Care Units in Nottingham and Oxford. Appointed to present post as Senior Lecturer in 1995. Promoted to Reader in 2001. Carries out research in pain, breathlessness and exercise capacity. Regularly lectures on national and international courses. Palliative care prescribing advisor to the British National Formulary (2002-). Expert reviewer for Prodigy national palliative care guidelines for general practitioners. Joint author of the Palliative Care Formulary that has sold over 30,000 copies, and the 3rd edition of Symptom Management in Advanced Cancer, with Code A Code A. Previously Chair of the Mid-Trent Cancer Services Network Palliative Care Group, Nottingham Cancer Centre Palliative Care Group and

was the inaugural Secretary for the Science Committee of the Association for Palliative Medicine of Great Britain and Ireland. Member of the National Institute for Clinical Excellence Lung Cancer Guidelines Development Group. Operates the international Palliative Medicine mailbase mailing list and co-owns and edits www.palliativedrugs.com that publishes the Palliative Care Formulary on the internet. With over 15,500 members it is the largest Palliative Care resource of its kind. Provisional Member of the Expert Witness Institute.

5. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Code A including the death certificate.

[2] Full set of medical records of Code A on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

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

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

[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) Draft Protocol for Prescription Administration of Diamorphine by Subcutaneous Infusion, Medical Director (December 1999).

vi) 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).

6. CHRONOLOGY/CASE ABSTRACT

Events at the Gosport War Memorial Hospital, Mulberry Ward, 13th December 1995 until 5th January 1996

Code A, an 82 year old man who lived in Hazeldene residential home was admitted on the 13th December 1995 to Mulberry Ward, Gosport War Memorial Hospital under the care of Code A consultant in old age psychiatry (pages 62 of 181). He was depressed and reported feeling hopeless and suicidal. He had been verbally aggressive towards his wife and the staff at the residential home. He was staying in bed all day and not eating well (pages 62 and 125 of 181). He was known to Code A

Banks having suffered from chronic depression for over 30 years resulting in multiple admissions to hospital. He also had an underactive thyroid gland and problems with constipation (page 62 of 181). His medication consisted of sertraline 100mg once a day, lithium carbonate 400mg once a day, thioridazine 50mg four times a day, diazepam 10mg twice a day, temazepam 10mg at night, thyroxine 50microgram once a day, magnesium hydroxide 10ml at night and codanthrusate 2 capusles at night (pages 62 and 88 of 181). Examination revealed him to be withdrawn, a little agitated and irritable. He had a slight tremor on moving, a shuffling gait and required the help of two others to mobilise (page 63 of 181). It was considered that depression was his main problem (page 63 of 181).

Over the next few days he experienced a fall and problems with diarrhoea. His laxatives were discontinued and an abdominal x-ray carried out. This revealed distension of the large bowel with only a small gas bubble seen in the region of the rectum. The report concluded that these features could represent distal large bowel obstruction but as there was no faecal residue, the changes may be due to pseudo-obstruction (page 116 of 181). His low mood and poor mobility persisted. As thioridazine can cause Parkinsonism (i.e. a collection of features similar to those seen in patients with Parkinson's disease, e.g. difficulty initiating movements, rigidity, tremor etc.) the dose was reduced to 25mg four times a day and procyclidine 5mg twice a day was commenced (page 64 of 181). Procyclidine is an antimuscarinic drug that can help with Parkinsonism.

After about one week, on the 22nd December 1995 he was found to have a chest infection and erythromycin, an antibiotic, was commenced (page 64 of 181). On review by Code A on the 27th December 1995, Code A

was noted to be 'chesty, poorly, abusive and not himself at all' (page 65 of 181). As he had not responded to the erythromycin, another antibiotic, cefaclor was commenced and the procyclidine was discontinued. He had been catheterised for urinary retention the week before (page 65 of 181). Microbiology tests of his sputum revealed a pseudomonas infection (page 112 of 181). A chest x-ray showed no evidence of focal lung disease (page 116 of 181). It was decided to reassess his mood once his medical problems had been addressed.

After about three weeks in hospital, on the 2nd January 1996 it was reported that he remained poorly, lethargic, his skin was breaking down and he was now nursed on a Pegasus bed. He was reported to be asking 'why don't you let me die?' (page 65 of 181). Blood test results on the 2nd January 1996 were mostly normal. There was a raised white blood cell count. $15.7x10^9$/L, due to an increase in neutrophils, $14.4x10^9$/L, in keeping with an infection (page 114 of 181). Liver enzymes were mildly abnormal with raised alkaline phosphastase of 110 IU/L, AST (aspartate aminotransferase) of 127 IU/L and a low albumin of 27g/L (upper limit of normal 95, 40 and lower limit of 37 respectively)(page 85 of 181). Rather than attribute his deterioration purely to his depression, Code A was referred to a geriatrician to see if any medical problems were contributing to his decline (page 65 of 181). A referral letter was written in the notes to Code A Consultant Geriatrician, on the 2nd January 1996 that noted Code A Code A mobility had deteriorated drastically during his admission and although his chest infection was now improving, he remained bed bound, expressing the wish to die. It also noted Code A complaints of intermittent abdominal pain (page 66 of 181).

When reviewed by Code A on the 3rd January 1996, it was again noted that Code A was deteriorating, with a poor food intake and some breaks in his skin (page 66 of 181). In case undesirable effects of some of his medication were contributing to his decline, the diazepam was reduced to 2mg three times a day and the thioridazine and temazepam discontinued (pages 67 and 81 of 181).

He was seen by Code A on the 4th January 1996. She listed Code A problems as 'chronic resistant depression – very withdrawn, completely dependent (Bartell 0), catheter by-passing, superficial ulceration of left buttock and hip, and hyoproteinaemic'. She suggested high protein drinks, bladder washouts twice a week, dressing to his skin ulcers and transfer to a long stay bed. Code A felt his residential home place could be given up as he was unlikely to return (page 67 of 181). In the typed letter of the 8th January 1996, that summarised this review, Code A stated that Code A Code A prognosis was poor and that he was unlikely to return to Hazeldene Rest Home (page 5 of 49).

Events at Gosport War Memorial Hospital, Dryad Ward, 5th January 1996 to 24th January 1996

On transfer to Dryad Ward on the 5th January 1996, the medical notes record Code A problems as consisting of 'immobility, depression, a broken sacrum with small superficial areas of the right buttock, a dry lesion on his left ankle and both heels suspect. Catheterised, transfers with hoist, may help to feed himself. Long standing depression on lithium and sertraline' (page 13 of 49). Code A medication was continued unchanged on transfer: sertraline 50mg twice a day, lithium carbohydrate

400mg at night, diazepam 2mg three times a day, thyroxine 50microgram once a day and daktacort cream (page 16 of 49). The nursing notes suggest that Code A settled into the ward well and went on to detail his pressure sores (page 25 of 49).

On the 8th January, a pain relief preparation 'arthortec' one tablet twice a day, containing a non-steroidal anti-inflammatory drug, diclofenac, was commenced and continued until the 10th January 1996 (page 16 of 49).

On the 9th January 1996 the medical notes entry reads 'painful right hand held in flexion, try *hot water* (this should be clarified as the handwriting is difficult to decifer). Also increasing anxiety and agitation,?sufficient diazepam, ?needs opiates' (page 13 of 49). The nursing notes record that he was very sweaty but was apyrexial (temperature not elevated) and that Code A stated that he had generalised pain (page 25 of 49).

On the 10th January 1996, oramorph (morphine solution, 10mg/5ml) 2.5ml (5mg) every four hours was prescribed but none given until the 11th January (page 17 of 49). Possibly also on the 10th January, diamorphine 40–80mg and hyoscine (hydrobromide) 200–400microgram SC (subcutaneous) in 24 hours were also prescribed (page 17 of 49). These were not used on the 10th or 11th January, and the drug chart appears to have been rewritten sometime on the 11th January (pages 18 and 19 of 49). The diamorphine was rewritten as 80–120mg along with hyoscine (hydrobromide) 200–400microgram and midazolam 40–80mg SC (subcutaneous) in 24 hours. The nursing notes for this day record 'Condition remains poor. Seen by Code A To commence on oramorph 4 hourly. This evening Code A seen and is aware of poor condition. To stay in long stay bed' (page 25 of 49).

On the 11th January 1996 the diazepam was increased from 2mg to 5mg three times a day and the oramorph given as 5mg every 4 hours, with 10mg at night until the morning of the 15th January 1996 (page 19 of 49). On the 12th January 1996, the sertraline and lithium carbonate were discontinued.

On the 13th January 1996 the nursing notes record 'Catheter bypassing. Code A appears distress, suby g washout given. However, catheter continues to bypass heavily. Catheter removed, tip of same looks very mucky...' (page 25 of 49).

A medical notes entry on the 15th January 1996 summarises 'For TLC (tender loving care). Discussed with Code A agrees in view of the poor quality for TLC' (page 13 of 49). A syringe driver was commenced at 08.25am on the 15th January containing diamorphine 80mg, hyoscine hydrobromide, 400microgram and midazolam 60mg SC over 24 hours (pages 18,25,26 of 49). The nursing notes for that day detail 'Seen by Code A Syringe driver commenced....' and at 19.00pm ' Code A informed of Code A deterioration during the afternoon. Now unresponsive. Unable to take fluids and diet. Pulse strong and regular' (page 26 of 49).

On the 16th January 1996 haloperidol 5–10mg SC over 24 hours was prescribed (page 20 of 49) with Code A receiving haloperidol 5mg on the 16th January 1996 and 10mg on the 17th January 1996. The nursing notes entry reads 'Condition remains very poor. Some agitation was noticed when being attended to. Seen by Code A Haloperidol 5–10mg to be added to the driver' (page 26 of 49).

On the 17th January 1996, the dose of diamorphine was increased to 120mg and the midazolam to 80mg SC over 24 hours and both then

remained unchanged for the remainder of Code A life. The dose of hyoscine hydrobromide was increased twice on the 17th January to 600microgram then 1200micrograms SC over 24 hours; as was the dose of haloperidol, increasing to 10mg and then to 20mg SC over 24 hours (pages 6, 7 and 20 of 49). The dose of hyoscine hydrobromide then remained unchanged for the remainder of Code A life. There are several entries in the nursing notes on the 17th January: (09.00am) 'Seen by Code A medication increased 08.25am as patient remains tense and agitated. Chest very 'bubbly'. Suction required frequently this morning. Patient bed bathed, mouth care tolerated well. Skin marking easily despite hourly turning and use of Pegasus mattress and remains distressed on turning.' (14.30pm) 'Seen by Code A medication reviewed and altered. Syringe driver renewed at 15.35pm (two drivers)..... Code A informed of deterioration.' (20.30pm) 'Further deterioration in already poor condition. Appears more settled although still aware of when he is being attended to....' (page 27 of 49).

On the 18th January 1996 the medical notes report 'further deterioration, SC (subcutaneous) analgesia continues, difficulty controlling symptoms, try nozinan' (levomepromazine) (page 15 of 49). This was commenced at a dose of 50mg SC over 24 hours (page 6 of 49). The nursing notes report 'poorly condition, continues to deteriorate.....' (page 27 of 49). Code A has visited for most of the day. Appears comfortable in between attention. Oral suction given with some effect' (page 28 of 49).

On the 19th January 1996 the nursing notes read 'A marked deterioration in an already poorly condition.....Breathing very intermittent, colour poor' (page 28 of 49). On the 20th January 1996 the medical notes entry reads

'Has been unsettled on haloperidol in syringe driver. Discontinue and change to higher dose nozinan, increase nozinan 50→100mg in 24 hours (verbal order)' (pages 6, 7 and 15 of 49). The nursing notes for the 20th January 1996 read Code A and both Code A have visited. Code A contacted regards to regime. Verbal order taken to double nozinan and omit haloperidol. Syringe driver recharged at 18.00hours. Appears comfortable at time of report...' (page 28 of 49).

On the 21st January 1996, the medical notes entry reads 'Much more settled. Quiet breathing. Respiratory rate 6 per minute. Not distressed, continue' (page 15 of 49). Nursing entry for this day reads 'Very settled today' (page 28 of 49). On the 22nd January 1996 the nursing notes record 'poorly but very peaceful' (page 29 of 49). On the 23rd January 1996, the nursing notes record 'Poorly condition remains unchanged, has remained peaceful' (page 29 of 49). An untimed entry then reads 'Patients condition deteriorated suddenly at 01.40am and Code A died at 01.45am' (page 29 of 49). A verification of death entry was made in the medical notes (page 15 of 49).

On the death certificate, cause of death was given as 1a Bronchopneumonia.

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Syringe drivers, diamorphine, midazolam, haloperidol, levomepromazine (nozinan) and hyoscine hydrobromide

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 2–4hour 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 patients' 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 BNF (March 1995) recommends 20–100mg SC over 24hours. 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.

Haloperidol is an antipsychotic. It is frequently used in syringe drivers for its antipsychotic and anxiolytic effects in patients with terminal delirium/agitation or as an anti-emetic. Compared to other antipsychotics, like levomepromazine, it is less sedative but can cause more problems with extrapyramidal effects and should be used with caution in patients with parkinsonism or Parkinson's disease. Extrapyramidal effects include parkinsonism, acute dystonia, acute akathesia and tardive dyskinesia. Parkinsonism consists of tremor, rigidity and slowing of movements; acute dystonia is spasm of muscles including those involving the eyes, head,

neck, trunk and limbs. They are usually abrupt in onset and associated with anxiety; acute akathesia is a form of restlessness of the muscles in which the person is compelled to move or change position and is associated with variable degrees of patient distress; tardive dyskinesia typically presents as involuntary chewing movements of the face and orofacial muscles.

A typical starting dose of haloperidol for an adult is 3–5mg a day with an upper dose range of 10–30mg orally or SC. A smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The BNF (March 1995) recommends 5–30mg SC over 24hours. The Wessex protocol suggests a range of 1.5–3mg up to three times a day orally. It is usual to prescribe additional doses for use 'as required' often in the dose range of 2.5–5mg SC. The dose is often prescribed so that it can be given hourly if required.

Levomepromazine is an antipsychotic. It is frequently used in syringe drivers for its antipsychotic and anxiolytic effects in patients with terminal delirium/agitation or as an anti-emetic. It is more sedative than haloperidol.

A typical starting dose of levomepromazine for an adult is 50mg SC over 24 hours, with an upper dose range of 300mg SC. A smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The BNF (March 1995) recommends 50–200mg SC over 24hours. The Wessex protocol suggests a range of 25–200mg SC over 24hours. It is usual to prescribe additional doses for use 'as required' often in the dose range of 6.25–25mg SC. The dose is often prescribed so that it can be given hourly if required.

Hyoscine hydrobromide is an antimuscarinic drug most commonly given to reduce excessive saliva or retained secretions ('death rattle'). It also has

anti-emetic, antispasmodic (smooth muscle colic) and sedative properties. Repeated administration can lead to cummulation and this can occasionally result paradoxically in an agitated delirium, highlighted in both in the BNF and the Wessex protocol (page 41). It is usually given in a dose of 600–2400micrograms SC over 24hours (BNF (March 1995)) or 400–600micrograms as a stat SC dose. The Wessex protocol gives a dose range of 400–1200micrograms over 24hours.

The titration of the dose of analgesic, antipsychotic or sedative medication is guided by the patients symptom control needs. The number and total dose of 'as required' doses required over a 24hour period are calculated and this guides the increase necessary in the regular dose of the drugs in the syringe driver in a way that is proportional to the patients needs. The ideal outcome is the relief of the symptoms all of the time with no need for additional 'as required' doses. In practice, this can be difficult to achieve and the relief of the symptoms for the majority of the time along with the use of 1–2 'as required' doses over a 24hour period is generally seen as acceptable.

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

Events at Gosport War Memorial Hospital, Mulberry Ward 13th December 1995 to 5th January 1996

Code A was an 82 year old man who suffered from chronic depression. Deterioration in his mental and physical state led to his admission for assessment on Mulberry Ward under the care of Code A. Examination revealed him to be depressed and withdrawn and a little agitated and irritable. He had signs of Parkinsonism which may have been due to undesirable effects of his medication. Despite a reduction in his medication his situation failed to improve. He developed a chest infection that required two different sorts of antibiotic to treat. Despite this, his physical deterioration and poor mental state continued. Rather than attribute his deterioration purely to depression, Code A was appropriately referred to a geriatrician, Code A It was documented that

his mobility had deteriorated drastically during his admission and that he had become bedbound, was complaining of intermittent abdominal pain and expressing the wish to die. His diazepam was reduced and thioridazine and temazepam discontinued, but still Code A failed to improve. Code A review indicated that Code A prognosis was poor and that he was unlikely to return to Hazeldene Rest Home. This implies that his transfer to Dryad Ward was for terminal care. There are no issues relating to the standard of care or treatment proferred to Code A during his admission to Mulberry Ward.

Events at Gosport War Memorial Hospital, Dryad Ward 5th January 1996 to 24th January 1996

Compared to the notes during Code A stay on Mulberry Ward, infrequent entries in the medical notes during his stay on Dryad Ward make it difficult to closely follow Code A progress over the last three weeks of his life. There are seven entries taking up just one and a half pages in length. In summary and in approximate chronological order, Code A Code A was prescribed Arthrotec, a non-steroidal anti-inflammatory drug. There was no record or assessment of pain in the medical notes, but the nursing notes recorded that he stated that he had generalised pain. He later complained of a painful right hand held in flexion for which *?hot water* (to be clarified) was suggested. Increasing anxiety and agitation were also noted. Code A queried whether he was receiving sufficient diazepam or required opiates. The possible cause of his painful right hand held in flexion is not documented in the medical notes.

The Arthrotec was discontinued after two days and he was commenced on morphine regularly. It is not clear from the notes what pain this was prescribed for, why the Arthrotec was stopped or why a 'weak' opioid like codeine was not felt appropriate. On the same day, a syringe driver was prescribed containing diamorphine 40–80mg and hyoscine (hydrobromide) 200–400microgram in 24hours to be used 'as required'. This was never given but when the drug chart was rewritten, apparently the next day, the dose range of diamorphine was increased to 80–120mg and midazolam 40–80mg added without reason.

His diazepam was increased on the 11th January 1996 and his sertraline and lithium carbonate discontinued on 12th January 1996 both without reason. On the 13th January 1996 the nursing notes record Code A to appear distressed. It is unclear if this was related to his urinary catheter bypassing or was more generalised.

On the 15th January 1996 a syringe driver was commenced containing diamorphine 80mg, hyoscine hydrobromide 400micrograms and midazolam 60mg. The indication for this is not clear. Once the syringe driver was commenced he became unresponsive and his family informed.

On the 16th January 1996 the nursing notes stated that he was agitated when being attended to. Haloperidol 5mg was prescribed and administered, although there was no entry in the medical notes. On the 17th January 1996 the dose of diamorphine was increased to 120mg, the haloperidol to 10mg (subsequently 20mg), the midazolam to 80mg and the hyoscine hydrobromide to 600microgram (subsequently 1200microgram). No reason is given in the medical notes, although the

nursing notes report Code A to be tense and agitated and have a very 'bubbly' chest.

The medical notes entry on the 18th January 1996 report symptoms were difficult to control but does not specify which symptoms. Levomepromazine was then commenced at a dose of 50mg SC over 24hours. On the 20th January 1996 an entry in the medical notes report Mr Pittock to be unsettled and the dose of levomepromazine was increased from 50 to 100mg and the haloperidol was then discontinued. Thereafter Code A appeared to be settled until his death in the early hours of the 24th January 1996. Given the nature of Code A decline and problems with respiratory tract secretions, bronchopneumonia appears to be the most likely cause of his death, as stated on the death certificate.

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

The overall care given to Code A whilst on Mulberry Ward, Gosport War Memorial Hospital was not substandard.

The medical care provided by Code A to Code A following his transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (Good Medical Practice, General Medical Council, 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

- in providing care you must 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
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs
- in providing care you must be willing to consult colleagues.

Specifically:

i) The notes relating to Code A transfer to Dryad Ward are inadequate. On transfer from one service to another, a patient is usually reclerked highlighting in particular the relevant history, examination findings and any planned investigations to be carried out.

ii) Pain is the most likely reason for prescribing the non-steroidal anti-inflammatory drug (Arthrotec). However, pain was not documented in the notes, nor was any pain assessed.

iii) Code A painful right hand held in flexion does not appear to have been appropriately assessed. From its description it may have been tetany causing carpopedal spasm and the common causes of this should have been considered, e.g. a low serum calcium or magnesium deficiency. Less likely is a dystonia but given that some of his medications could cause extrapyramidal effects (see technical background) this possibility should also have been considered. As hypocalcaemia is reported to cause mood disturbance such as anxiety and agitation, it would have been particularly relevant to consider.

iv) It should be clarified why Code A felt Code A needed opioids. From the medical notes, it appears to relate to his increasing anxiety and agitation. This

is not an appropriate indication for the use of opioids. If opioids were being suggested for his painful hand, this would also be inappropriate. The medical notes state no other pain. The nursing notes do state he had generalised pain, but the lack of a full pain assessment makes it difficult to know what pain this represented; for example, was it related to muscle and/or joint stiffness from immobility, his pressure sores or abdomen?

v) It is not clear from the medical notes the indication for which the morphine was commenced. If it was for pain then this should have been documented and assessed. It was a reasonable starting dose for someone of his age and morphine is used in palliative care for generalised pain related to muscle or joint stiffness due to immobility or painful pressure sores.

vi) It is not clear what the indications were for prescribing the syringe driver on the 10th January 1996 and for the medications it contained. It is not usually necessary to utilise the SC route unless a patient is unwilling or unable or to take medications orally (e.g. difficulty swallowing, nausea and vomiting). From the drug chart Code A did not appear to have these problems (page 18 of 49). No instructions were given on the drug chart on when the syringe driver should be commenced, how this would be decided and by whom. The dose of diamorphine was initially written as a dose range of 40–80mg, only to be subsequently rewritten the next day as 80–120mg without explanation of why a higher dose range was necessary. Based on Code A existing opioid dose, all of the doses of diamorphine are likely to be excessive for his needs. Given his total dose of oramorph (morphine solution) of 30mg in 24hours, an appropriate dose of diamorphine using a 1:2 or the more usual 1:3 dose conversion ratio, would have been 10–15mg in 24hours. There is no justification given for

this in the medical notes. Similarly, the indications for including the hyoscine hydrobromide and midazolam should have been documented. The dose range of midazolam of 40–80mg would generally be seen as excessive for someone of Code A age. However, taking into account he was a long term user of benzodiazepines, a higher than usual starting dose would likely be necessary.

vii) The dose of diazepam was increased on the 11th January 1996 with no mention of this in the medical notes.

viii) The sertraline and lithium carbonate were discontinued on the 12th January 1996 with no mention of this in the medical notes. It was unclear if this was on the advice of the psychogeriatricians or not; my understanding is that sertraline should not be discontinued abruptly as this is associated with a withdrawal syndrome that can include anxiety, agitation and delirium. A gradual withdrawal of lithium is also advised (BNF).

ix) A syringe driver was ultimately commenced on the 15th January 1996. It is not documented why it had become necessary to give these medications via a syringe driver. Code A appeared to have been taking his oral medications and the medical entry noted that he 'will eat and drink'. There was no mention in the medical or nursing notes of pain, retained secretions, agitation or anxiety that day. If he was more drowsy and unable to take his medication it would have been reasonable, particularly if he required morphine for pain relief. However, taking into account Code A dose of morphine, the starting dose of diamorphine (80mg) was likely to be excessive for his needs as detailed above. The reasons for including the hyoscine hydrobromide (400microgram) and midazolam (60mg) over 24hours were not documented. The dose of midazolam of 60mg over 24hours is an above average starting

dose for somebody of Code A age (see technical issues). He had however, been on long term benzodiazepines and in these patients a larger than usual starting dose may be necessary.

x) On the 16th January 1996 the nursing notes reported some agitation when Code A Code A was being attended to. Haloperidol 5mg SC over 24hours was added to the syringe driver. Haloperidol is a reasonable part of the approach to treating delirium or terminal agitation in someone of Code A age. It should be given with caution, given Code A parkinsonism, as it can cause extrapyramidal effects (see technical issues). However, it is not clear from the notes that his agitation had been assessed and hence the possible underlying causes of the agitation considered. Drugs (or their withdrawal) are one of the common causes of agitation or terminal restlessness. Of particular relevance to Code A, these would include the use of opioids, particularly in inappropriate and excessive doses, hyoscine hydrobromide and benzodiazepines (Wessex Protocol, pages 30, 34). It is possible that a reduction in the dose of diamorphine may have helped Code A agitation.

xi) On the 17th January 1996 the dose of diamorphine was increased to 120mg and the midazolam to 80mg SC over 24hours with no reason given in the notes. The nursing notes suggest that Code A remained tense and agitated. There is no documentation that a medical assessment was undertaken to determine whether his being 'tense' related to muscle and joint stiffness, possible extrapyramidal effects from the haloperidol or that other causes of agitation had been considered. Again, rather than increase the diamorphine, a reduction may have been more appropriate. Similarly, the discontinuation or reduction in the dose of haloperidol, or substitution for

an antipsychotic with a lower risk of causing extrapyramidal effects, e.g. levomepromazine, may have been appropriate.

The nursing notes suggest that Code A was 'bubbly' due to retained secretions and this appears to be the reason for the hyoscine hydrobromide dose being increased twice in one day from 400 to 600microgram then to 1200microgram SC over 24hours.

xii) The medical notes entry on the 18th January 1996 suggested that Code A Code A symptoms were difficult to control but did not document which symptoms. Levomepromazine 50mg SC over 24hours was commenced. This is an appropriate drug to use for terminal agitation when haloperidol is insufficient. The dose is in keeping with that recommended by the BNF and the Wessex Protocol. However, it would have been usual to substitute it for the haloperidol rather than use it concurrently.

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

In relation to the above:

Issue i (lack of clear documentation that an adequate assessment has taken place)

A medical assessment usually consists of information obtained from the patient or others (the history) and the findings of a physical examination that is documented in a structured fashion. Although the history can be restricted to the most salient points, it is unusual to omit relevant sections, e.g. past medical history, drug history, etc.) and given Code A medical problems, in

my view, a general examination should have been undertaken and documented.

Reclerking of a patient when a different medical team takes over responsibility of care, helps to ensure that they are aware of the patient's current problems, relevant medical history and physical condition. If new problems subsequently develop, and abnormal physical findings are found on examination, it can be helpful for the doctor when considering the differential diagnosis and management to know if the findings are really new or old. A clear assessment and documentation of subsequent medical care are particularly useful for on-call doctors who may have to see a patient whom they have never met for a problem serious enough to require immediate attention.

Issue ii (lack of adequate assessment and documentation of Code A *pain and use of Arthrotec).*

There should have been an adequate assessment of the patients' condition. If Code A complained of pain, this should have been noted and attempts made to assess as a minimum the site, severity, aggravating/relieving factors and likely cause of the pain. This is undertaken in order to identify the most likely underlying cause of the pain. Different pain relieving approaches can be helpful for some pains and not others. Knowledge of the cause of the pain thus provides a rational basis to how the pain is managed. Without a documented pain assessment I am unable to comment on the appropriateness of the use of Arthrotec.

The prescribing of drugs should be documented in the notes in keeping with the GMC guidelines.

Issue iii (lack of adequate assessment and documentation of Code A *painful right hand)*

There should have been an adequate assessment of the patients' condition. If a patient is experiencing what sounds like tetany (painful muscle spasms), the possible causes of this should be considered and appropriate investigations carried out. As a minimum, in my view, blood levels of calcium should have been measured, as if low, simple replacement of calcium could have improved a distressing symptom. It would be a reasonable course of action to be taken by all but the junior of doctors.

Issue iv (possible inappropriate use of opioids for Code A *anxiety and agitation)*

It should be clarified for what reason Code A was considering the use of opioids. Opioids are not indicated for the relief of anxiety and agitation per se. The prescribing of drugs should be documented in the notes in keeping with the GMC guidelines.

Issue v (lack of adequate documentation regarding the use of oral morphine/lack of adequate assessment and documentation of Code A *pain)*

There should be clear documentation in the medical notes of why and when the morphine was commenced. If it were for pain, attempts should have been made to assess as a minimum the site, severity, aggravating/relieving factors and likely cause of the pain.

Issue vi (lack of adequate documentation regarding the prescription of the syringe driver 'as required' on 10th January/ prescription of treatment that may exceed the patients' needs)

There should have been clear documentation in the medical notes as to why a syringe driver was prescribed 'as required'. It is unusual to prescribe a syringe driver 'as required' especially containing drugs with a range of possible doses. This is because of the inherent risks that would arise from a lack of 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 a drug as a range, particularly a wide range, is generally discouraged. Doctors, based upon an assessment of the clinical condition and needs of the patient usually decide on and prescribe any change in medication. It is not usual in my experience for such decisions to be left for nurses to make alone.

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

The daily dose of diamorphine 40mg–80mg, rewritten one day later as 80–120mg is not justified at all in the notes. It is likely to be excessive for Code A Code A needs. An appropriate dose of diamorphine would have been 10–15mg in 24hours. Doses of opioids excessive to a patient's needs are associated with an increased risk of drowsiness, delirium, nausea and vomiting and respiratory depression.

The reasons for the inclusion of midazolam and hyoscine hydrobromide in the syringe driver should also have been documented. Decisions made and the prescribing of drugs should be documented in the notes in keeping with the GMC guidelines.

Issues vii and viii (lack of adequate documentation regarding the change in medication)

There should be clear documentation in the medical notes of why the diazepam was increased and the sertraline and lithium carbonate were discontinued. Decisions made and the prescribing of drugs should be documented in the notes in keeping with the GMC guidelines.

Issue ix (lack of adequate documentation regarding the prescription of the syringe driver on 15th January/prescription of treatment that may exceed the patients' needs)

There should be clear documentation in the medical notes of why the syringe driver was commenced containing those drugs. In particular, why a dose of diamorphine, that exceeded his current opioid requirements was justified. An appropriate dose of diamorphine would have been 10–15mg in 24hours. Doses of opioids excessive to a patient's needs are associated with an increased risk of drowsiness, delirium, nausea and vomiting and respiratory depression. Decisions made and the prescribing of drugs should be documented in the notes in keeping with the GMC guidelines.

Issue x (lack of adequate assessment and documentation of Code A *agitation)*

There should have been an adequate assessment of Code A agitation. This would have included considering, as a minimum, if any of the common causes of agitation were possibly contributing to his agitation (e.g. as listed in the Wessex protocol pages 30, 34). The assessment should have been documented in the medical notes. Such an approach should have allowed consideration if drugs (or their withdrawal) were a possible contributory factor to Code A agitation. In particular, whether the dose of opioid was appropriate and not excessive to his needs.

Issue xi (lack of adequate documentation regarding the change in dose of drugs in the syringe driver on the 17th January 1996)

There should be clear documentation in the medical notes as to why the dose of diamorphine was increased to 120mg, the midazolam to 80mg SC over 24hours and the hyoscine hydrobromide dose increased twice from 400 to 600 microgram then to 1200microgram SC over 24hours.

Issue xii (lack of adequate assessment and documentation of Mr Pittock's symptoms, willingness to consult colleagues)

If symptoms are 'difficult to control', this should prompt an adequate (re)assessment to carefully (re)consider the possible contributing factors to ensure that all reasonable steps had been taken to attend to any underlying causes as appropriate.

If, despite the initial management plan, symptoms are 'difficult to control', it would also be seen as good practice for a doctor to seek additional

information or advice. There is no documentation in the notes that suggests that Code A did this, for example, seeking additional information or advice from the Wessex protocol, one of the consultants, another colleague or a member of the palliative care team.

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

Code A had a duty to provide good palliative and terminal care and an integral part of this is the relief of pain and other symptoms to ensure the comfort of the patient. In doing so, as in every form of medical care provision, she would be expected to demonstrate a good standard of practice and care. In this regard, Code A fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, October 1995 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient, providing treatment that was excessive to the patients' needs and willingness to consult colleagues.

Most significantly, the dose range of diamorphine prescribed for the 'as required' syringe driver, and the dose finally administered (80mg), far exceeded that generally considered to be an appropriate starting dose (10–15mg) given Code A existing opioid usage. It is unclear how Code A determined or justified this dose. A dose of diamorphine excessive to Code A needs would be associated with an increased risk of drowsiness, confusion, agitation, nausea and vomiting and respiratory depression.

Code A was described as tense and agitated several times following the syringe driver being commenced. This may have been due to a number of reasons, e.g. his depression, the developing pneumonia or a terminal

agitation. In this regard the use of midazolam, haloperidol and levomepromazine could be seen as justified. However, an assessment of the possible causes of his agitation should have been carried out, particularly if seen as difficult to manage. This would have included considering if drugs, such as the diamorphine, were a possible contributing factor to his agitation. At the very least, it should have prompted a review of the appropriateness of Code A dose of diamorphine.

In patients with cancer, the use of diamorphine and other sedative medications (e.g. midazolam, haloperidol, levomepromazine) when appropriate for the patients needs, do 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 other sedatives 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.

There appears little doubt that Code A was 'naturally' coming to the end of his life. His death was in keeping with a progressive irreversible physical

decline, documented over several weeks by different medical teams, accompanied in his terminal phase by a pneumonia. At best, Code A could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Code A a peaceful death, albeit with what appears to be an excessive use of diamorphine. This may have been due to an apparent lack of sufficient knowledge, illustrated, for example, by the prescription and use of doses of diamorphine by syringe driver that were inappropriately large for Code A circumstances and did not reflect his current opioid requirements; the reliance on large dose ranges of diamorphine by syringe driver rather than a fixed dose along with the provision of smaller 'as required' doses that would allow Code A Code A needs to guide the dose titration; and a lack of consideration that the opioids may have been aggravating his agitation. It is my opinion however, that given the lack of documentation to the contrary, Code A could also be seen as a doctor who breached the duty of care she owed to Code A by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Code A by unnecessarily exposing him to excessive doses of diamorphine that could have resulted in a worsening of his agitation. Code A response to this was to further increase Code A dose of diamorphine. Despite the fact that Code A was dying 'naturally', it is difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death. As a result Code A 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).

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

Palliative Care Handbook, Guidelines on Clinical Management, Third Edition

'Wessex Protocol' Salisbury Palliative Care Services May 1995.

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: 25th April 2005

Code A April 26th 2005

DRAFT REPORT

regarding

STATEMENT OF Code A

RE: Code A (BJC/71)

PREPARED BY: Code A
Reader in Palliative Medicine and Medical Oncology

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of Code A re: Code A Code A In particular, if it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This Report is based on the following documents:

[1] Statement of Code A RE: Code A as provided to me by Hamsphire police (signed and dated 3-3-05).

[2] Statement of Code A as provided to me by Hampshire police (undated).

[3] Report regarding Code A (BJC/71) Code A 25th April 2005.

3. COMMENTS

Having compared and contrasted the above documentation, I make the following comments that in my view may be relevant. They are in the order in which they arise in the Statement of Code A RE: Code A

Points 3 and 4

In the statement of Code A outlines that in 1998, the demands on her time were such that firstly her note keeping suffered in consequence and that the medical records did not set out each and every review with a full assessment of a condition of a patient at any given point. Secondly, in relation to prescribing she felt obliged to adopt a policy of proactive prescribing. In the statement Code A RE: Code A states that this also applied to 1996.

Point 13

Code A states that given the very considerable interval of time she now has no real recollection of Code A Given the lack of adequate documentation in the medical records, subsequently a number of the points she makes are based on what she believed she would have done (e.g. points 15, 18, 21, 23, 24, 25, 29, 31, 34, 41, 42).

Point 16

Code A clarifies that the illegible words in the medical notes entry of the 9th of January 1996 were not '*try hot water*' but 'try arthrotec'. It remains unclear what assessment Code A made of Code A painful hand, the possible cause(s) of it and therefore why arthrotec was deemed an appropriate treatment.

Point 18

Code A highlights that the arthrotec was prescribed on the 8th January 1996 prior to her entry regarding the pain in Code A hand on the 9th January 1996. She states she does not know if the date is an error or she had seen him the previous day and prescribed the arthrotec, and made a substantive note the following day.

She also states that she noted Code A had increased anxiety and agitation and raised the possibility that it might be necessary to increase the diazepam and prescribe opiates. Code A should be asked to clarify exactly why she felt the opioids were indicated. In my view opioids are not indicated for the primary relief of anxiety or distress.

Point 19

Code A states that Code A noted Code A dementia. I think this should be depression. Code A depression was a major problem and well documented. However, dementia was not previously mentioned anywhere in his medical records.

Point 21

Code A states that she prescribed oramorph for Code A on the 10th January 1996, 'no doubt in consequence of liasing with Code A at the time of the ward round'. She indicates that it would have been for the relief of pain, anxiety and distress. Code A does not clarify which pain this refers to. In my view opioids are not indicated for the primary relief of anxiety or distress.

Code A also states that she proactively wrote up a prescription for diamorphine and a dose range of 40–80mg subcutaneously over 24hours, together with the 200–400microgram of hyoscine and 20–40microgram of midazolam. She states that 'we were concerned that the oramorph might be insufficient and that further medication should be available just in case he needed it'. Code A does state who 'we' refers to, clarifies the basis for the concern that the oramorph might be insufficient, nor justifies why that dose of diamorphine was considered necessary. Code A should be asked to explain why, given her stated concern, 'as required' oral or SC doses of (dia)morphine or a benzodiazepine (e.g. diazepam/midazolam) were not considered appropriate.

Point 23

Code A states that the following day she rewrote the proactive prescription for the hyoscine, diamorphine and midazolam, with the latter two drugs at a slightly greater level than had been written the previous day, i.e. diamorphine 80–120mg and midazolam 40–80mg. Code A states that she would have been concerned that although it was not necessary to administer the medication at that stage, Code A pain, anxiety and distress might develop significantly and that appropriate medication should be available to relieve this if necessary. I do not understand the logic behind this explanation. Code A had not required the syringe driver prescribed from the day before and so Code A would have no way at all of knowing or in anyway anticipating that an even greater level of these two drugs would be necessary.

Points 24, 25 and 26

Code A states that she believes she would have seen Code A on Monday 15th January 1996 and that she may have been told that his condition had deteriorated considerably over the weekend and 'he appeared to be experiencing marked agitation and restlessness and to be in significant pain and distress'. She anticipates that due a lack of time she did not make a clinical entry in the notes but that diamorphine 80mg, midazolam 60mg and hyoscine hydrobromide 400microgram were commenced via syringe driver at 08.25am that day.

Code A has not described why she considered a syringe driver to have become necessary when Code A appeared to have been taking his oral medications. There was no mention in the nursing notes of pain, retained secretions, agitation or anxiety that day. Code A does not state for what pain

the diamorphine was used. Code A states that she 'tried to judge the medication, including the increase in the level of opiates, to ensure that there was appropriate and necessary relief of his Code A condition, whilst not administering an excessive level, and to ensure that this relief was established rapidly and maintained through the syringe driver'. These are reasonable aims. However, Code A does not illustrate in a clear way how the dose of diamorphine was determined and it would be helpful for Code A to specifically state on what basis a dose of 80mg was selected.

She states that she had to take into account the fact that the lithium and sertraline with their additional sedative effects had previously been discontinued and that he would have developed some tolerance to the oral regime. Code A Code A should be asked to clarify which aspects of Code A oral regime she believes tolerance would have developed to. Tolerance to a drug means that over time an increasing dose would be required to have the same effect. It is likely he would have developed tolerance to benzodiazepines as he had been a long-term user of diazepam. As such it would be seen as reasonable to use a larger than usual starting dose of the midazolam particularly when taking the discontinuation of the lithium and sertraline into account. However, as Code A Code A had only been receiving opioids for four days, tolerance is unlikely to have developed and would not in my view be an acceptable reason to justify such a relatively large increase in his opioid dose.

Points 28 and 29

On the 16th January 1996, Code A states that Code A condition remained very poor and that there had been some agitation when he was being attended to. It would appear therefore that the medication commenced the

previous day had been largely successful in relieving Code A condition, but not entirely. At the same time, it would seem that Code A pain, distress and agitation had been such that he was indeed tolerant to the medication given, including the level of diamorphine I felt appropriate'. I do not understand fully Code A Code A final sentence and she should be asked to clarify exactly what she means by it.

It remains unclear if Code A assessed the cause of Code A agitation and considered the possible underlying cause(s). Of particular relevance to Code A Code A would be drugs (or their withdrawal) particularly the use of opioids, hyoscine hydrobromide and benzodiazepines (e.g. midazolam).

Whilst haloperidol is a reasonable part of the approach to treating delirium for terminal agitation, its use should not be a substitute for considering other causes of agitation that may need to be addressed.

Point 31

On the 17th January 1996 Code A states that due to Code A being tense and agitated she increased the level of his diamorphine to 120mg. She states this was with the specific aim of relieving the agitation. Code A should be asked to state on what basis, recommendation or guidelines she was using diamorphine for the specific aim of relieving agitation. Diamorphine is not indicated for the relief of agitation and is not mentioned as a treatment for such in contemporary guidelines such as the Wessex Protocol or the BNF Prescribing in Palliative Care section. Again from the medical, nursing notes and Code A statement it remains unclear if an assessment of the possible causes of his agitation was undertaken. Increasing the haloperidol to 10mg and

the hyoscine to 600microgram were reasonable steps based on his agitation and retained respiratory secretions.

Points 34 and 35

Code A states that in the entry dated the 18th January 1996 she noted 'difficulty controlling symptoms, try nozinan' (levomepromazine). Which symptoms were difficult to control are not specified but Code A believes that it was for Code A agitation. Haloperidol was increased to 20mg and levomepromazine 50mg was added to the syringe driver. Increasing the dose of antipsychotic medication for terminal agitation is reasonable but Code A should be asked to explain why the levomepromazine was given in addition to the haloperidol rather than substituted for it. It remains unclear if Code A undertook an assessment of Code A agitation.

Point 36

Code A states that the nursing notes record that Code A appeared comfortable in between attentions. She infers from this that he had adequate relief from symptoms but would experience pain, distress and agitation when receiving care. Code A should be asked to clarify why if this was the case the syringe driver not modified again; why smaller doses of the diamorphine, midazolam, levomepromazine or haloperidol and hyoscine hydrobromide were not prescribed 'as required' to be administered prior to turning Code A and if, given that the symptoms were difficult to control, whether she sought advice?

Points 38, 39 and 40

Code A states that 'Code A would have been advised of Code A condition and the drug regimen. The only modification was in the antipsychotic medication (levomepromazine), it would seem that Code A did not consider the general regimen to be inappropriate.....'. Code A should be asked for his view of this.

4. CONCLUSION

Code A admits to poor note keeping and proactive prescribing due to time pressures in 1996. Even with significant episodes in Code A care however, no entry was made. Having read Code A statement regarding Code A I believe that the main issues raised in my report (BJC 71), dated 24th April 2005, remain valid and have not yet been satisfactorily addressed due to a lack of clarity regarding:

- the nature of Code A pain and its possible cause(s)
- the justification for the proactive prescribing of a syringe driver containing diamorphine, hyoscine and midazolam 'just in case he needed it'
- the lack of use of 'as required' doses of the above drugs instead of, or subsequently, alongside the syringe driver
- the basis for Code A use of diamorphine specifically for the relief of agitation
- the lack of assessment of the possible cause(s) of Code A agitation
- how the dose of diamorphine Code A ultimately received (80mg) was calculated in a way that can be clearly related to his existing dose of opioid
- given the difficulty of controlling the symptoms, whether Code A sought advice.

As some of the above points relate directly to Code A knowledge of the management of pain and other symptoms in a palliative care setting it would be helpful if she could state what specific training she had received in relation to

this. In particular, where she obtained her understanding from with regards to the indications for the use of morphine/diamorphine, the phenomenon of tolerance to opioids, the methods of determining an appropriate dose of diamorphine given a patients oral morphine dose and what prescribing guidelines she was aware of and/or followed.

Specific implications of the statement of **Code A** *regarding* **Code A** *regarding my report (BJC 71), dated 24th April 2005*

Code A statement clarifies that the 'arthrotec' (and not 'hot water') was prescribed for **Code A** painful right hand held in flexion. This relates to specific issue ii (pages 23 and 28) in my report.

Version 2 of complete report 31st January 2005 – Code A

SUMMARY OF CONCLUSIONS

Code A was an 83 year old gentleman with a long recurrent history of severe depression resistant to treatment. This was complicated by drug induced parkinsonism and subsequent mental and physical frailty and dependency. His admission to the Gosport War Memorial Hospital Mental health beds on the 29th November and transfer to then medical beds on the 5th January 1997 was the end point of these chronic disease process. He continues to deteriorate and dies on the23rd January 1997

The major problem in assessing Code A care is 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 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 other drugs or other treatments prescribed". The major gaps in the written notes, the lack of evidence of appropriate examinations, use of unusual drug regimes without adequate documentation in the medical notes, changes in prescription without proper documentation, all represent poor clinical practice clinical practice to the standards set by the General Medical Council. However, by itself, these do not prove that the medical or nursing care provided to Code A was sub-optimal, negligent or criminally culpable.

In my view the drug management as Gosport was sub-optimal. There was no written justification at any stage for the high doses of Diamorphine and Midazolam written up in the drug charts and subsequently prescribed to Code A The notes and the drug charts leave confusion as to whether at one stage there may have been three syringe drivers being used. The dose of Nozinan may have been prescribed by verbal prescription and not written up in the drug chart. Combinations of the higher than standard doses of Diamorphine and Midazolam, together with the Nozinan were very likely to have caused excessive sedation and may have shortened his life by a short period of time, that in my view would have been no more than hours to days. However, this was a dying man, the family appeared to have been appropriately involved and the patient did eventually die without distress on 24th January. While his care is sub-optimal I cannot prove it beyond reasonable doubt to be negligent or criminally culpable

Version 2 of complete report 31st January 2005 – Code A

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his 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

Name **Address** **Telephone**	**Code A**
DOB	Code A
Place	Windsor, England.
GMC	Full registration. No: Code A
Defence Union	Medical Defence Union. No: Code A

EDUCATION	Leighton Park School, Reading, Berks.	1969-1973
	St John's College, Cambridge University.	1974-1977
	St Thomas' Hospital, London SE1	1977-1980

DEGREES AND QUALIFICATIONS

BA, Cambridge University	1977
(Upper Second in Medical Sciences)	

MB BChir, Cambridge University	1980
MA, Cambridge University	1981
MRCP (UK)	1983
Accreditation in General (internal) Medicine and Geriatric Medicine	1989
FRCP	1994
MBA (Distinction) University of Hull.	1997
Certificate in Teaching	2001
NHS/INSEAD Clinical strategists program	2003

SPECIALIST SOCIETIES

British Geriatrics Society

British Society of Gastroenterology

British Association of Medical Managers

PRESENT POST

Code A

Associate member General Medical Council 2002-present

PREVIOUS POSTS

Associate Dean.
London Deanery. 2004

Medical Director (part time) 1997-2003
Queen Mary's Hospital

Operations Manager (part time) 1996-1997
Queen Marys Hospital, Sidcup, Kent

Senior Registrar in General and Geriatric Medicine
Guy's Hospital London and St Helen's Hospital

Hastings.	1985-1987
Registrar in General Medicine and Gastroenterology	
St Thomas' Hospital, London.	1984-1985
Registrar in General Medicine	
Medway Hospital, Gillingham, Kent	1983-1984
SHO rotation in General Medicine	
Kent & Canterbury Hospital, Canterbury	1982-1983
SHO in General Medicine	
Kent & Sussex Hospital, Tunbridge Wells	1981-1982
House Physician, St Thomas' Hospital	1981
House Surgeon, St Mary's Portsmouth	1980

PUBLICATIONS

Code A

Version 2 of complete report 31st January 2005 – Code A

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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 Code A

[2] Full set of medical records of Code A on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

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

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

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

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

5.1. Code A had a very long history of depression as clearly set out in a summary (13). In 1959 he had reactive depression, it occurred again in 1967. In 1979 he had agitation and in 1988 agitated depression.

5.2. He had a further long admission with agitated depression in 1992 (8) complicated by an episode of cellulitis (30). This culminated in an admission to long-term residential care in January 1993 (34). He had further admissions to hospital under the care of the psychiatric team including June 1993 (37) when some impaired cognition was noted. In 1995 there was a home visit for further psychiatric problems (42).

5.3. In 1995 (44) there was a change in behaviour; loss of weight and increased frailty was noted. He was falling at the residential home. He was expressing grief, frustrations and aggression. At this time his psychiatric medications included Diazepam, Temazepam, Thioridazine, Sertraline, Lithium, and Codanthrusate for constipation. His other problems were hypothyroidism and Parkinsonism with a tremor. (Note: this was not Parkinson's disease but tremor, rigidity and akinesia which occurs similar to Parkinson's disease but as a result of long-term anti-psychotic medication).

5.4. On 29th November 1995 he was admitted under the psychiatrist Code A Code A (46) to Gosport War Memorial Elderly Mental Health beds. His mental test score was documented at 8/10 (50). He was discharged back to residential home on 24th October (46) with a continued diagnosis of depression (56). However, his very poor mobility and shuffling gate was noted (57).

5.5. On 13th December 1995 he was re-admitted (62) to mental health beds at the Gosport War Memorial under Code A stating "everything is horrible". He was verbally aggressive to the staff and was not mobilising and staying in bed all day. He felt hopeless and suicidal. (62).

5.6. On 22nd December, diarrhoea started and he also had chest symptoms. It was thought he had a chest infection, and was treated with Erythromycin (64). On 27th December he was "chesty, not himself", and his bowels were causing concern. The physiotherapist noted that he had signs in his chest (65). A second course of a different antibiotic (Cephalosporin) was prescribed (81). The nursing

cardex documents that he started becoming faecally incontinent on 20th December and then had further episodes of diarrhoea (140). It is also noted that by 1st January (147) he was drowsy with very poor fluid intake.

5.7. On 2nd January 1996 Code A consultant geriatrician was asked to see (66) and on 3rd January he was noted to be clinically deteriorating with poor food intake (66), albumin of 27 (67). An abdominal x-ray on 27th December describes possible "pseudo-obstruction" (116). This is a condition when the large bowel fails to work and starts to dilate, usually in patients who have multiple illnesses including Parkinsonism, electrolyte imbalance, infections, antibiotics and other drugs. Prognosis is often poor and depends on resolving the underlying causes.

5.8. On 4th January 1996 Code A is seen by Code A, Consultant Geriatrician who noted severe depression, total dependency, catheterisation, lateral hip pressure sores and hypoproteinaemia. (67) He states that the patient should be moved to a long-stay bed at the Gosport War Memorial Hospital and that his residential home place should be given up as he was unlikely to return. On 5th January he is transferred to Dryad Ward for "long-term care" (151). Code A also states (5M) "Code A is aware of the poor prognosis".

5.9. Medical notes after transfer (13M and 15M). On 5th January a basic summary of the transfer is recorded, on the 9th January increasing anxiety and agitation is noted and the possibility of needing opiods is raised. The nurses cardex on 9th said that he is sweaty and has "generalised pain" (25M). On 10th January a medical decision is recorded "for TLC". In the medical discussion (13M) with Code A also apparently agrees "for TLC". I am not sure of the signature of 10th January in the medical notes (13M). The nursing cardex records they commenced Oramorph and that Code A is aware of the poor outcome (25M).

5.10. The 15th January the nursing notes document that a syringe driver has been commenced (25M) and by the evening the patient is unresponsive (26M). However on 16th January there is some agitation when being attended to and Haloperidol is added to the syringe driver (26M). On the 17th the patient remains tense and agitated,(27M) the nursing cardex states that Code A attended, reviewed and altered the dosage of medication. The syringe driver is removed at 15.30 hours and the notes say "two drivers" (27M).

5.11. The next medical note is on 18th January, eight days after previous note on 10th January. This states further deterioration, subcut

analgesia continues..... try Nozinan. On 20th January the nursing notes state that Code A was contacted regarding the drug regime and there was a verbal order to double the Nozinan and omit the Haloperidol (28M). This is confirmed in the medical notes on 20th January (15M). The medical notes on 21st January state "much more settled", respiratory rate of 6 per minute, not distressed and on 24th January the date of death is verified by Code A in the medical notes (15M).

Note: Nozinan is a major tranquilliser similar to Chlorpromazine but more sedating. It is usually used for patients with schizophrenia and because of its sedation is not usually used in the elderly, though it is not completely contraindicated. Used subcutaneously in palliative care for nausea and vomiting at a dose of 25 – 200 mgs for 24 hours although British National Formulary, 39 Page 14, states that 5 – 25 mgs for 24 hours can be effective for nausea and vomiting with less sedation.

5.12. **Drug Chart Analysis:**

On 5th January at transfer (16M), Code A is written up for the standard drugs that he was on in the mental health ward including his Sertraline and Lithium (for his depression) Diazepam (for his agitation) Thyroxine for his hypothyroidism. The drug chart also had Diamorphine 40 – 80 mgs subcut in 24 hours, Hyoscine 200 – 400 micrograms subcut in 24 hours and Midazolam 20 – 40 mgs subcut in 24 hours. Midazolam 80 mg subcut in 24 hours written up but not dated and never prescribed. (18M)

5.13. On 10th January, Oramorph 10 mgs per 5 mls is written up for 2.5 mls four hourly and prescribed on the evening of 10th and the morning of the 11th. On the 11th Oramorph 10 mgs per 5 mls is written up to be given 2 mls 4 hourly 4 times a day with 5 mls to be given last thing at night. This is then given regularly between 11th and up to early morning on 15th January. This is a total daily dose of 26 mgs of morphine (19M).

5.14. Diamorphine 80 – 120 mgs subcut in 24 hours is written up on 11th January "as required" as is Hyoscine 200 – 400 micrograms in 24 hours, Midazolam 40 – 80 mgs in 24 hours. 80 mgs of Diamorphine together with 60 mgs of Midazolam are then started by syringe driver on the morning of the 15th January and re-started on both the mornings of the 16th and 17th January. (18M). On 16th January Haloperidol 5 mgs – 10 mgs subcutaneous for 24 hours is written up, prescribed over 24 hours on both 16th and 17th. I am not clear if this

was mixed in the other syringe driver or was the "second pump" referred to in the nursing cardex. (20M and 27M)

Diamorphine 120 mgs subcut in 24 hours is then prescribed on 18th January, together with Hyoscine 600 mgs subcut in 24 hours. The drug charts (20M) show this starting on the morning of 17th January and at 08.30 hours. If this correct there may have been up to three syringe drivers running, one with Diamorphine 80 mgs, one with Diamorphine 120 mgs in and one with the Haloperidol. The reason for this confusion needs clarification.

The subsequent drug charts all appear to be missing for the final 6 days, however the nursing notes (27M, 28M and 29) suggest that there was a fairly constant prescription of 120 mgs of Diamorphine 24 hours, Midazolam 80 mgs 24 hours, Hyoscine 1200 mgs, Haloperidol 20 mgs and Nozinan 50 mgs. On the 20th there was no Haloperidol and the Nozinan was increased 100 mgs a day. This is still the prescription on 23rd January (27M).

6 TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

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

I will also consider whether Code A received the proper standard of care and treatment from the medical and nursing staff including identifying any actions or omissions by the medical team, nursing team or attendant GP's that contributed to the demise of Code A.

6.2 In particular I will discuss a) whether Code A had become terminally ill and if so whether symptomatic treatment was appropriate and b) whether the treatment provided was then appropriate.

6.3 Code A has an unfortunate long history of depression, which had become more difficult and complex to manage and increasingly distressing in terms of his agitation related to his depressive symptomatology.

6.4 He had many treatments including high level drug treatment over many years and many episodes of electro convulsive treatment (ECT).

6.5 The complex and unresolved psychiatric problem led to a requirement to move to a residential accommodation in 1993. However he had further relapses and problems in 1995. A change occurred by September 1995 where the residential home was now noticing weight loss, increasing frailty and falls. Although a subsequent admission only came to the conclusion that he was depressed I have no doubt that his terminal decline was starting from that time.

6.6 By October 1995 he had extremely poor mobility and a shuffling gate. When re-admitted in December is aggressive, essentially immobile and extremely mentally distressed alongside his increasing physical frailty.

6.7 It is impossible in retrospect to be absolutely certain what was causing his physical as well as his mental decline. It may be that he was now developing cerebrovascular disease on top of his long standing drug induced Parkinsonism together with his persistent and profound depression agitation. It is not an uncommon situation for people with long standing mental and attendant physical problems, to enter a period of rapid decline without a single new diagnosis becoming apparent.

6.8 His deterioration is complicated by a probable chest infection (64, 81), which does not respond particularly well to appropriate antibiotic and physiotherapy treatment. He also has bowel complications attendant on all his other medical and drug treatment (116).

6.9 Code A, psychiatric service asked Code A Consultant Geriatrician, to see the patient on 2nd January and he is actually seen on 4th January 1996. Code A describes a very seriously ill gentleman. His comments that a long-stay bed will be found at the Gosport War Memorial and that he is unlike to return to his residential bed, reflect the fact that it was probably in his mind that this gentleman was probably terminally ill.

6.10 Code A is then transferred to Dryad Ward and is apparently seen by Code A. A short summary of his problems is written in the notes but no physical examination, if undertaken, is documented.

It is normal clinical practice when accepting a patient to a new inpatient environment to undertake and record a basic physical examination. This will form a baseline for future management and a clinical record for other members of staff. The lack of a record of any examination, if undertaken, would be poor clinical practice.

6.11 It remains clear from the nursing record that he remains extremely frail with very little oral intake on 7th January (25M). When seen again by Code A on 9th, there is the first note suggesting that Opiates may be an appropriate response to his physical and mental condition.

6.12 It is my view that this gentleman by this stage had come to the end point of a series of mental and physical conditions and that his problems were now irreversible. He was in considerable mental distress and had physical symptoms partly related to that and partly related to other medical problems. In my view he was dying and terminal care with a symptomatic approach was appropriate.

6.13 On the 10th Oramorph was started. Oramorph and Diamorph are particularly used for pain in terminal care. The nursing notes document that he had some pain; but most of his problems appeared to be restlessness, agitation and mental distress. However, despite the lack of serious pain, morphine like drugs are widely used and believed to be useful drugs in supporting patients in the terminal phase of the restlessness and distress that surrounds dying. I would not criticise the use of Oramorph in conjunction with his other psychiatric medication at this stage.

6.14 The decision that he was now terminally ill and for symptomatic relief appears to have been made appropriately with both the family and the ward staff and there was no disagreement with this decision.

This is indicated in the medical notes by the comment "poor TLC" (13M) together with the statement that it was discussed with the wife "for TLC" (note TLC= tender loving care). Beyond the statement in the medical notes that the patient was "for TLC" there is no specific justification given for the Oramorph in particular to be started. The notes are at best very thin and sparse and good medical practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patients 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 provided". The lack of information in the written notes, as documented in this report, represents poor clinical practice to the standards set by the General Medical Council.

The Drug Chart analysis (para. 5.12) described Diamorphine, Hyoscine and Midazolam all written up to be prescribed with a dosage range. This is quite common clinical practice, the aim of which is to allow the nursing team to have some flexibility in the management of a patient needing symptom control at the end of their life without having to call a doctor to change the drug charts every time a change in dosage is needed to maintain adequate palliation. However, there seems no rationale for writing up the dose of Midazolam at 80 mgs separate from the prescription above for 40 – 80 mgs.

6.15 The dose of Oramorph given from the early morning of 15th January was 26 mgs of morphine a day (see paragraph 1.14) (19M). On the 15th a syringe driver is started containing 80 mgs Diamorphine and 60 mgs of Midazolam. If a straight conversion is being given from Morphine to Diamorphine then you normally halve the dose i.e. 26 mgs of Oramorphine might be replaced by 13 mgs of Diamorphine (Wessex protocol). If you are increasing the dose because of breakthrough agitational pain then it would be normal to increase by 50% each day, some clinicians might increase by 100%. This would suggest that the maximum dose of Diamorphine to replace the stopped Oramorphine might be up to a maximum of 30 mgs of Diamorphine in 24 hours. Starting 80 mgs of Diamorphine is approximately three times of the dose that could conventionally be argued for.

As individuals response to Morphine or Diamorphine can be extremely difficult to predict, this is why clinicians will usually start with a low dose, then increase, with regular and close review to assess the patients response and to find a balance between pain, symptom relief and excessive doses. The main side effects of excessive dosage would be depression of respiration and consciousness. No justification is provided in the notes for starting at approximately 3 times the dose that could be conventionally argued for.

I believe the dose of Oramorph originally prescribed between 11th and 15th January was appropriate, however, no justification is given within the notes for originally writing up the higher than usual doses of Diamorphine and Midazolam on 11th January, the same time as the Oramorph was started, nor indeed is any rationale

made in the medical or nursing notes, the decision to commence the syringe driver on the 15th January. This lack of medical documentation is poor clinical practice.

Where clinicians significantly deviate from standard clinical practice, it is poor clinical practice not to document that decision clearly. It is very unwise from a medico legal perspective.

6.16 Midazolam was also started at a dose of 60 mgs per 24 hours. The main reason for using this is terminal restlessness and it is widely used subcutaneously in doses from 5 – 80 mgs per 24 hours for this purpose. Although 60 mgs is within current guidance, many believe that elderly patients need a lower dose of 5 – 20 mgs per 24 hours (Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270). This would again suggest that the patient was being given a higher dose of Midazolam then would usually be required for symptom relief. Where clinicians significantly deviate from standard clinical practice, it is poor clinical practice not to document that decision clearly. It is very unwise from a medico legal perspective.

The nursing notes documented anxiety, agitation and generalised pain for which the Midazolam and the strong opioids (Oramorph and Diamorphine) were started. Midazolam is often used for the restlessness of terminal care and although Oramorphine and Diamorphine are usually used for severe pain, in clinical practice it is often used as well for the severe restlessness of terminal care. One study of patients on a long stay ward (Wilson J.A et.al. Palliative Medicine 1987:149-153) found that 56% of terminally ill patients on a long-stay ward receive opioid analgesia. Hyoscine is also prescribed in terminal care to deal with excess secretions which can be distressing for both patient and carers. I believe this was appropriately prescribed and given.

6.17 Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Based on the evidence suggesting unusually high dosage of these medications being used I have considered whether there was evidence in the notes of any drug complications, in particular whether giving three times the normal starting dose for both Diamorphine and Midazolam together caused excessive sedation or other side effects might be considered gross negligence or an unlawful act. I was only able to find two pieces of evidence. The first was a statement in the nursing notes (26M) that by the evening that the syringe driver was started, the patient was unresponsive. The aim of palliative

care is to provide symptom relief not possible over sedation leading to unconsciousness. However, this did not continue and Code A was noted to be more alert and agitated again on the 16th.

Secondly on the 21st January (15M) a respiratory rate of 6 per minute is noted suggesting some possible respiratory depression.

6.18 A further drug, Nozinan, a sedating major tranquilliser is added to the drug regime, 50 mgs a day on the 18th January and increased to 100 mgs a day on the 20th January. Though this is within the therapeutic range in palliative care, 25 – 200 mgs a day when it is used for nausea and vomiting, the BNF advises 5 – 20 mgs a day and that the drug should be used with care in the elderly because of sedation.

The rationale for starting Nozinan appears to be the fact that the patient had become unsettled on Haloperidol (a different sort of major tranquilliser) and Nozinan is more sedating that Haloperidol. A verbal order to increase the dose of Nozinan from 50 to 100 mgs is documented in the medical notes (M15). This suggests that the 100 mgs was not actually written up within the Drug Charts, which if true, would be poor clinical practice. The absence of the drug charts makes this harder to determine.

6.19 The prediction of how long a terminally ill patient would live is virtually impossible and even palliative care experts show enormous variation (Higginson I.J. and Constantini M. Accuracy of Prognosis Estimates by 4 Palliative Care Teams: A prospective cohort study. BMC Palliative Care 2002 1:21). The combination of the high doses of Diamorphine, the high doses of Midazolam and the high doses of Nozinan are in my view likely to have caused excessive sedation beyond the need the symptom control in this dying man. In my view the medication is likely, but not beyond reasonable doubt, to have shortened life. However, I would have expected this to have been by no more than hours to a few days had a lower dose of all, or indeed any, of the drugs been used instead.

7. OPINION

7.1 Code A was an extremely ill, frail and dependent gentleman on his admission to Gosport War Memorial Hospital and was at the end point of a chronic disease process of depression and drug related side effects that had gone back for very many years.

7.2 The major problem in assessing Code A care is 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 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 other drugs or other treatments prescribed". The major gaps in the written notes, the lack of evidence of appropriate examinations, use of unusual drug regimes without adequate documentation in the medical notes, changes in prescription without proper documentation, all represent poor clinical practice clinical practice to the standards set by the General Medical Council. However, by itself, these do not prove that the medical or nursing care provided to Code A was sub-optimal, negligent or criminally culpable.

7.3 In my view the drug management as Gosport was sub-optimal. There was no written justification at any stage for the high doses of Diamorphine and Midazolam written up in the drug charts and subsequently prescribed to Code A. The notes and the drug charts leave confusion as to whether at one stage there may have been three syringe drivers being used. The dose of Nozinan may have been prescribed by verbal prescription and not written up in the drug chart. Combinations of the higher than standard doses of Diamorphine and Midazolam, together with the Nozinan were very likely to have caused excessive sedation and may have shortened his life by a short period of time, that in my view would have been no more than hours to days. However, this was a dying man, the family appeared to have been appropriately involved and the patient did eventually die without distress on 24th January. While his care is sub-optimal I cannot prove it beyond reasonable doubt to be negligent or criminally culpable.

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129

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: _____

Code A statements Version 1 22 April 2005

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of Code A re Code A. In particular, it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This report is based on the following document:

2.1 Job Description for Clinical Assistant Post to the Geriatric Division in Gosport as provided to me by the Hampshire Constabulary (February 2005).

2.2 Statement of Code A re Code A as provided to me by Hampshire Constabulary (April 2005). Appendix 1

2.3 Statement of Code A as provided to me by Hampshire Constabulary (February 2005). Appendix 2

2.4 Report regarding Code A (BJC/ 71) Code A 2005.

3. COMMENTS

3.1 Comments on Job Description (2.1)

3.1.1 This confirms the Clinical Assistant is responsible for a maximum of 46 patients and confirms that all patients are under the care of a named Consultant Physician who would take overall responsibility for their medical management. A Clinical Assistant should take part in the weekly consultant ward rounds.

3.1.2 A specific responsibility is the writing up of the original case notes and ensuring the follow up notes are kept up to date and reviewed regularly.

3.1.3 The post is for five sessions a week i.e. is half what a full time doctor would commit to the post. However, the time to be spent in the unit is not specified as the time is allowed to be "worked flexibly".

3.1.4 There appears to be some confusion between the statements in the job summary, that "patients are slow stream or slow stream for

rehabilitation but holiday relief and shared care patients are admitted" and the statement in the previous sentence "to provide 24 hour medical care to the long stay patients in Gosport". The job description appears to be confusing patients for rehabilitation with long stay patients.

3.1.5 There is no comment on the medical cover to be provided when the post holder is unavailable for out of hours or longer period of leave such as holidays. Lack of explicit cover might explain some gaps in the notes.

3.2 Report on the statement of Code A re Code A (2.2).

The comments refer by paragraph to the statement, and by paragraph to the report (BJC/ 71)

3.2.1 I have read the statement of Code A as provided to me by the Hampshire Constabulary (April 2005). Appendix 1.

3.2.2.Paragraph 7. I agree that Code A was admitted to Mulberry Ward on 14th September 1995. Paragraph 5.4 my report (BJC/71) incorrectly stated 29th November 1995. Paragraph 10 of my report (BJC/71) I incorrectly assumed that Code A was male and refers to "him" in paragraph 6.9.

3.2.3 Paragraph 13. Does imply that an external examination of Code A Code A pressure areas may have been undertaken. However, as set out in Paragraph 6.10 of my report (BJC/71) no general physical examination is otherwise recorded to have taken place.

3.3 Report on the Statement of Code A as provided to me by the Hampshire Constabulary (2.3):

3.3.1Page 1 paragraph 3: States that she works eight general practice surgery sessions. It is my understanding that most full time General Practitioners work eight or nine sessions. This suggests to me that she is undertaking a full time General Practitioner job and a half time community hospital job. Despite the fact the job description says that the job can be worked flexibly, an opinion should be obtained from an experience General Practitioner as to whether this workload is actually deliverable within a reasonable working week.

3.3.2 Page 1 paragraph 4: The job description states 46 beds, Code A Code A states 48 beds. The CHI report says 44 beds (20 on Dryad and 24 on Daedalus) Code A uses the phrase "continuing care for long stay elderly patients". The job description also referred to slow stream or slow stream rehabilitation as well as holiday relief and shared care patients. There may have been confusion between staff in terms of the objectives of individual patient management.

3.3.3 Page 1 paragraph 5: This statement is incorrect as the post of Clinical Assistant is not a training post but a service post in the NHS. The only medical training grade posts are pre-registration house officers, senior house officers, specialist registrars and GP registrars.

3.3.4 Page 1 paragraph 5: States that she and her partners had decided to allocate come of the sessions to "out of hours aspects of the post". This would appear to be a local arrangement of the contractual responsibilities: it needs to be clarified if this was agreed with the Portsmouth and South East Hampshire Health Authority. This would influence how much time was expected to be provided for the patients and influence the pressure on Code A to deliver the aspects of care provided.

3.3.5 Page 2 paragraph 3: This does confirm that there were consultants responsible for all the patients under the care of Code A. Thus a consultant should always have been available for discussing complex or difficult management decisions. However,(page 3 paragraph 1) , in my view it would be completely unacceptable of the Trust to have left Code A with continuing medical responsibilities for the inpatients of Gosport Hospital without consultant supervision and regular ward rounds. This would be a serious failure of responsibility by the Trust in its governance of patients and in particular failings and in my view the Trust would need to take part of the responsibility for any clinical failings.

3.3.6 Page 3 paragraph 3: This again suggests that Code A was trying to provide her half time responsibilities by fitting the work around her full time responsibilities as a General Practitioner. She suggests 5 patients were admitted each week, implying approximately 250 admissions and discharges a year. With a bed occupancy around 80%, this would suggest an average length of stay of 5 – 6 weeks. However, CHI state the actual figures were somewhat less, 1997/98 were 169 FCE's for Dryad and Daedalus and 197 FCE's in 1998/99. A new patient assessment including history and examination, writing up the notes, drug charts, talking to the nurses, talking to any relatives present and undertaking blood tests if these had to be taken by a doctor rather than any other staff, would take a maximum of 60 minutes.

Page 5 paragraph 2: The patients who were genuinely long stay or continuing care do not need to be reviewed medically every day, nor would a medical record be made daily. Indeed with average length of stay of six or more weeks, it is clear that many patients were genuinely long-stay patients and one would expect them to be medically reviewed no more than once a week and any medical comments to be no more than once a week. However, whenever patients' physical or mental state has changed and they are reviewed by a doctor, it would be normal practice to always make a comment in the notes. Patients who are in rehabilitation and making a good progress, then review and

comments in the notes once or twice a week would also be the norm.

It is my view that with less than 200 FCE's and a total of 44 inpatients, then this should be satisfactorily managed by somebody working half time as a Clinical Assistant with regular consultant supervision.

3.3.7 Page 4 paragraph 2: This suggests that Code A is stating that she takes personal responsibility for most changes in medication, rather than it being a nursing decision.

3.3.8 Page 9 paragraph 2: An individual doctor must take responsibility for their prescribing however I would agree that consultants should also take responsibility for ensuring patients under their care were having appropriate medical management. It does appear that there was a consultant responsible for all patients in both Dryad and Daedalus Ward.

4. Conclusions

4.1. Having read all the documents provided by Hampshire Constabulary, the only changes I would wish to make in my expert report are in paragraphs 5.4. to change the date to the 14th September; in paragraph 6.9 to change "his" to "her"; and in paragraph 6.10 to state that no physical examination, apart from possible examination of pressure areas, is documented.

Form MG15(T)

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RECORD OF INTERVIEW

Number: Y20E

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

Person interviewed: Code A

Place of interview: FRAUD SQUAD OFFICE NETLEY

Date of interview: 03/03/2005

Time commenced: 0915 Time concluded: 0940

Duration of interview: 25 MINS Tape reference nos. (→)

Interviewer(s): Code A

Other persons present: Code A SOLICITOR

Police Exhibit No: CSY/JAB/4A Number of Pages: 22

Signature of interviewer producing exhibit

Person speaking	Text
Code A	This interview is being tape recorded I am Code A Code A my colleague is -
	Code A
	I'm interviewing Code A , Doctor can you please give your full name and your date date of birth.
	Code A
	Also present is Code A who is Code A Solicitor. Can you please give your full name.

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SOLICITOR — Yes certainly it's Code A.

Code A — If you have a role about your, or if you have sorry a statement about your role here today maybe now.

SOLICITOR — No I'm just Code A Solicitor.

Code A — Okay. This interview is being conducted in an office within the Fraud Squad at Netley Support Headquarters in Hampshire . The time is 09:15 hours and the date is the 3rd of March 2005 (03/03/2005). 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 you are entitled to free legal advice, you have Code A with you, have you had enough time to speak to him before this interview started.

Yes thank you.

Okay. If at any time you want to speak to Code A then just say and we'll stop the interview so that you can consult in private. I must also tell you that you've attended voluntarily, you are not under arrest, you have come here of your own freewill, therefore if at any time you wish to leave then your completely free to do so. You do not have to say anything but it may harm your defence if you do not mention when questioned something, which you later rely on in Court. Anything you do say maybe given in evidence. That's what's called the Caution Doctor, do you understand that Caution.

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Code A

I do.

Could you just for our peace of mind explain what you think that Caution means.

SOLICITOR

Well Officer again perhaps you could explain that so that Code A absolutely clear sometimes it's rather difficult for people in this situation to put it across.

Code A

The Caution comes in, in three parts really. The first part is your right in law you don't have to say anything and the last bit is quite obvious, and anything you do say maybe given in evidence it's being tape recorded and should this matter ever go to Court the tapes can be played or a transcript could be read. It's the, the bit in the middle where it says it may harm your defence if you do not mention when questioned something, which you later rely on in Court. In a nutshell if you don't say something now but you later give a reason or an answer if this matter goes to Court then the Court may and it is only a may put an inference on that and wonder why you didn't say that earlier. Do you understand what I'm saying.

I do.

Does that sound a reasonable explanation Code A

SOLICITOR

I think we can have small trite arguments but the essense of what you've said.

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Code A — Okay. Alright. This interview is not being monitored today so nobody else is listening, listending in if it was being monitored there would a red light situated somewhere which would, which would illuminate. Now during the interview I'll probably ask most of the questions but my colleague Code A will be making notes, don't let that worry you it's just so that we've got a reference straight away of what's been said. Code A can I just cover something with you. I believe you've been given some advance disclosure on the 4th of November which is the last time that we met.

SOLICITOR — Yes that's right.

Code A — And the disclosure consisted of a set of medical notes pertaining to Code A and a summary is that correct.

SOLICITOR — That's correct yes.

Code A — Excellent. This investigation as you're no doubt already aware is being conducted by the Hampshire Constabulary it started in September 2002, I accept that it's over two years now but the investigation will probably continue for some considerable time still. 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. No decision has been made as to whether an offence or any offences have been committed but it's important to be aware that the offence range being investigated runs from an assault all the way up to murder and part of the ongoing enquiries to interview witnesses who were involved in the

care and treatment of the patients during that period. You were a Clinical Assistant at the Gosport War Memorial Hospital at the time of the these deaths, so your knowledge of the working and of the hospital and the care and treatment of the patients is very central to this enquiry. The interview today will be concentrating on Code A Code A who was an 82 year old man and he died on Dryad Ward on Code A Now I've done most of the speaking now but perhaps in your own words Doctor you can tell me your recollection of Code A and the care and treatment.

SOLICITOR — Officer can I say that Code A has produced a pre prepared statement so that she can convey to you all the information that she thinks she can about Code A and his case. I would invite if your content with this Code A to read that out as her account responding to your invitation just now. I have to say for the reasons that I articulated on the previous occasion though my advice to Code A is that she should then make no further comment to questions.

Code A — Right.

SOLICITOR — Put to her and hopefully this is a detailed pre prepared statement, which will take care of necessary information you seek.

Code A — As you mention that yes if you could read it Code A Code A but you you're indicating that once you've read the prepared statements your not going to answer any

further questions put to you about this matter. Is that correct.

Code A

Correct.

Okay. If you, if you could it read then please Doctor.

SOLICITOR

It's simply the form as I do have a copy of the statement for you.

Code A

That would be ever so handy.

SOLICITOR

Of course no problem at all it will save you making notes.

Code A

Yeah. Thank you.

I am Code A 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.

I understand you are concerned to interview me in relation to a patient at the Gosport War Memorial Hospital, Code A Code A 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 Gosport War Memorial Hospital. I adopt that statement now in relation to general issues insofar as they relate to Code A

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 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.

In any event, it is apparent from Code A medical records that he was 83 years of age and had been suffering from depression since his 50's. Code A had been

living in a residential home, Hazeldene and also had been an in-patient at the Knowle Hospital where he had received Electro Convulsive Therapy as treatment for severe depression. Having returned to Hazeldene, early in 1995 it is recorded that by September that year Code A Code A had taken to his bed and was no longer eating and drinking properly. In view of his general condition and depression, he then appears to have been admitted to Mulberry Ward at the Gosport War Memorial Hospital having been seen at Hazeldene by a Community Psychiatric Nurse in September 1995.

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

From Code A records it appears then that he was admitted to Mulberry Ward on the 14th September 1995 (14/09/1995) under the care of Consultant in Old Age Psychiatry, Code A. Mulberry Ward is the long stay elderly mental health ward at the Gosport War Memorial Hospital. On admission it was recorded that there had been a deterioration of Code A mood and physical capabilities over recent months. Whilst on Mulberry Ward, Code A depression was treated

with Lithium, Sertraline, and he also received Diazepam and Thioridazine.

Code A was then discharged from Gosport War Memorial Hospital on 24th October 95 (24/10/1995). The subsequent discharge letter to Code A GP from Code A Code A , Registrar to Code A stated that Code A Code A had scored 8 out of 10 on a mental health score, and that he had been offered ECT for his depression but had turned it down as it had not been very effective previously. Code A referred to his frail physical condition, but said that his mood had improved quite a bit during his admission and that he seemed to have more energy. He was apparently to be followed up as a day patient.

Code A was then re admitted to Mulberry Ward from Hazeldene on 13th December 1995 (13/12/1995). The nursing staff at the residential home were said to have found it increasingly difficult to manage him as he had become both physically and verbally aggressive. On 20th December his physical condition was described as poor, and he later developed a chest infection and areas of pressure ulceration.

With his condition remaining poor, Code A wrote a note on 2nd January 1996 (02/01/1996) requesting Code A Code A Consultant Geriatrician, to see Code A Code A In her note Code A said that on admission Code A mobility had initially deteriorated rapidly and that he had developed a chest infection. She reported

that his chest was now clearing, but he remained bed bound, expressing the wish to die. The following day, Code A Code A was said to be deteriorating.

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

In noting that his prognosis was poor I believe that Code A Code A felt that Code A was unlikely to get better and sadly he was not likely to live for a significant period.

Accordingly, Code A was admitted to Dryad ward the following day, 5th January, though under the care of Consultant Geriatrician Code A , and I undertook his assessment. Unfortunately, given the very considerable

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interval of time I now have no real recollection of Code A Code A but my admission note in his records reads as follows:

"5th January 96 Transfer to Dryad Ward from Mulberry
Present problem
Immobility depression
Broken sacrum. Small superficial areas
Ankle dry lesion Left ankle
Both heels suspect

Catheterised
transfers with hoist
may help to feed himself

Long standing depression on Lithium and Sertraline"

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

I believe that I would have seen Code A each weekday when on duty at the hospital. 5th January 1996 (05/01/1996) being a Friday, I would have seen him again on 8th January and reviewed his condition. I have not made a note, but anticipate that his condition may have been essentially unchanged.

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I saw Code A again on Tuesday 9th January and made the following entry in his notes:

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

The nursing note for 9th January documents that Code A Code A had taken a small amount of diet. He was noted to be very sweaty that morning, but apyrexial. He stated that he had generalised pain and it was noted that he would be seen by me that morning.

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

The notes show that Code A and I then saw Code A Code A the following day, 10th January. Code A

noted his dementia, that he was catheterised, had superficial ulcers, his Barthel score remained zero, and he would eat and drink. She wrote that Code A was "for TLC" (Tender loving care). This indicated that Code A Code A effectively agreed with Code A assessment and felt Code A was not appropriate for attempts at rehabilitation but was for all appropriate nursing care and treatment only. She noted that she had had discussion with Code A who had agreed that in view of his very poor condition this was appropriate.

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

The prescription chart shows that I prescribed Oramorph for Code A the same day, no doubt in consequence of liaison with Code A at the time of the ward round. This would have been for relief of pain, anxiety and distress. The dose is recorded at 2.5 mls in what is a 10mg/5ml ratio, 4 hourly. The regime was written up for doses at 6.00 a.m., 10.00 a.m., 2.00 p.m. (14:00) and 6.00 p.m. (18:00). It appears that I also proactively wrote up a prescription for diamorphine , in a dose range of 40-80mgs subcutaneously over 24 hours, together with 200-400mcgs of hyoscine and 20-40mgs of midazolam via the same route. I anticipate we were concerned that the Oramorph might be insufficient and that further medication should be available just in case he needed it.

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

I anticipate that I would have seen Code A again the following day. Although I did not make a clinical entry in Code A records, I wrote up a further prescription chart for the various medications Code A was then receiving. In addition I increased the Oramorph available for Code A pain, anxiety and distress, by adding an evening dose of 5mls to the four daily dose doses, to tide Code A overnight. I also provided a further prescription for hyoscine, diamorphine and midazolam, with the latter two drugs being at a slightly greater level than I had written the previous day, at 80-120 and 40-80mgs respectively. I would have been concerned that although it was not necessary to administer the medication at that stage, Code A pain, anxiety and distress might develop significantly and that appropriate medication should be available to relieve this if necessary. The Sertraline and lithium were discontinued from this point, given Code A poor condition.

I anticipate that I would then have seen Code A on the Friday morning, but I would then have been away from the hospital over the weekend. I returned on the morning of Monday 15th January, and would have reviewed all of the patients on both Dryad and Daedalus wards in the usual

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way, including Code A I believe I may have been told that his condition had deteriorated considerably over the weekend and he appeared to be experiencing marked agitation and restlessness and to be in significant pain and distress, through his mental and physical condition. Unfortunately, I did not have an opportunity to make a clinical entry in Code A notes, I anticipate due to lack of time, but the nursing note indicates that I saw Code A and that 80mgs of diamorphine, 60 of midazolam, and 400mcgs of hyoscine over 24 hours were commenced subcutaneously via syringe driver at 08.25 (08:25) that morning.

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

I tried to judge the medication, including the increase in the level of opiates to ensure that there was the appropriate and necessary relief of his condition, whilst not administering an excessive level, and to ensure that this relief was established rapidly and maintained through the syringe

driver. This had to take into account the fact that the lithium and Sertraline with their additional sedative effects had previously been discontinued and that he would have developed some tolerance to the oral regime.

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

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

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

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Code A apparently visited later that day and was said now to be aware of Code A poorly condition.

I believe I saw Code A again the following morning, 17th January. It appears from the nursing notes that Code A Code A was tense and agitated and so I decided to increase the level of his medication. I wrote a further prescription for 120mgs of diamorphine, noted by me on the drug chart to have been at about 08.30 (08:30). This was with the specific aim of relieving the agitation, and from concern that as Code A would be becoming inured to the medication and tolerant of it, so he might experience further agitation, and the pain and distress might return. I also increased the haloperidol to 10mgs and the hyoscine to 600mcgs, the latter to dry the secretions on his chest, suction being required that morning.

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

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

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

"18th January 96 Further deterioration
subcutaneous analgesia continues
difficulty controlling symptoms
try nozinan".

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

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

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

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I would not have been on duty over the weekend, and it appears that one of my GP partners, Code A, was available. The records show that on Saturday 20th January, he was consulted about Code A Code A, and he advised that the nozinan should be increased to 100mgs and the haloperidol discontinued. My expectation is that Code A would have been advised of Code A condition and the drug regime. The only modification being in the antipsychotic medication, it would seem that Code A did not consider the general regime to be inappropriate in view of Code A condition.

Code A sufficient specifically recorded in the notes that Code A had been unsettled on haloperidol, that it should be discontinued and changed to a higher dose of nozinan.

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

I would have seen Code A again on the Monday morning, 22nd January. I have not made a note, but the

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nursing records indicate that Code A was poorly but peaceful.

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

Sadly, in the early hours of Code A deteriorated suddenly, and he died at 01:45 (01:45).

Code A

Thank you Doctor again that's very full, very informative. Can I just ask you is this statement made by you Doctor. This prepared statement. Can I ask you if you could sign it and endorse it with the fact that you've handed it to me, possibly sign that one and time and date it please.

This one.

Yeah the one you read from would be the best one.

On, on the back page or on the front.

Is there room on the last page, yeah just put it on the last page please.

Is today's date the 3rd.

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Code A

Yes. And if you could just put on there handed to Code A Code A Lovely thank you. Would you consider countersigning Code A you did the other one.

SOLICITOR

Yes no problem.

Code A

Right for the purpose of the tape I'm going to give this prepared statement an Identification Reference and I'm going to call it JB/PS/3 that's by Code A Prepared Statement and that's the third one we've had from you. Right I intend to call a halt to the interview pretty much now so that we can go away and consider all this information that you've told us. Before is there anything you want to ask Code A

No there isn't.

No okay. Well we'll going to go away and have a read through. Before we turn the tapes off Doctor is there anything you wish to say, anything you wish to clarify.

Nothing.

Code A

SOLICITOR

No thank you.

Code A

Okay well we'll give you a notice explaining the tape recording procedure, feel free to use the canteen and if you

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want get a breath of fresh air and we'll come back. The time is 09:40 and we'll turn the recorder off.

STATEMENT OF Code A - RE: Code A
Code A

1. I am Code A 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, Code A. 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 Code A

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

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

7. From Code A records it appears then that he was admitted to Mulberry Ward on the 14th September 1995 under the care of Consultant in Old Age Psychiatry, Code A. Mulberry Ward is the long stay

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

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

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

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

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

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

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

"5-1-96 Transfer to Dryad Ward from Mulberry

Present problem

Immobility depression

broken sacrum. Small superficial areas

ankle dry lesion L ankle

both heels suspect

Catheterised

transfers with hoist

may help to feed himself

Long standing depression on Lithium and

Sertraline"

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

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

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

"9-1-96 Painful R hand held in flexion

Try arthrotec

Also increasing anxiety and agitation

? sufficient diazepam

? needs opiates"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30. Code A apparently visited later that day and was said now to be aware of Code A poorly condition.

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

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

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

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

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

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

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

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

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

Code A did not consider the general regime to be inappropriate in view of Code A condition.

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

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

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

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

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

signed Code A

dated 3-3-05

Handed to Code A

Code A