FFW/89/01

Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

RUBY LAKE

6053801 v

Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

Code A

Code A

1

GENERAL MEDICAL COUNCIL

Code A

Index to Code A's File

File 1

1. Detailed Summary of Evidence.

2. Report prepared by Code A dated 10 July 2005. in expertfile

3. Report prepared by Code A dated 5 September 2005. in expertfile

4. Interview of Code A dated 14 July 2005 at 09:07.

5. Statement of Code A regarding Code A

6. Witness List and Witness Statements provided to Hampshire Constabulary.

   (a) Code A dated 1 December 2004.

   (b) Code A dated 20 December 2004.

   (c) Code A dated 4 January 2005.

   (d) Code A dated 5 January 2005.

   (e) Code A dated 11 January 2005.

   (f) Code A dated 12 January 2005.

   (g) Code A dated 18 January 2005.

   (h) Code A dated 19 January 2005.

   (i) Code A dated 24 January 2005.

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DRAFT REPORT

regarding

Code A (BJC/67)

PREPARED BY: Code A

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

Code A was a frail 84 year old who was admitted to hospital having fallen and fractured her left hip on 5th August 1998. This was surgically repaired and she had a difficult post-operative course due to events associated with her pre-existing heart and kidney problems, leading to heart failure, atrial fibrillation and renal impairment, along with a chest infection and episodic confusion/agitation at night. A combination of fluids, diuretics and antibiotics were required to support her through this period. At the time of Code A s review, she summarised Code A as frail and quite unwell and was uncertain as to whether there would be significant improvement. Subsequent to Code A 's review, Code A experienced chest pains that appeared either related to her ischaemic heart disease or were musculoskeletal in origin, for which GTN (an anti-anginal treatment) or codeine/paracetamol were effective respectively. Apart from these episodes of pain, Code A appeared to be progressing rather than deteriorating whilst awaiting transfer to Gosport War Memorial Hospital and had begun to mobilise. On the day prior to transfer, for a period of time, she was noted to appear confused and had a temperature. However, on the day of the transfer she was reported to be well, comfortable and happy with a normal temperature.

Infrequent entries in the medical notes during her stay on Dryad Ward make it difficult to closely follow Code A 's progress over the last three days of her life. She apparently settled in well, but the next day complained of chest pain. A syringe driver containing diamorphine and midazolam was commenced later that day. Code A became drowsy, her chest bubbly and the doses of drugs in the syringe driver were modified

over the next two days to diamorphine 60mg, midazolam 60mg and hyoscine hydrobromide 800microgram/24h. Code A was confirmed dead at 18.25h on the 21st August, the cause of death stated as bronchopneumonmia.

Code A does not appear to have provided Code A a good standard of clinical care as defined by the GMC; Code A was not adequately medically assessed by Code A at the time of her transfer or after her complaints of chest pain; there was no justification given for the prescription of morphine or the drugs administered in the syringe driver.

A lack of documentation makes it difficult to understand why Code A may have deteriorated in the rapid way that she did. A rapid deterioration often suggests an acute underlying medical cause. In this regard, a thorough medical assessment when she complained of chest pain (or indeed at the time of her transfer) may have identified possible contributing factors, such as a chest infection, that could have been appropriately treated. It is therefore possible that her physical state had deteriorated in a temporary or reversible way and that with appropriate medical care she would have recovered.

If it were that Code A had naturally entered the terminal phase of her 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 inappropriate use of medication due to a lack of sufficient knowledge. However, given the lack of medical and nursing records to the contrary, reasonable doubt exists that Code A had definitely entered her terminal stage. Given this doubt, at worst, 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 failing to adequately assess her physical state at the time of her transfer and when she complained of chest pain, failing to take suitable and prompt action when necessary and if her physical state had deteriorated in a temporary or reversible way exposing her to the inappropriate use of diamorphine and midazolam in doses that could have contributed more than minimally, negligibly or trivially to her 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 her death against the acceptable standard of the day. Where appropriate, if the care is felt to be suboptimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

3. ISSUES

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

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

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

4. BRIEF CURRICULUM VITAE

Code A

5. DOCUMENTATION

This Report is based on the following documents:

[1] Set of medical records on paper and CD-ROM of Code A (BJC-67).

[2] Set of medical records on paper of Code A (JR-19A).

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

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

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

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

[7] Portsmouth Health Care NHS Trust Policies:

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

ii) Prescription Writing Policy (July 2000).

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

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

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

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

[9] British National Formulary (BNF). Section on Prescribing in Palliative Care (March 1998).

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

Elderly (March 1998).

6. CHRONOLOGY/CASE ABSTRACT

Events at the Royal Naval Hospital, Haslar

Code A an 84 year old widow who lived alone, was admitted on the 5th August 1998 to the Royal Naval Hospital, Haslar, Gosport under the care of Code A following a fall at home in which she sustained a fractured neck of her left femur (top part of her left leg)(page 53 of 181). Her past medical history revealed a number of heart problems; left ventricular failure (heart failure), a probable myocardial infarction ('heart attack'), hypertension (raised blood pressure), cardiomegaly (enlarged heart), aortic valve sclerosis (thickening of one of the heart valves) and atrial fibrillation (irregular heart beat) (page 52 of 181; pages 37, 42 and 59 of 443). In addition, renal failure (in association with the use of a non-steroidal anti-inflammatory drug), generalised osteoarthritis, gout, leg ulcers, liposclerosis, sicca (Sjogren's) syndrome (dry eyes and mouth) and possibly rheumatoid arthritis (all summarised on page 73 of 443). Subsequently, a consultant rheumatologist considered that she possibly had CREST syndrome (page 352 of 443). This is the association of calcinosis (calcification of the skin), Raynaud's phenomenon (poor circulation to the fingers) oesophageal involvement (difficulty swallowing), sclerodactyly (thin fingers) and telangiectasia (dilated blood vessels in the skin). It is a variant of systemic sclerosis (scleroderma), a systemic connective tissue disorder characterised mainly by inflammation of subcutaneous connective tissue, followed by a progressive fibrosis leading to atrophy of skin, subcutaneous fat and associated tissue and an

arteritis (inflammation of the small blood vessels) of the skin. It may also affect skeletal muscles and other organs, e.g. the heart (cardiomyopathy causing heart failure), lungs (fibrosis causing shortness of breath), kidneys, (causing renal failure) and gastro-intestinal tract (hypomotility leading to bacterial overgrowth, which in turn leads to malabsorption). In addition to the problems with the skin, symptoms can thus include oesophageal reflux or heartburn, difficulty swallowing, bloating after meals, weight loss, diarrhoea, constipation, shortness of breath, joint pain and dry and sore eyes. The disease is generally progressive, with some experiencing remission with a slow progression. Those with only skin involvement have a better prognosis. Death may occur from gastro-intestinal, cardiac, kidney or pulmonary involvement.

Code A 's medication consisted of allopurinol 100mg twice a day (to prevent gout), bumetamide 1mg once a day (a water tablet), digoxin 62.5microgram once a day (for atrial fibrillation).

Code A reported that she was usually mobile, independent and self caring, could walk 100 yards before stopping due to her arthritis rather than angina (page 52 of 181).

Abnormal findings on initial examination were a 'regularly irregular' pulse rate of 72 beats per minute and a possible mass in the right iliac fossa (page 53 of 181). Blood tests revealed a raised white cell count (12.87 x 10^9/L; normal 4–11) due to a neutrophillia (page 6 of 181) and an elevated urea (16.8 mmol/L; normal 2.5–6.1)(page 9 of 181). According to a chest x-ray report, the lung fields were clear but the heart was enlarged (page 27 of 181). However, it should be clarified if this report relates to the chest x-ray taken on the 5th August 1998, as the date of the report is given as the

7th September 1998. Her ECG (electrocardiograph) on the 5th August 1998 revealed a normal heart rhythm but abnormal T wave inversion in leads I and avl and poor R wave progression in the anterior chest leads (page 86 of 181). I am not a cardiologist, who would be best placed to interpret ECGs, but my understanding is that the changes in this and Code A Code A other ECGs, could be consistent with the use of digoxin, cardiac ischaemia (reduced blood flow to the heart muscle) or left ventricular hypertrophy (enlargement of one of the chambers in the left side of the heart).

Code A underwent a left hemi-arthroplasty on the 5th August 1998 (page 57 of 181). The operation went without incident but Code A had a difficult post-operative course.

On the 6th August Code A had problems with vomiting and shortness of breath. Her pulse was regular but her jugular venous pressure was elevated 3cm (assessed by how high above the sternal angle (part of the breast bone) the blood level is in the large veins of the neck when sitting and resting back 45°) and bilateral fine crackles were heard in the bases of her lungs (page 60 and 61). In view of these findings it was considered that she had excess fluid in the circulation causing heart failure. Infection was another possibility and her white cell count was elevated at 18.8 x 10^9/L (mainly due to neutrophils, the type increased by infection). Code A's intravenous infusion of fluid was stopped for several hours and subsequently restarted at a slower rate. A urinary catheter was inserted to monitor her urine output and she was commenced on antibiotics, Augmentin 375mg three times a day by mouth (page 61 of 181).

Over the following days, it appeared difficult to give her sufficient fluids to maintain a reasonable urine output and avoid renal impairment (urea and creatinine increased to 17.3mmol/L and 144micromols/L respectively) without easily risking fluid overload and heart failure. Hence her intravenous fluids were adjusted several times and additional diuretics (to remove excess water) were given intermittently (pages 63 and 64 of 181).

On the 9th August, Code A 's problems were listed as poor mobility, shortness of breath on exertion, nausea and diarrhoea (page 64 and 65 of 181). Blood tests revealed ongoing renal impairment (urea of 25.6mmol/L and creatinine 141micromol/L).

On the 10th of August Code A was reported to be unwell, drowsy and experiencing vomiting and diarrhoea. Her pulse had increased to a rate of 120 per minute and was now irregularly irregular. Her blood pressure was 120/60mmHg (probably low for her; she had previous readings of 160/90) (page 62 of 181)). Two ECGs were carried out in succession that revealed changes from her original ECG (page 86 of 181). The automatic report of the first stated 'sinus arrhythmia, rate varies from 79 to 158, ventricular premature complex, diffuse ST-T abnormalities' (page 84 of 181). The second ECG showed atrial fibrillation (irregular heart beat, page 82 of 181). She was reviewed by a more senior doctor, a senior house officer, who found inspiratory crepitations (crackles) at her left lung base (page 67 of 181). It was considered that she was dehydrated, with a chest infection and had possibly had a myocardial infarction (page 68 of 181). Blood tests revealed a re-increase in her white cell count to 15.27 x 10^9/L and an increase in her urea to 25mmol/L. A chest x-ray revealed an infection at the base of her left lung and no heart failure (page 69 of 181). Intravenous

fluids were given and her antibiotic, Augmentin, was switched to intravenous administration 600mg three times a day, instead of orally. Later that day, Code A was reported to have improved (page 69 of 181). An entry in the nursing records noted 'antibiotics changed to IV (intravenous) as unable to swallow large tablets' (page 165 of 181).

On the 11th August 1998, her improvement continued. Her temperature was normal, she had a clear chest and a good urine output. She was switched to oral antibiotics (page 70 of 181). Later that night she again appeared to have heart failure and required further intravenous furosemide (page 71 of 181).

On the 12th August, the antibiotics and intravenous fluids were discontinued. Code A was not in heart failure, the diarrhoea had settled and she had sat out. She was noted to be developing a bed sore on her sacrum (base of the spine). The plan was to allow her to mobilise with a physiotherapist and encourage oral fluids (page 71 of 181). She was referred to Code A 'from the point of view of her future management' with a referral letter summarising that Code A 's post-operative recovery was slow, with episodes of confusion, pulmonary oedema (due to left ventricular failure), vomiting and diarrhoea (page 72 and 73 of 181). Code A Code A reviewed Code A later that day and listed her problems as: left cemented hemi-arthroplasty of hip; LBBB plus LVF – improving (left bundle branch block (an ECG abnormality) and left ventricular failure; sick sinus syndrome/AF (atrial fibrillation); dehydration – but improving (possibly referring to a urea 17.7mmol/L on the 12th August (page 107 of 181); bilateral buttock ulcers; bilateral leg ulcers; hypokalaemia (low potassium) 3.0mmol/L (lower limit of normal 3.6mmol/L; page 107 of 181);

normochromic anaemia (possibly referring to a haemoglobin of 105g/L (lower limit of normal 105g/L) on the 11th August; page 92 of 181); vomiting and diarrhoea query cause. Code A suggested potassium supplements (Slow K, 2 twice a day) for the low potassium; to hydrate orally and stool cultures to look for infection. Code A noted that 'it is difficult to know how much she will improve but I'll take her to an NHS continuing care bed at GWMH next week' (page 73 and 74 of 181). Code A's summary of this assessment was dictated on the 14th August and typed on the 17th August (page 23 of 181) in which she summarised Code A as 'frail and quite unwell at present' and notes that she is uncertain as to whether there will be significant improvement (page 23 of 181).

Stool cultures taken on the 8th August were normal with no blood, mucous or fat globules (page 113 of 181) and urine and blood cultures taken on the 10th August revealed no bacterial growth (pages 35 and 111 of 181). The cardiac enzymes measured on the 10th and 12th August did not suggest that she had had a heart attack (pages 107 and 109 of 181).

On the 13th August an entry in the nursing notes (unspecified time in the am) records that Code A complained of central chest pain, oxygen was given, together with 2 sprays of GTN (glyceryl trinitrate; an anti-anginal treatment given by spray under the tongue) with effect. An ECG was reviewed by a doctor and no further action taken (page 168 of 181). There is no mention of this episode in the medical notes.

Several entries in the nursing notes report that Code A was at times agitated in the night, e.g. 8th, 10th, 12th, 13th August 1998 (pages 164, 166, 167,168 of 181).

On the 14th of August Code A is reported as well and to have stood with the physiotherapist (page 74 of 181). Her potassium level was improving (potassium 3.4mmol/L; page 101 of 181).

On the 15th August the nursing records at 07.00h note that 'Code A had some pain due to arthritis in her left shoulder overnight. She had paracetamol as charted with good effect' (page 169 of 181). Later that day the nursing notes record 'c/o (complaining of) pain in left shoulder/chest on inspiration, O_2 (oxygen) remains in situ. Dr's (doctors) to review, ? muscular' (page 169 of 181). In the entry in the medical notes follows, the house officer notes that it was 'left sided chest pain in ribs through to her back – since being manhandled. Worse on coughing, tender over ribs. ECG – nil changes (page 78 of 181), no effect with GTN (Glyceryl Trinitrate)' (page 75 of 181). Her oxygen saturation level was normal on the oxygen (98%). Her pulse was noted to be 100 beats per minute irregularly irregular (as in atrial fibrillation). The impression was that this was 'musculoskeletal chest pain but consider PE (pulmonary embolism, a blood clot that has travelled to the lungs) or angina' (page 75 of 181). Blood tests revealed a normal potassium of 4.5mmol/L, a stable urea of 20.4mmol/L and normal cardiac enzymes. Code A was prescribed codeine phosphate 30mg and she received a dose at 22.35h (page 175 of 181) with 'good effect' (page 170 of 181). The nursing notes of the 16th August timed at 07.00h summarise this medical review. Later the same day at 17.00h, they record that Code A had had a comfortable afternoon, that her oxygen saturations were 96% without oxygen and that she had gone out with her family around the grounds (page 172 of 181). Code A received another dose of codeine 30mg at 22.00h on the 16th August

(page 175 of 181). The only other analgesic that she received was paracetamol 1gram at 20.00h on the 17th August (for a raised temperature) and at 08.08h on the 18th August (not specified if for pain or a raised temperature) (page 175 of 181).

On the 17th August the medical notes record that Code A was well, did not have a raised temperature or chest pain, was mobilising slowly and awaiting transfer to Gosport War Memorial Hospital (76 of 181). The nursing notes for the 17th August report that Code A had a good nights sleep after settling late and frequently calling out (page 170 of 181). A later entry (20.15h) reports that Code A 'seemed confused this afternoon...Pyrexial at 38.8ºC at 19.45h, paracetamol given' (page 171 of 181).

On the 18th August an entry in the nursing notes made at 02.00h reports 'increased shortness of breath, recommenced on oxygen therapy, encouraged to expectorate. Apyrexial.....' (page 171 of 181). There is no mention that a doctor was informed at that time of her increased confusion and pyrexia.

On the 18th August the medical notes entry timed at 09.00h report that Code A Code A was well, comfortable and happy but that the evening before she had a temperature of 38.5ºC. It was now 37.3ºC. She was mobilising well and was due transfer to Gosport War Memorial Hospital that day. Her oxygen was discontinued and the transfer went ahead (page 76 of 181). The transfer letter written for the staff at Gosport War Memorial Hospital summarised in some detail Code A 's progress and current status, e.g. noting that 'she has had a slow recovery, exacerbated by bouts of angina and breathlessness. This appeared secondary to fluid overload.....this has

now resolved, it appears.....and she Code A is usually lucid and only very occasionally seems confused at night' (page 22 of 443). There is no mention that her temperature had recently been elevated or that she had been using oxygen up to the day of transfer.

Events at Dryad Ward Gosport War Memorial Hospital

Code A was transferred to Dryad Ward, Gosport War Memorial Hospital on the 18th August 1998, under the care of Code A There are two entries in the medical notes that cover a period of three days taking up one page in length (page 77 of 443). One is the note made on transfer, the other is the confirmation of death. This makes events difficult to follow in any depth. What follows is a record of events summarised from the medical notes, summary notes and nursing care plan.

The 18th August 1998 entry in the medical notes made by Code A reads (abbreviations removed), 'Transfer to Dryad Ward continuing care. History of presenting complaint: fractured left neck of femur 5th August 1998. Past medical history: angina and congestive cardiac failure. Catheterised, transfers with two, needs some help with activities of daily living. Bartel score of 6. Get to know. Gentle rehabilitation. I am happy for nursing staff to confirm death (page 77 of 443). The next entry on the 21st August 1998 notes that Code A had died at 18.25h (page 77 of 443).

The medication chart reveals that she was prescribed digoxin 62.5micrograms once a day, Slow K 2 twice a day, bumetamide 1mg once a day, allopurinol 100mg twice a day (although it appears it was only given once a day) as she had been at Haslar hospital (page 369 of 443). New additions were temazepam 10–20mg at night, although none was taken

and morphine (Oramorph, 10mg/5ml) 5–10mg as required (page 369 of 443). Doses of morphine were administered on the 18th August (5mg at 14.15h) and 19th August (10mg at 00.15h and 11.50h)(page 369 of 443). It is unclear why she received the dose on the 18th August. The nursing summary notes on the 18th August report Code A to be 'a pleasant lady, happy to be here..... settled quite well. Fairly cheerful this pm' (page 394 of 443). The nursing care plan dated the 18th August 1998 noted 'settled and slept well from 22.00h until midnight. Woke very distressed and anxious. Says she needs someone with her. Oramorph 5mg given 00.15h with little effect. Very anxious during the night. Confused at times' (page 388 of 443). I assume this entry, although dated the 18th August, relates to the night of the 18th August/early hours of the 19th August, but this should be clarified.

On the 19th August 1998 various untimed entries in the nursing plan reported: 'helped a little in washing and dressing, unsteady in walking' (page 374 of 443); 'catheter draining well/clear urine' (page 382 of 443); 'assisted wash given. Patient very breathless' (page 384 of 443). The nursing summary notes records at 11.50h 'complaining of chest pain. Not radiating down arm - no worse on exertion, pulse 96, grey around mouth. Oramorph 10mg/5ml given. Doctor notified. Pain only relieved for a short period - very anxious. Diamorphine 20mg, midazolam 20mg commenced in syringe driver' (page 394 of 443). There is no entry in the medical notes relating to the chest pain or commencement of the syringe driver. The diamorphine, hyoscine hydrobromide and midazolam were prescribed by Code A (page 368 of 443). The nursing care plan entry for the 19th August then reads 'comfortable night. Settled well. Drowsy but rousable

this am. Sips of oral fluids tolerated. Syringe driver satisfactory (page 388 of 443).

On the 20th August, entries in the nursing care plan report 'condition continues to deteriorate. Remains very "bubbly", suction attempted without success, distressed when turned. Syringe driver recharged at 07.35h. Oral care given, catheter draining. Looks flushed (page 388 of 443). The nursing summary notes recorded at 12.15h 'condition appears to have deteriorated overnight, driver recharged 10.10h diamorphine 20mg, midazolam 20mg, hyoscine 400microgram. Family informed of condition. Daughter present at time of report' (page 394 of 443). At an unspecified time at 'night' the entry reads 'general condition continues to deteriorate very "bubbly", suction attempted without success. Position changed frequently Ruby ? rousable and distressed when moved. Syringe driver recharged diamorphine 60mg, midazolam 60mg and hyoscine 800microgram 07.35h. Code A has enquired 08.00h Code A's condition' (pages 394 and 395 of 443).

The medication chart contains prescriptions for diamorphine 20–200mg/24h, hyoscine (hydrobromide) 200–800micrograms/24h and midazolam 20–80mg/24h by SC infusion (page 368 of 443). It is unclear when this prescription was written as it is undated. A syringe driver containing diamorphine 20mg and midazolam 20mg was commenced at 16.00h on the 19th August 1998 (page 368 of 443). This appears to be have been changed at 09.15h on the 20th August 1998 to also contain 400micrograms of hyoscine hydrobromide. Red writing through this prescription appears to read 'destroyed'. This is unclear however, even on the CD-ROM. This may have been because a new syringe driver was

commenced at 16.50h on the 20th August to contain diamorphine 40mg, midazolam 40mg and hyoscine hydrobromide 800micrograms (page 368 of 443). This in turn also appears to have red writing through saying 'destroyed'. A syringe driver was commenced on the 21st August at 07.35h containing diamorphine 60mg, midazolam 60mg and hyoscine hydrobromide 800microgram.

Code A was confirmed dead on the 21st August at 18.25h. The cause of death stated on the copy of the death certificate supplied, dated the 25th August 1998 was 1A Bronchopneumonia.

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Syringe drivers, diamorphine, midazolam and hyoscine hydrobromide

A syringe driver is a small portable battery-driven pump used to deliver medication subcutaneously (SC) via a syringe, over 24h. 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 35 (March 1998)). 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 24h dose. Hence for someone receiving 30mg of diamorphine in a syringe driver over 24h, a breakthrough dose would be 5mg. One would expect it to have a 2–4h duration of effect, but the dose is often prescribed to be given hourly if required. As the active metabolites of morphine are excreted by the kidneys, caution is required in patients with impaired kidney function.

Midazolam is a benzodiazepine, a diazepam like drug. It is commonly used in syringe drivers as a sedative in patients with terminal agitation. Sedation can be defined as the production of a restful state of mind. Drugs that sedate will have a calming effect, relieving anxiety and tension. Although drowsiness is a common effect of sedative drugs, a patient can be sedated without being drowsy. Most practitioners caring for patients with cancer in their terminal phase would generally aim to find a dose that improves the patient's symptoms rather than to render them unresponsive. In some patients however, symptoms will only be relieved with doses that make the patient unresponsive. A typical starting dose for an adult is 30mg/24h. A smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The Wessex protocol suggests a range with the lowest dose of 5mg/24h. The regular dose would then be titrated every 24h 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 24h, the 'as required' dose would be 5mg given as a stat SC injection. The duration of effect is generally no more than 4h, 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.

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 cumulation 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 600–2400microgram/24h SC (BNF (March 1998)) or 400–600microgram as a stat SC dose. The Wessex protocol gives a dose range of 400–1200microgram/24h.

The titration of the dose of analgesic, sedative or antisecretory medication is guided by the patients symptom control needs. The number and total dose of 'as required' doses required over a 24h 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 24h period is generally seen as acceptable.

8. OPINION

Events at Haslar Hospital 5th August 1998 to 18th August 1998

Code A was a frail 84 year old who was admitted to hospital having fallen and fractured her hip. This was surgically repaired but she had a difficult post-operative course due to events associated with her pre-existing heart and kidney problems, leading to heart failure, atrial fibrillation and renal impairment, along with a chest infection and episodic confusion/agitation at night. A combination of fluids, diuretics and antibiotics were required to support her through this period. At the time of Code A's review on the 12th August 1998, she summarised Code A as frail and quite unwell and was uncertain as to whether there would be significant improvement.

Subsequent to Code A's review, Code A experienced a number of pains: 1) a central chest pain requiring the use of oxygen together with GTN (glyceryl trinitrate; an anti-anginal treatment given by spray under the tongue) with effect (page 168 of 181); 2) a pain in her left shoulder put down to arthritis (page 169 of 181) and 3) a pain in her left shoulder/chest worse on inspiration (page 169 of 181) considered most likely to be musculoskeletal in origin, due to the presence of tenderness over her ribs, lack of effect of GTN (anti-anginal treatment) and a normal ECG (page 75 of 181). For this pain, Code A received codeine 30mg with good effect (page 170 of 181) and she took two doses in total. The only other analgesic that she received was paracetamol on two occasions although for at least one of these it was for a raised temperature.

Apart from these episodes of pain, Code A appeared to be progressing rather than deteriorating whilst awaiting transfer to Gosport War Memorial

Hospital and had began to mobilise. However, on the afternoon of the day prior to transfer she was noted to appear confused and had a temperature of 38.8ºC for which paracetamol was given (page 171 of 181). Nevertheless, on the day of the transfer she was reported to be well, comfortable and happy with a normal temperature.

Events at Gosport War Memorial Hospital, Dryad Ward 18th January 1998 to 21st August 1998

Compared to the notes during Code A 's stay at Haslar Hospital, infrequent entries in the medical notes during her stay on Dryad Ward make it difficult to closely follow Code A 's progress over the last three days of her life. There are two entries taking up less than one page in length. In summary, and in approximate chronological order, Code A was prescribed morphine (as Oramorph) on the day of her transfer. There was no record or assessment of any pain in the medical or nursing notes relating to this. A dose of 5mg was administered on the 18th August at 14.50h and doses of 10mg on the 19th of August at 00.15 and 11.50h (page 369 of 443). One of these doses (00.15h) appears to have been in response to Code A waking up distressed and anxious saying that she needed someone with her. This is not a usual indication for the use of oramorph and indeed the nursing care plan entry goes on to say it had little effect (page 388 of 443). A further dose (11.50h) was given for what appears to have been chest pain. It is not clear what the underlying nature of this chest pain is from the nursing summary notes. It reports that the pain was only relieved for a short period of time by the morphine and that Code A was very anxious. The nursing summary notes indicate that the

doctor was notified (page 394 of 443). There is no entry in the medical notes to indicate that Code A was subsequently medically assessed. However, a syringe driver containing diamorphine 20mg and midazolam 20mg/24h was commenced at 16.00h the same day. These drugs were prescribed by Code A (page 368 of 443). However, it is unclear whether they were prescribed the day of Code A's transfer on the 18th August 1998 or after Code A's complaints of chest pain on the 19th August 1998 and this should be clarified.

Subsequently Code A became drowsy, her chest bubbly and she was reported to be distressed when being turned by the nurses. The doses of drugs in the syringe driver were modified over the next two days to contain diamorphine 60mg, midazolam 60mg and hyoscine hydrobromide 800microgram/24h. There is no indication in the medical notes as to who decided that the diamorphine and midazolam were to be increased, why the hyoscine hydrobromide was added and increased and why smaller doses of these medications to be given 'as required' doses were not considered appropriate. Code A was confirmed dead at 18.25h on the Code A the cause of death stated as bronchopneumonmia.

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?

Care afforded to Code A *whilst at Haslar Hospital*

A review of Code A's temperature chart indicates that her temperature had been 38ºC or above several times over the two days prior to her transfer (page 137 of 181). As infection is a common cause of this, and

given in particular Code A 's difficult post-operative period, it would in my opinion have been appropriate to consider the common sites of a possible infection and to undertake an examination with this in mind, e.g. of her chest, wound and urine as a minimum. If this did happen, it is not documented in the notes. Further, it would have been helpful to have mentioned her fluctuating temperature in the nursing transfer letter. Her increased temperature was however documented in the medical notes and it should be clarified if these were sent with Code A to Gosport War Memorial Hospital.

Care afforded to Code A *whilst at Gosport War Memorial Hospital*

The medical care provided by Code A to Code A following her 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, October 1995, (pages 2–3) with particular reference to:

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

Specifically:

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

ii) There is no documentation relating to why the morphine was prescribed.

iii) There is no documented medical assessment of Code A after she complained of chest pain on Dryad Ward.

iv) There is no justification documented for the use of the diamorphine and midazolam by syringe driver on the 19th August 1998.

v) There is no justification documented in the medical notes relating to the increases in the dose of diamorphine to 40mg and subsequently 60mg/24h; midazolam to 40mg/24h and subsequently 60mg/24h and hyoscine hydrobromide to 800microgram/24h.

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

Issue i and ii (failure to take an adequate history and examination on transfer; failure to keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed; in providing care you must prescribe only the treatment, drugs or appliances that serve the patients' needs)

Upon Code A 's transfer to Dryad Ward there should have been an adequate assessment of her condition based on the history and findings from a clinical examination. This would be important given her difficult post-operative course

and would also act as an important baseline against which to compare any future changes. For example, a thorough assessment may have detected signs of a chest infection that could have led to antibiotics being given. It may also have been appropriate to have undertaken some investigations. Code A Code A s potassium level had returned to normal, but she was continued on the potassium supplements. Regular blood test monitoring is advisable in this situation to ensure potassium levels do not become abnormally and dangerously high.

The plan for Code A was for 'gentle rehabilitation' and so it should be clarified if Code A wrote in the medical notes that she was happy for the nursing staff to confirm death as a 'routine' comment, added to all patients' notes, rather than because of any specific concerns relating to Code A. If it was because of specific concerns, I would have expected this to have prompted a particularly thorough physical assessment.

There is no record made of the reason for prescribing the morphine as required on the day of Code A 's transfer. Morphine is indicated for the relief of pain, breathlessness or cough. In patients with cancer this is generally when underlying causes have been treated, when appropriate and possible, and simpler measures have been tried and failed. If the morphine was prescribed for pain this was not documented in the medical or nursing notes, nor was any pain assessed. As the Wessex Guidelines (page 2) point out, an accurate pain assessment is essential both for diagnostic and therapeutic purposes. An assessment should have included as a minimum the noting of the site, severity, aggravating/relieving factors that together with a physical examination would help identify the most likely cause of the pain. It is particularly unclear why morphine was considered necessary given M Code A had been previously obtaining relief from paracetamol or codeine. In someone of this age and frailty, in my opinion, 2.5–5mg would have been a more reasonable starting dose.

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

Given Code A 's known history of ischaemic heart disease, any complaints of chest pain, in my opinion, should be assumed to be related to the heart until proven otherwise. Any complaint of chest pain must therefore be taken seriously and warrant a medical review that would include a pain history and examination of the chest, heart and lungs as a minimum. If indicated, further tests, e.g. temperature, ECG, chest x-ray would then be carried out.

The notes during Code A 's stay at Haslar Hospital suggest possibly two different types of chest pain. The first was central and responded to anti-anginal therapy (GTN) (page 168 of 181) and would be consistent with a cardiac cause of her pain. This may have been the episodes of angina the nursing transfer note was referring to (page 22 of 443). The pain could also be consistent with oesophageal spasm (the tube that connects the mouth to the stomach). The other pain was originally considered due to arthritis in her left shoulder. However, later the same day it appeared to be a combination of pain in her left shoulder and chest made worse on breathing in. Examination revealed tenderness over the ribs, no changes on her ECG and there was no relief from GTN. It was therefore considered that this pain was most likely musculoskeletal (page 75 of 181). She received codeine for this with good effect. This type of pain could also be consistent with pleurisy, which can be caused by a chest infection. The lack of a documented medical assessment of Code A 's condition on Dryad Ward, makes it impossible to provide a firm opinion, but given her intermittent temperatures and subsequent difficulties with respiratory tract secretions, it is a possibility that she was experiencing chest pain related to a chest infection. In keeping with this, the cause of her death two days later was given as bronchopneumonia.

Issues iv and v (failure to adequately assess the patient's condition; failure to keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients

and any drugs or other treatment prescribed; in providing care you must prescribe only the treatment, drugs or appliances that serve the patients' needs)

There should be clear documentation that justifies the use of the syringe driver and the drugs it contained.

It is not usually necessary to utilise the subcutaneous (SC) route unless a patient is unwilling or unable to take medications orally (e.g. difficulty swallowing, nausea and vomiting). From the drug chart Code A did not appear to have these problems that day (page 369 of 443). It is unclear when the syringe driver was actually prescribed by Code A and this should be clarified. The dose of diamorphine was written as a dose range of 20–200mg/24h. Without details of the indication for the use of diamorphine, it is difficult to comment on the appropriateness of the starting dose of diamorphine of 20mg/24h. However, given that the most morphine Code A had received in one day was 20mg, in my opinion, if a syringe driver was deemed necessary, a starting dose of diamorphine 10mg/24h would have been more appropriate. The dose of midazolam was written as a dose range of 20–80mg/24h. Without details of the indication for the use of midazolam, it is difficult to comment on the appropriateness of the starting dose of midazolam of 20mg/24h, but it is consistent with that recommended by the BNF (March 1998). The dose of hyoscine hydrobromide was written as a dose range of 200–800microgram/24h. Although its use is not justified in the medical notes, from the nursing notes it appears to have been included in the syringe driver because of respiratory secretions.

The medication chart lacks clear prescribing instructions on what combination of drugs can be given, and in what dose in the syringe driver. Each of the drugs are written as a large dose range and, in my opinion, that for the diamorphine (i.e. 20–200mg/24h) is likely to far exceed Code A's needs. There are no instructions on the medication chart to indicate by how much the dose of the drugs can be altered within this range, how often and by whom,

e.g. the hyoscine hydrobromide was written as a dose range of 200–800microgram/24h but was commenced at a dose of 400micrograms/24h; doses in the syringe driver were increased before the previous syringe driver had run the full course, and it should be clarified who decided this. For these reasons, prescribing any drug as a range is generally discouraged. Doctors, based upon an assessment of the clinical condition and needs of the patient, should decide on and prescribe any change in medication. Such decisions are not usually left to a nurse to make alone.

There is no justification documented in the medical notes for the use of diamorphine or midazolam in the syringe driver. The nursing notes appear to suggest it was in response to Code A's complaints of chest pain and this should be clarified. Code A's previous complaints of chest pain were possibly related either to her ischaemic heart disease or to musculoskeletal pain from her chest wall and neither of these in my opinion would justify the use of a syringe driver with diamorphine and midazolam. If the pain was thought due to ischaemic heart disease then anti-anginal therapy should have been administered; if considered musculoskeletal, the notes from Haslar suggest that paracetamol and/or codeine were effective for this.

There are however, numerous causes of chest pain, underscoring the importance of undertaking a thorough medical assessment of Code A's condition. Nevertheless, for none of the common causes of chest pain that I can think of that Code A was at risk of, would it be usual practice to commence a syringe driver containing diamorphine and midazolam. For example, if she was experiencing pleurisy due to a chest infection, antibiotics would usually be given. Whilst waiting for the antibiotics to work, pain relief may be necessary, but this would usually consist of paracetamol or codeine and only if these had been ineffective, morphine. If a patient was particularly distressed by severe pain despite the above, then small doses of diamorphine and midazolam might be justified. However, in these circumstances, in my opinion, rather than commence a syringe driver, it would be most appropriate

to offer small doses on an as required basis, e.g. diamorphine 2.5mg and midazolam 2.5mg SC, for someone of Code A 's age and frailty.

There should have been an ongoing assessment documented in the medical notes to explain why Code A required increases in the dose of diamorphine from 20, to 40 and subsequently 60mg/24h over a three day period. Without knowing the specific indication for the use of diamorphine and its subsequent increase, it is impossible to know if it was likely to be appropriate or excessive to her needs. Increasing doses of opioids that are excessive to a patient's needs would be associated with increasing drowsiness, delirium (confusion), nausea and vomiting and respiratory depression.

The dose of midazolam increased from 20 to 40 to 60mg/24h over a three day period and all are likely to lead to drowsiness in a frail, elderly patient. Although the nursing care plan notes that Code A was distressed on turning, no additional detail is given that would help in considering appropriate management, e.g. was the distress due to pain, generalised stiffness, pressure area sores, was it short-lived or prolonged etc.

Medications to control symptoms are usually commenced at a starting dose appropriate to the patient, e.g. considering their age, frailty etc. and their particular symptom control needs, and titrated upwards only to control these symptoms without necessarily rendering the patient unresponsive. If there were concerns that the patient might experience, for example, episodes of pain or anxiety, it would be much more usual, and indeed seen as good practice, to prescribe appropriate doses of morphine/diamorphine, or diazepam/midazolam respectively that could be given intermittently as required orally or SC. This allows the 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 (see technical issues).

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

Code A was old and frail with significant medical problems. Nevertheless, she had been supported through a difficult post-operative period and despite her reports of chest pain and the intermittently raised temperatures, in general she had progressing rather than deteriorating at the time of her transfer to Dryad ward. Code A was not adequately medically assessed by Code A at the time of her transfer in my opinion. There was no justification given for the prescription of morphine. Code A seemed to settle into Dryad Ward well, but complained of chest pain the following day. It is documented in the nursing notes that a doctor was informed but there is no documented evidence that Code A Code A assessed Code A A syringe driver was commenced containing diamorphine and midazolam with no documented justification for its use. It should be clarified if Code A did see Code A and when and why she prescribed the drugs for use in the syringe driver.

A lack of documentation makes it difficult to understand why Code A may have deteriorated in the rapid way that she did. A rapid deterioration often suggests an acute underlying medical cause. In this regard, a thorough medical assessment when she complained of chest pain (or indeed at the time of her transfer) may have identified possible contributing factors, such as a chest infection, that could have been appropriately treated. It is therefore possible that her physical state had deteriorated in a temporary or reversible way and that with appropriate medical care she would have recovered. It is possible that Code A had naturally entered the terminal phase of her life. However, this is generally heralded by a more gradual decline over several days or weeks and this did not appear to be the case with Code A for example, the plan for Code A made only the day before her deterioration

was for 'gentle rehabilitation.' Finally, sometimes even in the presence of an acute medical deterioration, a decision is taken not to medically intervene other than to make the patient comfortable. This is usually considered if the patient's quality of life and biological prospects are so poor that medical interventions could be seen as prolonging the dying process. Even so, in these circumstances, in my opinion, the reasoning behind this decision should be clearly documented and the relatives involved in the decision making whenever possible. On reading the notes, Code A s quality of life and biological prospects did not appear to obviously justify such an approach.

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

If it were that Code A had naturally entered the terminal phase of her 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 inappropriate use of medication due to a lack of sufficient knowledge. For example, insufficient use of small doses of medication on an as required basis, to guide appropriate dose titration; inappropriately large dose ranges of drugs prescribed for use in syringe drivers without sufficient safeguards.

However, in my opinion, given the lack of medical and nursing records to the contrary, reasonable doubt exists that Code A had definitely entered her terminal stage. Given this doubt, at worst, 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 failing to adequately assess her physical state at the time of her transfer and when she complained of chest pain, failing to take suitable and prompt action when necessary and if her physical state had deteriorated in a temporary or reversible way exposing her to the inappropriate use of diamorphine and midazolam in doses that could have contributed more than minimally, negligibly or trivially to her death. As a result Code A leaves herself open to the accusation of gross negligence.

9. LITERATURE/REFERENCES

British National Formulary (March 1998), Prescribing in Palliative Care Section.

Palliative Care Handbook, Guidelines on Clinical Management, Third Edition

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

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

10. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.

8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. STATEMENT OF TRUTH

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

Signature: _____ Date: _____

Code A

5th September 2005

DRAFT REPORT

regarding

STATEMENT OF Code A

RE: Code A **(BJC/67)**

PREPARED BY: Code A

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of 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 as provided to me by Hampshire police (signed and dated 14-07-05).

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

[3] Report regarding Code A, 23rd August 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

Points 16 and 17

Following her assessment of Code A concluded that 'it is difficult to know how much she will improve but I'll take her to an NHS continuing care bed at GWMH next week'. Code A takes this statement to mean that Code A considered Code A may very well not recover.....and might die.' As this statement could also be interpreted that Code A may not recover her physical state as it was prior to her fracture, clarification of its meaning should be sought from Code A

Point 20

Code A states that she is 'unable now at this remove of time to recall anything about her Code A .' Given the lack of adequate documentation in the medical notes, subsequently a number of the points she makes are based on what she believed she would have done, e.g. points 24, 28, 29, 31, 33, 35 and 38.

Point 20

Code A should be asked to clarify why, given her stated awareness that 'Mrs Lake was in a frail condition and quite unwell' [point 22], she did not undertake and record a physical examination in her transfer note of the 18th August ~~1998~~?

Point 21

Code A states she noted a Bartel score of 6, but anticipates this would have been reflected by others. On the Bartel ADL Index page, dated 18-08-98, Mrs Lake's score is 9 (i.e. better)(page 373 of 443).

Point 22

Code A should be asked to clarify if the use of the statement 'I am happy for nursing staff to confirm death' was a routine blanket statement added to patients notes upon their transfer to GWMH. This may already be apparent from the large number of medical records already examined. If Code A only entered this statement into the notes of those patients considered likely to die, there is a paradox with Code A Whilst I accept prognostication is difficult in elderly frail patients, if it were considered likely that Code A would die, it would seem unusual to note that she was for 'gentle rehabilitation', rather than for palliative

or terminal care for example. Noting that she was for 'gentle rehabilitation' is suggestive that there was at least a possibility of some improvement as opposed to none at all.

Code A highlights that Code A had undergone the trauma of a fractured neck of femur, a significant operation in consequence, had heart failure and a possible myocardial infarction. Code A should be asked to state why, given that she considers the latter two such significant factors, she did not record them in the medical notes when Code A was transferred on 18th August 1998. Whilst I understand that a fall and surgery would increase morbidity and mortality in the frail elderly' I am unaware of any evidence that a hospital transfer per se has an adverse impact on prognosis. Code A should be asked to clarify the basis for this statement.

Point 24

Prior to her transfer to GWMH, Code A did not appear to be troubled with pain as a result of her fracture, operation, sacral sores or leg ulcers. The only documented pain was of chest pain, sometimes central, sometimes more towards the left side of her chest and/or shoulder. Relief was obtained either with GTN or codeine phosphate 30mg. Code A should be asked to explicitly state if she took a pain history, and her rationale for commencing the Oramorph, rather than continuing with codeine phosphate.

Point 26

Code A notes that Code A awoke 'very distressed and anxious, saying that she needed someone with her'. She states that 10mg of oramorph was given at 12.15am and that 'in view of the fact she was suffering from anxiety and distress

the oramorph would be appropriate.' In my experience it is not usual to prescribe an opioid to an anxious (and apparently delirious (page 388 of 443)) patient unless pain was specifically contributing to the anxiety or delirium. As Code A Code A considers morphine to be an appropriate treatment for anxiety per se, she should be asked to explicitly state the source, guidelines or authority that suggest this to be the case. It is of note that the morphine had little effect.

Point 27

Code A states that 'Oramorph was also appropriate in view of Code A 's history of congestive cardiac failure.' In my view, a *history* of congestive cardiac failure is not an appropriate additional reason to prescribe morphine. Of most relevance would be Code A 's current physical state, but given that a thorough assessment does not appear to have been undertaken, it is unclear if she had any ongoing problems relating to congestive cardiac failure. Immediately prior to her transfer to GWMH, the Hasler notes do not appear to suggest she was experiencing problems related to congestive cardiac failure.

Whilst not commonplace, opioids are used for the relief of breathlessness associated with chronic heart failure. As I understand it, this is usually when all other more usual therapies have been optimised. In my opinion, if Code A believed Code A to be experiencing symptoms as a result of congestive cardiac failure, a thorough assessment should have been undertaken and her current anti-failure treatment optimised or the addition of more effective anti-failure therapy instituted, obtaining advice from the local cardiologists as appropriate.

Code A states that temazepam might have made Code A 's heart failure worse. Whilst there are general concerns about the inappropriate use of

benzodiazepines such as temazepam as hypnotics in the frail elderly, I am not aware of any specific reasons why benzodiazepines like temazepam might worsen heart failure. Code A should be asked to detail the evidence that forms the basis of this statement. Further, why, if Code A had concerns regarding the use of temazepam in patients with heart failure, did she prescribe it Code A when she transferred to Dryad Ward?

Points 29 and 30

Given Code A has no recollection of Code A together with the inadequate documentation, in my view the appropriateness of prescribing the diamorphine, hysocine and midazolam remains uncertain.

Code A states that she was 'concerned that she Code A should have relief from the pain of her fractured hip and sacral ulcers and from her anxiety and distress which had been apparent overnight.' In my experience, two weeks after a hip fracture and its surgical repair, it would be unusual for there to be residual pain that would require morphine as analgesia. The Hasler physiotherapy notes dated 17-08-05 (page 18 of 181) state that Code A was 'mobilising with a zimmer frame with supervision and was managing well' and make no mention of pain. This is relevant as if there was significant residual pain from the hip fracture and its surgical repair, this would be most apparent on weight bearing and movement.

There had been no mention of pain due to her chronic leg ulcers or sacral ulcers, which had developed post-operatively, in the nursing notes made at Hasler or GWMH. Increasing pain from ulcers should prompt an examination, e.g. to exclude infection. Even then it would be unusual to prescribe morphine if weaker opioids had not been tried.

The reason for Code A becoming anxious and distressed at night is not clear. However, she had a number of disturbed nights at Hasler and whilst it is not documented exactly how the nursing staff supported Code A it did not entail the administration of opioids or other sedatives.

Code A states that 'opiates.... would also assist in relieving the pulmonary oedema from congestive cardiac failure.' In my opinion, if Code A believed Code A to be experiencing symptoms due to congestive cardiac failure, a thorough assessment should have been undertaken and more usual therapies should have been utilised, e.g. diuretics, such as furosemide.

Point 31

Code A states she has no recollection of events and in the absence of comprehensive notes, it is unclear to me how she could state that she would have been 'quite content that Oramorph should be given for the [chest] pain.' In my view, the appropriateness of the use of Oramorph can only be determined if the likely cause of the chest pain is known, and this would have required a thorough medical evaluation to have been undertaken.

Code A states that 'there is no ECG available at the hospital and it would have been difficult to say if Code A had experienced another myocardial infarction but I anticipate that there was increasing cardiac failure.' If these serious developments in Code A 's physical state were being considered, I would consider it essential that a thorough medical evaluation of Code A to have been undertaken as soon as possible. There is no evidence that this did occur, even though Code A was on site (she reports she was due to chair a primary care group steering group meeting at GWMH at 12.30 p.m. [point 28]).

Intravenous opioids such as diamorphine are used to relieve chest pain from a myocardial infarction (a 'heart attack') and may be a helpful adjunct to intravenous diuretics (e.g. furosemide) and oxygen for the relief of associated pulmonary oedema. The nursing notes on the 19-08-98 at 11.50am suggest that chest pain and anxiety were the main problems, rather than breathlessness (page 394 of 443). This is relevant as shortness of breath is likely to be the predominant symptom in congestive cardiac failure, particularly when acute and severe. Nevertheless, the diamorphine, midazolam and hyoscine by syringe driver appear to have been prescribed by Code A in response to Code A's poor night, rather than in response to her reports of chest pain.

Points 32 and 33

Code A states that the Oramorph was unhelpful in relieving the chest pain over any prolonged period and that Code A was said to be very anxious. She is uncertain if she was informed of this at this time but in her view institution of the diamorphine and midazolam was entirely appropriate. As Code A prescribed the syringe driver, she takes responsibility for its use. Code A should be asked to state specifically the reasons she felt the diamorphine and midazolam were indicated. If this was because of cardiac failure she should be asked to clarify the source, guidelines or authority that suggest diamorphine and midazolam by subcutaneous infusion are considered appropriate treatment for cardiac failure over and above the more usual means of managing cardiac failure such as diuretic therapy.

Code A should be asked to clarify, as she considered the use of diamorphine and midazolam appropriate to relieve Code A's symptoms, why they were not

prescribed as p.r.n. (as required) stat subcutaneous doses, either alone or alongside the syringe driver.

Point 35

Code A states that the hyoscine would have assisted in reducing the pulmonary oedema and secretions consequent on Code A 's heart failure. My understanding is that hysocine hydrobromide dries secretions from the salivary glands and major airways of the lung, but would be unlikely to provide any assistance in reducing pulmonary oedema due to congestive cardiac failure. Indeed, the use of hysocine hydrobromide is cautioned against in patients with heart problems. Code A should be asked to clarify the source, guidelines or authority that suggest that hysocine hydrobromide is of assistance in reducing pulmonary oedema.

Points 36, 37 and 40

Code A comments on Code A 's 'distress' or 'stress' several times. However, in my view it is unclear what the possible source(s) of this distress and stress were and as such it is difficult to judge how appropriate it was to increase the dose of diamorphine.

Point 40

Code A indicates that the use of the diamorphine, midazolam and hysocine were administered solely with the intention of relieving pain, anxiety and stress Code A was suffering, in conjunction with her congestive cardiac failure.

In my view, given Code A 's inability to recall Code A the lack of a documented medical assessment and that chest pain rather than

breathlessness appeared to be the predominant symptom as recorded in the nursing notes, it remains unclear if Code A did have cardiac failure. Further, Code A should be asked to comment on why, if she considered that congestive cardiac failure was such a significant factor in Code A's death, she recorded bronchopneumonia as the sole cause of death on the death certificate.

4. CONCLUSION

Code A admits to poor note keeping and proactive prescribing due to time pressures. However, even with episodes considered potentially serious and significant by Code A no entry was made in the medical notes and it is unclear if Code A was medically assessed at all, even when she experienced chest pain that did not improve with Oramorph. Having read Code A's statement regarding Code A I believe that the main issues raised in my report (BJC/67), dated 23rd August 2005, remain valid and have not yet been satisfactorily addressed, for example:

- the reason for the prescription of morphine to Code A on transfer to Dryad Ward rather than continuation of the codeine
- given the lack of a thorough medical assessment there remains, in my view, inadequate justification for the prescription of diamorphine and midazolam by syringe driver on the 19th August 1998
- a thorough medical assessment of Code A should have been undertaken when she complained of chest pain, in order to identify possible cause(s) and appropriate treatment(s) to offer
- given the lack of a thorough medical assessment there remains reasonable doubt that Code A had irreversibly entered her terminal stage. For example, given Code A's intermittently raised temperature and subsequent

problems with respiratory tract secretions, it is possible that she was experiencing chest pain due to a chest infection and that antibiotics may have been an appropriate and effective treatment. Similarly, if it was confirmed on physical examination that she had congestive cardiac failure, it would have been much more appropriate to administer those drugs commonly indicated for this situation, e.g. diuretics.

It remains that 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 failing to adequately assess her physical state when she complained of chest pain, failing to take suitable and prompt action when necessary and if her physical state had deteriorated in a temporary or reversible way exposing her to the inappropriate use of diamorphine and midazolam in doses that could have contributed more than minimally, negligibly or trivially to her death. As a result Code A leaves herself open to the accusation of gross negligence.

Specific implications of the statement of Code A *regarding* Code A *regarding my report (BJC/67), dated 123rd August 2005*

1. Code A 's statement clarifies that she prescribed on the drug chart the syringe driver with diamorphine, midazolam and hyoscine in those dose ranges in response to Code A 's poor night, i.e. *prior* to her complaining of chest pain; it was subsequently commenced later that day, after she complained of chest pain.
2. If Code A is suggesting that the use of opioids were justified on the basis that Code A had heart failure, the report may need to be supplemented with information on the role of opioids in acute and chronic heart failure.

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STATEMENT OF Code A - RE: 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 Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. I confirm that these comments are indeed a fair and accurate summary of the position in 1998 when I was involved in the care of Code A

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

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

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

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

8. Code A returned to Code A clinic on the 4th November 1993. Code A Code A enior registrar felt that on examination she was reasonably well but noted elevated blood pressure and that she remained in atrial fibrillation which was said to be controlled.

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

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

Code A

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

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

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

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

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

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

normochromic anaemia. Code A had been suffering with vomiting and diarrhoea.

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

17. It was apparent from Code A note that she recognised that Code A might very well not recover, and I anticipate from those circumstances given her underlying condition, including heart failure, Code A might die.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Signed into presence of DC Yates

Code A 16-7-05

Code A

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

* Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	*	◆
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2				
3				
4				
5				

Code A

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
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Code A

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

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WITNESS LIST

Date of completion:

* Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

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Code A

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

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Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

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Code A

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R v

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Code A

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

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◆ Previous convictions? Enter Y or N

R v

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Code A

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WITNESS LIST

Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
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