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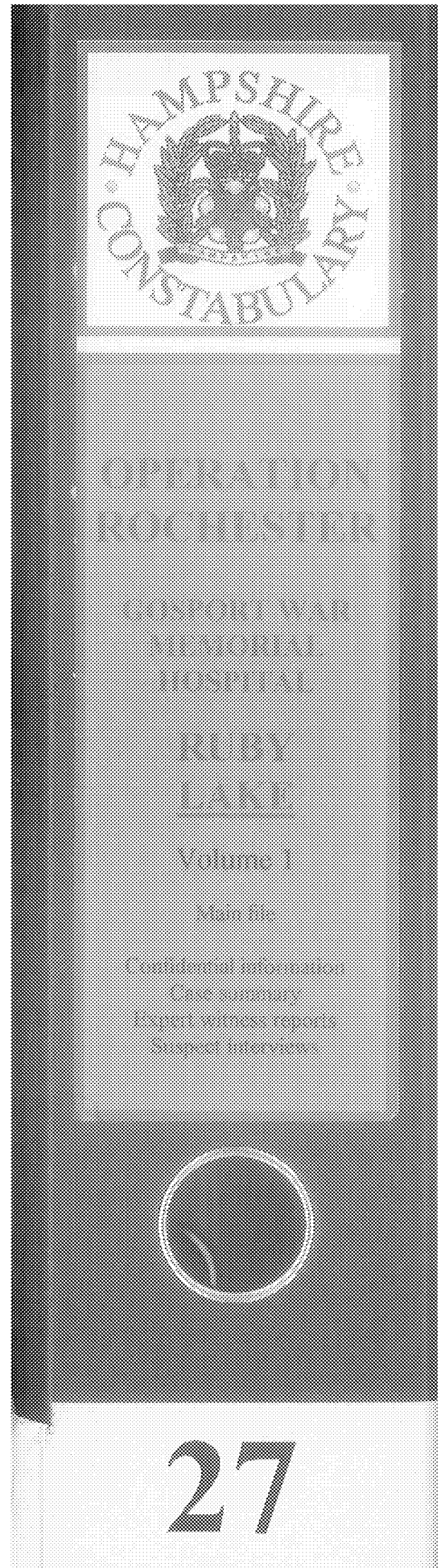
HAMPSHIRE CONSTABULARY
Volume 1
27

GMC AND BARTON INDEX OF FILES RECEIVED FROM HAMPSHIRE POLICE ON 18 JANUARY 2007.

1. Index of all evidence obtained
2. Generic Case File
3. Generic Case File (exhibits)
4. Generic Case File (exhibits)
5. Generic Case File (further exhibits)
6. Generic Case File further evidence re: Devine, Cunningham and Lake
7. Generic Case File further evidence - interviews with Dr Reid
8. Devine Volume 1
9. Devine Volume 2
10. Devine Additional Evidence
11. Devine Hospital Medical Records
12. Spurgin Volume 1
13. Spurgin Volume 2
14. Spurgin - further evidence
15. Spurgin - further evidence
16. Spurgin Hospital Medical Records
17. Spurgin Hospital Medical Records
18. Cunningham Volume 1
19. Cunningham Volume 2
20. Cunningham Hospital Medical Records
21. Cunningham Hospital Medical Records
22. Packman Volume 1
23. Packman Volume 2
24. Packman - further evidence
25. Packman police interviews with Dr Reid
26. Packman Hospital Medical Records
27. Lake Volume 1

28. Lake Volume 2
29. Lake Hospital Medical Records
30. Lake Hospital Medical Records
31. Service Volume 1
32. Service Volume 2
33. Service Hospital Medical Records
34. Service Hospital Medical Records
35. Gregory Volume 1
36. Gregory Volume 2
37. Gregory Hospital Medical Records
38. Gregory Hospital Medical Records
39. Wilson Volume 1
40. Wilson Volume 2
41. Wilson Hospital Medical Records
42. Wilson Hospital Medical Records
43. Lavender Volume 1
44. Lavender Volume 2
45. Lavender Hospital Medical Records
46. Lavender Hospital Medical Records
47. Lavender Hospital Medical Records
48. Pittock Volume 1
49. Pittock Volume 2
50. Pittock Hospital Medical Records
51. Further evidence re: Wilson, Lavender & Pittock
52. GP Records for Spurgin, Pittock, Service, and packman
53. GP Records for Devine, Cunningham and Lavender
54. Copy Extracts from Patient Admission Records
55. Extracts from controlled drugs record book dated 26 June 1995 - 24 May 1996

56. Richards (Eversheds) file: 1 of 2
57. Richards (Eversheds) file: 2 of 2
58. Richards: Medical Records
59. Richards: Further Medical Records
60. Richards: Further Medical Records
61. Richards (Police) - Witness Statements file
62. Richards (Police) - Transcripts of Interviews file
63. Page (Experts' Reports and Medical Records)
64. Wilkie (Eversheds) file: Experts' Reports and Medical Records
65. Clinical Team Assessments for Page, Cunningham, Wilkie, Wilson and Richards.
66. Clinical Team Assessments for Devine, Gregory, Lavender, Packman, Spurgin, Lake and Pittock

OPERATION ROCHESTER

Investigation Overview 1998-2006.

Background.

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

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

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

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

Police Investigations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Second Police Investigation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Intervening Developments between Second and Third Investigations

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

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

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

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

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

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

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

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

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

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

Third Police Investigation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Senior Investigating Officer summary and general case summary.

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

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

The ten category three cases were:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- *'Failure to consult colleagues Including:-*

  Enid Spurgin – orthopaedic surgeon, microbiologist
  Geoffrey Packman – general physician, gastroenterologist
  Helena Service – general physician, cardiologist
  Elsie Lavender – haematologist
  Sheila Gregory – psychogeriatrician
  Leslie Pittock – general physician/palliative care physician
  Arthur Cunningham – palliative care physician.

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

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

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

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

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

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

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

Summary of Evidence

Case of Ruby LAKE

Background, family observations

Ruby LAKE, nee WHITE, was born on Code A the Isle of Wight and was the youngest of ten children. She worked in a shop and a housemaid on the Isle and in 1935 married Ronald LAKE who was in the Army Medical Corp. They had three daughters Pauline, Dianne and Margaret.

After the war Mr LAKE became a Methodist Minister and the family moved around the country before settling on retirement in Alverstoke. Mr LAKE died in 1983. Mrs LAKE continued to live in the family home surrounded by her own friends and led a full and independent life, fully able to look after herself although as she got older she did suffer with gout, leg ulcers and arthritis.

At the start of August 1998 Mrs LAKE had a fall at home and broke her hip. She was treated at the Royal Hospital Haslar, had an operation that day and was given a new hip. Mrs LAKE stayed in Haslar for 2-3 weeks, during this time she had her up and down days, although she was lucid and able to hold a conversation. Mrs LAKE was transferred to the Gosport War Memorial Hospital as part of the recovery process and was expected to come out at some stage. This was on Monday 17th August 1998.

On the Tuesday when the family visited she was in a private room, that was clean and she was well cared for. Mrs LAKE was able to talk and the family didn't have any concerns. It was only during the evening of Wednesday 19th August that Mrs LAKE became agitated and distressed. By the Thursday she was asleep and unable to respond either through hand gestures or orally. At this time Mrs LAKE was on a syringe driver and the family were aware that Mrs LAKE was very ill and not expected to live that much longer.

On Friday 21st August 1998 Mrs LAKE was peaceful all day and was to all intents and purposes asleep. She died in the early evening with the family close by.

The hospital staff were helpful and quite caring but no one spoke to the family in any great detail regarding Mrs LAKE's condition.

Mrs LAKE's death was certified by Dr BARTON and the cause of death was Bronchopneumonia, she was subsequently cremated.

The family have no concerns regarding the care of their mother apart from the speed of her decline but accept this can happen to people who have hip replacements.

Medical history of Ruby LAKE.

Mrs Ruby Lake, an 84 year old widow who lived alone, her GP was Dr North. She suffered badly from leg ulcers and on 29/6/98 she was admitted to the Gosport War Memorial Hospital from her home with leg ulcers for bed rest/ rehabilitation. Whilst in hospital there was an indication that Mrs Lake was suffering

from chronic renal failure (P 79) and had an irregular heartbeat (P 73). Whilst at GWMH she was seen by a Consultant Dermatologist, Dr Barrett who had treated her on previous occasions. After approximately one week she was considered to be well enough to go home which she did with follow up visits from a community nurse Ann Humphries.

On the 5th August 1998 Mrs Lake was admitted to the Royal Naval Hospital, Haslar, Gosport under the care of Surgeon Captain Farquharson-Roberts, 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.
Mrs Lake'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).

Mrs Lake 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 (12.87×10^9/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). 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

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

On the 6th August Mrs Lake 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). Mrs Lake'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, Mrs Lake'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 Mrs Lake 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, Mrs Lake 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. Mrs Lake 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 Dr Lord 'from the point of view of her future management' with a referral letter summarising that Mrs Lake'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). Dr Lord reviewed Mrs Lake 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. Dr Lord suggested potassium supplements (Slow K, 2 twice a day) for the low potassium; to hydrate orally and stool cultures to look for infection. Dr Lord 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). Dr Lord'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 Mrs Lake 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 Mrs Lake 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 Mrs Lake 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 Mrs Lake 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 'Ruby 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. Mrs Lake 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 Mrs Lake 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). Mrs Lake 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 1 gram 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 Mrs Lake 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 Mrs Lake had a good nights sleep after settling late and frequently calling out (page 170 of 181). A later entry (20.15h) reports that Mrs Lake 'seemed confused this afternoon...Pyrexial at 38.8°C 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 Mrs Lake was well, comfortable and happy but that the evening before she had a temperature of 38.5°C. It was now 37.3°C. 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 Mrs Lake'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 [Mrs Lake] 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.

Gosport War Memorial Hospitial

Mrs Lake was transferred to Dryad Ward, Gosport War Memorial Hospital on the 18th August 1998, under the care of Dr Lord. 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 Dr Barton, 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 Mrs Lake 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 Mrs 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). 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 Dr Barton (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. Daughter has enquired 08.00h Ruby'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 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.

Mrs Lake 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.

Dr Jane Barton

The medical care provided by Dr Barton to Mrs Lake 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 Mrs Lake'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 Mrs Lake 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.

In Dr Wilcock's opinion he further comments:-

Dr Barton does not appear to have provided Mrs Lake a good standard of clinical care as defined by the GMC; Mrs Lake was not adequately medically assessed by Dr Barton 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 Mrs Lake 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 Mrs Lake had naturally entered the terminal phase of her life, at best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mrs Lake 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 Mrs Lake had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lake by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lake 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 Dr Barton leaves herself open to the accusation of gross negligence.

Interview of Dr Jane BARTON

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

On Thursday 14th July 2005 Dr BARTON, in company with her solicitor, Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Ruby LAKE at the Gosport War Memorial hospital. She was interviewed on a total of three occasions during the course of that day. The interviewing officers were DC Christopher YAYES and DC Geoff QUADE.

The commenced at 0907 and lasted for 25 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/7.
This statement dealt with the specific issues surrounding the care and treatment of Ruby LAKE

Expert response to the statement of Dr BARTON

Dr Wilcock

Dr Barton admits to poor note keeping and proactive prescribing due to time pressures. However, even with episodes considered potentially serious and significant by Dr Barton, no entry was made in the medical notes and it is unclear if Mrs Lake was medically assessed at all, even when she experienced chest pain that did not improve with Oramorph. Having read Dr Barton's statement regarding Ruby Lake, 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 Mrs Lake 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 Mrs Lake 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 Mrs Lake had irreversibly entered her terminal stage. For example, given Mrs Lake'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 Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lake by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lake 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 Dr Barton leaves herself open to the accusation of gross negligence.

DRAFT REPORT

regarding

RUBY LAKE (BJC/67)

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

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

Mrs Ruby Lake 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 Dr Lord's review, she summarised Mrs Lake as frail and quite unwell and was uncertain as to whether there would be significant improvement. Subsequent to Dr Lord's review, Mrs Lake 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, Mrs Lake 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 Mrs Lake'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. Mrs Lake 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. Mrs Lake was confirmed dead at 18.25h on the 21st August, the cause of death stated as bronchopneumonmia.

Dr Barton does not appear to have provided Mrs Lake a good standard of clinical care as defined by the GMC; Mrs Lake was not adequately medically assessed by Dr Barton 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 Mrs Lake 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 Mrs Lake had naturally entered the terminal phase of her life, at best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mrs Lake 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 Mrs Lake had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lake by failing to provide treatment with a reasonable amount of

skill and care. This was to a degree that disregarded the safety of Mrs 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 Dr Barton leaves herself open to the accusation of gross negligence.

2. INSTRUCTIONS

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

3. ISSUES

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

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

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

Code A

5. DOCUMENTATION

This Report is based on the following documents:

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

[2] Set of medical records on paper of Ruby Lake (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

Mrs Ruby Lake, 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 Surgeon Captain Farquharson-Roberts, 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.

Mrs Lake'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).

Mrs Lake 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 Mrs Lakes 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).

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

On the 6th August Mrs Lake 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). Mrs Lake'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, Mrs Lake'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 Mrs Lake 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, Mrs Lake 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. Mrs Lake 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 Dr Lord 'from the point of view of her future management' with a referral letter summarising that Mrs Lake'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). Dr Lord reviewed Mrs Lake 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. Dr Lord suggested potassium supplements (Slow K, 2 twice a day) for the low potassium; to hydrate orally and stool cultures to look for infection. Dr Lord 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). Dr Lord'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 Mrs Lake 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 Mrs Lake 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 Mrs Lake 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 Mrs Lake 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 'Ruby 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. Mrs Lake 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 Mrs Lake 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). Mrs Lake 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 Mrs Lake 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 Mrs Lake had a good nights sleep after settling late and frequently calling out (page 170 of 181). A later entry (20.15h) reports that Mrs Lake '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 Mrs Lake 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 Mrs Lake'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 [Mrs Lake] 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

Mrs Lake was transferred to Dryad Ward, Gosport War Memorial Hospital on the 18th August 1998, under the care of Dr Lord. 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 Dr Barton, 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 Mrs Lake 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 Mrs Lake 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 Dr Barton (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. Daughter has enquired 08.00h Ruby'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.

Mrs Lake 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

Mrs Ruby Lake 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 Dr Lord's review on the 12th August 1998, she summarised Mrs Lake as frail and quite unwell and was uncertain as to whether there would be significant improvement.

Subsequent to Dr Lord's review, Mrs Lake 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, Mrs Lake 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, Mrs Lake 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 Mrs Lake's stay at Haslar Hospital, infrequent entries in the medical notes during her stay on Dryad Ward make it difficult to closely follow Mrs Lake'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, Mrs Lake 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 Mrs Lake 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 Mrs Lake 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 Mrs Lake 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 Dr Barton (page 368 of 443). However, it is unclear whether they were prescribed the day of Mrs Lake's transfer on the 18th August 1998 or after Mrs Lake's complaints of chest pain on the 19th August 1998 and this should be clarified.

Subsequently Mrs Lake 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. Mrs Lake was confirmed dead at 18.25h on the 21st August, 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 Mrs Lake whilst at Haslar Hospital

A review of Mrs Lake'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 Mrs Lake'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 Mrs Lake to Gosport War Memorial Hospital.

Care afforded to Mrs Lake whilst at Gosport War Memorial Hospital

The medical care provided by Dr Barton to Mrs Lake 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 Mrs Lake'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 Mrs Lake 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 Mrs Lake'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. Mrs Lake'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 Mrs Lake was for 'gentle rehabilitation' and so it should be clarified if Dr Barton 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 Mrs Lake. 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 Mrs Lake'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 Mrs Lake 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 Mrs Lake'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 Mrs Lake'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 Mrs Lake'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 Mrs Lake did not appear to have these problems that day (page 369 of 443). It is unclear when the syringe driver was actually prescribed by Dr Barton 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 Mrs Lake 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 Mrs Lake'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 Mrs Lake's complaints of chest pain and this should be clarified. Mrs Lake'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 Mrs Lake's condition. Nevertheless, for none of the common causes of chest pain that I can think of that Mrs Lake 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 Mrs Lake's age and frailty.

There should have been an ongoing assessment documented in the medical notes to explain why Mrs Lake 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 Mrs Lake 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?

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

Mrs Lake 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. Mrs Lake was not adequately medically assessed by Dr Barton at the time of her transfer in my opinion. There was no justification given for the prescription of morphine. Mrs Lake 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 Dr Barton assessed Mrs Lake. A syringe driver was commenced containing diamorphine and midazolam with no documented justification for its use. It should be clarified if Dr Barton did see Mrs Lake and when and why she prescribed the drugs for use in the syringe driver.

A lack of documentation makes it difficult to understand why Mrs Lake 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 Mrs Lake 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 Mrs Lake, for example, the plan for Mrs Lake 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, Mrs Lake'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 Mrs Lake had naturally entered the terminal phase of her life, at best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mrs Lake 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 Mrs Lake had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lake by failing to provide

treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs 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 Dr Barton 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: _____

Dr Code A 5th September 2005

DRAFT REPORT

regarding

STATEMENT OF DR JANE BARTON

RE: RUBY LAKE (BJC/67)

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

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of Dr 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 Dr Jane Barton RE: Ruby Lake as provided to me by Hampshire police (signed and dated 14-07-05).

[2] Statement of Dr Jane Barton as provided to me by Hampshire police (undated).

[3] Report regarding Ruby Lake (BJC/67) Dr A Wilcock, 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 Dr Jane Barton RE: Ruby Lake.

Points 16 and 17

Following her assessment of Mrs Lake, Dr Lord 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'. Dr Barton takes this statement to mean that Dr Lord considered 'Mrs Lake may very well not recover.....and might die.' As this statement could also be interpreted that Mrs Lake may not recover her physical state as it was prior to her fracture, clarification of its meaning should be sought from Dr Lord.

Point 20

Dr Barton states that she is 'unable now at this remove of time to recall anything about her [Mrs Lake].' 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

Dr Barton 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

Dr Barton 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

Dr Barton 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 Dr Barton only entered this statement into the notes of those patients considered likely to die, there is a paradox with Mrs Lake. Whilst I accept prognostication is difficult in elderly frail patients, if it were considered likely that Mrs Lake 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.

Dr Barton highlights that Mrs Lake had undergone the trauma of a fractured neck of femur, a significant operation in consequence, had heart failure and a possible myocardial infarction. Dr Barton 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 Mrs Lake 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. Dr Barton should be asked to clarify the basis for this statement.

Point 24

Prior to her transfer to GWMH, Mrs Lake 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. Dr Barton 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

Dr Barton notes that Mrs Lake 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 Dr Barton 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

Dr Barton states that 'Oramorph was also appropriate in view of Mrs Lake'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 Mrs Lake'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 Dr Barton believed Mrs Lake 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.

Dr Barton states that temazepam might have made Mrs Lake'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. Dr Code A should be asked to detail the evidence that forms the basis of this statement. Further, why, if Dr Code A had concerns regarding the use of temazepam in patients with heart failure, did she prescribe it Mrs Code A when she transferred to Dryad Ward?

Points 29 and 30

Given Dr Barton has no recollection of Mrs Lake together with the inadequate documentation, in my view the appropriateness of prescribing the diamorphine, hysocine and midazolam remains uncertain.

Dr Barton states that she was 'concerned that she [Mrs Lake] 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 Mrs Lake 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 Mrs 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 Mrs Code A it did not entail the administration of opioids or other sedatives.

Dr Code A states that 'opiates.... would also assist in relieving the pulmonary oedema from congestive cardiac failure.' In my opinion, if Dr Code A believed Mrs 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

Dr Barton 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.

Dr Barton states that 'there is no ECG available at the hospital and it would have been difficult to say if Mrs Lake had experienced another myocardial infarction but I anticipate that there was increasing cardiac failure.' If these serious developments in Mrs Lake's physical state were being considered, I would consider it essential that a thorough medical evaluation of Mrs Lake to have been undertaken as soon as possible. There is no evidence that this did occur, even though Dr Barton 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 Dr Barton in response to Mrs Lake's poor night, rather than in response to her reports of chest pain.

Points 32 and 33

Dr Barton states that the Oramorph was unhelpful in relieving the chest pain over any prolonged period and that Mrs Lake 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 Dr Barton prescribed the syringe driver, she takes responsibility for its use. Dr Barton 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.

Dr Barton should be asked to clarify, as she considered the use of diamorphine and midazolam appropriate to relieve Mrs Lake'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

Dr Barton states that the hyoscine would have assisted in reducing the pulmonary oedema and secretions consequent on Mrs Lake'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. Dr Barton 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

Dr Barton comments on Mrs Lake'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

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

In my view, given Dr Barton's inability to recall Mrs Lake, 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 Mrs Lake did have cardiac failure. Further, Dr Barton should be asked to comment on why, if she considered that congestive cardiac failure was such a significant factor in Mrs Lake's death, she recorded bronchopneumonia as the sole cause of death on the death certificate.

4. CONCLUSION

Dr Barton admits to poor note keeping and proactive prescribing due to time pressures. However, even with episodes considered potentially serious and significant by Dr Barton, no entry was made in the medical notes and it is unclear if Mrs Lake was medically assessed at all, even when she experienced chest pain that did not improve with Oramorph. Having read Dr Barton's statement regarding Ruby Lake, 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 Mrs Lake 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 Mrs Lake 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 Mrs Lake had irreversibly entered her terminal stage. For example, given Mrs Lake'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 Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lake by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lake 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 Dr Barton leaves herself open to the accusation of gross negligence.

Specific implications of the statement of Dr Barton regarding Mrs Lavender regarding my report (BJC/67), dated 123rd August 2005

1. Dr Barton'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 Mrs Lake'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 Dr Barton is suggesting that the use of opioids were justified on the basis that Mrs Lake had heart failure, the report may need to be supplemented with information on the role of opioids in acute and chronic heart failure.

Version 2 of complete report 29th August 2005 – Ruby Lake

SUMMARY OF CONCLUSIONS

Ruby Lake an 84-year-old lady with a number of chronic diseases, suffers a fall and a fractured neck of femur in August 1998. She is admitted to hospital and has operative treatment but develops post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorates and dies in the Gosport War Memorial Hospital.

In my view a major problem in assessing this case is the poor documentation in Gosport Hospital in both the medical and nursing notes, making a retrospective assessment of her progress difficult. Good Medical Practice (GMC 2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed".... "good clinical care must include – taking suitable prompt action where necessary".... "prescribe drugs and treatments, including repeat prescriptions only when you have adequate knowledge of the patient's health and medical needs". The lack of detail in particular in the medical notes, the lack of recording of why decisions were made or if the patient was properly examined represent poor clinical practice to the standard set by the General Medical Council.

In my view the combination of a lack of a documented clinical examination, the lack of prescription of appropriate oral analgesia on admission to Gosport, the decision to start a syringe driver without documentation of a clinical diagnosis or the reason for it in the medical notes, together represent a negligent standard of medical care.

Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Mrs Lake's death. However, I am unable to satisfy myself to the standard of beyond reasonable doubt that it made more than a minimal contribution.

1. INSTRUCTIONS

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

2. ISSUES

Version 2 of complete report 29th August 2005 – Code A

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

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

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

Code A

Code A

Code A

Code A

Version 2 of complete report 29th August 2005 – Code A

Code A

Code A

Code A

Code A

Code A

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Code A (BJC/67)

[2] Operation Rochester Briefing Document Criminal Investigation Summary.

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

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

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

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

5.1. Ruby Lake an 84-year-old lady in 1998, was admitted as an emergency on 5th August 1998 to the Haslar Hospital (H52).

5.2. In 1982 she had been diagnosed with osteoarthritis (211). In 1989 she was noted to have varicose leg ulcers (73) and in 1990 was documented as having gross lipodermatus sclerosis (239). In 1993 she had problems with left ventricular failure, atrial fibrillation, aortic sclerosis and during that admission had a bout of acute renal failure with her urea rising to 25.7 (60). Her Barthel was 18 in 1993 (179).

5.3. In 1995 she was admitted with an acute arthritis and was noted to have a positive rheumatoid factor (30) and a positive ANF. She had mild chronic renal failure, which was noted to be worse when using non-steroidal anti-inflammatory drugs (31) her creatinine rose to 178 when Brufen was introduced (69). Her mental test score was 10/10 (70) but she did have some mobility problems and was seen by an Occupational Therapist and a Physiotherapist (93) (164).

5.4. In 1997 she was under the care of the Dermatologist with considerable problems from her leg ulcers and she was now having pain at night and was using regular Co proxamol (239). In 1998 she was seen by a Rheumatologist who thought she had CREST syndrome including leg ulcers, calcinosis, telangiectasia, and osteoarthritis, (353).

5.5. On 29th June 1998 she was admitted to the Gosport War Memorial Hospital under the care of her GP Dr Code A (300). The medical clerking is virtually non-existent (75), simply saying that she was admitted for her leg ulcer treatment and her pulse, blood pressure and temperature being recorded. It was noted that she was having continual pain and Tramadol 50 mgs at night was added to her regular 3 times a day Co proxamol. (197) She was seen by a Consultant Dermatologist during this admission (76).

5.6. The nursing cardex showed that she was continent with no confusion (298) however; she was sleeping downstairs (299). Her Barthel was 12 (314) and her Waterlow pressure score was 16 (high risk). She appears to have been discharged home.

5.7. She was admitted to the Haslar Hospital on 5th August having fallen and sustained a fractured neck of femur. This is operated upon successfully. By the 8th she is noted to be short of breath and probably in left ventricular failure with fluid overload (H63). Her renal function has deteriorated from a urea of 16 and a creatinine of 119 on admission (H9) to a urea of 25 and a creatinine of 127 (H68) by the

10th. Certainly on the 10th she appear unwell (H17) and it was not clear if this was a possible myocardial infarction or a chest infection (H17). However a chest x-ray is thought to show a chest infection and she is treated with regular Augmentin, an antibiotic (H69). On 11th her white count is significantly raised at 18.8 (H96). She has a mild anaemia post operatively of 10.5 (H92) her haemoglobin was normal on admission at 13.1 (H16).

5.8. On 13th August she is found to be brighter and sitting out and walking short distances with frame (H18) and this functional improvement continues, documented in the notes up to 17th August (H18). However, she is noted to have had an episode of chest pain on 15th August (H75). There is no doubt that her ECG changes between her admission ECG (H86) and the ECG(s) on 13th August and 15th August (H80 and H78). This is not commented on in the notes.

5.9. The nursing cardex shows that she is unsettled most nights, for example, 10/8 (H166), 13/8 (H168), 16/8 (H170) and on the night before discharge from Haslar on 17th August she "settled late after frequent calling out". The nursing notes also show that she had a continuing niggling pyrexial and was still significantly pyrexial the day before discharge (H137). It also documents that on the day of discharge, she has increased shortness of breath and oxygen is restarted (H171).

5.10. Her drug chart shows that she receives low molecular weight Heparin as a prophylaxis against deep venous thrombosis (Calciparine) from admission until discharge. Diamorphine 2.5 mgs IV is giving as a single dose on 5th August (H128). Co-proxamol is given from 5th – 8th August (H128) and then replaced by Paracetamol written up on the 'as required' part of the drug chart, which she receives almost every day, up to and including the day she is discharged 18th August (H175). The discharge letter mentions her regular drugs of Allopurinol, Bumetanide, Digoxin and Slow K, but does not mention the analgesia (H44).

5.11. She is seen by Dr Lord on 14th August (25-26). She notes that Mrs Lake's appetite is poor, is in atrial fibrillation and may have Sick Sinus Syndrome (an irregularity of cardiac rhythm). She has been dehydrated, hypokalaemic, and has a normochromic anaemia. She notes her leg ulcers and her pressure sores. She agrees to transfer her to the Gosport War Memorial Hospital and is uncertain as to

whether there will be significant improvement.

5.12. She is admitted to Dryad Ward on 18th August (77) and the medical notes states that she had a fractured neck of femur and a past medical history of angina and congestive cardiac failure. The rest of the medical notes, note that she is continent, transfers with two, needs help with ADL's, a Barthel of 6. The management plan is "get to know, gentle rehabilitation". The next line states "I am happy for the nursing staff to confirm death". The next and final line in the medical notes (77) is a nursing note from 21st August that Mrs Lake had died peacefully at 18.25 hrs.

5.13. The nursing care plan, on admission, noted her pressure sores (375), her leg ulcer care (377) and notes that she communicates well (387) but does have some pain (387).

5.14. On 18th August the nursing continuation notes state that she awoke distressed and anxious and was given Oramorphine (388), it states that she was very anxious and confused at times. On 19th August it said that she was comfortable at night, settled well, drowsy but rousable. Syringe driver satisfactory. On 20th August it stated continued to deteriorate. The nursing summary (394) states on 18th August, pleasant lady, happy to be here. On 19th August at 11.50 am she complains of chest pain and looks "grey around mouth". Oramorphine is given. She is noted to be very anxious and the doctor is notified. The pain is apparently only relieved for short period and she is commenced on a syringe drive.

On 20th August she continued to deteriorate overnight, the family have been informed and "very bubbly". On 21st August she deteriorates slowly.

5.15. Drug Chart Review: Admission on 18th August, Digoxin, Slow K, Bumetanide and Allopurinol are written up as per the discharge note from Haslar (369). On the 'as required' part of the drug chart (369) Oramorphine 10 mgs in 5 mls, 2.5 – 5 mgs is written up together with Temazepam. No Temazepam is given but 3 doses of Oramorph are given, one on the 18th August and two doses on 19th August.

5.16. On 19th August (368) Diamorphine 20 – 200 mgs sub cut in 24 hours is written up 20 mgs is started on 19th August, 20 mgs is started on 20th August, then discarded, and 40 mgs started, on 21st August 60

mgs is started. Hyoscine 200-800 micrograms subcut in 24 hours is also prescribed on 19th August. 400 micrograms is started on 20th August and replaced later in the day by 800 micrograms, which is continued on 21st August. Midazolam 20 – 80 mgs subcut in 24 hours is written up and 20 mgs prescribed on 20th August, replaced later in the day by 40 mgs and finally by 60 mgs on 21st August.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

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

6.2. Mrs Lake had a number of chronic diseases prior to her terminal admission following a fractured neck of femur. She had cardiac disease with known atrial fibrillation, aortic sclerosis and heart failure, documented in 1993. She also had not just osteoarthritis but an auto-immune arthritis that was thought variously to be either rheumatoid arthritis or variant auto-immune arthritis (the CREST syndrome). She also had problems as a result of her long-standing varicose swelling of her lower limbs, with many years of unresolved and very painful leg ulcers. Finally she had impaired renal function, developed mild acute renal failure when she was given on occasion, non-steroidal anti-inflammatory drugs.

6.3. She is admitted by her GP into a GP bed consultant ward in June 1998. Beyond measuring her blood pressure, there is no medical clerking and the medical notes are rudimentary at best. Significant information is available from the nursing cardex, which confirms that she is continent and there is no confusion. However, she does have some dependency with a Barthel of 12. Her pain relief is increased by adding Tramadol (an oral opiate like drug) to her Co proxamol and she is able to be discharged home, having been seen by the Dermatologist.

6.4. As is all too common, she subsequently has a fall and suffers a fractured neck of femur. She is admitted to the Haslar Hospital for operative repair. There is always a very significant mortality and morbidity after fractured neck of femurs in old people, particularly in those who have previous cardiac and other chronic diseases.

6.5. She is clearly unwell on 10th August, this is thought to have probably have been a chest infection and she is treated appropriately with antibiotics. However, her pyrexia never actually settles prior to discharge. She also suffers from at least one other episode of chest pain, again no diagnosis is come to in the medical notes, although her ECGs do appear to have changed during her admission, suggesting that this was either coronary event, including a possible heart attack or even a possible pulmonary embolus, despite her prophylactic anti-DVT therapy.

6.6. She is documented to be confused on many evenings, including the evening before transfer from Haslar to Gosport War Memorial Hospital. There may be multiple reasons for this, simply having an operation after a fractured neck of femur can cause acute confusion which is more obvious in the evenings. Chest infections and cardiac events can also cause acute confusion. She was on regular oral Co proxamol and Tramadol prior to her admission. The Tramadol was not continued and the Co proxamol was replaced after a few days with Paracetamol which she does receive on a regular basis for pain, although it is not clear whether this is pain from her leg ulcers or her chest. It is therefore possible that she is also getting drug withdrawal symptoms and this is a further contributing factor to cause her restlessness and confusion at night.

6.7. She is seen by Dr Lord who does a thorough assessment and arranges for an appropriate transfer to Gosport War Memorial Hospital. It is clear though from the notes that on the day of transfer she is still not right. She had been pyrexial the day before, she had been confused the night before transfer and she is more breathless needing oxygen on the day of transfer. It might have been wiser not to transfer her in this unstable clinical state.

6.8. When she is transferred to the Gosport War Memorial Hospital she is seen by Dr Barton who fails to record a clinical examination, apart from a statement regarding her functional status, that she is catheterised, needs two to transfer and needs help with ADL and documents a Barthel of 6. An opportunity to assess her apparent unstable clinical state appears to have been missed. The nursing cardex states the Bartel is 9 (373) and that in the nursing cardex, she can wash with the aid of one and is independent in feeding.

6.9. The continuation notes of Dr Barton (77) then mention rehabilitation with a statement about being happy for the nursing staff to confirm death. There are no further medical notes at all

and in view of the subsequent changing clinical condition documented in the nursing cardex on 19th August and that the nurses contacted the doctor (388) this is a poor standard of care. It also makes it very difficult to assess whether appropriate medical management was given to Mrs. Lake.

6.10. On admission the regular drugs being prescribed at Haslar were continued but the Paracetamol and Tramadol she had received in the Gosport War Memorial Hospital only a month before were not prescribed, nor was any other milder analgesia such as Paracetamol. The only analgesia written up was Oramorphine on the 'as required' part of the drug prescription. While it is probably appropriate for somebody who might have been having episodes of angina and left ventricular failure while in Gosport to have a Morphine drug available for nurses to give, it is very poor prescribing to write up no other form of analgesia, particularly if a doctor is not on site. The nursing staff could have no alternative but to go straight to a strong opioid analgesia. On her first night she is documented as anxious and confused. This is then treated by giving a dose of Oramorphine despite there being no record in the medical or nursing cardex that it was pain causing this confusion. It should be noted this was probably no different from her evenings in Haslar which did not need any specific medication management. In my view this is poor nursing and medical care in the management of confusion in the evening.

6.11. On 19th August an event happened at 11.50 in the morning with the nursing notes recording that she had marked chest pain and was grey around her mouth. This could have been a heart attack, it could have been a pulmonary embolus, it could have been another episode of angina, it could simply have been some non-specific chest pain. No investigations are put in train to make a diagnosis, she does not appear to have been medically assessed, or if she was it was not recorded in the notes and would be poor medical practice. However, if the patient was seriously distressed, it would have been appropriate to have given the Oramorphine 10 mgs that was written up on the 'as required' side of the drug chart. The first aim would be to relieve distress while a diagnosis was made.

6.12. Later on 19th August s syringe driver is started containing Diamorphine 20 mgs and 20 mgs of Midazolam. The only justification for this is recorded in the nursing notes (394) where it says pain is relieved for a short period. I am unable to find any records of observations, for example, pulse or blood pressure

while the patient continues to have pain.

6.13. The syringe driver is continued the next day and Hyoscine is added and the dose of Diamorphine, Midazolam and Hyoscine all increase during the afternoon of the 20th and again when the syringe driver is replaced on 21st. Mrs Lake dies peacefully on 21st August.

6.14. Diamorphine is specifically prescribed for pain, is commonly used for pain in cardiac disease as well as in terminal care. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Diamorphine subcutaneously after oral morphine is usually given at a maximum ratio of 1 to 2 (up to 10 mgs of Diamorphine for 20 mgs or Oramorphine). She had received 20 mgs of Oramorphine on 19th and appears to have been in continuing pain so I thinks it is probably reasonable to have started with 20 mgs of Diamorphine in the syringe driver over the first 24 hours.

6.15. Midazolam is widely used subcutaneously as doses from 5 – 80 mgs per 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 20 mgs for the first 24 hours, which is within current guidance, although many believe that elderly patients need a lower dose of 5 – 20 mgs per 24 hours (palliative care). (Chapter 23 in the Brocklehurst's Text Book of Geriatric Medicines 6th Edition 2003). The original dose of Diamorphine appeared to be for continued chest pain. It is unusual to use continuous Diamorphine for chest pain without making a specific diagnosis. It is possible the patient had had a myocardial infarction and was now in cardiogenic shock. In that case it would be very reasonable to use a syringe driver and indeed to add Midazolam and Hyoscine over the subsequent 48 hours. This can only be supposition without adequate documentation.

6.16. In my view it is impossible from the notes to determine the cause of death and a Coroner's Post Mortem should have been held.

7. OPINION

7.1. Ruby Lake an 84-year-old lady with a number of chronic diseases, suffers a fall and a fractured neck of femur in August 1998. She is admitted to hospital and has operative treatment but develops post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorates and dies in the

Gosport War Memorial Hospital.

7.2. In my view a major problem in assessing this case is the poor documentation in Gosport Hospital in both the medical and nursing notes, making a retrospective assessment of her progress difficult. Good Medical Practice (GMC 2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed".... "good clinical care must include – taking suitable prompt action where necessary".... "prescribe drugs and treatments, including repeat prescriptions only when you have adequate knowledge of the patient's health and medical needs". The lack of detail in particular in the medical notes, the lack of recording of why decisions were made or if the patient was properly examined represent poor clinical practice to the standard set by the General Medical Council.

In my view the combination of a lack of a documented clinical examination, the lack of prescription of appropriate oral analgesia on admission to Gosport, the decision to start a syringe driver without documentation of a clinical diagnosis or the reason for it in the medical notes, together represent a negligent standard of medical care.

Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Mrs Lake's death. However, I am unable to satisfy myself to the standard of beyond reasonable doubt that it made more than a minimal contribution.

8 LITERATURE/REFERENCES

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

9. EXPERTS' DECLARATION

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

10. STATEMENT OF TRUTH

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

Version 2 of complete report 29th August 2005 – Ruby Lake

Signature: _____ Date: _____

Form MG15(T)

RESTRICTED

RECORD OF INTERVIEW

Enter type: ROT

I

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

Person interviewed: BARTON, JANE ANN

Place of interview: NETLEY SUPPORT HEADQUARTERS

Date of interview: 14/07/2005

Time commenced: 0907 Time concluded: 0932

Duration of interview: 25 MINUTES (→) Tape reference nos. Code A /8

Interviewer(s): DC Code A YATES / DC Code A QUADE

Other persons present: MR BARKER, SOLICITOR

Police Exhibit No: CSY/JAB/8A Number of Pages: 20

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This interview is being tape recorded. I am DC Code A Chris YATES. My colleague is …
DC QUADE	DC Code A Geoff QUADE.
DC YATES	… I'm interviewing Doctor Jane BARTON. Doctor will you please give your full name and your date of birth?
BARTON	Jane Ann BARTON, Code A

RESTRICTED

DC YATES — Also present is Mr BARKER, who is Doctor BARTON's solicitor. Can you please introduce yourself with your full name?

BARKER — Certainly my name is Ian Stephen Petrie BARKER and I confirm that I am Doctor BARTON's solicitor.

DC YATES — Thank you. This interview is being conducted in an office within the Fraud Squad at Netley Support Headquarters in Hampshire. The time is 0907 hours and the date is the 14th of July 2005. At the conclusion of the interview I'll give you a notice explaining what will happen to the tapes. I'm also going to point out that, for the purpose of the tape this noise that we're hearing now is drilling, some sort of building work going on nearby. So we're going to have to try and speak up so when we listen to the tapes later. I must remind you doctor that you're still entitled to free legal advice. Mr BARKER is here as your legal advisor. Have you had enough time to consult with Mr BARKER in private or would you like further time?

BARTON — Fine thank you.

DC YATES — If at any time you wish to stop the interview and take legal advice, just say so and we'll stop the interview and you'll be able to do that. Also like to point out that you have attended voluntarily, you're not under arrest and you've come here of your own free will. So if at any time you wish to leave you're free to do so. Do you understand that doctor?

BARTON I do.

DC YATES I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court. Anything you do say maybe given in evidence. Do you understand that caution?

BARTON I do.

DC YATES Okay. I usually ask you for our own peace of mind if you can break it down and then get told to do it myself so I will split it up anyway. The caution can be broken into three sections, firstly it's your right not to say anything when asked questions by us. The second part is the slightly more confusing part, if this matter should go to court it may harm your defence if you wish to rely on something as part of your defence if you had that opportunity to mention it now. In other words the court might draw an inference and say well why didn't you say that earlier and the last part is, it's a tape recorded interview so if necessary the tape can be played or a transcript could be read should this go to court. Does that sound a fair break down of that caution?

BARKER Yes I'd use more words but I'm happy with that.

DC YATES Okay. On this occasion the room that we're in hasn't been equipped for monitoring so nobody else is listening to this interview. As before it'll be me speaking to you the majority of the time but DC QUADE will certainly be

taking some notes. I think Mr BARKER the last time we met was May ...

BARKER — It was indeed, yes.

DC YATES — ... and we handed you by way of advanced disclosure for this interview copies of the medical notes of Ruby LAKE and a brief synopsis of her care, is that right?

BARKER — No just, I think that you provided me with some details in relation to another patient, which hasn't proceeded.

DC YATES — That's right we did, didn't we.

BARKER — But subsequently one of your colleagues ...

DC YATES — Has dropped it off.

BARKER — ... did deliver the materials in relation to Ruby LAKE and I can confirm if it assists that I've passed those to Doctor BARTON.

DC YATES — Excellent, okay. Right this investigation is being conducted by the Hampshire Constabulary. It's been known as Operation Rochester, it started in September 2002, already been running close to three years now and it will continue to run for some time yet. It's an investigation into allegations of the unlawful killing of a number of patients at the Gosport War Memorial Hospital between 1990 and 2000. No decision has been made as to whether an offence or any offence has been committed but it's

important to be aware that the offence range being investigated runs from potential murder right the way down to assault. Part of the ongoing enquiries is to interview witnesses who were involved in the care and treatment of the patients during that period. Doctor you were a clinical assistant for the Gosport War Memorial Hospital at the time of these deaths so your knowledge of the working of the hospital, the care and the treatment of the patients is very central to our enquiry. The interview today will concentrate on the care and treatment of Ruby LAKE. Ruby was an elderly lady who had a fall at home and broke her left leg on the 5th of August 1998 and was admitted to Haslar Hospital. She was transferred to Dryad Ward on the 18th of August 98 and died on the 21st of August 98. Perhaps Doctor in your own words you can tell me what you recollect about Ruby LAKE and the care and treatment she received whilst on Dryad Ward at the Gosport War Memorial Hospital and I know you've got a prepared statement. Is that what you wish to read?

BARTON Yes.

DC YATES Did you make, this is a statement that you've made?

BARTON I did.

DC YATES Okay well if you'd like to read it then Doctor.

BARTON I am Dr Jane BARTON of the Forton Medical Centre, White's Place, Gosport, Hampshire . As you are aware, I am a General Practitioner, and from 1988 until 2000, I was

in addition the sole Clinical Assistant at the Gosport War Memorial Hospital (GWMH).

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

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 Mrs LAKE.

Ruby LAKE 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 a fractured left neck of femur and had undergone left semi hemiarthroplasty.

Mrs LAKE 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.

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.

Mrs LAKE was then discharged from hospital towards the end of September 1993 and after discharge was seen on 30th September by Consultant Geriatrician Dr Althea LORD. Dr LORD wrote to Mrs LAKE' s GP on the 30th September noting the diagnosis as left ventricular failure, controlled atrial fibrillation, aortic sclerosis, improving renal failure and osteoarthritis. She said that Mrs LAKE had done well since discharge.

Mrs Code A returned to Dr Code A clinic on the 4th November 1993. Dr Code A senior 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.

In August 1997 Mrs LAKE was then referred by her General Practitioner to Dr BARRETT, Consultant Dermatologist at the GWMH. The GP noted that Mrs LAKE 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, Dr NORTH, was concerned to see Dr BARRETT's assessment and advice.

It seems that in due course Mrs LAKE's condition improved. She was reviewed by Dr BARRETT at his Dermatology Clinic on the 3rd January 1998, and he wrote to Mrs LAKE's 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.

In March 1988 Mrs LAKE was referred by her GP once more, to Consultant Rheumatologist Dr McCRAE with further difficulties associated with her osteoarthritis. Dr McCRAE's senior registrar reported to the GP that Mrs LAKE 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 left lower lumbar pain which had been worse since a fall at Christmas.

Following x-rays, Dr McCRAE 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.

In June 1988 Mrs LAKE 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, Mrs LAKE was given 2.5mgs of Diamorphine intravenously for pain relief.

Mrs LAKE 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.

On the 12th August the Registrar seems to have thought that Mrs LAKE was much improved but she was developing sacral bed sores. The following day Dr LORD was asked to review her by Surgeon Captain FARQUHARSON-ROBERTS. His House Officer recorded in a note to Dr LORD in Mrs LAKE's records that post-operative recovery had been slow with periods of confusion and pulmonary

oedema, although she had been alert and well over the last two days. Dr LORD duly saw Mrs LAKE 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, Dr LORD noted that Mrs LAKE 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. Mrs LAKE was said to be dehydrated but improving. She had bilateral buttock and leg ulcers and hypokalaemia - a low potassium level, together with normochromic anaemia. Mrs LAKE had been suffering with vomiting and diarrhoea.

Dr LORD suggested that Mrs LAKE 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. Dr LORD also noted that Mrs LAKE 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 Mrs LAKE would improve but that she would take her to an NHS continuing care bed at the GWMH the following week.

It was apparent from Dr LORD's note that she recognised that Mrs LAKE might very well not recover, and I anticipate from those circumstances given her underlying condition, including heart failure, Mrs LAKE might die.

Dr LORD then wrote to Surgeon Captain FARQUHARSON-ROBERTS 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 Mrs LAKE's appetite was poor and that she was eating and drinking small amounts. Dr LORD confirmed to Surgeon Captain FARQUHARSON-ROBERTS 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 Mrs LAKE was frail and quite unwell at present.

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

Following on from Dr LORD's assessment, Mrs LAKE was then duly admitted to the GWMH on the 18th August 1998. It is apparent from her records that I admitted her, although 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 # no 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'.

As is apparent from my note the history of the 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 Mrs LAKE 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 Mrs LAKE had a significant degree of dependence.

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

Having assessed Mrs LAKE, I then prescribed various medications for her, specifically Digozin 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.

In addition, I prescribed Oramorph for pain relief. I was concerned that Mrs LAKE 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 10mgs in a 5ml solution and at a dose range of 2.5 to 5mls four hourly.

The records show that 5mgs of Oramorph was given at 2.15pm (1415) and the nursing entry for that afternoon indicates that Mrs LAKE seems to have settled quite well and was fairly cheerful.

Mrs LAKE was then noted to have settled and slept well from 10pm (2200) 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 (0015), but apparently with little effect and Mrs LAKE 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.

Oramorph was also appropriate in view of Mrs LAKE's history of congestive cardiac failure. Temazepam might have made Mrs LAKE's heart failure worse and it is conceivable at this stage Mrs LAKE was experiencing further heart failure.

I would have reviewed Mrs LAKE again the following morning, the 19th August. I believe that I was chairing a Primary Care Group Steering group meeting at the GWMH starting at about 1230 pm so I would have seen Mrs LAKE and all the other patients on the Dryad and Daedalus Wards in advance of that.

I have not made a specific entry of this in Mrs LAKE's 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 Mrs LAKE's 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 ovemight. Opiates provided for that purpose would also assist in relieving the pulmonary oedema from congestive cardiac failure.

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.

The nursing record shows that at 1150 am on 19th August Mrs LAKE complained of chest pains. The nurse specifically noted that this was not radiating down the arm and was no worse on exertion. Mrs LAKE's 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, although I have no recollection of events at this remove of time. There is no ECG machine available at the hospital and it would have been difficult to say if Mrs LAKE had experienced another myocardial infarction but I anticipate there was increasing cardiac failure.

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 Mrs LAKE was said to be very anxious. Accordingly, the syringe driver was

commenced with 20mgs of Diamorphine and 20mgs of Midazolam at 4pm (1600) that afternoon.

I do not know if I was informed of this at the time but given the fact that Mrs LAKE 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 Mrs LAKE had received quantities of Oramorph which sadly had not been sufficient.

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

Unfortunately it seems that Mrs LAKE's condition was perceived to be deteriorating. The syringe driver was re-charged at 1010 am, on the 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 Mrs LAKE's heart failure. The nursing record also indicates that Mrs LAKE's family were informed of her condition, with her daughter being present. Again, I anticipate I would have reviewed Mrs LAKE that morning but did not have an opportunity to note this in her records.

Over the course of the next night, Mrs LAKE's 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 been previously administered in consequence of those secretions. Mrs LAKE was apparently distressed when turned and clearly in spite of the fact that the Diamorphine and Midazolam were administered, they were not entirely successful in relieving Mrs LAKE's distress.

In view of the continuing distress, it appears that the driver was re-charged at 7.35 (0735) - the following morning, this time with 60mgs of Diamorphine, 60mgs of Midazolam and 800 mcgs of Hyoscine.

I believe I would have reviewed Mrs LAKE's 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 Mrs LAKE, 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.

Unfortunately, as evidenced by the nursing notes, Mrs LAKE's 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 (1825).

The Diamorphine, Midazolam and Hyoscine were prescribed and in my view administered solely with the intention of relieving the pain, anxiety and stress which Mrs LAKE was suffering, in conjunction with her

congestive cardiac failure. At no time was any medication provided with the intention of hastening Mrs LAKE's demise.

DC YATES — Thank you very much doctor. Again it was very full and informative. Could I ask you though, if I give you a pen to sign the bottom and to date it. I think Mr BARKER might ...

BARKER — Are you referring to paragraph eleven?

DC YATES — ... it might well have been.

BARKER — I think it was, at the top of paragraph eleven it says 'In March 1988' and I think that the sequence is in fact 98.

DC YATES — 98. In paragraph eleven.

BARTON — Do you want me to initial that as well?

DC YATES — If it is in fact supposed to be 1998, if you could just change it and initial it. I think that was it. Can you think of any other questions that need to be made?

BARKER — No I think there maybe one or two typographical errors but it's nothing that will change the meaning.

DC YATES — If I could just ask you to sign there doctor and maybe endorse that you're handing it to me, DC YATES, and date it.

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BARKER — Do you want me countersign it?

DC YATES — Yes please, thank you. Thank you very much. Right unless there's anything you want to ask Geoff?

DC QUADE — No there isn't.

DC YATES — I intend to call a stop to the interview at the moment just so that we can go through this prepared statement. I may well wish again to put a number of questions to you about this. If I do would you be prepared to answer those questions?

BARTON — No.

BARKER — Can I just say that Doctor BARTON has given you that answer on the basis of advice previously tended to her by me and for the reasons that have been previously articulated in other interviews ...

DC YATES — Yeah.

BARKER — ... I won't bother to repeat it, as you know.

DC YATES — Okay, before we stop the tapes then is there anything you wish to clarify about what's been said or anything you wish to add?

BARTON — Nothing.

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DC YATES No there's a notice there explaining what will happen to the tapes, we'll give you that. The time is 0932 hours and we'll turn the recorder off.

STATEMENT OF DR JANE BARTON - RE: RUBY LAKE

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

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

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 Mrs Lake.

4. Ruby Lake 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. Mrs Lake 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 Dr Althea Lord. Dr Lord wrote to Mrs Lake's GP on the 30th September noting the diagnosis as left ventricular failure, controlled atrial fibrillation, aortic sclerosis, improving renal failure, and osteoarthrosis. She said that Mrs Lake had done well since discharge.

8. Mrs Lake returned to Dr Lord's clinic on the 4th November 1993. Dr Lord's senior 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 Mrs Lake was then referred by her General Practitioner to Dr Barrett, Consultant Dermatologist at the GWMH. The GP noted that Mrs Lake 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 Dr North was concerned to see Dr Barrett's assessment and advice.

10. It seems that in due course Mrs Lake's condition improved. She was reviewed by Dr Barrett at his Dermatology Clinic on the 3rd January 1998, and he wrote to Mrs Lake's 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.

11. In March 1998 Mrs Lake was referred by her GP once more, to Consultant Rheumatologist Dr McCrae with further difficulties associated with her osteoarthritis. Dr McCrae's senior registrar reported to the GP that Mrs Lake 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, Dr McCrae 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 Mrs Lake 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, Mrs Lake was given 2.5mgs of Diamorphine intravenously for pain relief.

14. Mrs Lake 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 Mrs Lake was much improved but she was developing sacral bed sores. The following day Dr Lord was asked to review her by Surgeon Captain Farquharson-Robert. His House Officer recorded in a note to Dr Lord in Mrs Lake's 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. Dr Lord duly saw Mrs Lake 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, Dr Lord noted that Mrs Lake 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. Mrs Lake was said to be dehydrated but improving. She had bilateral buttock and leg ulcers and hypokalaemia - a low potassium level, together with

normochromic anaemia. Mrs Lake had been suffering with vomiting and diarrhoea.

16. Dr Lord suggested that Mrs Lake 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. Dr Lord also noted that Mrs Lake 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 Mrs Lake 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 Dr Lord's note that she recognised that Mrs Lake might very well not recover, and I anticipate from those circumstances given her underlying condition, including heart failure, Mrs Lake might die.

18. Dr Lord then wrote to Surgeon Captain Farquharson-Roberts 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 Mrs Lake's appetite was poor and that she was eating and drinking small amounts. Dr Lord confirmed to Surgeon Captain Farquharson-Roberts 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 Mrs Lake 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 Dr Lord's assessment, Mrs Lake 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 Mrs Lake 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 Mrs Lake 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 Mrs Lake was in a frail condition and quite unwell, as of course previously noted by Dr Lord. I was conscious that Mrs Lake might not recover hence my note that I was happy for nursing staff to confirm death. Mrs Lake 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 Mrs Lake, 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 Mrs Lake 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 Mrs Lake seemed to have settled quite well and was fairly cheerful.

26. Mrs 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 Mrs Lake 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 Mrs Lake's history of congestive cardiac failure. Temazepam might have made Mrs Lake's heart failure worse, and it is conceivable at this stage Mrs Lake was experiencing further heart failure.

28. I would have reviewed Mrs Lake 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 Mrs Lake, 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 Mrs Lake's 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 Mrs Lake's 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 Mrs Lake complained of chest pains. The nurse specifically noted that this was not radiating down the arm and was no worse on exertion. Mrs Lake's 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 Mrs Lake 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 Mrs Lake 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 Mrs Lake 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 Mrs Lake had received quantities of Oramorph which sadly had not been sufficient.

34. It appears that in consequence, Mrs Lake 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 Mrs Lake's 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 Mrs Lake's heart failure. The nursing record also indicates that Mrs Lake's family were informed of her condition, with her daughter being present. Again, I anticipate I would have reviewed Mrs Lake that morning, but did not have an opportunity to note this in her records.

36. Over the course of the next night, Mrs Lake's 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. Mrs Lake 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 Mrs Lake's 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 Mrs Lake's 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 Mrs Lake, 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, Mrs Lake's 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 Mrs Lake was suffering, in conjunction with her congestive cardiac failure. At no time was any medication provided with the intention of hastening Mrs Lake's demise.

Signed into presence of DC Yates

16-7-05

Code A