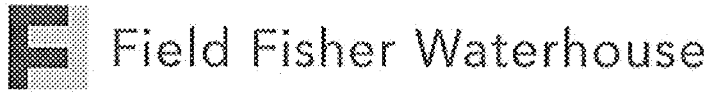

GENERAL MEDICAL COUNCIL

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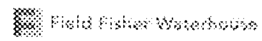

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GMC
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EXPERT REPORTS
OF PROFESSOR
DAVID BLACK

RUBY LAKE

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

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

PRESENT POST

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PREVIOUS POSTS

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PUBLICATIONS

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BOOK

Code A

Code A

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

Code A

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Ruby Lake (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 North (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

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

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

9. EXPERTS' DECLARATION

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

10. STATEMENT OF TRUTH

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

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

Signature:________________________________ Date: ________________

LESLIE PITTOCK

SUMMARY OF CONCLUSIONS

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

The major problem in assessing Mr Pittock's care is the lack of documentation. Good Medical practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on history and symptoms and if necessary an appropriate examination".... "In providing care you must keep clear accurate legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any other drugs or other treatments prescribed". The major gaps in the written notes, the lack of evidence of appropriate examinations, use of unusual drug regimes without adequate documentation in the medical notes, changes in prescription without proper documentation, all represent poor clinical practice clinical practice to the standards set by the General Medical Council. However, by itself, these do not prove that the medical or nursing care provided to Mr Pittock was sub-optimal, negligent or criminally culpable.

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

1. INSTRUCTIONS

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

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.
2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.
2.3. If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups.

Code A

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Version 2 of complete report 31st January 2005 – Leslie Pittock

Code A

BOOK

Code A

RECENT SIGNIFICANT PRESENTATIONS

Code A

Code A

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Leslie Pittock.

[2] Full set of medical records of Leslie Pittock on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.12. **Drug Chart Analysis:**

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

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

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

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

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

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

6 TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

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

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

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

6.3 Mr Pittock Code A had become more difficult and complex to manage and increasingly distressing in terms of his agitation related to his Code A symptomatology.

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

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

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

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

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

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

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

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

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

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

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

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

This is indicated in the medical notes by the comment "poor TLC" (13M) together with the statement that it was discussed with the wife "for TLC" (note TLC= tender loving care). Beyond the statement in the medical notes that the patient was "for TLC" there is no specific justification given for the Oramorph in particular to be started. The notes are at best very thin and sparse and good medical practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patients condition, based on the history and symptoms and, if necessary, an appropriate examination"...... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the

information given to patients and any drugs or other treatments provided". The lack of information in the written notes, as documented in this report, represents poor clinical practice to the standards set by the General Medical Council.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. OPINION

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

7.2 The major problem in assessing Mr Pittock's care is the lack of documentation. Good Medical practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on history and symptoms and if necessary an appropriate examination".... "In providing care you must keep clear accurate legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any other drugs or other treatments prescribed". The major gaps in the written notes, the lack of evidence of appropriate examinations, use of unusual drug regimes without adequate documentation in the medical notes, changes in prescription without proper documentation, all represent poor clinical practice clinical practice to the standards set by the General Medical Council. However, by itself, these do not prove that the medical or nursing care provided to Mr Pittock was sub-optimal, negligent or criminally culpable.

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

8 LITERATURE/REFERENCES

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

9. EXPERTS' DECLARATION

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

10. STATEMENT OF TRUTH

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

Signature:______________________________ Date: ______________

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of Dr Jane Barton re Leslie Pittock. In particular, it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This report is based on the following document:

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

2.2 Statement of Dr Jane Barton re Leslie Pittock as provided to me by Hampshire Constabulary (April 2005). Appendix 1

2.3 Statement of Dr Jane Barton as provided to me by Hampshire Constabulary (February 2005). Appendix 2

2.4 Report regarding Leslie Pittock (BJC/ 71) Dr D Black 2005.

3. COMMENTS

3.1 Comments on Job Description (2.1)

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

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

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

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

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

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

3.2 Report on the statement of Dr Jane Barton re Leslie Pittock (2.2).

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

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

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

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

3.3 Report on the Statement of Dr Jane Barton as provided to me by the Hampshire Constabulary (2.3):

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

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

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

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

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

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

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

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

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

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

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

4. Conclusions

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

ROBERT WILSON

Version 2 of complete report 19th November 2005 – Robert Wilson

SUMMARY OF CONCLUSIONS

Mr Robert Wilson a 74 year old gentleman with known severe alcoholic liver disease who was admitted with a complex and painful fracture of the left upper humerus. His physical condition deteriorates at first in hospital, with alteration in mental state, renal impairment and subsequent gross fluid retention. He then starts to improve and is transferred to the Gosport War Memorial Hospital for further assessment and possible rehabilitation or continuing care. He is started on regular oral strong opiate analgesia for pain in his left arm and rapidly deteriorates and dies within 5 days of admission.

There is weakness in the documentation of his condition, in particular on the admission to the Gosport War Memorial Hospital on 14th October, and on the15th October when the regular oral strong opiate analgesia is commenced. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) 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 provide clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatments provided". The lack of clinical examination on admission and on the day of 15th October when the decision was made to start regular strong oral opiate analgesia represents poor clinical practice to the standards set by the General Medical Council.

It is my belief that the prescription of a total of 50 mgs of Oramorphine on the 15th October following the 20 mgs that were given on the 14th October was not an appropriate clinical response to the pain in Mr Wilson's left arm. In my view this dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th-16th October, in particular, his rapid mental state deterioration. In my view this treatment was negligent, and more than minimally contributed to the death of Mr Robert Wilson on 19th October.

1. INSTRUCTIONS

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

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to his 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

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4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Robert Wilson (BJC/55)

[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).

5.1. Robert Wilson a 74 year old gentleman in 1998 attended Queen Alexandra Hospital, Portsmouth A&E Department on the 21st September 1998 (125-127) with a fracture of the left femoral head and tuberosity (169).

5.2. Mr Wilson had suffered many years before with Malaria and Diphtheria (143) but was first noticed to be abusing alcohol at the time of an endoscopy in 1994 (313). In 1997 he was admitted to

hospital with a fall, epigastric pain and was found to have evidence of severe alcoholic liver disease (129). During the 1997 admission, an ultra sound showed a small bright liver compatible with cirrhosis and moderate ascites (129). His Albumin was very low at 19 (150) and a bilirubin was 48 (129). All these are markers of serious alcoholic liver disease with a poor long term prognosis. His weight was 100 kgs (152). There is no record of follow up attendance.

5.3. When he attends A&E it is originally intended to offer him an operation on his arm, which he refuses. However, he is kept in A&E overnight for observation (161-2). It becomes apparent by the next day that he is not well, is vomiting (163) and he is needing Morphine for pain (11). His wife is on holiday (11) and it is not thought possible for him to go home so he is transferred on 22nd September to the Care of the Elderly team at the Queen Alexandra Hospital (163).

5.4. The day after admission he is no longer thought fit enough to have an operation on his arm, although he would now be prepared to. He is recognised to have been an extremely heavy drinker with considerable oedema and abdominal distension on admission (167). He has abnormal blood tests on admission including a mild anaemia of 10.5 with a very raised mean cell volume of 113 and his platelet count is reduced at 133 (239). Five days later his haemoglobin has fallen to 9.7 and the platelet count has fallen to 123 (237). There are no further full blood counts in the notes, although his haemoglobin was normal with haemoglobin of 13 in 1997 (241).

5.5. He is noted to have impaired renal function with a Urea of 6.7 and a Creatinine of 185 on admission (209) and on 25th September Urea of 17.8 and a Creatinine of 246 (203). He is started on intravenous fluids on 27th September (12) and his renal function then continues to improve so that by the 7th October both his Urea and Creatinine are normal at 6.1 and 101 (199).

5.6. His liver function is significantly abnormal on admission and on 29th his albumin is 22, his bilirubin 82 (he would have been clinically jaundice) there is then little change over his admission. On the 7th October is albumin is 23 and his bilirubin also 82 (199). His AST is 66 (171).

5.7. His vomiting within 24 hours of admission may have been due to alcohol withdrawal but he had also been given Morphine for pain (11). He is started on a Chlordiazepoxide regime (11) as standard

management plan to try and prevent significant symptoms of alcohol withdrawal. This has some sedative effects as well.

5.8. His physical condition in hospital deteriorates at first. He is noted to have considerable pain for the first 2 – 3 days, he is found to have extremely poor nutritional intake and has eaten little at home (12). His renal function deteriorates as documented above. He is communicating poorly with the nursing staff (28) and is restless at night on 30th September (30). His Barthel deteriorates from 13 on 23rd September to 3 on the 2nd October (69), his continued nutritional problems are documented by the dietician on 2nd October (16). In the nursing cardex he is vomiting, he has variable communication problems, he is irritable and cross on 1st October (30). On 4th October (16) his arm is noted to be markedly swollen and very painful and it is suggested he needs Morphine for pain (31). The following day he knocks his arm and gets a laceration (16).

5.9. There is ongoing communication with his family which is complicated by inter-family relationships between his first wife's family and his current wife. The plan by 6th October is that he will need nursing home care when he leaves hospital and his Barthel at this stage is 5 (16) (69). However on the 5th the nursing cardex note that he is starting to improve (32) although, he remains catheterised and has been faecally incontinent on occasion.

5.10. On 7th October is now more alert and is now telling the staff that he wishes to return home (17). The nursing staff notes that he is now much more adamant in his opinions (33). However on 8th he had refused to wash for 2 days (18). He is then reviewed at the request of the medical staff by a psycho-geriatrician. The opinion is that he has early dementia, which may be alcohol related and depression. He is noted to be difficult to understand with a dysarthria (117-118). He is started on Trazodone as an antidepressant and as a night sedative, he is still asking for stronger analgesics on 8th October (35). The letter also mentions (429) rather sleepy and withdrawn.......... his nights had been disturbed.

5.11. On the 9th October an occupational therapy assessment is difficult because he is reluctant to comply and a debate occurs about whether he is capable of going home (19). By the 12th October (21) his Barthel has improved to 7 (69) so Social Services say that he no longer fits their criteria for a nursing homeand he should now be considered for further rehabilitation (21). The nursing cardex notes that his catheter is out (35) he is eating better but he

still gets bad pain in his left arm (36). His arms, hands and feet are noted to be significantly more swollen on 12th October (36). His weight has now increased from 103 kgs on 27th September to 114 kgs by 14th October (61,63). However his Waterlow score remains at "high risk" for all his admission (71). A decision is made to transfer him for possible further rehabilitation, although the medical review on 13th October states in view of the medical staff and because of his oedematous limbs, he is at high risk of tissue breakdown. He is also noted to be in cardiac failure with low protein and at very high risk of self neglect and injury if he starts to take alcohol again. He currently needs 24 hour hospital care (21).

5.12. On 14th October he is transferred to Draed Ward and the notes (179) say "for continuing care". The notes document the history of fractured humerus, his alcohol problem, current oedema and heart failure. No examination is documented. The notes state that he needs help with ADL, he is incontinent, Barthel 7, he lives with his wife and is for gentle rehabilitation. I am unable to read four words. The single word on the line above incontinence, two words after lives with wife (this may be a street address) and the word in front of gentle mobilisation.

5.13. The next medical notes (179) are on 16th October and state that he had declined overnight with shortness of breath. On examination he is reported to have a weak pulse, unresponsive to spoken orders, oedema plus plus in arms and legs. The diagnosis is "? silent MI, ? liver function" and the treatment is to increase the Frusemide. The nursing cardex for 14th October confirms he was seen by Dr Barton, that Oramorphine 10 mgs was given and he was continent of urine. On 15th October the nursing notes 9265) state commenced Oramorphine 10 mgs 4 hourly for pain in left arm, poor condition is explained to wife. On 16th on the nursing cardex he is "seen by Dr Knapman am as deteriorated overnight, increased Frusemide". However I find some possible confusion with the nursing care plan (278), this states for 15th October, settled and slept well, Oramorphine 20 mgs given 12 midnight with good effect, Oramorphine 10 mgs given 06.00 hours. Condition deteriorated overnight, very chesty and difficulty in swallowing medications. Then on 16th it states has been on syringe driver since 16.30 hours. As will be seen from the analysis of the drug chart, Mr Wilson received the Oramorph at midnight on 15th and then 06.00 hours Oramorph on 16th. The first clinical deterioration is on the night of 15th – 16th October not the night of the 14th – 15th October.

5.14. The next medical note is on 19th October which notes that he had been comfortable at night with rapid deterioration (179) and death is later recorded at 23.40 hours and certified by Staff Nurse Collins. The nursing cardex mentions a bubbly chest late pm on 16th October (265). On the 17th Hyoscine is increased because of the increasing oropharyngeal secretions (265). Copious amounts of fluid are being suctioned on 17th. He further deteriorates on 18th and he continues to require regular suction (266). The higher dose of Diamorphine on the 18th and Midazolam is recorded in the nursing cardex (266).

5.15. Two Drug Charts: The first is the Queen Alexandra drug chart (106-116). This records the regular laxatives, vitamins and diuretics given for his liver disease. The reducing dose of Chlordiazepoxide stops on 30th September for his alcohol withdrawal and the Trazodone started for his mild depression and night sedation. In terms of pain management Morphine, slow IV or subcutaneous 2.5 – 5 mgs written up on the prn side and 5 mgs given on 23rd September and 2.5 mgs twice on 24th September. Morphine is also written up IM 2 – 5 mgs on 3rd October and he receives 2.5 mgs on 3rd and 2.5 mgs on 5th. He is also written up for prn Codeine Phosphate and receives single doses often at night up until 13th October but never needing more than 1 dose a day after 25th September. Regular Co-dydramol starts on 25th September until 30th September when it is replaced by 4 times a day regular Paracetamol which continues until his transfer.

In summary, his pain relief for the last week in the Queen Alexandra is 4 times a day Paracetamol and occasional night time dose of Codeine Phosphate.

5.16. The second drug chart is the drug chart of the Gosport War Memorial Hospital (258-263). His diuretics, anti-depressant, vitamins and laxatives are all prescribed regularily. The regular Paracetamol is not prescribed but is written up on the as required (prn) after the drug chart. This is never given. Regular prescriptions also contains Oramorphine 10 mgs in 5 mls to be given 10 mgs 4 hourly, starting on 15th October (261). 10 mgs is given at 10 am, 2pm and 6 pm on 15th, 6am, 10 am and 2 pm on 16th. A further dose of 20 mgs at night given at 10 pm is given at 10 pm on 15th October. Although these prescriptions are dated 15th October it is not clear if they were written up on the 14th or 15th.

5.17. On a further sheet of this drug chart (262) regular prescription has been crossed out and prn written instead. Oramorphine, 10 mgs in

5 mls, 2.5 – 5 mls 4 hourly is then prescribed on this sheet. It is not dated but it would appear 10 mgs is given at 2.45 on 14th October and 10 mgs at midnight on 14th October. Further down this page Diamorphine 20 – 200 mgs subcut in 24 hours from Hyoscine 200 – 800 micrograms subcut in 24 hours, Midazolam 20 – 80 mgs subcut in 24 hours are all prescribed. It is not clear what date these were written up. The first prescription is 16th October and the 20mls of Diamorphine with 400 micrograms of Hyoscine are started at 16.10. On 17th October, 20 mgs of Diamorphine, 600 micrograms of Hyoscine are started at 5.15 and the notes suggest that what was left in the syringe driver at that stage was destroyed (262). At 15.50 hours on 17th October, 40 mgs, 800 mgs of Hyoscine and 20 mgs of Midazolam are started and on 18th 60 mgs of Diamorphine, 1200 micrograms of Hyoscine (a new prescription has been written for the Hyoscine) and 40 mgs of Midazolam are started in the syringe driver at 14.50 and again the notes suggest the remainder that was previously in the syringe driver is destroyed.

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 Robert Wilson. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Robert Wilson, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2. The principle underlying medical problem in Mr Wilson is his alcoholic liver disease. There is no doubt that he had hepatocellular failure based on long-standing alcohol abuse, with evidence at least back to his admission in 1997 where he has evidence of portal hypertension giving him a significant ascites. He also at that stage had a low albumin and a persistently raised bilirubin, hall-markers of a poor medium to long-term prognosis.

6.3. The presenting problem on admission was his complex fracture of his left upper arm, which ideally would have had an operative repair. First he refuses this, and then by the time he agrees it his physical status has significantly deteriorated to a point that he was not fit for an anaesthetic. He gets continual pain from this arm throughout his admission. His admission treatment is strong opiate analgesia; this is then replaced by regular oral mild opiate analgesia and finally by regular Paracetamol supplemented by

mild oral opiate analgesia (Codeine Phosphate) at night. There is no doubt though that he does have continuing pain from this arm.

6.4. His health deteriorates for at least the first 7 – 8 days after his admission. He develops impaired renal function; there is evidence of change in mental state with comments on poor communication, sleepiness, irritability and restlessness, and "dysarthria". There are a number of possibilities for this. The first possibility is that he is having alcohol withdrawal, combined with the sedative effect of Chlordiazepoxide to prevent marked symptoms of alcohol withdrawal delirium. The psycho-geriatrician wonders if he has alcohol related dementia plus some depression. I believe it is very likely that he has early hepatic encephalopathy, a change in mental state that goes with hepatic failure. This includes disturbed consciousness with sleep disorder, personality change and intellectual deterioration. It is often precipitated by acute events including gastro-intestinal blood loss and drugs, in particular opiates. There is evidence of other deterioration in his liver function including a reduced platelet count suggesting an enlarged spleen due to portal hypertension, his bilirubin which is significantly higher than his previous admission and his persistent very low albumin. His haemoglobin does fall during admission. It is possible that he has had a small gastro-intestinal bleed at some stage but this is not pursued.

6.5. Despite all of this, there is a an improvement in his condition recorded in both his better functioning on the ward with the nursing staff, his greater alertness and communication improvement. The fact that his catheter can be removed and he becomes continent and that his overall measured functional status through the Barthel score improves to a point that Social Services will no longer place him in a nursing home, although he clearly needs nursing care. However, his weight dramatically increases by 11 kgs during his admission and this will be almost entirely fluid retention going to his abdomen, legs and potentially his chest. This is not adequately managed medically.

6.6. He is transferred on 14th October for ongoing assessment, possible rehabilitation and decisions about long-term care arrangements. No examination has been recorded on admission by the medical staff. Not even a basic clinical examination has been undertaken which appears to me to be poor clinical practice to the standards set by the General Medical Council.

6.7. The only management that is really needed at this stage is to continue the management that was ongoing from the Queen

Alexandra Hospital while gently addressing the fluid balance problems. However the regular oral analgesics that he was on are not written up regularly, no explanation is given for this. Strong opioid analgesia is written up and two doses of 10 mgs Oramorphine are given on the day of transfer, the 14th October. At the Queen Alexandra Hospital the single doses on the 3rd and 5th October has been at 2.5 mgs. Regular Oramorphine to a total dose of 50 mgs is then given on the 15th October. It is now being given regularly and it is not clear whether the original intention to give it regularly was from the admission on the 14th, though the prescription is clearly written and starts at 10 am on 15th. There is no documentation in the nursing or medical notes to suggest the patient was seen by a doctor on 15th where the decision to start the regular dose of Morphine appears to be made.

6.8. The decision to give regular Morphine at this dose on 15th October is crucial to the future understanding of this case. "*......the effects of hepatitis or cirrhosis on drug deposition range from impaired to increased drug clearance in an unpredictable fashion...... the oral availability for high first class drugs such as Morphine.....is almost double in patients with cirrhosis compared to those with normal liver function. Therefore the size of the oral dose of such drugs should be reduced in this setting" (Harrison).* In my view the decision to give regular oral doses of high oral doses of strong opiates on 15th was negligent. The appropriate use of weaker analgesics had not been used, though these had controlled his symptoms the previous week in the Queen Alexandra Hospital. The dose of Morphine used, particularly in the presence of severe liver disease, was very likely to have serious implications.

6.9. By the 16th October there has been a very significant clinical deterioration overnight and Mr Wilson is examined by a doctor. He is noted to be unwell and unresponsive to spoken orders. While it is possible that Mr Wilson has gone into heart failure to frank left ventricular failure due to his salt and water retention documented previously, the unresponsiveness makes it almost certain in my view that he is either now unresponsive because of a direct cerebral effect of the Morphine or he is being precipitated again into Hepatic Encephalopathy. The situation may or may not have been reversible but he is probably now entering a period of irreversible terminal decline. However, it would have been appropriate to have obtained senior medical opinion as to whether other management should be considered. In my view, the failure to obtain senior medical opinion was poor clinical practice.

6.10. He is no longer able to take oral medication and as the clinical decision has been made that he is now in terminal decline he is started on a syringe driver containing Diamorphine and Hyoscine. Diamorphine, Hyoscine (and Midazolam) are all compatible in the same syringe driver. Hyoscine is particularly useful for patients with a large amount of secretion as is documented in this case. When starting Diamorphine in a syringe driver it is conventional to do it at a dose of 2 to 1 i.e. half the dose of Diamorphine in the syringe driver than was being given orally. On 15th October 50 mgs in total of Oramorphine was prescribed, it was reasonable to start 20 mgs in the syringe driver on 16th October. The dose of Diamorphine is increased on both 17th and 18th and Midazolam is started on 17th. Apart from comments about secretions in the nursing cardex, there is no rationale for the increase in dose of Diamorphine or the addition of Midazolam provided in either the medical or nursing notes. It is not clear whether the decision to increase the dose is a medical or nursing decision. I have indicated in section 5 that there are significant problems with the use of the drug chart in Gosport which seems to have been used in an irregular fashion.

6.11. It is my view the regular prescription and dosage of Oramorphine was unnecessary and inappropriate on 15th October and in a patient with serious hepatocellular dysfunction was the major cause of the deterioration, in particular in mental state, on the night of 15th and the 16th. In my view it is beyond reasonable doubt that these actions more than minimally contributed to the death of Mr Wilson.

7. OPINION

7.1. Mr Robert Wilson is a 71 year old gentleman with known severe alcoholic liver disease who was admitted with a complex and painful fracture of the left upper humerus. His physical condition deteriorates at first in hospital, with alteration in mental state, renal impairment and subsequent gross fluid retention. He then starts to improve and is transferred to the Gosport War Memorial Hospital for further assessment and possible rehabilitation or continuing care. He is started on regular oral strong opiate analgesia for pain in his left arm and rapidly deteriorates and dies within 5 days of admission.

7.2. There is weakness in the documentation of his condition, in particular on the admission to the Gosport War Memorial Hospital on 14th October, and on the15th October when the regular oral strong opiate analgesia is commenced. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) 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 provide clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatments provided". The lack of clinical examination on admission and on the day of 15th October when the decision was made to start regular strong oral opiate analgesia represents poor clinical practice to the standards set by the General Medical Council.

7.3. It is my belief that the prescription of a total of 50 mgs of Oramorphine on the 15th October following the 20 mgs that were given on the 14th October was not an appropriate clinical response to the pain in Mr Wilson's left arm. In my view this dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th-16th October, in particular, his rapid mental state deterioration. In my view this treatment was negligent, and more than minimally contributed to the death of Mr Robert Wilson on 19th October.

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129
6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.
7. Diseases of the Liver and Biliary System. Sheila Sherlock and James Dooley. 9th Edition Oxford 1993.
8. Harrisons Principles of Internal Medicine. Kesper, Braunwald, Fauci, Hauser, Longo, Jameson. 16th Edition New York 2005 (page 19).

9. EXPERTS' DECLARATION

Version 2 of complete report 19th November 2005 – Code A

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

10. STATEMENT OF TRUTH

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

Signature: ______________________________ Date: ______________

Code A statements Version 1 21st November 2005

CONTENTS

1. **INSTRUCTIONS**

To examine and comment upon the statement of Dr Jane Barton re Robert Wilson. In particular, it raises issues that would impact upon any expert witness report prepared.

2. **DOCUMENTATION**

This report is based on the following document:

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

2.2 Statement of Dr Jane Barton re Robert Wilson as provided to me by Hampshire Constabulary (November 2005). Appendix 1

2.3 Statement of Dr Jane Barton as provided to me by Hampshire Constabulary (February 2005). Appendix 2

2.4 Report regarding Robert Wilson (BJC/ 55) Professor D Black 2005.

3. **COMMENTS**

3.1 Comments on Job Description (2.1)

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

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

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

3.1.4 There appears to be some confusion between the statements

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

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

3.2 Report on the statement of Dr Jane Barton re Robert Wilson (2.2).

3.2.1. I agree with paragraph 20 of Dr Barton's statement. Thus the final paragraph of 5.15 in my report should read "... a day paracetamol and fairly regular doses of Codeine Phosphate at night.

3.2.2. The words mentioned in paragraph 5.12 of my report that I was unable to read are: hoisting...Sarisbury Green.....plan.

3.2.3 Paragraph 9 of Dr Barton's statement says 'Diamorphine', but I believe the drug chart states 'Morphine'

3.2.2 These alterations do not effect the conclusions in my report.

3.3 Report on the Statement of Dr Jane Barton as provided to me by the Hampshire Constabulary (2.3):

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

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

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

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

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

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

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

comment in the notes. Patients who are in rehabilitation and making a good progress, then review and comments in the notes once or twice a week would also be the norm.

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

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

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

4. Conclusions

4.1. Having read all the documents provided by Hampshire Constabulary, I would wish to make minor changes to my expert report.

4.2. I agree with paragraph 20 of Dr Barton's statement. Thus the final paragraph of 5.15 in my report should read "... a day paracetamol and fairly regular doses of Codeine Phosphate at night.

4.3. The words mentioned in paragraph 5.12 of my report that I was unable to read are: hoisting...Sarisbury Green.....plan

4.4. Paragraph 9 of Dr Barton's statement says 'Diamorphine', but I believe the drug chart states 'Morphine'

4.5. These alterations do not effect the conclusions in my report

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APPENDIX 1

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APPENDIX 2

Edna Purnell

Edna PURNELL
Code A
Died: 03/12/1998

SUMMARY OF CONCLUSIONS

Edna Purnell, a 91 year old lady with moderately severe dementing illness who suffered a fracture neck of femur which she never properly recovered medically or functionally and subsequently deteriorated and died in the Gosport War Memorial Hospital. The post mortem showed bronco pneumonia which is the common end point pathological process found at post mortem after prolonged debilitating illness.

It was appropriate to transfer her to the Gosport War Memorial Hospital where many aspects of her care and the approach to symptom management of someone who was terminally ill were appropriate.

There is some evidence of poor medical practice in the Gosport War Memorial Hospital

The use of the drug chart in the Gosport War Memorial Hospital is significantly deficient

1. INSTRUCTIONS

To examine the medical records, the statement of Mr Michael Wilson 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.

2. ISSUES

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

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

3. CHRONOLOGY/CASE ABSTRACT. The numbers in brackets refer to the page of evidence.

3.1. Edna Purnell was a 91 year old lady at the time of her death in the Gosport War Memorial Hospital on 3rd December 1998.

3.2. Her long standing problems included palpitations, anxiety, vaginal prolapse, herpes zoster, previous right Colles fracture, transient ischaemic episodes and cervical spondylosis (70). She was also noted to have aortic valve disease (118).

3.3. However, her main problem was a dementing illness. Possible early evidence in October 1995 (47) definite evidence by November 1995 (45). Subsequently seen by the psycho-geriatric team on a domiciliary visit in January 1996, a formal diagnosis of dementia of moderate severity is made (37) which is followed up by the psycho-geriatric team and it is clear by October 1997 that she is failing at home (31). Following a probable stroke in October 1997 (21) she moves to Addenbrookes Residential Home and the community psychiatric nurse notes her to be settled in May 1998 (14).

3.4. She is admitted to the Hasler Hospital on 25 October having had a fall and suffered a fractured right neck of femur (58). Unfortunately none of the Hasler notes were available in the medical records provided to me. The only information is her nursing discharge letter (58, 60) and part of her drug chart in the statement of Mr Michael Wilson. The nursing letter states post operatively her condition was very poor and that she remained not for active resuscitation. It also states that she had suffered with senile dementia and required full assistance with washing, feeding although her oral intake had been reasonable with encouragement. Despite the best efforts she had sustained pressure sores on her heels. The letter states that "Mrs Purnell is a challenging patient and wish you every success in her care".

3.5. The drug charts in Hasler notes note that 10 mgs of Morphine were given intramuscularly on 26th October. They also note that Diclofenac was given orally on 30th and 31st October and that soluble Co-codamol (a weak oral opioid) was given up until 5th November. However, as I only have the as required prescription part of that drug chart I cannot comment on whether other oral analgesia was being given on a regular basis.

3.6. Dr Lord visits Mrs Purnell at Hasler on 5th November. The letter documents recent fracture, post operative oedema, poor mobility, faecal and urinary incontinence (with a catheter)and bilateral pressure sores. As a result of her assessment she states that the son and daughter-in-law were present and that she explained to them rehabilitation was going to be very difficult given the mental state and pressure sores, but she would be given a "gentle rehabilitation" in an NHS continuing care bed for a month initially. She might well need a nursing home subsequently.

3.7. On the 11th November she is transferred to Gosport War Memorial Hospital. A problem list is recorded in the medical notes (125) although it is not clear if she is medically examined. She is extremely dependent as documented in the nursing notes (161) and a Barthel of 2 out of 20 (185).

3.8. On the 12th November in the medical notes she " is in pain despite Co-codamol (unreadable word) Oramorphine". The nursing cardex confirms the pain (161) stating "has been complaining of great deal of pain". On 15th November there is an unreadable medical record stating that she is for Diazepam.

3.9. The nursing records document that Mr Wilson has concerns about possible opiate sedation on 14th and there was a discussion about her prognosis and the needs to control her pain. She continues to complain of pain on 15th November (160).

3.10. The nursing and medical notes are extremely detailed on 17th November following a visit to the ward by Mr Wilson who raises concerns about his mother's medical care which leads to a confrontational situation. Mrs Purnell is examined in detail by a Dr Brodie, who finds her semi-conscious with arms and legs flexed and appears in distress when moved. The doctor finds her in distress which need analgesia although her son is not happy for her to receive analgesia. The doctor appropriately discusses her with the consultant, Dr Lord who agrees the plan and for subcutaneous fluids. Another consultant is covering so comes in to assess the patient (Dr Reid) (126 – 127). Dr Reid is also quite clear having assessed her that she is in pain and distress and this must be relieved. He also reports some recent swallowing difficulties, however she continues to receive oral medication until the 22nd November.

3.11. On 18th November (127) she is less well and there is evidence of Cheyne-Stoking respiration and subcutaneous fluids needs to be continued. The assessment is that her prognosis is extremely poor. There appears to be considerable difficulty contacting the son. On 19th she remains poorly but on 20th she is recorded as being comfortable with Oramorphine.

3.12. On 23rd November she is groaning and in pain and frowns when lightly handled. She was taking liquids, Oramorphine and Diazepam the day before. The management plan is to continue sub-cut fluids where appropriate, to use Oramorphine/Diamorphine, Diazepam or Midazolam to keep comfortable and if more than one injection of Diamorphine is required for a syringe driver. The consultant's view is that she is now obviously dying and the management should continue to be to keep her free of pain and distress (140).

3.13. Further medical records confirm further deterioration on 28th November and the 1st December. The record on 28th stating that Mrs Purnell was now on sub-cut analgesia. Death is recorded on 3rd December by a RGN and the final note written subsequently on 18th December states the cause of death was bronchopneumonia and

senile dementia (139). This chronology is also confirmed in the nursing notes. The nursing notes states that on 24th November she was seen by Dr Barton (154) because her condition was deteriorating, she was distressed and reluctant with oral medication that the syringe driver should start. On 25th she continued to deteriorate and it occurred until 27th when her subcutaneous fluids were discontinued. The nursing notes continued to record her deterioration each day with the syringe driver being re-charged. The nursing notes say that Diamorphine was increased to 30 mgs on 1st December (165) although the drug chart says 40 mgs. On the 2nd December she is bubbly and 40 mgs a day of Diamorphine is recorded in the syringe driver. Death is verified at 1130 on 3rd December (166).

3.14. The Gosport War Memorial drug charts are slightly confusing in that there appear to be 3 front sheets (147, 148 and 149). It is possible that an extra front sheet was simply added to a previous drug chart as the space for the "as required" prescription drug box becomes full.

3.15. In summary, two tablets of Co-codamol are prescribed at 0830 on 12th November (which had been written up on admission) thereafter Oramorphine at 10 mgs and 5 mls at a dose of 2.5 – 5 mls is given starting on 12th November when three doses are given and then one or two doses most days until 24th November. There is no particular pattern for the timing of this although on 8 days there is a dose given late at night.

3.16. Diclofenac suppositories are written up on 17th November on a PRN basis but do not appear to be prescribed. Diamorphine is written up on a PRN basis SC/IM by Dr Lord on 23rd November but does not appear to have been prescribed. Diamorphine 20 – 200 mgs sub-cut in 24 hours, Hyoscine 200 – 800 micrograms sub-cut in 24 hours and Midazolam 20 – 80 mgs sub-cut in 24 hours are all written up on the PRN side of the drug chart on 19th November but do not appear to have been given. On the regular side of the drug chart Diamorphine 20 – 200 mgs sub-cut in 24 hours, Midazolam 20 – 80 mgs sub-cut in 24 hours and Hyoscine 200 – 800 micrograms sub-cut in 24 hours are all written up on 24th November. 20 mgs of Diamorphine is prescribed each day until 1st December when 40 mgs is prescribed until she dies. Midazolam 20 mgs is prescribed on 24th November and then 40 mgs each day until the day she dies. Hyoscine 200 micro grams is given on 2nd December and 400 on 3rd December.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Co-codamol 1 – 2	11/11	As required (PRN)	?	12/11 0830
Oramorphine 10 mgs in 5 mls Oral 2.5 – 5 mls	12/11	As required (PRN)	AK	*12/11 1405 5 mgs 1830 5 mgs 2234 10 mgs *13/11 1025 10 mgs 2225 10 mgs 14/11 1030 10 mgs *15/11 0050 10 mgs *16/11 2215 10 mgs *18/11 0105 10 mgs 2015 10 mgs *19/11 2316 10 mgs 20/11 1155 10 mgs 1800 5 mgs *21/11 2315 10 mgs *22/11 0630 10 mgs 2240 10 mgs 24/11 0920 10 mgs ** = Late evening dose on that date*
Diamorphine SC/IM 2.5 mgs – 5 mgs	23/11	As required (PRN)	LORD	-----
Diamorphine	19/11	As required	BARTON	-----

20 – 200 mgs SC in 24 hours		(PRN)		
Midazolam 20 – 80 mgs SC in 24 hours	19/11	As required (PRN)	BARTON	-----
Diamorphine 20 – 200 mgs SC in 24 hours	24/11	Regular	BARTON	24 – 30 Nov 20 mgs daily 1 – 3 Dec 40 mgs daily
Midazolam	24/11	Regular	BARTON	24 Nov 20 mgs daily 25 Nov – 3 Dec 40 mgs daily

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Edna Purnell, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Edna Purnell was a very elderly lady with multiple medical problems although moderately severe dementia was the main functional problem leading to residential care. There is debate in the notes whether this was Alzheimer's or vascular dementia, indeed it is not uncommon for elderly people to have both.

4.3. She was admitted to the Hasler Hospital having had a fall and a fractured neck of femur on 25th October. She was already known to have osteoporosis having previously had a Colles fracture. Unfortunately the prognosis of patients with dementia and a fractured neck of femur is extremely poor, very few return to their previous functional state and an in-hospital mortality rate at 25% is not uncommon. Those that remain immobile and incontinent immediately after the operation have by far the highest mobility

and mortality. Although the notes from Hasler are missing, the nursing summary documents that she remains totally dependent, develops bed sores and is seen as "a very challenging problem". Her dependency is also confirmed by the Barthel of 2 recorded upon admission to the Gosport War Memorial Hospital (GWMH).

4.4. She is thoroughly assessed by Dr Code A in Hasler who also sees the relatives at that time. The letter makes it clear that rehabilitation was going to be very difficult and Dr Code A expects her to remain severely dependent. She has already indicated at this early stage the likelihood of a nursing home placement. Dr Code A does not expect the patient to improve but is giving the family time to come terms with her changed status.

4.5. On admission to GWMH her problems are assessed but it is not clear whether she is medically examined. If she is not I would regard this as poor practice as it fails to give an accurate base line in the notes for future management of her medical problems.

4.6. It is then clearly document in both the medical and nursing notes that she is in considerable pain on 12th November despite the appropriate use of oral co-codamol. There is no medical examination recorded in the notes or any explanation as to where this pain is coming from. If the (incomplete) medical cardex from Hasler is correct she has not received analgesia for 6 days so what has changed? Is the pain coming from her pressure sores, which is very likely, has some other medical condition occurred, for example dislocating her hip during the transfer or some other post-operative complication? Failure to adequately examine the patient to explain her symptoms is poor medical practice. The use of oral strong opioid analgesia after weak opioid analgesia has failed is perfectly appropriate and the doses used are well within recognised standard dosages. However there is no explanation in the notes of why oral weak opioid analgesia is not continued on a regular basis using the stronger opioid analgesia for breakthrough pain. Without explanation I would consider this poor medical practice.

4.7. Mrs Purnell makes no improvement during her time at GWMH and indeed appears to enter a period of slow decline. In Table 1 demonstrates she requires a dose of analgesia most nights to manage her symptoms and allows her to sleep. The causes of decline are often multi-factorial. Her failure to get over the anaesthesia, a possible further vascular event causing swallowing difficulties, poor nutrition, pressure sores from dependency and hypostatic pneumonia. In the presence of multiple other

pathology and old age, a relentless downhill course is not uncommon and it often becomes appropriate to manage symptoms and any distress.

4.8. A crisis occurs on 17th when there is a conflict on the ward between the son and the nursing staff although there had been previous discussions on the 14th. As a result of this there is a very detailed clinical examination undertaken by a Dr Brodie which documents she is semi-conscious, has got arms and legs flexed and appears to be in distress when moved. He appropriately discusses her with Dr Lord and starts subcutaneous fluids. She is then reviewed by another consultant, Dr Reid, in detail who assesses the situation and makes it quite clear that the prognosis is very poor (a statement often put in notes to indicate the consultant believes the patient will die shortly) and that symptom control and support is paramount. I would agree with the assessment and management at this stage.

4.9. Medical and nursing notes then document slow further decline in Mrs Purnell's clinical condition up until 23rd November and she is reviewed by a consultant, Dr Lord. There are detailed notes that she is groaning and in pain and frowns when lightly handled. A clear plan of management is set out in particular if she cannot take medication orally then she should have a syringe driver. I would agree with this management.

4.10. The medication for the syringe driver is written up by Dr Barton on 24th November and starts the same day although there is no record in the medical notes of who actually decided the starting dose in the syringe driver. However in my view a syringe driver was appropriate management at this stage in Mrs Purnell's care. She is started on 20 mgs of Diamorphine in 24 hours together with 20 mgs of Midazolam. As Mrs Purnell had received between 10 and 20 mgs of Oramorphine most days for the previous 12 days I believe this was within the appropriate range of doses to use. Midazolam was also started at 20 mgs in 24 hours. Midazolam is a sedative which can be suitable for very restless patients and is usually initially given in a dose of 20 mgs in 24 hours although some believe the dose should be much lower (5 – 20 mgs) in older people in particular the most frail. She was also on regular oral diazepam at this stage. There is nothing specific in the notes to explain why it was thought that both Midazolam and Diamorphine were required or why a dose of 40 mgs of Midazolam after the first 24 hours was needed. There is a potential risk of over sedation in the last few days although I am certain this lady was terminally ill.

4.11. The use of drug chart is poor. Diamorphine and Midazolam are written up on the PRN part of the drug chart on 19th November but although they are not prescribed there is no documentation in the notes as to why this occurred. A very large dose range is written up on the regular side of the drug chart when a new prescription should have been written for each change in dosage. The dosages of the controlled drugs were not written in words and figures nor was the total dosage to be given made clear in the prescription.

5. OPINION

5.1. Edna Purnell, a 91 year old lady with moderately severe dementing illness who suffered a fracture neck of femur which she never properly recovered medically or functionally and subsequently deteriorated and died in the Gosport War Memorial Hospital. The post mortem showed bronco pneumonia which is the common end point pathological process found at post mortem after prolonged debilitating illness.

5.2. It was appropriate to transfer her to the Gosport War Memorial Hospital where many aspects of her care and the approach to symptom management of someone who was terminally ill were appropriate.

5.3. There is some evidence of poor medical practice in the Gosport War Memorial Hospital. In particular:

- The lack of a documented medical examination on admission.
- The poor assessment of pain and the reason for it on the 12th November.
- The failure to use, or document why not, regular weaker oral analgesia was not used after the 12th November
- The absence of documentation of who made the final decision to choose the dose of diamorphine and midazolam on 24th November and why the dose of midazolam was increased to 40 mgs on 25th November.

5.4. The use of the drug chart in the Gosport War Memorial Hospital is significantly deficient. In particular:

- The prescription of a large range of a controlled drug and both the "daily review prescriptions" and the regular sides of the drug chart.
- The failure to re-write the dose of drugs when changed on the regular side of the drug chart

- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. 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.

7. 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: ______________

Laura Cope (0161 923 6500)

From: Hall, Tamsin [tamsin.hall Code A
Sent: 26 March 2008 15:02
To: Code A
Subject: Fw: Code A - expert reports

Tamsin Hall Solicitor Field Fisher Waterhouse sent by blackberry

Mobile. 07920 549695

-----Original Message-----
From: Black, David <DBlack Code A
To: Hall, Tamsin
Sent: Wed Mar 26 09:22:05 2008
Subject: RE: Barton - expert reports

Tamsin
Re Pharmacy.
I think the questions to ask for the expert to explain :
-how the drug chart in use in GWMH should have been used and followed by the medical and nursing staff
-to be quite specific about the law on prescribing controlled drugs in the 1990's, and to give examples of how controlled drugs should have been written up on the GWMR drug chart (PRN, regular, syringe driver)
- to critique the use of the drug chart against this practice in number of cases (but not to comment on the actual doses used)

When I get to reviewing all the other cases I will need the files sent again to the KSS deanery address.
regards
David

From: Hall, Tamsin [mailto:tamsin.hall Code A
Sent: 19 March 2008 17:47
To: Black, David
Subject: Barton - expert reports

Dear David

I hope that you had a nice holiday.

I wanted to check that you have everything you need to tackle the reports on Purnell and Stevens over this weekend. Please let me know tomorrow if you do not.

I could do with speaking to you next week to clarify further your recommendation that we also instruct a pharmacy expert in order that I approach the right person.

Also, once you have completed the general reports it would be useful to think about how best to get the records/papers on the other patients to you in order that you may draft those reports. We have the original records from the Police now - so we may be able to courier these to you one at a time and then send you another set as you finish with them?

I am out of the office at a hearing tomorrow and on Tuesday, however I am in the office for the rest of next week.

Have a Happy Easter and I look forward to speaking to you next week.

Regards

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
Code A

Code A

Consider the environment, think before you print!

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Eva Page

Eva PAGE
Code A
Died: 03/03/1998

SUMMARY OF CONCLUSIONS

Mrs Eva Page, an elderly lady who was admitted to Queen Alexander Hospital in February 1998. She was subsequently transferred to the Gosport War Memorial Hospital with a terminal illness almost certainly a carcinoma of the lung on a background of other chronic diseases including stroke and cardiac disease.

Her investigations and management were appropriate to her condition while in the Queen Alexandra Hospital.

The use of the drug chart in the Gosport War Memorial Hospital was seriously deficient.

There is inadequate documentation of clinical review of the patient in particular on 3rd March and inadequate documentation regarding decision making to start the syringe driver. This represents poor medical practice.

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.

2. ISSUES

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

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

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

3.1. Eva Page was an 88 year old lady at the time of her final admission to hospital on 6th February 1988.

3.2. She lived in a residential home for a number of years and was reported as being independent in 1995 (32). During 1995 she had been admitted to hospital with chest pain (28) left ventricular failure in atrial fibrillation (22) and Digixon toxicity (14). At the time of her

admission with Digixon toxicity she had also been noted to have a transient impairment of renal function (14).

3.3. Eva Page was admitted to hospital on the 30th March 1997 (10) with confusion, right sided weakness and a probable dysphasia caused by a probable stroke (90) (112), however she improved rapidly and her comprehension was good and she was much less confused by the time of her discharge back to her residential home on 6th May 1997 (116).

3.4. The next documented hospital admission was 6th February 1998 when she was admitted to Victory Ward from home (157) (medical notes 246). The notes document that she had several days of rapid deterioration but she had been depressed for the last few weeks, increasingly withdrawn and had been started on Sertraline, an anti-depressant (246). Investigations showed a modestly raised urea of 8.4 (247), a low albumin of 30 (247) and a white cell count of 13.

3.5. Further investigations showed an abnormal chest x-ray that was thought to be a very suspicion of a carcinoma of bronchus (248) confirmed by an x-ray report (240). A decision is made not to bronchoscope her (249) and on 15th February there is a discussion with the son about the diagnosis (249). She has a documented fall on the ward (250) and the medical notes confirm her continued confusion. There is a good summary in the notes on 19th February (252) confirming that she is sleepy but responsive, incontinent of urine and faeces and has a low MTS (252-3).

3.6. On 25th February she is confused with some agitation (254) and the medical notes document that she has started on Thioridazine because of her anxiety and distress.

3.7. The nursing notes confirm her rapid physical decline during her time after admission. Her Barthel falls from 13 on admission to only 4 on 23rd February (162). Her Waterlow score also rises from 11 to 20 on 21st February (164). She has very little food intake during her admission (204-217). There is continual evidence from the nursing notes of anxiety, fear and variable confusion (180, 183, 184). She is catheterised, leaking faeces, frightened and agitated on 23rd February (189).

3.8. On 27th February she is transferred to Dryad Ward (254). The notes document her diagnosis of Ca Bronchus made on a chest x-ray on admission; she is generally unwell and off legs; and needs help with eating and drinking, and has a Barthel of 0. The notes also state that the family have been seen and are aware of prognosis and that Dr

Barton is happy for the nursing staff to confirm death (255). Needs hoisting and opiates commenced.

3.9. On 28th February (255), Mrs Page is confused, agitated particularly at night but not in pain. Medical notes say for regular Thioridazine (412). The next medical notes are 2nd March: there has been "no improvement on the major tranquilisers. I suggest adequate opiates to control fear and pain". A further note on 2nd March by a different doctor says "spitting out Thioridazine, quieter – now on sub-cut Oramorphine". "Fentanyl patch started today. Agitated and calling out even when staff present". "Diagnosed carcinoma bronchus ?Cerebral metastases". Continue Fentanyl patches. The son is seen. The next note in the medical section is on 3rd March and states the patient continues to deteriorate and died peacefully at 2130 hours. Death verified and signed by the staff nurse.

3.10. Drug Cardex. The drug chart before transfer to the Gosport War Memorial Hospital (234) shows that Thioridazine 10mgs was given 3 times a day on 25th and 26th February.

3.11. The drug chart at Dryad (222-224) demonstrates that on the once only prescription side that Diamorphine 5mgs was given at 0800 and 1500 mgs – date not visible on photocopies. On the PRN part of the drug chart Thioridazine 25mgs sub-cut is written up on 27th February and prescribed on 28th February at 1300. Oramorphine 10 mgs of 10ml is written up on 27th February and a single dose of 5mgs given on 28th February. Fentanyl patch 25 mgs is written up on 2nd March and prescribed once on 2nd March at 0800. There is no documentation if this ever removed.

3.12. On the regular side of the drug chart, Digoxin, Frusemide, Ramipril, Sotalol and Sertraline are written up and then crossed off and never given. Thioridazine is written up on 28th February and prescribed twice a day on 1st and 2nd March. Heminevrin is written up on 28th February and given once in the evening on 28 February and once on 1st March. Diamorphine 20-200 mgs sub-cut in 24 hours is prescribed on the regular prescription part of the drug chart which has been crossed out and PRN written. Hyoscine 200-800 mcgs in 24 hours and Midazolam 20-80 mgs sub-cut in 24 hours are also written up in the same way. I could not identify which day these prescriptions were written but 20 mgs of Diamorphine with 20mgs of Midazolam were both started in a syringe driver at 1050 am on 3rd March.

3.13. All the prescribing of opiates on Dryad Ward appear to be in Dr Barton's handwriting.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Diamorphine 5mg	? Date	Once only	BARTON	0800 am ? date 1520 am ? date
Thioridazine 25mg	27th February	PRN	BARTON	1300 am 28th Feb
Oramorphine 10 mgs in 10 mls	27th February	PRN	BARTON	5mg 28th Feb
Fentanyl 25mgs x 5 days	2nd March	PRN	BARTON	0800 am 2nd March
Diamorphine 20 – 200 mg S/C in 24 hours	? Date	"PRN" Regular prescription crossed out	BARTON	20 mg 1050 am 3rd March
Midazolam 20 – 80 mg S/C in 24 hours	? Date	"PRN" Regular prescription crossed out	BARTON	20 mg 1050 am 3rd March

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Eva Page, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Page was an elderly frail lady with multiple pathology having documented evidence of cardiac and cerebro vascular disease with intermittent confusion diagnosed previously.

4.3. The final admission seems to have been preceded by fairly rapid physical decline. The diagnosis of probable carcinoma of the lung was made on radiological grounds on her admission to the Victory Ward. This was an appropriate diagnosis and would explain her rapid physical decline. A decision was made not to bronchoscope which would have been extremely difficult and an unlikely to have changed management in any way. This was also appropriate.

4.4. The nursing cardex and medical notes confirm her rapid physical and mental deterioration after admission. The objective evidence from both her decreasing Barthel, increasing Waterlow dependency and her rapidly falling albumin are all signs of a rapidly deteriorating condition, and compatible with a diagnosis of carcinoma of lung.

4.5. Although it is not specifically mentioned in the medical notes it is clearly documented in the nurses' notes that before transfer the she is for palliative care (at 157).

4.6. It was decided to transfer to the Gosport War Memorial Hospital to be nearer her son. There is a good summary of her problems written in the notes shortly prior to transfer (252).

4.7. On admission to Dryad Ward there is a very basic summary of the condition and dependency of Mrs Page but in view of the clear understanding that she was for palliative care and the good summary in the notes just prior to transfer I do not think that this was an unreasonable summary.

4.8. During her stay in the Queen Alexander Hospital and the Gosport War Memorial Hospital she continues to be frightened, agitated and confused. She is started on a major tranquiliser (Thioridazine) before transfer and this continued after transfer. The continued notes on 2nd March suggests that this drug management regime which then included Heminevrin was not being successful. All these symptoms are compatible with someone rapidly deteriating with carcinoma of lung, and probably also indicate mild delirium. A psycogeriatric opinion would not be needed in these circumstances.

4.9. The medical notes on the 27th February (254) state that opiates have been commenced but it is not clear though from the drug chart what this is referring to unless she received two doses of Diamorphine on the 27th, however, the photocopy is inadequate (222) to determine if this was the case. She receives a single dose of 5mg Oramorphine on 28th February and the next opiate

documented in the drug chart is the Fentanyl patch on 2nd March (222).

4.10. There is no doubt in my mind that this lady was rapidly deteriorating and dying and that in view of her failure to get adequate palliation from a regular major tranquiliser for her continued distress and agitation that it was appropriate to start a regular opiate by a syringe driver. It was also evident that she was not able to take her tablets orally (255).

4.11. Clinically it is slightly surprising that she was started with Fentanyl as this is likely to take 24 hours to have a maximal affect and that it might have been more clinically appropriate to start a syringe driver on 2nd March.

4.12. Diamorphine 20mgs in 24 hours and Midazolam 20mg in 24 hours was then started on 3rd March. It is not clear if the patient was seen by a doctor on 3rd March. It is not clear when the prescription was written up and if the decision to start Diamorphine and Midazolam on 3rd March was a medical or nursing decision. It is also not clear from the notes whether the Fentanyl patch was removed. 20mgs of Diamorphine by subcutaneous infusion is equivalent to oral morphine at 10mgs every 4 hours. In my opinion this would be high but not an unreasonable dose in somebody where there was a good reason to start an opiate and there had been an inadequate response to the Fentanyl in the previous 24 hours. Midazolam is a sedative which can be suitable for a very restless patient and is usually initially given in a dose of 20 – 80 mgs in 24 hours although some believe the dose should be much lower (5 – 20 mgs) in older people but particularly the most frail.

4.13. In my view a dose of Diamorphine and Midazolam was on the high side but within written clinical guidelines such as the British National Formulary. However, if the Fentanyl patch was continued there would have been a risk of over sedation for example causing unnecessary respiratory depression. The medical notes are inadequate to make an assessment as to whether the doses that were given were appropriate to her condition or excessive.

5. OPINION

5.1. Mrs Eva Page, an an 88 year old lady was admitted to Queen Alexander Hospital in February 1998 subsequently transferred to the Gosport War Memorial Hospital with a terminal illness almost

certainly a carcinoma of the lung on a background of other chronic diseases including stroke and cardiac disease.

5.2. Her investigations and management were appropriate to her condition while in the Queen Alexandra Hospital.

5.3. The use of drug charts in The Gosport War Memorial Hospital is seriously deficient. In particular:

- The use of the regular side of the drug chart for a PRN prescription.
- The prescription of a large range of controlled drugs (in particular diamorphine) on a PRN basis.
- The failure to write dosages in words and figures as well as total dosages to be given.

5.4. There is inadequate documentation of medical review of the patient. In particular:

- The failure to record who made the final decision to start the syringe driver on the 3rd of March.
- The failure to record the clinical condition of the patient that led to that decision.
- The failure to document how the final starting dose of the drugs in the syringe driver was made, in particular why the dose used was chosen.
- The failure to record in the medical or nursing notes if the Fentanyl patch was removed or the reason for not removing it.
- The failure to document relevant medical or nursing assessments to check on possible side effects (for example oversedation) with the high starting dose of both Diamorphine and Midazolam used.

6. 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.

7. 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: ________________

Alice Wilkie

Alice Wilkie Report Version 4 by David Black – March 21 2008

Alice WILKIE
Code A
Died: 21/08/1998

SUMMARY OF CONCLUSIONS

Alice Wilkie, a 92 year old lady with severe end-stage Alzheimer's disease who was certainly entering the terminal phase of her disease at the time of her admission with pyrexial illness, possibly a UTI, on 31 July 1998.

Her investigations and management in the Queen Alexandra Hospital were generally acceptable. It was appropriate to transfer her to the Gosport War Memorial Hospital.

The documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital.

The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient.

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.

2. ISSUES

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

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

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence except for two unnumbered pages which are referred to as UN).

3.1. Alice Wilkie was a 92 year old lady at the time of her death in the Gosport War Memorial Hospital on 21st August 1998.

3.2. Alice Wilkie's main problem was progressive dementia presumably of the Alzheimer's type. In 1992 her dementia was already known (243) and she was having problems with wandering (164). She started to

have respite care for her dementing illness in 1994 (189). Depixol was already started in 1995 (186). By 1996 she was having problems with aggressive behaviour (201) and was subsequently started on Carbamezepine as well as her major tranquilisers to help try and manage her behavioural problems (207). Eventually she ended up in a specialist psychiatric residential home by the summer of 1997. As she continued to have regular Depixol injections through 1998 although on 21st July the dose was reduced because of reported sleepiness (221). This appeared to be her last dose of Depixol, which was subsequently withdrawn by the psycho-geriatric team on 6th August (222). This was as a result of a visit by the community psychiatric nurse, part of the psycho-geriatric team, who saw the patient on Daedalus Ward. The psycho-geriatric team also either saw the patient or contacted the ward on 12th August (222).

3.3. From a medical as opposed to psychiatric perspective there had been a number of problems including rectal bleeding in 1993 and 1994 and known diabetes, controlled by diet since at least 1995 (381). She had a previous pneumonectomy many years before for possible tuberculosis. In 1995 she had problems with an oesophageal stricture (201) and was put on long term Omeperazole.

3.4. On 31st July 1998 she was admitted as an emergency to the Queen Alexander Hospital. The letter from the admitting GP (69) states that she had had a urinary tract infection and had fallen the night before and was now refusing fluids. Medical clerking (85-86) notes that Mrs Wilkie was pyrexial but there were no other specific abnormalities apart from conjunctivitis noted on examination. The diagnosis was of a urinary tract infection which had not responded to oral antibiotics.

3.5. Various investigations are undertaken but her blood tests are normal (87) and a sample of urine from her catheter grows nothing (101). Her blood glucose is appropriately requested, she is thought to be diabetic but was never measured or reported (91). She is known to have a long term catheter (24, 86). There is no biochemical evidence of dehydration with a normal sodium urea and creatinine (91).

3.6. The nursing notes also document her admission pyrexia and undertake a nutritional assessment which show that she is at high risk (33, 34). She is also noted to be almost completely dependent with a Barthel score of 1 on 31st July and a 2 on 5th August (22). The temperature chart shows that she becomes apyrexial by 1st August (39).

3.7. On the 3rd August she is apyrexial and is on subcutaneous fluids but had 500 mls of oral intake the previous day. The plan was to stop the subcutaneous fluids (88).

3.8. The nursing notes demonstrate that she has settled by 1st August (24) and also comments that she is sleeping well on 3rd August (23).

3.9. The next medical notes are on the unnumbered sheets where Alice Wilkie is seen by a consultant, Dr Lord on 4th August. However, this history sheet is marked GWM. It is difficult to be certain but I assume this was added when the patient was transferred to the Gosport War Memorial Hospital on 6th August because Mrs Wilkie must have been seen on 4th August in the Queen Alexander Hospital.

3.10. Dr Lord refers as diagnosis – see problem sheet, I believe this is the sheet (83) which summarises the problems as dementia, urinary tract infection, dehydration and catheterised. Dr Lord's notes summarise the very severe dementia and dependency and the current functional status. The plan is then made to continue the oral antibiotic, to continue the subcutaneous fluids (although it had already been decided the day before to stop these) (88) and states the overall prognosis as poor and that Mrs Wilkie is now too dependent to return to her residential home. She is therefore to be transferred to Deadalus Ward for continuing care, observation and possible placement, although she does ask that her bed is kept at the residential home for a further period. Dr Lord confirms the do not resuscitate status of Mrs Wilkie (UN) previously made by the medical team in the Queen Alexander Hospital (88).

3.11. Mrs Wilkie is transferred on 6th August. There is a very brief note in the medical notes that she is to continue the Augmentin. There is no evidence that she is on subcutaneous fluids at that time or that any subcutaneous fluids are given at the Gosport War Memorial Hospital.

3.12. On 10th August, the consultant, Dr Lord reviews Mrs Wilkie and notes that she has improved a little and that she is now eating and drinking better but remains very confused and highly dependent. The request is that the residential place is given up, and a plan is made to review in a month's time the possibility of a long term nursing home placement.

3.13. The next medical note is on 21st August in Dr Barton's handwriting which states marked deterioration over the last few days. Subcutaneous analgesia commenced yesterday, family aware and happy. Someone has written in a different handwriting "syringe driver" on the photocopied page.

3.14. The final note is on 21st August at 1830 where charge nurse confirms death. The family were present.

3.15. Nursing notes at the Gosport War Memorial state that on admission that she is for assessment and observation (115) and document that she has a Waterlow score of 15 on admission which is high risk (123) and "does have pain at times" (117). Although the signature is unreadable in the medical notes, the nursing contact record (125) confirms that it was a Dr Peter who admitted Mrs Wilkie into the Gosport War Memorial Hospital on 6th August. The contact record also states that on 17th August that her condition has generally deteriorated over the weekend, the daughter seen and aware that mum's condition is worsening, agrees active treatment not appropriate and to use syringe driver. Mrs Wilkie is in pain. The notes also comment that there is some food and fluid intake up until 18th August (129).

3.16. There is a single drug chart (57-64) that goes from her admission on 31st July to 21st August.

3.17. The PRN side, a Promazine syrup 25mgs orally is prescribed as is magnesium hydroxide neither of which are given. Haloperidol 2.5 – 10 mgs subcutaneously is also prescribed and single dose of 2.5 mgs is given at 2045 on 1st August in the Queen Alexander Hospital.

3.18. Regular prescriptions of Prozac, Co-danthramer, Zopiclone, Lactulose and Augmentin are written up. Zopiclone and Co-danthramer certainly continue until 15th August and the Augmentin until 9th August.

3.19. Diamorphine 20 – 200 mgs subcut in 24 hours is written up on the daily review prescriptions part of the drug chart together with Hyoscine 20 – 80 micrograms subcut in 24 hours and Midazolam 20 – 80 mgs subcut in 24 hours although there is nothing to say which days the prescriptions was written up. However, Diamorphine 30 mgs and Midazolam 20 mgs appear to have both been started at 1350 in a syringe driver on 20th August and the same does re-prescribed on 21st August.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Diamorphine 20 – 200 mgs	No date	Daily review prescriptions	BARTON	30 mgs 20/08 30 mgs 21/08
Midazolam 20 – 80 mg	No date	Daily review prescriptions	BARTON	20 mgs 20/08 20 mgs 21/08

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Alice Wilkie, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Wilkie was a very elderly lady with severe end-stage Alzheimer's disease. This disease is documented in the notes for at least 6 years with increasing behavioural problems requiring both pharmacological intervention and specialist residential care.

4.3. She also had a number of medical problems in particular her oesophageal stricture and diabetes although this diagnosis was completely ignored in her final admission. Although her admission to Queen Alexander is presented as an acute UTI there had probably been a longer period of deterioration. The GP's letter documents weight loss and her dose of Depixol had been reduced 10 days earlier because of sleepiness. However, there is no doubt she was pyrexial on admission and her condition had significantly deteriorated to the point where she could not be managed in the residential home.

4.4. She was appropriately investigated and treated with antibiotics and subcutaneous fluids in the Queen Alexander Hospital and becomes apyrexial. She is seen by a consultant Geriatrician who makes an adequate assessment and arranges for Mrs Wilkie to be transferred to the Gosport War Memorial Hospital for a period of observation to determine a final outcome.

4.5. The consultant states the prognosis is poor, this usually means that the expected outcome is the patient is not going to leave

hospital and really is in the terminal phase of their illness. Although it is quite appropriate to have a plan that should that not be the case a long term nursing placement might be needed as she was not far too dependent to return to her residential home. I believe this was all appropriate management.

4.6. The patient is transferred to Gosport War Memorial on 6th August and the admission clerking is unacceptably brief. Indeed it is not clear the admitting doctor, a Dr Peter saw the patient although the nursing cardex does refer to "clerked in". It is impossible from the notes to make a judgement of the clinical status of Mrs Wilkie on arrival.

4.7. However, she is reviewed by Dr Lord on 10th August who does an assessment and this would suggest that she is now clinically stable as Dr Lord remarks "eating and drinking better". The plan is to review progress in a month's time.

4.8. There is nothing further in the medical notes until the day of her death, the 21st August which states a marked deterioration over the last few days. Her syringe driver had been started the day before.

4.9. There are clues in the nursing records that deterioration must have started several days before, for example in the contact record on 17th August (125) states her condition has generally deteriorated over the weekend, however, there is no evidence at all that this lady was seen by the medical staff, or if they did, no record has been written in the notes. However, it is also impossible to tell from the notes whether the nursing staff informed the medical staff that there had been any change in condition.

4.10. A syringe driver is started on 20th August. There is absolutely no documentation as to the clinical reason to do this. There is one comment in the nursing notes about pain at times (117) but no evidence from the drug chart of any other analgesia apart from the syringe driver is needed or used. In my view the failure to document any medical reasons for her deterioration or why she was started on a syringe driver is unacceptable medical practice. I cannot exclude the possibility that she needed symptom palliation during her last few days but there is no evidence that I can find in the medical or nursing notes to justify use of the syringe driver.

4.11. Diamorphine 30 mgs in 24 hours and Midazolam 20 mgs in 24 hours were started on 20th August. The prescriptions are not dated so it is impossible to tell when they were originally written, it is also impossible to tell who made the final decision to start the Diamorphine on 20th August or indeed who chose the starting dose of 30 mgs when 20 mgs was the lowest dosed prescribed.

4.12. 30 mgs of Diamorphine by subcutaneous infusion is equivalent to oral morphine at 15 mgs every 4 hours. In my view this is an unnecessarily high dose for someone who has received no previous opiate analgesia or indeed any other analgesia. Midazolam is a sedative which can be suitable for a very restless patient and is usually initially given in a dose of 20 mgs in 24 hours although some believe the dose should be much lower (5-20 mgs in older people, in particularly the most frail). There is nothing in the notes to explain why it was thought that both Midazolam and a high dose of Diamorphine were required in this patient. In my view the doses of Diamorphine and Midazolam were unacceptably high as a starting dose from the evidence available in the notes. There would have been a very significant risk of over sedation, for example causing respiratory depression, impaired conciousness and a possibility of shortening her life by some hours or days.

5. OPINION

5.1. Alice Wilkie, a 92 year old lady with severe end-stage Alzheimer's disease who was certainly entering the terminal phase of her disease at the time of her admission with pyrexial illness, possibly a UTI, on 31 July 1998.

5.2. Her investigations and management in the Queen Alexandra Hospital were generally acceptable. It was appropriate to transfer her to the Gosport War Memorial Hospital.

5.3. The documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital. In particular:

- The lack of a documented medical assessment on admission.
- The lack of any medical records after 10th August until the day of her death.
- The lack of any description of why she was deteriorating sometime after 10th August.
- The failure to explain why a syringe driver was required for symptom control.

- The lack of any written justification of the doses of Diamorphine and Midazolam actually used in the syringe driver.
- Any observations to look for possible side effects of the high doses of Diamorphine and Midazolam used.
- Inability to tell from the notes who made the final decision to start the syringe driver and the dose to be used.

5.4. The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient. In particular:

- The prescription of a large range of a controlled drug (in particular, Diamorphine) in the "daily review prescriptions" side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.
- The failure to date the prescriptions of Diamorphine, Hyoscine and Midazolam.

6. 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.

7. 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: _______________

ENID SPURGIN

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: BLACK, DAVID ANDREW

Age if under 18: (if over 18 insert 'over 18') Occupation: CONSULTANT PHYSICIAN

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: D BLACK Date: 27/06/2005

SUMMARY OF CONCLUSIONS

Mrs Enid SPURGIN was a 92-year-old lady admitted to the Haslar Hospital on 19th March 1999 following a fall. She undergoes an operation for a proximal femoral fracture and then transferred to the Gosport War Memorial Hospital on 26th March 1999. She is known to have become increasingly frail with poor eyesight, depression and mild memory impairment.

In the Gosport War Memorial Hospital she is in continual pain for which no definite diagnosis is made. She develops a wound infection and then deteriorates rapidly and receives pain relief and palliation for her terminal decline, including subcutaneous Diamorphine and Midazolam and dies on 13th April 1999.

The expert opinion is:

Mrs Enid SPURGIN presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture. The prognosis after such a fracture, particularly in those with impairments of daily living before their fracture is generally poor, both in terms of mortality or in terms of morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and complications. A significant problem in Mrs SPURGIN's case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, (GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and

symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include - taking suitable and prompt action when necessary"...... "referring the patient to another practitioner, when indicated"...... "in providing care you must - recognise and work within the limits of your professional competence"...... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

I believe that there are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport. The failure to address the cause of this lady's pain, consider any other actions from 26th March until 7th April. The use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes.

Subsequent management of this lady's pain was within current practice with the exception of the starting dose of Diamorphine. The starting dose of Diamorphine at 80mg in the syringe drive is at best poor clinical judgement. However, I am unable to satisfy myself beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

1. INSTRUCTIONS

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

2. ISSUES

2.1 Was the standard of care afforded to this patient in the days leading up to her death in

keeping with the acceptable standard of the day.

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

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

Code A

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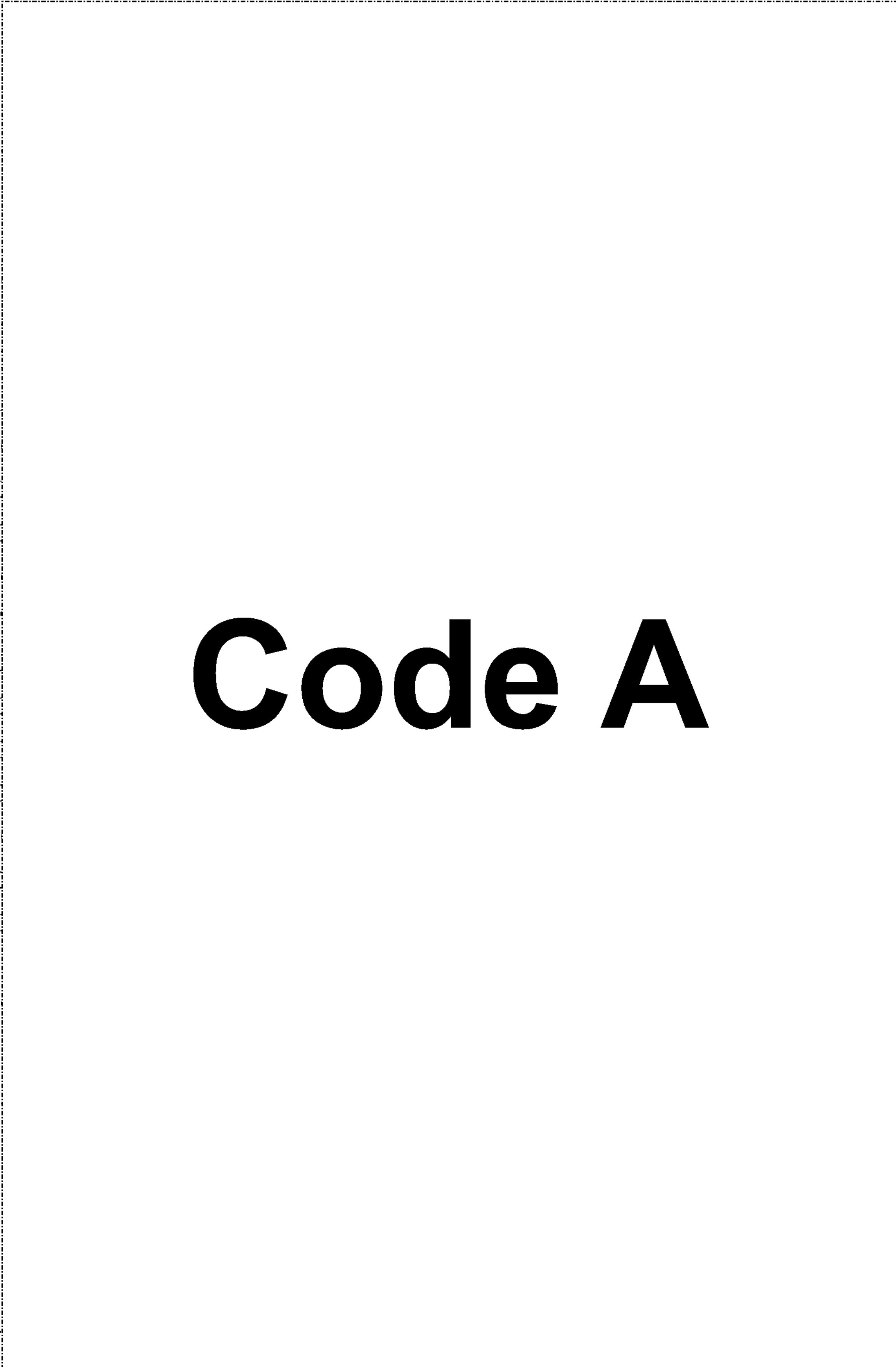

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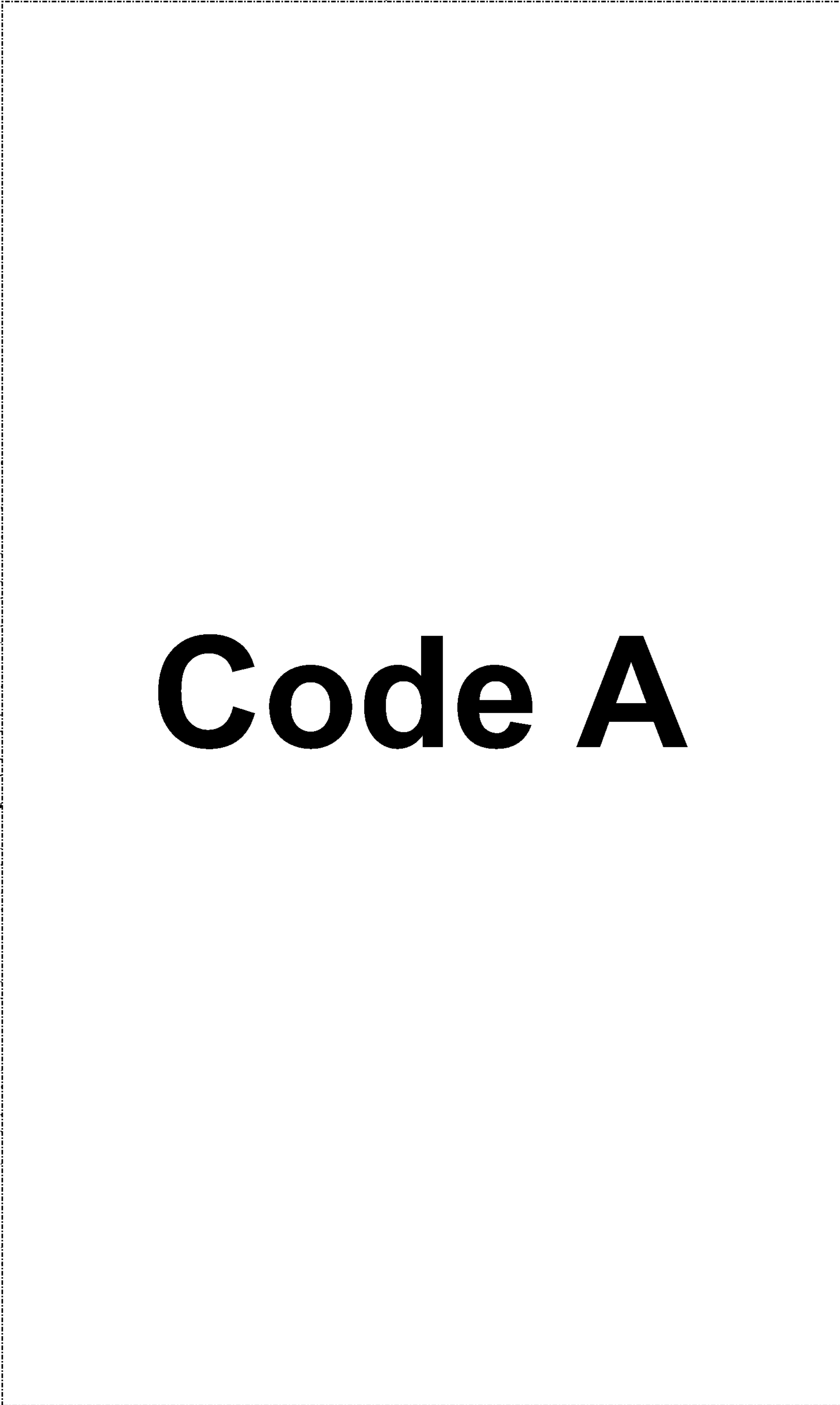
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4. DOCUMENTATION

This Report is based on the following documents:

RESTRICTED

[1] Full paper set of medical records of Enid SPURGIN

[2] Full set of medical records of Enid SPURGIN on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

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

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

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

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

5.1 At the time of her death in 1999 Edith SPURGIN was a 92-year-old lady. She had been previously noted to have a stress fracture of her right hip, not needing operative intervention in 1981. (M38). She was also noted to have Paget's disease in her pelvis in 1988 (M39). She had a probably myocardial infarction in 1989 (M6). In 1997 she had been seen by a Dr MEARS , a Consultant Psycho-Geriatrician, for depression(144). He also noted poor eyesight (145). At that time she was on an anti-depressant and was noted to have a normal minim-mental test score of 27/30 (148). She was followed up by a Community psychiatric nurse over the following year who believed that she was now showing evidence of memory impairment (152) (158).

5.2 Enid SPURGIN was admitted to the Haslar Hospital on the 19th March1999 following a fall, was diagnosed as having a proximal femoral fracture, treated by an operation "a dynamic hip screw", on 20th March 1999 (20). The notes for Haslar are not currently available to me, the only information is the hand written one page summary that says post operatively she can be mobilised from bed to chair with two nurses and can walk short distances with a Zimmer frame. It noted she has been incontinent at night and has a small sore on the back of her right leg, which is swollen. This letter states that the only medication she is on is Paracetamol prn. The only nursing information from Haslar is an admission assessment and pressure sore assessment

on 19th March (64 & 66).

5.3 The next medical notes we have until her death, are written on a single page from Gosport Hospital (24). This states that the patient was transferred to Dryad Ward on 26th March, with a history of a fractured neck of femur and no significant past medical history. The medical notes state she was not weight bearing, she was not continent, her skin was tissue ? (illegible). The medical plan was " sort out analgesia".

5.4 The next medical note is on the 7th April, "still in a lot of pain and very apprehensive. MST increased to 20 mgs bd yesterday, try adding Flupenthixol. For x-ray of right hip as movement still quite painful - also about 2" shortening right leg."

5.5 The next medical note is 12th March, "now very drowsy (since Diamorphine infusion established) reduced to 40 mgs per 24 hours, if pain recurs increase to 60mgs". Able to move hips ? (illegible) pain, patient not rousable. Final note is dated 1.15 am 13th April. Died peacefully.

5.6 Nursing notes from Mrs SPURGIN's admission on 26th March continually refer to pain. The first night she has difficulty in moving, Oramorphine is given (80). The admission care plan mentions she was experiencing a lot of pain and movements (84). The desired outcome is "to eliminate pain if possible and keep Enid comfortable, which should facilitate easier movement and mobilisation". 27th March, "is having regular Oramorphine but still in pain" (84). 28th March (84) "has been vomiting with Oramorph, advised by Dr BARTON to stop Oramorph is now having Metoclopramide three times a day and Co-dydramol".

5.7 On 29th (85) pain needed to be reviewed and on 31st March 10 mgs bd of MST (Morphine slow release tablets) is documented. "Mrs SPURGIN walked with the Physiotherapist but was in a lot of pain". She was still having pain on 1st and 3rd April (85).

5.8 On 4th April (86) it is noted that the wound is now oozing serous fluid and blood. On 7th April, it is documented that she was seen by Dr BARTON who thought the wound site was

infected and started Mrs SPURGIN on Metronidazole and Ciprofloxacin (both antibiotics) (107). On the 8th April, her MST is increased to 20 mgs bd, on 9th it is documented that she should remain on bed rest until Dr REED had reviewed the x-ray of the hip.

5.9 Mrs SPURGIN clinically deteriorates significantly on the 11th April. She is now very drowsy and unrousable at times and refusing food and drink (107). The wound looks red and inflamed and feels hot (107). A discussion with Dr BARTON (107), a decision is made to commence a syringe driver.

5.10 The patient is seen by Dr REED (108) Diamorphine is reduced. On the early morning of 13th April, death is confirmed (108).

5.11 Dependency is also confirmed by a Waterlow score of 32 on the 26th March (i.e. very high risk for pressure sores) (92) and a Barthel of 6/20 on 29th March (94) and 5/20 on 10th April (94).

5.12 Drug management in Gosport concentrate on the use of analgesia:

5.13 At the point of admission Oramorphine 10 mgs in 5 mls (2.5 - 5 mgs 4 hourly prn) is written up on the "as required" part of the drug chart. A few doses are documented to have been given on 31st March - 11th April.

5.14 On the regular prescription Oramorphine 2.5 mgs 4 hourly and 5 mgs at night is written up, first dose given by 10 am on 26th March (125). This is then changed to 5 mgs four hourly with 10 mgs at night up until 28th March, then the Oramorphine is then discontinued and Co-dydramol 2 tablets 6 hourly written and prescribed from 28th March - 1st April (125).

5.15 Metoclopramide 10 mgs three times a day is written up continuously from 28th March to 11th April, but is only actually given to the patient intermittently. Morphine slow release tablets 10 mgs bd (MST) are written up on 31st March and given to 6th April. MST 20 mgs bd is written up on 6th April and given to 11th April.

5.16 Ciprofloxacin 500 mgs bd is written up on 7th April and continued until 11th April and Metronidazole 400 mgs bd is also written up on 7th April and given to 11th April. (134)

5.17 Finally, Diamorphine 20 - 100 mgs is written up on 12th April. 80 mgs in a syringe driver started at 8 am and according to the drug chart "dose is discarded at 16.40 hours and reduced the dosage to 40 mgs in 24 hours". The pump is discontinued at 1.30 am on the patients death on 13th March. Midazolam 20 - 80 mgs is written and is prescribed. 20 mgs put in the syringe driver at 8 am. It appears this was increased to 40 mgs at 16.40 hours and discontinued at 1.30 am on 13th April.

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 Enid SPURGIN. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Mrs SPURGIN, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2 It is difficult to provide a comprehensive opinion in the absence of the Haslar notes and the very sparse nature of the Gosport notes.

6.3 Mrs SPURGIN a very elderly lady of 92 years, had a number of chronic conditions including poor eyesight, depression, mild memory impairment, ischaemic heart disease, previous fracture of her right hip and known Paget's disease of her pelvis. She had a fall at home resulting in a further proximal femoral fracture and required a dynamic hip screw. This would have been a more complex procedure because of the previous fracture and the possibility that there was Paget's disease in her femur. However, from the one page summary from Haslar, it would appear that she was making reasonable progress at the point of transfer to Gosport. The prognosis in a 92 year old lady with her previous problems, that she would be likely to

return to independent existence at home would already be extremely low.

6.4 The problem documented in Gosport on the point of admission is continued pain, this is difficult to reconcile with the one page summary from Haslar, which says that Mrs SPURGIN is purely on intermittent Paracetamol. There are various possibilities. She may have been undertreated for pain in Haslar, she may have had a dislocation in the ambulance transferring her (this does occur), she may have been starting to develop infection in the wound or she may have had some other orthopaedic problem that was not picked upbetween leaving Haslar and arriving in Gosport. I was also unable to find any report of the x-ray that was taken at Gosport on 7th April.

6.5 The medical assessment undertaken in Gosport was inadequate. There is no record of a significant history or general examination being performed, or if it was it was not recorded. No explanation at all is sought for why this lady is in pain, particularly if she had not been in pain in Haslar.

Good medical practice (GMC, 2001) states "good medical care must include an adequate assessment of the patients condition based on the history and symptoms and if necessary an appropriate investigation"........... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any other drug or treatments prescribed". The major gaps in the written notes particularly on admission presents poor clinical practice, to the standards set by the General Medical Council.

6.6 However, it was appropriate to provide pain relief. Normally this would be done in a stepwise fashion, starting with the milder pain killers, such as the Paracetamol, she was already on in Haslar. Then to stronger oral medication (such as moderate opioids) and then to stronger opioid analgesia. However, she is started on a regular dosage of stronger opioid analgesia immediately from the point of her admission into Gosport. The reason for this is not documented and represents poor clinical practice.

6.7 The nursing notes document that her pain does not settle and is considerably interfering with her attempts at rehabilitation. She is then troubled with vomiting and the opioid analgesia is in fact stopped and replaced with oral co-dydramol. Her vomiting does apparently settle but her pain continues, so she is restarted on a strong opioid analgesia on 31st March. I believe this was appropriate pain management at this stage.

6.8 She is seen by a consultant on 7th April, who is clearly concerned that there is continuing pain and arranges for an x-ray. There is no record of the result of this x-ray in the notes. However, there appears to be a working assumption that she may have a wound infection and is appropriately started on antibiotics. On 11th April there is a rapid deterioration in her condition. This is documented in the nursing notes but there is no medical note made on the 11th April. The nursing notes suggest that she was seen by Dr BARTON on 11th April, and a decision was made to start a syringe driver. However, I do wonder if this is incorrect and that she was seen early in the morning of 12th April as a syringe driver starts at 8am and not on the 11th April. No medical note is made by Dr BARTON.

6.9 In view of the clinical deterioration on 11th April, despite the patient receiving appropriate antibiotics, I believe it was appropriate to start a syringe driver, as there is no doubt in my view that Mrs SPURGIN was now dying. The likeliest cause is an unresolved infection in the wound and in her hip but the original cause of the pain remains undiagnosed. The opportunity for any possible remediation is well past at this stage. Diamorphine is then written up, prescribed at 80 mgs per 24 hours. The prescription in the notes was 20 - 200 mgs of Diamorphine in 24 hours and it is not clear whether Dr BARTON or the nurse in charge suggested the dose of 80 mgs. At that time Mrs SPURGIN was on 20 mgs twice a day (i.e. 40 mgs) of Morphine Sulphate, slow release. Diamorphine subcutaneously is usually given at a maximum ratio of 1 - 2 (i.e. up to 20 mgs Diamorphine in 24 hours for 40 mgs of Morphine) (Wessex Guidelines). However, her pain was not controlled and it would have been appropriate to give a higher dose of Diamorphine. Conventionally this would be 50% greater than the previous days, (Wessex Guidelines). Some people might give up to 100%. Thus a starting dose of Diamorphine of 40 mgs in 24 hours would seem appropriate. Mrs SPURGIN was prescribed 80 mgs which in my view was excessive, though this was reduced to 40 mgs after the intervention of the consultant

Dr REED, some 8 hours later.

6.10 Midazolam was also added to the infusion pump on 12th April. Midazolam is widely used subcutaneously in doses from 5 - 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was originally 20 mgs for 24 hours which is within current guidelines. This was increased to 40 mgs later in the day, which although remains within current guidelines, many believe that elderly patients may need a lower dose of a maximum 20 mgs in 24 hours (Palliative Care. Chapter 23 in Brocklehurst Text Book of Geriatric Medicine, 6th edition, 2003). Morphine is compatible with Midazolam and can be used in the same syringe driver.

6.11 Mrs SPURGIN is thought to have been excessively sedated, the dose of Diamorphine is reduced on 12th April. She subsequently dies.

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

6.12 In my view the dose of Diamorphine used in the last hours was inappropriately high, however, I cannot satisfy myself to the standard of "beyond reasonable doubt" that this had the definite effect of shortening her life in more than a minor fashion of a few hours.

7. OPINION

7.1 Mrs Enid SPURGIN presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture. The prognosis after such a fracture, particularlyin those patients with impairments of daily living before their fracture is generally poor, both in terms of mortality or in terms of morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and

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complications. A significant problem in Mrs SPURGIN's case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, (GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include - taking suitable and prompt action when necessary"...... "referring the patient to another practitioner, when indicated"...... "in providing care you must - recognise and work within the limits of your professional competence"...... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

I believe that there are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport. The failure to address the cause of this lady's pain, or consider any other action from 26th March until 7th April. The use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes.

7.2 Subsequent management of this lady's pain was within current practice with the exception of the starting dose of Diamorphine. The starting dose of Diamorphine at 80mg in the syringe drive is at best poor clinical judgement. However, I am unable to satisfy myself beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

8 LITERATURE/REFERENCES

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

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Palliative Medicine 1987; 1:149-153.

5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129

6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.

9. EXPERTS' DECLARATION

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

8 At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

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

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: BLACK, DAVID ANDREW

Age if under 18: (if over 18 insert 'over 18') Occupation: CONSULTANT PHYSICIAN

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: D BLACK Date: 23/11/2005

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of Dr Jane BARTON re Enid SPURGIN . In particular, it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This report is based on the following document:

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

2.2 Statement of Dr Jane BARTON re Enid SPURGIN as provided to me by Hampshire Constabulary (November 2005). Appendix 1

2.3 Statement of Dr Jane BARTON as provided to me by Hampshire Constabulary (February 2005). Appendix 2

2.4 Report regarding Enid SPURGIN (BJC/ 45) Professor D BLACK 2005.

3. COMMENTS

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3.1 Comments on Job Description (2.1)

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

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

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

3.1.4 There appears to be some confusion between the statements in the job summary, that "patients are slow stream or slow stream for rehabilitation but holiday relief and shared care patients are admitted" and the statement in the previous sentence "to provide 24 hour medical care to the long stay patients in Gosport". The job description appears to be confusing patients for rehabilitation with long stay patients.

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

3.2 Report on the statement of Dr Jane BARTON re Enid SPURGIN (2.2).

3.2.1. I agree with the drug information in paragraph 16 of Dr BARTON's statement. Thus although paragraph of 5.13 of my report is correct, in paragraph 5.14 the dosages written should all read mls not mgs.

3.2.2. The word mentioned in paragraph 5.3 of my report that I was unable to read is: paper.

3.2.3 I agree that a further single dose of Oramorphine 5mg was given on the 11th April at 7.15am (paragraph 34 of Dr BARTON's statement). Thus the total dose of Morphine given on the 11th of April was 45mg, not 40mg as written in paragraph 6.9 of my report.

3.2.2 These alterations do not effect the conclusions in my report.

3.3 Report on the Statement of Dr Jane BARTON as provided to me by the Hampshire Constabulary (2.3):

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

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

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

3.3.4 Page 1 paragraph 5: States that she and her partners had decided to allocate come of the

sessions to "out of hours aspects of the post". This would appear to be a local arrangement of the contractual responsibilities: it needs to be clarified if this was agreed with the Portsmouth and South East Hampshire Health Authority. This would influence how much time was expected to be provided for the patients and influence the pressure on Dr BARTON to deliver the aspects of care provided.

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

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

Page 5 paragraph 2: The patients who were genuinely long stay or continuing care do not need to be reviewed medically every day, nor would a medical record be made daily. Indeed with average length of stay of six or more weeks, it is clear that many patients were genuinely long-stay patients and one would expect them to be medically reviewed no more than once a week and any medical comments to be no more than once a week. However, whenever patients'

physical or mental state has changed and they are reviewed by a doctor, it would be normal practice to always make a comment in the notes. Patients who are in rehabilitation and making a good progress, then review and comments in the notes once or twice a week would also be the norm.

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

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

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

4. Conclusions

4.1 Having read all the documents provided by Hampshire Constabulary, I would wish to make minor changes to my expert report.

4.2 I agree with the drug information in paragraph 16 of Dr BARTON's statement. Thus although paragraph 5.13 of my report is correct, in paragraph 5.14 the dosages written should all read mls not mgs.

4.3 The word mentioned in paragraph 5.3 of my report that I was unable to read is: paper.

4.4 I agree that a further single dose of Oramorphine 5mg was given on the 11th April at 7.15am (0715) (paragraph 34 of Dr BARTON's statement) . Thus the total dose of Morphine given on the 11th of April was 45mg, not 40mg as written in paragraph 6.9 of my re

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4.5 These alterations do not effect the conclusions in my report

APPENDIX 1

APPENDIX 2

Signed: D BLACK

Signature Witnessed by: