ROBERT WILSON

D779

OPERATION ROCHESTER

Report summarising screening assessment of first 61 cases analysed

This report is compiled from the annotations made during the initial screening of each case. No subsequent editing or amendment is included in this report. However, it should be noted that only the first 20 cases were screened truly blind. In assessing the first 20, I applied the same standards as I would to my own practice, ie that of an experienced medical practitioner in the specialty of palliative medicine. It is my personal belief that excellent clinical practice, ie the best possible decision making given the clinical information available and the patient's preferences, should be the same in all settings, whether specialist or generalist.

However, during the conference after the screening of the first 20 cases it was made clear to me that I was setting an unrealistically high standard for practice in a rehabilitation/continuing care setting. My assessments of all subsequent cases were influenced, therefore, by the views of the other members of the clinical team. There will not be complete consistency in my assessments between the first 20 cases and the subsequent ones.

The screening matrix used for scoring in all cases was as follows:

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B				
Unexplained By Illness C				

In each case the screening assessment was made contemporaneously with the study of that case record. It was not made retrospectively at a later date from my handwritten notes, although they informed my judgement by summarising the important points I abstracted when going through each record.

The following table brings together the assessment notes made on each patient and my own screening assessment score, prior to discussion with other members of the clinical team.

Exhibit	Patient	Assessment Note	Assessment score
BJC/56	Wilson, Robert	NS	B3

Code A

BJC/55	Wilson,Robert	3B	Initial dose of morphine inappropriate in a person with known alcoholic liver disease. Rapid opiate dose escalation. Rapid increase in body weight documented in notes with no apparent clinical response.	

Scoring:

Care

1 Optimal care

2 Sub-optimal Care

3 Negligent Care. That is to say, care outside the bounds of acceptable clinical practice.

Death/Harm

D 965

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Code A

General Comments

Code A

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

BJC/55
ROBERT WILSON
75

Code A

PL grading B3

6.58 BJC/55 Robert Wilson

Code A

Mr Wilson's past medical history:-

Code A

14th 0

15th 0

16th 0

17th 0

REPORT BY:- IRENE WATERS RGN, RHV, LL.M., M.N. M.Sc.Public Health
SPECIALIST FIELD:- NURSING CARE
REPORT ON THE NURSING CARE AT GOSPORT WAR MEMORIAL HOSPITAL
INSTRUCTED BY:- HAMPSHIRE POLICE

18th

Code A

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness				

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

SUMMARY OF CONCLUSIONS

Code A

1. INSTRUCTIONS

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

2. ISSUES

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

3. CURRICULUM VITAE

Name Professor David Andrew Black

Address Code A

Telephone

DOB Code A

Place

GMC

Defence Union

EDUCATION Code A

DEGREES AND QUALIFICATIONS

BA, Cambridge University	1977
(Upper Second in Medical Sciences)	
MB BChir, Cambridge University	1980
MA, Cambridge University	1981
MRCP (UK)	1983
Accreditation in General (internal) Medicine	
and Geriatric Medicine	1989
FRCP	1994
MBA (Distinction) University of Hull.	1997

Certificate in Teaching	2001
NHS/INSEAD Clinical strategists program	2003

SPECIALIST SOCIETIES

British Geriatrics Society

British Society of Gastroenterology

British Association of Medical Managers

PRESENT POST

Dean Director of Postgraduate Medical and Dental Education

Code A 2004-present

Honorary Chair in Medical Education. Code A

Medical School. 2005

Consultant Physician (Geriatric Medicine) 1987-present

Queen Mary's Hospital, Sidcup, Kent.

Associate member General Medical Council 2002-present

PREVIOUS POSTS

Code A

Code A 2004

Medical Director (part time) 1997-2003

Queen Mary's Hospital

Operations Manager (part time) 1996-1997

Queen Mary's Hospital, Sidcup, Kent

Senior Registrar in General and Geriatric Medicine

Guy's Hospital London and St Helen's Hospital

Hastings. 1985-1987

Registrar in General Medicine and Gastroenterology

St Thomas' Hospital, London. 1984-1985

Registrar in General Medicine

Medway Hospital, Gillingham, Kent 1983-1984

SHO rotation in General Medicine

Kent & Canterbury Hospital, Canterbury	1982-1983
SHO in General Medicine	
Kent & Sussex Hospital, Tunbridge Wells	1981-1982
House Physician, St Thomas' Hospital	1981
House Surgeon, St Mary's Portsmouth	1980

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RECENT SIGNIFICANT PRESENTATIONS

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The future of Geriatric Medicine in the UK. Workshop: American Geriatrics Society May 2002

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Intermediate Care Update: London National Elderly Care Conference. June 2003.

Appraisal- an update. GMC symposium on revalidation. Brighton. June 2003.

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Maintaining Professional Performance. BAMM Annual Summer School. June 2004
Chronic Disease management. BGS Council Study Day. Basingstoke. July 2004
MMC post FP2. BGS Study Day. Basingstoke. July 2004
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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.

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Code A

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DRAFT REPORT

regarding

ROBERT WILSON (BJC/55)

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

AT THE REQUEST OF: Hampshire Constabulary

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1. SUMMARY OF CONCLUSIONS

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because of breathlessness (or pain) and thus it is difficult to justify why his dose of diamorphine was trebled over a 48h period.

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

Dr Barton and her partners had a duty to provide a good standard of practice and care that would include good palliative and terminal care. In this regard Dr Barton and Dr Knapman fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient (Dr Barton and Dr Knapman) and providing treatment that could be excessive to the patients needs (Dr Barton).

The dose of oral morphine prescribed for Mr Wilson's arm pain both p.r.n. and regularly were likely to be excessive for his needs. As a result, the initial dose of diamorphine 20mg/24h would also likely to be excessive to his needs. The subsequent increase in the dose of diamorphine to 60mg/24h over the following 48h was not obviously justified. Mr Wilson was likely to be unconscious; he was not reported to be distressed by pain, the secretions or his breathing and he appeared to tolerate regular suctioning. A dose of diamorphine excessive to Mr Wilson's needs would be associated with an increased risk of drowsiness, confusion, agitation, nausea and vomiting and respiratory depression.

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

not appear to hasten the dying process. This has not been examined in patients dying from other illnesses to my knowledge, but one would have no reason to suppose it would be any different. The key issue is whether the use and the dose of diamorphine and other sedatives were *appropriate* to the patient's needs. Although the principle of double effect could be invoked here (see technical issues), it remains that a doctor has a duty to employ effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose opioid that was *appropriate* and not excessive for a patients needs.

Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate and contemporaneous patient records, had been attempting to allow Mr Wilson a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge, illustrated, for example, by the reliance on large dose range of diamorphine by a syringe driver rather than a fixed dose along with the provision of smaller p.r.n. doses that would allow Mr Wilson's needs to guide the dose titration. Dr Barton could also be seen as a doctor who breached the duty of care she owed to Mr Wilson by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Wilson by unnecessarily exposing him to receiving excessive doses of diamorphine.

However, Mr Wilson had significant medical problems. His clinical condition was not stable in that his oedema and thus heart failure were worsening over his time in Queen Alexander Hospital, despite the

reintroduction of diuretic therapy. In this regard an acute deterioration in Mr Wilson's heart failure would not have been that unusual, whether or not precipitated by a myocardial infarction, and his death was in keeping with severe heart failure and liver failure which combined to cause a rapid irreversible physical decline. Although the dose of morphine may well have contributed to his reduced level of consciousness, either directly or by precipitating a hepatic coma, it is difficult to say with any certainty that the dose of morphine he received would have contributed more than minimally, negligibly or trivially to his death because the heart and liver failure could also have done this. Similarly, although the doses of diamorphine used were likely to have been excessive to his needs, it is difficult to say with any certainty that the dose of diamorphine he received would have contributed more than minimally, negligibly or trivially to his death, because drowsiness/unconsciousness, the one feature of excess opioid seen in this case, is also a feature of the terminal stage of heart failure and liver failure.

9. LITERATURE/REFERENCES

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10. EXPERTS' DECLARATION

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

11. STATEMENT OF TRUTH

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

Signature: _____ Date: _____