SUMMARY OF CONCLUSIONS

Gladys Richards presents an example of a common, complex problem in geriatric medicine. A patient with one major progressive and end stage pathology (a dementing illness) develops a second pathology, has surgery, has a complication after that surgery, has more surgery and gradually deteriorates and dies.

In my view a major problem in assessing this case is 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 an 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 case 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 and treatments, including repeat prescriptions only where you have adequate knowledge of the patients health and medical needs". The lack of detail in the medical notes, the absence of evidence of asking for advice on 17th August and the lack of recording why decisions were made or if the patient was properly examined present poor clinical practice to the standards set by the General Medical Council. In particular, I am concerned the anticipatory prescription of Opioid analgesia on her admission to Gosport War Memorial Hospital. If no justification for this can be identified or proven, then I believe that this was negligent practice and may have contributed to her fall on the ward. I also believe that the dose of Diamorphine, in particular prescribed on the 17th August, was sub optimally high. However I do not believe this contributed in any significant way to Mrs Richards death and that her death was by natural causes.

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.

3. CURRICULUM VITAE

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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
Kent, Surrey and Sussex Deanery. 2004-present

Consultant Physician (Geriatric Medicine) 1987-present
Queen Marys Hospital, Sidcup, Kent.

Associate member General Medical Council 2002-present

PREVIOUS POSTS

Associate Dean.
London Deanery. 2004

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

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

Senior Registrar in General and Geriatric Medicine
Guy's Hospital London and St Helen's Hospital
Hastings. 1985-1987

Registrar in General Medicine and Gastroenterology
St Thomas' Hospital, London. 1984-1985

Registrar in General Medicine
Medway Hospital, Gillingham, Kent 1983-1984

SHO rotation in General Medicine
Kent & Canterbury Hospital, Canterbury 1982-1983

SHO in General Medicine

Kent & Sussex Hospital, Tunbridge Wells	1981-1982
House Physician, St Thomas' Hospital	1981
House Surgeon, St Mary's Portsmouth	1980

PUBLICATIONS

Acute Extrapyramidal Reaction to Nomifensine
DA Black, IM O'Brien
Br Med J, 1984; 289; 1272

Transit Time in Ulcerative Proctitis
DA Black, CC Ainley, A Senapati, RPH Thompson
Scand J Gasto, 1987; 22; 872-876.

Lingual Myoclonus and Dislocated Jaw
DA Black, S Das
Br Med J, 1986; 292; 1429

Endoscopic Sclerotherapy for Bleeding Oesophageal Varices in the Elderly
DA Black, RPH Thompson
J Clin and Exper Gerontol, 1987; 9: 131-138

Mental State and Presentation of Myocardial Infarction in the Elderly
DA Black
Age and Ageing, 1987; 16; 125-127

Hyperbilirubinaemia in the Elderly
DA Black, I Sturgess
J Clin and Expt Geront, 1987, 9, 271-284

Malabsorption: Common Causes and their Practical Diagnosis
DA Black
Geriatrics 1988, 43, 65-67

Pseudotumour Cerebri in a patient with Castleman's Disease
DA Black, I Forgacs, DR Davies, RPH Thompson
Postgrad Med J, 1988; 64; 217-219

Non-Surgical Intervention; A First Choice in obstructive Jaundice
DA Black

Geriatric Medicine, 1988; 18(4); 15-16

Endoscopy: Investigation of choice for many Elderly GI Problems

DA Black

Geriatric Medicine, 1988; 18(9); 14-16

Hepatic Stores of Retinol and Retinyl Esters in Elderly People

DA Black, E Heduan and WD Mitchell

Age and Ageing, 1988; 17; 337-342

Elderly People with low B12 Levels do need Treatment

DA Black

Geriatric Medicine 1989, 19(1); 21-22

NSAIDS and Ulcer disease in Old Age

DA Black

Geriatric Medicine (special supplement) April 1989; 4-5, 8-11

The Independent Living Fund

DA Black

Br Med J (editorial) 1989, 298; 1540

Ischaemic Hepatitis

DA Black

Geriatric Medicine, 1989, 19(9); 92

Laparoscopic cholecystectomy: not without pitfalls in the elderly

DA Black

Geriatric Medicine 1991 21(10); 21

The successful medical management of gastric outflow obstruction associated with the use of non-steroidal anti-inflammatory drugs in the elderly

RJ Geraghty, DA Black and SA Bruce

Postgrad Med J 1991; 67; 1004-1007

Bronchodilator response to nebulized salbutamol in elderly patients with stable chronic airflow limitation

RJ Geraghty, C Foster, DA Black & S Roe

Respiratory Medicine 1993 23(5); 46-57

The reality of community care: a geriatricians viewpoint

DA Black
In: Care of elderly people. South East Institute of Public Health 1993; 81-89

Accidents: a geriatrician's viewpoint
DA Black
In: Care of elderly people. South Thames Institute of Public Health. 1994; 53-58.

Community Care Outcomes
DA Black
Br J of Clin Pract 1995 49(1); 19-21

Choice and Opportunity
DA Black
Geriatric Medicine 1996 26(12) 7.

Emergency Day Hospital Assessments
DA Black
Clinical Rehabilitation. 1997; 11(4); 344-347

Geriatric Day Hospital. A future?
DA Black
Opinion in General and Geriatric Medicine. 1997, 1.1, 4-6.

The Health Advisory Service
DA Black
JAGS 1997; 45; 624-625.

The Rhetoric and Reality of Current Management Training for NHS Clinical Directors
DA Black
MBA dissertation. 1997. University of Hull.

Community Institutional Medical Care- for the frail elderly.
DA Black & CE Bowman
Br Med J. (Editorial). 1997, 315; 441-442.

Remains of the day.
DA Black
Health Services Journal. 1998. 19 Feb. p32.

Nutritional problems in old age

DA Black
Opinion in General and Elderly Medicine. 1998. 2(1): 12-13.
Constipation in the elderly :causes and treatments.
DA Black
Prescriber. 1998; 9(19); 105-108.
Intermediate not Indeterminate Care
CE Bowman & DA Black
Hospital Medicine. 1998; 58; 877-9
Improving geriatric services
DA Black
JRColl Physicians Lond 1999; 33: 113. (also p152)
General internal medicine and speciality medicine- time to rethink the relationship.
JM Rhodes, B Harrison, D Black et al.
JR Coll Physicians Lond 1999, 33: 341-347.
Iron deficiency in old age
DA Black & CM Fraser.
British Journal of General Practice. 1999; 49; 729-730
A systems approach to elderly care
DA Black, C Bowman, M Severs.
Br J Health Care Management, 2000, 6(2), 49-52
The Modern Geriatric Day Hospital
DA Black.
Hospital Medicine. 2000.61(8);539-543
Complaints, Doctors and Older People
DA Black
Age and Ageing. 2000; 29(5):389-391.
NSF Overview
DA Black
Geriatric Medicine 2001; 31(4):11-17 & 31(5)
Anaemia

D Sulch, DA Black

Geriatric Medicine 2001; 31(6): 46-49

Professional Review Mechanism. Chapter in: Clinical Governance Day to Day.

DA Black.

British Association of Medical Managers 2002; 41-56.

Induction for newly appointed consultants

DA Black

Clinician in Management. 2002; 11(1); 9-13

Average length of stay, delayed discharge and hospital congestion.

DA Black and M Pearson

BMJ 2002;325:610-611

An audit of outcomes in day hospital based crisis interventions.

David A Black

Age Ageing 2003; 32; 360-361

Quality Improvement in the UK

DA Black

Chapter 119 In: Brocklehurst's Textbook of Geriatric Medicine. 6th Edition Ed: Tallis and Fillit. 2003.

The new NHS framework for handling performance concerns.

David A Black

Hospital Medicine 2004; 65 (2): 112-115

Not because they are old- revisited

DA Black

Age and Ageing. 2004;33; 430-432

BOOK

British Geriatrics Society compendium of policy statements and statements of good practice. Edited by DA Black & A Main. First Edition. 1995.

RECENT SIGNIFICANT PRESENTATIONS

Secondary care as part of the whole system. Laing & Buisson conference on intermediate care. April 2001

The impact of the NSF on everyday Clinical Care. Conference on Clinical governance in elderly care . RCP May 2001

The Geriatricians view of the NSF. BGS Autumn Meeting 2001

The Organisation of Stroke Care. Physicians and managers working together to develop services. Professional training and clinical governance in geriatric medicine. All at Argentinean Gerontological Society 50th Anniversary meeting. Nov 2001

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

Liberating Front Line Leaders. Workshop: BAMM Annual Meeting June 2002

Revalidation - the State of Play. A Survival Guide for Physicians. Mainz July 2002

Medical Aspects of Intermediate Care. London Conference on building intermediate care services for the future. Sept 2002

Developing Consultant Careers. Workshop: BAMM Medical Directors Meeting. Nov 2002

Lang and Buisson. Update on Intermediate Care Dec 2002

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

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

Innovations in emergency care for older people. HSJ Conference. London July 2003.

Emergency Care & Older People: separate elderly teams? RCP London March 2004

Professional Performance & New Consultants. London Deanery Conference April 2004

Mentoring as part of induction for new consultants. Mentoring in Medicine Conference. Nottingham. April 2004

The Future of Chronic Care- Where, How and Who? CEO & MD conference. RCP London. June 2004

Mentoring as part of consultant induction. Surviving to Thriving. New Consultant Conference, London June 2004

360 Degree Appraisal. Chairman National Conference. Nottingham June 2004

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

Designing care for older peoples. Emergency services conference. London July 2004.

The Modern Geriatric Day Hospital. Multidisciplinary Day. South East Kent hospitals. Sept 2004

Geriatricians and Acute General Medicine. BGS Autumn Meeting . Harrogate Oct 2004

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Gladys Richards (BJC/41)

[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. Gladys Richards was a 91 year old lady and in 1998 was admitted as an emergency on 29th July 1998 to the Haslar Hospital (H39).

5.2. She had had a progressive dementing illness documented as short term memory loss in 1998 (435), a mental test score of 4/10 in 1994 (443) and a mental test score of 0/10 in 1996 (451). She was admitted to the Glen Heathers Nursing Home in 1994 (202) and was moderately dependent with a Barthel of 11/20 at that time (200). She was seen by a psycho-geriatrician, Dr Banks, who in 1998 found that

she had end stage dementia (473). The nursing home noticed that she was wandering and very frail in July 1998 (563). The nursing home notes document multiple falls.

5.3. On admission to the Haslar Hospital, a fractured neck of femur is diagnosed and she is treated with a right hemi-arthroplasty (H50). Recovery seems uncomplicated, though it is complicated by agitation. She is seen by Dr Reed on 3rd August (23) who notes her long standing dementia. He finds her pleasant, co-operative, with little discomfort on passive movement and she should be transferred to the Gosport War Memorial hospital to see if it was possible to remobilise her (466,467).

5.4. Her drug charts in Haslar Hospital show that no regular pain killer is given during her first admission (H110), although Diclofenac was prescribed but not given. She does receive intravenous morphine 2.5. mgs on 31st July, then single doses on the 1st and 2nd August (H114). She then receives regular Co-codamol orally, although it is written up Prn, until 7th August. After this date t there appears to be no further painkillers given.

5.5. The nursing cardex in Haslar (H152, H167) does not mention any pain during her recovery.

5.6. She is discharged to the Gosport War Memorial Hospital on 11th August and seen by Dr Barton who notices her previous hysterectomy in 1953, her cataract operations, thats he is deaf and that she has "Alzheimer's Disease". She notes on examination that her impression is of a frail demented lady who is not obviously in pain. It is not clear if a general examination has been undertaken. She mentions that her Barthel score is 2 (heavily dependent), she transfers with a hoist. She also states "I am happy for nursing staff to confirm death".

5.7. The next medical note in on 14th August and states that sedation/pain relief has been a problem, screaming not controlled by Haloperidol and very sensitive to Oramorphine. Fell out of chair last night, right hip shortened and internally rotated, daughter aware and not happy. Is this lady well enough for another surgical procedure? She has an x-ray that notes the hip is dislocated and is transferred back to the Haslar Hospital.

5.8. The nursing notes for this first admission state that she had a Barthel of 3/20 on admission (40). Is highly dependent with a Waterlow score of 27 (41). The nursing care plan for the 12th (49) mentions that Haloperidol was given because she woke from sleep very agitated. It mentions that on the 13th August Oramorphine is given at 21.00 (50). It mentions an x-ray needed the following morning. On 14th August pain is mentioned in the right leg in the nursing cardex (50). I find no other mention of pain in the nursing cardex.

5.9. Oramorphine 10 mgs in 5mls (62) is written up prn on admission to Gosport Hospital, two doses are given on 11th August, one dose 12th August, one dose 13th August in the evening (as confirmed in the nursing cardex) and one dose on 14th August in the morning (as confirmed in the nursing cardex). Also on the prn side of the drug cardex on admission to Gospor tis prescribed Diamorphine 20 – 200 mgs subcutaneously, August, Hyoscine 200 – 800 mgs subcutaneously in 24 hours, both written up on 11th August. Midazolam 20 – 80 mgs subcut in 24 hours in written up on the 18th August. None of these drugs are prescribed until her subsequent return from Haslar.

5.10. On 14th August she is transferred to Haslar where a dislocation of a hip is confirmed by x-ray (H67) and is reduced under sedation (H67). She has an uneventful recovery and is transferred back to Gosport War Memorial on 17th August. Discharge summary mentioning Haloperidol, Lactulose, Co-codamol and Oramorphine 2.5 – 5mgs for pain (H79), although the Oramorphine was never given in Haslar.

5.11. Dr Barton writes in the notes on the 17th August after her re-admission to continue Haloperidol and only give Oramorphine if in severe pain, and that she wishes to see the daughter again. The nursing cardex 17th August says patient very distressed and appears to be in pain (45). In the afternoon of 17th August, states, "in pain and distress, agree with daughter to give her mother Oramorphine 2.5 mgs in 5 mls". Due to the pain, a further x-ray is ordered and no dislocation is seen (46) (75).

5.12. On 18th August, Dr Barton notes the patient is still in great pain, nursing is a problem, she suggests subcutaneous Diamorphine, Haloperidol and Midazolam and that she will see the daughters. The nursing cardex records the decision to pain control by syringe driver (46). She then receives Diamorphine 40 mgs daily in a syringe driver, with Haloperidol 5 mgs and 20 mgs Midazolam until her death

on 21st August 1998.

5.13. An unusual feature of the original Gosport War Memorial Drug Chart (64) is that Oramorphine 2.5 mgs 4 hourly was written up on the regular prescription side on the 11th August, together with 5 mgs at night regularly. It then has the letters prn against both of these prescriptions which presumably refers the prescriber back to the actual prescriptions which were given on a prn basis of Oramorphine (62).

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

6.2. Mrs Richards was suffering from the terminal stage of a dementing process, probably Alzheimer's disease. This is reflected in the comments earlier in 1998 by a consultant psycho-geriatrician that she had end stage disease and the well-documented progression of this over many years. Despite this though, she was still able to get around in the nursing home and as is often the case, even with the best forms of monitoring, having multiple falls.

6.3. As a result of one of these, she suffers a fractured neck of femur. Sadly this is very common, it is also common for the original fall to lead to a partial fracture which is not diagnosed and then only subsequently sometimes hours, sometimes days later, does it become a clinically obvious fractured neck of femur. Patients with dementia and fractured neck of femur are often missed in hospitals as well as in nursing homes, even by the most astute of staff.

6.4. She has a successful hemi-arthroplasty in Haslar, receives pain relief but does not need any pain relief for the 3 days on 7th – 10th August. She remains highly dependent though with a Barthel of 3/10. Although she is described as weight bearing in Haslar, the Barthel describes no mobility at all as does the fact that a hoist is needed for transfer at Gosport War Memorial. It is a fact that many patients with dementia, never walk again after a fractured

neck of femur and indeed the mortality rate in the months after a fractured neck of femur is extremely high, particularly in the very elderly and those with mental impairment.

6.5. However, she survived the first operation and is seen by Dr Reed, Consultant Geriatrician who believes that she should be transferred to Gosport War Memorial to see if any mobility can be regained. This is not unreasonable; it may make her new placement in a nursing home easier if she is able to have some increase in independence.

6.6. When she is transferred to Gosport War Memorial Hospital she is seen by Dr Barton who fails to record a clinical examination apart from a general statement she is a frail and demented lady. However, she does state she is not obviously in pain. Despite this, she has written up her drug charts for both low dose of Oramorphine and a high dose of Diamorphine. I can find no clinical justification at all for this in the notes. If she was worried about pain and feared that it would be hard for the nursing staff to get hold of the doctor, then it would be reasonable to write up a prn of a mild pain killer such as Paracetamol and then possibly a small dose of an Opioid if ordinary analgesia did not work. Dr Barton also writes up on the regular prescription side a significant dose of Oramorphine, although this has prn put next to it. I believe this to be highly sub-optimal prescribing.

6.7. Oramorph is actually given by the nursing staff on 11th, 12th and 13th, certainly prior to the definite diagnosis of the dislocation. I can find no justification for giving the drugs in the medical or nursing notes. The comment on the 14th August that pain relief has been a problem, could be relating to since the dislocation. If no reason can be documented or proven, then this is certainly sub-optimal drug prescribing and management. Indeed to prescribe a controlled drug without a clinical indication must be considered negligent in my view.

6.8. She is identified as having had dislocation of hip on 14th August. This probably resulted from the documented fall and is not uncommon in frail older people after a fractured neck of femur repair. The Diamorphine that had been given might have contributed in part to this, though she was also on major tranquillisers and suffering from severe dementia. All of which makes such an outcome quite likely.

6.9. She then returns to Haslar Hospital, the dislocation is reduced under local sedation, which heavily sedates her, and she is then returned back to Gosport War Memorial. She is never right from

the moment she returns. She is now documented to be in significant pain. No cause for this pain is suggested in the notes. In my view it would have been appropriate for Dr Barton to discuss Mrs Richards with the surgical team at Haslar Hospital, or with her consultant, to decide if anything further should be done at this stage. Unfortunately, not only is the mortality high after a single operation in a patient with end stage dementia but having a further operation is often an agonal event. It is also unexplained what was causing her pain. It seems to me that it would be not unreasonable at this stage to provide palliative care and pain relief. Diamorphine is specifically prescribed for pain and is commonly used for pain in terminal care. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Diamorphine subcutaneously after oral morhine, is usually given at a maximum rate of 1 – 2 (i.e. up to 10 mgs Diamorphine in 20 mgs of Oramorphine). The maximum amount of Oramorphine she had received in 24 hours was 20 mgs prior to starting the infusion pump. Thus as her pain was not controlled, it would be appropriate to give a higher dose of Diamorphine and in convention this would be 50% greater than the previous days (Wessex Guideline) but some people might give up to 100%. A starting dose of Diamorphine of 10 – 20 mgs in 24 hours would seem appropriate. Mrs Richards was actually prescribed 40 mgs, which in my view was unnecessarily high.

6.10. 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 20 mgs for 24 hours which is within current guidance, although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours (Palliative Care. Chapter 23 in Brocklehurst's Text Book of Geriatric Medicine 6th Edition 2003).

6.11. It was documented that Mrs Richards is peaceful on this dose in the syringe driver and a rattly chest is documented in the medical notes on 21st prior to her death (30).

6.12. I understand the post mortem and the cause of death said:
1a Bronchopneumonia.
In my view the correct Death Certificate would have said:
1a Fractured Neck of Femur
2 Severe dementia.
There is no doubt that after people have been dying over a number of days, if a post mortem is performed, then secretions and changes of Bronchopneumonia are often found in the lungs as the very final agonal event. This allows clinicians to put the phrase "Bronchopneumonia" on the death certificate.

Unfortunately, under current guidance to Coroners if 'fractured neck of femur' is written on the death certificate, then the Coroner has little option but to perform a post mortem as the death is deemed to be non accidental. Where patients have not died immediately after a fractured neck of femur, some Coroner's Officer's encourage clinicians to leave 'fractured neck of femur' off the death certificate to save the relatives the potential trauma of a post mortem. I believe this is poor national practice, but it is not a specific criticism in this case.

7. OPINION

7.1. Gladys Richards presents an example of a common, complex problem in geriatric medicine. A patient with one major progressive and end stage pathology (a dementing illness) develops a second pathology, has surgery, has a complication after that surgery, has more surgery and gradually deteriorates and dies.

7.2. In my view a major problem in assessing this case is 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 an 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 case 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 and treatments, including repeat prescriptions only where you have adequate knowledge of the patients health and medical needs". The lack of detail in the medical notes, the absence of evidence of asking for advice on 17th August and the lack of recording why decisions were made or if the patient was properly examined present poor clinical practice to the standards set by the General Medical Council. In particular, I am concerned the anticipatory prescription of Opioid analgesia on her admission to Gosport War Memorial Hospital. If no justification for this can be identified or proven, then I believe that this was negligent practice and may have contributed to her fall on the ward. I also believe that the dose of Diamorphine, in particular, prescribed on the 17th August, was sub optimally high. However I do not believe this contributed in any significant way to Mrs Richards death and that her death was by natural causes.

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.

Signature: Code A Date: 18/6/05