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Code A

From: Williams, David M
Sent: 09 May 2005 17:57
To: Niven, Nigel
Cc: Code A Grocott, David; Code A
Code A
Code A
Subject: OP ROCHESTER I Code C LAVENDER key points..

Dear All..

I have summarised the key points from the evidence files prepared in respect of these cases to inform the CPS counsel etc, and to act as a briefing note in the future.. I will deal with all of the Cat 3 's in the same way.. It will be worth taking the time to read, to give you a wide perspective and to identify common emerging themes..

The key healthcare witnesses will clearly continue to be the referring consultants and GP's, the supervising GWMH consultants, the nurses that administer the Diamorphine, those nurses that evidence the general care administered to the patients and evidence whether or not the patient was suffering any form of pain... please prioritise your statement taking accordingly..

Thanks.DW.

Operation
:HESTER LAVENDER

Operation
:HESTER PITTOCK.c

Operation ROCHESTER

Elsie LAVENDER.

KEYPOINTS May 2005.

Elsie Hester LAVENDER Born Code C

Diabetic and insulin dependant since the 1940's when she was 53.

Generally strong healthy and independent, other than poor eyesight and recorded high blood pressure in 1986.

February 1996 suffered a fall at her Gosport home address from the top to the bottom of the stairs, suffering head lacerations found by her home help.

She was admitted to Haslar Hospital on 5th February 1996.

Following admission noted to suffer pain in her shoulders, she received regular analgesia comprising Co-Proximal and Dihydrocodeine.

Examined by Doctor LORD on 13th February 1996, who confirms bilateral weakness of both legs.

Transpired that she had suffered a brain stem stroke, made excellent progress towards recovery and being prepared for release, walking with a frame, talking coherently (according to next of kin her Code C)

On 22nd February 1996 transferred to Daedelus Ward, Gosport War Memorial Hospital for rehabilitation.

Noted that Mrs LAVENDER suffering severe Code A e and leg ulcers.
Is catheterised throughout, suffering bed sores assessed as grossly dependent, mental test score normal.

On 24th February Nursing records report a meeting with Mrs LAVENDERS son, comment that' son is happy to make Mrs LAVENDER comfortable, and syringe driver explained'. Slow release morphine 10mgs was commenced.

In response to a question from Mrs LAVENDERS son about the timing of her release, DR BARTON allegedly told him 'you can get rid of the cat , you do know that your mother has come here to die'.

On 26th February it is noted on medical records that the patient is 'not so well', Oral morphine is increased to 20mgs.

On 27th February the nursing plan first mentions significant pain, describes pain on most days until 5th March when pain is uncontrolled and the patient is distressed.

On the 4th March Oramorph increased to 30mg and administered.

On 5th March notes indicate that the patient has deteriorated further and to start syringe driver analgesia. 100-200mgs with 40mgs of midazolam (pro-actively prescribed).

Mrs LAVENDER died on 6th March 1996.

Cause of death recorded and certified by Dr BARTON as 'cerebral-vascular accident diabetes mellitus.'

Case assessed by multidisciplinary key clinical team 2004.

Elsie LAVENDER. Code A – 6th March 1996. Head Injury or brain - stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. It was possibly musculoskeletal pain from a fall downstairs. Other forms of analgesia such as anti-inflammatory drugs or hot/cold packs might have worked. The most worrying aspect is the large dose escalation when converting Morphine to Diamorphine via syringe driver (Five fold increase). The cause of death is unclear and the dose escalation might have contributed.

Dr Jane BARTON. From Caution interview with Police 24th March 2005.

Workplace demands were substantial and a choice had to be made between detailed note making or spending more time with patients.

Felt obliged to adopt a policy of pro-active prescribing given constraints/demands on her time.

Consultant Geriatrician DR TANDY had recorded in a letter on 16th February that Mrs LAVENDER had most likely suffered a brain stem stroke leading to the fall. Dr TANDY confirmed atrial fibrillation on examination but heard no murmurs. Made mention of iron deficiency anaemia and stroke and agreed to take the patient to Daedalus Ward for rehabilitation as soon as possible.

Dr BARTON entered on the transfer assessment of 22nd February details of the fall, head laceration, leg ulcers, Code A needing a catheter, urine incontinence, needing help to dress and feed, she adds that the patient was profoundly dependent.

The prognosis for the patient was not good her being blind, diabetic, with brain stem stroke, and immobile. The hope was for rehabilitation.

Prescribed for congestive cardiac failure, diabetes, anaemia, asthma, and dihydrocodeine for pain relief.

The following day prescribed for a urinary tract infection.

On 24th prescribed morphine sulphate in addition to dihydrocodeine for pain relief.

Increased dosage for pain relief on 26th February, her bottom was very sore, Pegasus mattress arranged for pressure sores.

No recollection of meeting with the son of the patient on the 26th February.

The circumstances of the fall with pre-existing illness can have a serious and deleterious effect on health leading to death. May have mentioned to son that his mother was dying, believe would have discussed options for pain relief.

Might have explained that administration of proper pain relieving medication might have the incidental and undesired effect of hastening death.

Following discussion with son wrote up a proactive prescription for further pain relief for diamorphine, would have anticipated that the nursing staff would contact her so that she could authorise administration as necessary within the dosing range.

Saw the patient on 29th February and 1st March, to review condition which was slowly deteriorating.

Next saw on 4th March Oramorph slow release increased.

Reviewed again on 5th March, pain relief clearly inadequate, Mrs LAVENDER had had a poor night and was distressed, diamorphine and midazolam authorised via syringe driver, considered doses appropriate in view of uncontrolled pain.

On 6th March Mrs LAVENDER comfortable and peaceful, medication successful in relieving the significant pain and distress, Dr BARTON aware that she was dying, and content for a nurse to confirm death.

Expert Dr Andrew WILCOCK (Palliative medicine and Medical Oncology) comments:-

- Notes inadequate.
- Cause and treatment of Mrs LAVENDER'S urinary tract infection not properly assessed/treated.
- Morphine may have been inappropriate or excessive to the type of pain experienced and the possible role this played in her deterioration was not considered.
- Treatments were continued that may have aggravated her condition ie the diuretic.
- Excessive doses of diamorphine/midazolam from 26th February 1996.
- Blood tests of 27th February 1996 revealed low platelet count and deteriorating kidney function, not reflected in the notes and no action taken, not discussed with a consultant or specialist advice.
- On 29th February 1996 no mention of high blood sugar requiring high doses of insulin. No mention of pain in medical notes therefore inconsistent with nursing notes.
- No pain assessment recorded against increase in morphine of 4th March 1996.
- The reported deterioration mentioned in the notes of 5th March is not explained.
- There is reasonable doubt that Mrs LAVENDER had reached her terminal phase. Causes of her decline may have been reversible with appropriate treatment.
- Ultimately excessive doses of diamorphine and midazolam could have contributed more than minimally trivially or negligibly towards her death, Dr BARTON leaves herself open to the accusation of gross negligence.
- Cause of death registered as cerebrovascular accident, validity difficult to comment upon but final deterioration does not seem typical of cerebrovascular accident, more likely immobility from fall leading to infection.

Expert Dr David BLACK (Geriatrics) reports that Mrs LAVENDER represents the most complex and challenging problems of geriatric medicine.

- Patient suffered long standing multiple medical problems, after admission found to be doubly incontinent, totally dependent, suffering constant pain to shoulders and arms and found to have serious abnormalities in various blood tests.
- Increasing physical dependency and increased patient distress.
- Doctors and consultants failed to make adequate medical assessment and diagnosis of her condition.
- Dr BLACK believes Mrs LAVENDER was misdiagnosed and had suffered a quadriplegia from a high cervical spinal cord injury secondary to her fall.

- Abnormal blood tests could have represented systemic illness such as cancer of the bone marrow, the test should have been commented upon by the doctor in charge of the case as to their relevance.
- The lack of examination and comment on abnormal blood tests make it impossible to assess the care as sub optimal, negligent or criminally culpable.
- Likely she had several serious illnesses and entering the terminal phase of her life.
- Mrs LAVENDER received a negligent medical assessment both at Haslar and Gosport War Memorial Hospital, in particular not examined on admission to Gosport. No medical diagnosis made for pain, which would fit with spinal cord fracture. Without appropriate assessment impossible to plan appropriate management.
- The two options were to either get further specialist opinion or provide palliative care. Would have been wise to obtain specialist opinion, probably from the consultant in charge of the case. There is no evidence that this was done.
- Unusually large dose of diamorphine written up on 26th February 1996, and subsequent excessive dose reported on 5th March 1996, together with high dose of Midazolam likely to cause excessive sedation and respiratory depression.
- Cannot say beyond all reasonable doubt that life was shortened.

Evidence of other key witnesses.

Code A of the deceased. Spoke of his Code A making an excellent recovery at Haslar Hospital following her fall, and the occupational therapist speaking of preparing her to return home. Code A coherent, and walking with the assistance of a frame. Within a couple of days of admission to Gosport War Memorial Hospital DR BARTON told him that 'h Code A as come here to die', she deteriorated rapidly, he was not aware that Code A was being administered syringe driver diamorphine until the day prior to death.

Dr Althea LORD Community Geriatrician responsible for the ward rounds at Daedalus Ward of Gosport War Memorial Hospital. Was on annual leave from 23rd February 1996 – 18th March 1996 as a consequence had no input into the treatment or care of the patient Elsie LAVENDER. No formal arrangements in place for arranging locum cover, although this may be done in respect of long periods of absence (There is no evidence of Consultant supervision of this patient)

Sheelagh JOINES Registered Nurse GWMH Daedalus Ward, 1973-1997.. consisted of 8 stroke beds and 14 geriatric long stay beds, working to consultant Dr LORD and clinical assistant DR BARTON. Only Doctors authorised syringe drivers, which did not accelerate the process of dying. In 4 years at Daedalus only one family denied syringe driver treatment. It was agreed by Dr BARTON, DR LORD and Nurse JOINES that prescriptions would be written up in advance (pro-active prescribing) to enable use on a patient need basis. Ms JOINES wrote in notes that Dr BARTON had discussed Elsie LAVENDERS prognosis and the issue of syringe driver with the

son's wife, and that pain was not being controlled by DF 118 and as a result DDR BARTON prescribed further pain relief.

Yvonne ASTRIDGE Senior Staff Nurse made various entries onto the nursing care plan referring to condition of the patient and nursing care afforded. On 6th March 1996 wrote on medical notes that 'medication other than through syringe driver discontinued as patient un-rousable'

Christine JOICE Registered Nurse noted requirement for increased analgesia following Physio- exercises on 4th March 1996, Morphine sulphate tablets/Oramorph increased in dosage as a result.

Code A Registered Nurse delivered nursing care, bed bath, catheter and dressings.

Margaret COUCHMAN Registered Nurse entered on medical notes 1.3.1996 that patient 'complaining of pain in shoulders' this nurse commenced syringe driver diamorphine 100mg and midazolam 40mg on 5th March 1996 she explained that she had been informed by overnight staff that the patient had suffered a poor night distressed with uncontrolled pain, and had conformed to DR BARTON and Sister JOINES written instructions to commence syringe driver analgesia. Administered as the lowest amounts written up by Dr BARTON.

Irene DORRINGTON Registered Nurse, nursing note entries regarding general nursing care.

Catherine MARJORAM Senior Staff Nurse, has written on notes 6th March 1996 'Death Verified', explains that she would have checked heart and breathing before verifying. Given that there was no 24hr doctor, it was common for nurses to verify death.

Operation ROCHESTER.

Code C

KEYPOINTS May 2005.

Code A

Code A

5th January Code A transferred for long term care TO Gosport War Memorial Hospital.

Code A

Code A

Code A

Code A

Case assessed by multidisciplinary key clinical team. 2004.

Code A

Code A

Dr Jane BARTON. From caution interview with police 3.3.2005.

Workplace demands were substantial. A choice to be made between detailed note making or spending more time with patients.

Due to demands of work adopted a policy of pro-active prescribing.

Code A

Dr BARTON made the note of 9th January Code A, prescribed arthrotec for pain in the hand.

Code A

Code A

Code A

Code A

Tried to judge medication as necessary to provide appropriate relief whilst not excessive.

Dosages effectively increased appropriate to increased pain/ distress of patient.

Code A

Code A

Expert Dr Andrew WILCOCK (Palliative medicine and Medical Oncology) comments..

- Notes inadequate.
- Pain not appropriately assessed.
- Code A not appropriate as administered to alleviate anxiety and agitation.
- Not necessary to use Code A (unless patient unwilling or unable to take medicines orally)
- Doses of d Code A excessive to needs of the patient (far exceeding appropriate starting dose)
- Appropriate dose would be 10-15mgs.

Code A

- At best DR BARTON had attempted to allow a peaceful death, albeit with excessive use of Code A
- Opinion that Dr BARTON breached her duty of care, by failing to provide treatment with skill and care, difficult to exclude completely the possibility that a dose of diamorphine that was excessive to h needs may have contributed more than minimally negligibly or trivially to his death. Dr BARTON leaves herself open to the accusation of gross negligence.
- Code A

In his assessment of Dr BARTONS prepared statement Dr WILCOCK comments that:-

- According to Dr BARTONS job description she should take part in weekly consultant ward rounds.
- Consultants were responsible for patient care and should have been available to discuss complex patient issues.

- Given patient numbers 44, and admission numbers Dr BARTON should have been able to satisfactory manage in a half post as clinical assistant with regular consultant supervision.
- It is completely unacceptable for the trust to have left Dr BARTON with continuing medical responsibilities without consultant supervision and regular ward rounds, to fail to do so would be a serious failure of responsibility by the trust in its governance of patients.

Code A

- Problem in assessing care due to lack of documentation.
- Lack of notes represents poor clinical practice, no written justification for high doses of Diamorphine and Midazolam.
- Drug management afforded to patient is sub-optimal.
- Starting dose of Code A of diamorphine is approximately 3 times the dose that conventionally applied.
- Combination of higher than standard doses of drugs, Diamorphine, and Midazolam combined with Nozinan likely to have caused excessive sedation and may have shortened life by a short period of time, hours to days.
- Whilst care is sub-optimal cannot prove to be negligent or criminally culpable.
- Predictions of how long terminally ill patients live are impossible, even palliative care experts show enormous variation.
- Medication likely to have shortened life but not beyond all reasonable doubt.

Other key witnesses.

Code A

Code A

Dr Althea LORD employed as Consultant Geriatrician at GWMH, Queen Alexandra Hospital and St Mary's Hospital Portsmouth between March 1992 and June 2004. Consultant for all patients over 65yrs requiring specialist care for their physical health. Assessed Code A hances of survival were slim and un transfer to GWMH

Dryad ward in order to address patients physical and psychiatric needs. Not intended to be a comprehensive care plan.

Dr Jane TANDY employed by East Hants Primary Care trust as Consultant Geriatrician in elderly medicine since 1994, covered Dryad ward until late 1996. On 10th January 1996 DR TANDY had overall medical responsibility of the ward. Dryad was a long term care ward containing frail and elderly patients difficult to manage due to medical or nursing requirements. There was no resident doctor on the ward which was covered by local GP Dr BARTON. Dr TANDY's responsibilities included a ward round once fortnightly. No requirement for a GP to notify Dr TANDY of every change to drugs prescribed to patients, unless her advice was sought by the GP, this occurred infrequently.
On 10th January 1996, Dr TANDY conducted a ward round with Dr BARTON and Sister HAMBLIN and prescribed Code A to alleviate pain and distress. Thereafter Dr TANDY recites the drugs prescribed by Dr BARTON, and comments that she would have used lower dosage of Code A (than prescribed by Dr BARTON) her practice was to use the lowest dose to achieve the desired outcome diminishing adverse effects. There was no resident doctor to review the medication.

Code A

Nurse Gillian HAMBLIN. Consultants attended once fortnightly on Mondays unless on leave when it would be monthly. Her practice was to challenge Dr BARTON if she did not feel levels of drugs prescribed were appropriate. Syringe drivers used once a patient becomes incapable of swallowing. The term TLC means that a patient was very likely to die. Nurse HAMBLIN commenced the syringe driver diamorphine on Code A and an increased dosage on Code A There no policy or protocol regarding the use of syringe drivers prior to 2000.

Nurse Lynne BARRATT administered Code A to Code A Code A

Nurse Freda SHAW administered Diamorphine Code A

Code A n accordance with policy witnessed the accurate recording of Code A prescribed, and recorded on drug charts.

Nurse Code A e - charged the syringe driver wit Code A o Code A and witnesses and recorded the withdrawal of Diamorphine for the patient on 4 other occasions.

Code A

Nurse Code A variously administered Code A and verified the death of Mr Code C Code A
