

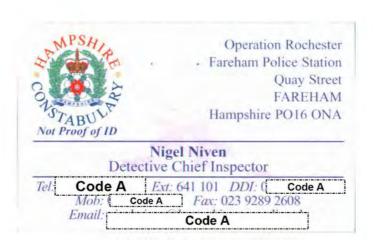
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Operation ROCHESTER File Note.

BJC/34 GEOFFREY PACKMAN Age 68

Dr Robin FERNER General Medicine(Key clinical team)

68-year-old married man morbid obesity Leg ulcers. Cellulitis. WBC 26 Hypertension 1999-08-06 Admitted and improves on antibiotics 1999-08-23 Transferred to GWMH 1999-08-26 Sudden collapse – pain in throat? MI. [diagnosis certainly plausible; note, however, anaemia and rectal bleeding] Treated with diamorph by verbal order. Then Oramorph 60 mg/day 1999-08-30 Syringe driver diamorphine 40mg [i.e. 2 x previous] midazolam.

Dr Peter LAWSON Geriatrics(Key clinical team)

I have more concerns with this case than the other members of the team. This man was treated for a myocardial infarction but died of a gastrointestinal bleed. I have been told that this was considered as the diagnosis in Queen Alexandra Hospital and the decision was made not to treat it. I have not found this and I believe they did not take this seriously in GWMH and treated him with opiates. I consider the cause of death to be natural (although potentially treatable) and the medical care terrible.

PL grading A3

If I can be shown a clear decision to treat the GI bleed conservatively the grading will be A2.

Mathew LOHN (quality assurance)

Mr PACKMAN was admitted to Gosport War Memorial Hospital in July 1999 with an irritating rash on his side and groin. It appears from the medical notes that he had an episode of black stools prior to being discharged from Portsmouth Hospitals NHS trust.

Following admission to Gosport War memorial Hospital on 23rd August 1999 Mr PACKMAN was noted as remaining very poorly with no appetite. It was noted in Mr PACKMANS nursing records that he was passing fresh blood per rectum on 25th August 1999.

On 26th August 1999 he complained of feeling unwell with indigestion pain in his throat together with nausea and vomiting.

At this point he was commenced on opiate medication. No active measures were taken to resuscitate Mr PACKMAN and following rapidly increasing doses of Diamorphine he died on 3rd September 1999.

There is a variation in the view taken of this case by the experts reviewing the notes. Concern is expressed by Dr LAWSON that although the death was natural the gastrointestinal bleed was potentially treatable.

An expert report from a gastrointestinal surgeon/physician is to be sought.

Dr Jonathon MARSHALL (Gastroentorologist)

Mr PACKMAN did not experience a significant life threatening gastrointestinal bleed while an in patient at Portsmouth Hospital. He developed a mild anemia of chronic disease secondary to his underlying medical problems during that part of his admission. His medical state was stable and there was no medical reasons to delay transfer to a 'step down' care facility from an acute hospital.

Mr PACKMAN is likely to have suffered a significant gastrointestinal bleed while an out patient at Gosport War Memorial Hospital (approx 3 days after transfer) Medical assessment at that time was limited and was managed with escalating doses of opiate analgesia before he died on 3rd September 1999.

His main problems recorded throughout his stay were obesity, leg oedema, cellulites, poor mobility, arthritis and pressure sores. His mental state was very good and he had no pain. Overall he doesn't look ill and it was mainly a nursing problem.

During the admission period at the previous hospital the only analgesia he received was paracetamol.

Following the passing of rectal blood a non urgent sigmoidoscopy examination would have been desirable to confirm haemorrhoids and exclude bowel cancer. Transfer for endoscopic therapy should have been considered.

There is no attempt apparently made to ascertain why Mr PACKMAN had become so acutely unwell.

Mr PACKMAN was obese. He would represent a high risk for surgery. It would be difficult to justify the potential mortality of elective surgery in a morbidly obese patient.

SIO decision.

This case will be referred to Drs Black and WILCOCK to give their expert opinion in relation the standard of care afforded to patient PACKMAN.

DW. Det Supt 1.6.2005.

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DOC 274. L'asussin.

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OHAS GOSPORT

What happened at Gosport?

concerns were raised with CHI about the death of an older person at Gosport War Memorial Hospital and whether the death was related to over prescription of diamorphine

What are CHI's main findings?

CHI worked closely with the police throughout the investigation, including its expert witness panel. Findings of the panel were treated as CHI findings in the writing of this report

the use of diamorphine in 1997-1998 was excessive and outside normal

practice

patients were being discharged from the acute hospital to the rehabilitation wards too soon and were sicker than the ward staff expected. The acute trust had not explained the extent of the patients illnesses sufficiently to relatives

Did any / How many patients died as a result of the excessive prescription?

CHI is not in a position to say if anybody died as a direct result of this.

the quantity and combination of drugs could have hastened death in frail older people as it can causes pneumonia and lung collapse

Was this a case of one clinician over prescribing?

 CHI investigates systems failures and does not look to unfairly apportion balme to individuals

in 1997-1998 there were no systems in place to monitor prescribing, no checking of prescriptions and no effective monitoring of the amounts of drugs going out of pharmacy. All contributed to the failure

What has happened to the clinical assistant? Is action being taken?

the individual is no longer the clinical assistant (resigned the post in July

the individual is still admitting patients to the GP ward at Gosport and is still

acting as a GP

there is no current action being taken against them (*this answer is subject to change if circumstances with the GMC change)

Was the over prescription of drugs deliberate euthanasia or an attempt to sedate patients?

CHI does not have any evidence to confirm either way.

prescribing was within guidelines set by the acute trust and Portsmouth Healthcare NHS Trust

COPEDATE LOSTINY? ..

Document1 Created on 22/05/02 10:22 these guidelines were probably too wide and were not tailored to those particular patients

What is the situation now - are patients safe?

- yes the review of recent anonymised case notes show no problems
- policies are in place and being implemented
- the analgesic ladder is being used and there is no evidence of anticipatory prescribing

Are the police or Crown Prosecution Service taking any further action?

- the CPS are not taking further action at present
- the police are looking at the conduct of their own investigation following three complaints

Why has the investigation taken so long - this happened in 1998?

- CHI was first contacted about the situation in August 2001
- CHI's investigation took longer than anticipated because of the decision to undertake a review of recent casenotes so that we could confirm if practices had changes and reassure current patients about their local health service

Why did CHI do the investigation when others have abandoned theirs or decided to take no further action?

- serious concerns were and continue to be raised, three years on
- CHI decided there were potential wide ranging lessons for the whole of the
- if services were safe, CHI wanted to be able to restore confidence in the local health services

If things are OK now, why did CHI invest so much time and money in the investigation?

concerns had been raised with us and until we had completed the investigation, we were not able to confirm whether or not things were safe

Should GPs be working in hospitals? Doesn't this show it is unsafe?

- there should be no problem if trusts have robust systems to ensure their performance is checked and that they are supervised
- GPs need to have appropriate training before undertaking work in hospitals

Is the level of out of hours care sufficient?

- the trust has clear guidelines covering out of hours cover
- CHI has recommended that the trust review these guidelines

Why didn't the consultant in charge do anything?

there was no formal system for appraising the clinical assistant and their practice wasn't checked. The consultant in charge may not, therefore, have been aware of the levels of prescription (Cocrosso)...

The former chief executive has been given a generous redundancy package - was he culpable and is this a pay off?

CHI cannot comment on his redundancy package

there was a wealth of information available to the trust but that wasn't

police checks of trust files did not instigate a trust review of prescribing

Why were rehab patients being given diamorphine?

 there was a problem in defining the level of care – some of the patients admitted for rehab were really palliative care patients

there is a place for sedation and pain relief where the prescription of

diamorphine at these levels would be appropriate

the confusion over levels of care meant some patients were being prescribed levels of pain relief and sedating medication that were inappropriate

Should diamorphine guidelines be reviewed?

national guidelines need to implemented by trusts so that they are appropriate to the patients concerned

Are patients now in pain?

the review of recent case notes did suggest that two patients may have been left in pain longer than necessary

Why didn't the trust investigate?

- the trust believed that they had been exonerated by the outcomes of the three complaints that were investigated by independent reviews / health service ombudsman
- there was an over reliance on external review processes that looked at individual care rather than systems

Isn't this report a whitewash that still doesn't give the families of the patients any answers?

CHI looks at systems not individual cases

CHI has done a fundamental review of policies and procedures to ensure

good quality patient care

practice has improved and we have a duty to acknowledge this, especially so local people can have confidence restored in the treatment and care offered by Gosport War Memorial Hospital

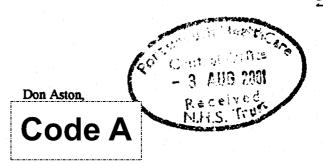
 when CHI finds practices that are unsafe, we say so. We are not hiding anything in publishing this report

From Rut DOC 274.

W

Code A

Mr Ian Piper, Operational Director, Portsmouth HealthCare NHS Trust, PO4 8LD



2nd August 2001

Dear Mr Piper,

Sunday Telegraph 29.7.01 - Police investigate nine deaths at cottage hospital

Please excuse this note. Its purpose is to try to make sure that investigators are fully aware of the major long-standing inconsistencies in the published sources of guidance available to doctors prescribing opioids such as diamorphine in terminal care. It is therefore apparently impossible for hospitals to set out protocols and individual doctors to adopt prescribing practices which do not clash with at least some guidance sources. These inconsistencies relate to indicative dose ranges, the proportion of patients said to be likely to require high doses (please see attached for some examples) and acceptable rate of dose increase as well as other inconsistencies which cannot be covered in a short note. Since 1997 the British Medical Association unaccountably publishes two sources, solely or jointly, and are the ones most likely to be consulted. The British National Formulary is restrictive in terms of indicative dose range, " open " concerning the proportion of patients likely to require high doses and very permissive regarding rate of dose increase. The sudden and unexplained major increase in the upper dose limit in no 33 is believed to have been only as a result of external lobbying. The British Medical Journals hospice-influenced ABC of palliative care (27.9.97 Volume 315) is permissive regarding dose range but very restrictive regarding the proportion of patients said to need high doses and restrictive regarding the acceptable rate of dose increase. Needless to say their Editors have been approached (as have senior doctors at the BMA) but they are not prepared to discuss the matter at all. It might have been hoped they would show more concern for their members/readers who have to do the actual prescribing.

Yours sincerely

Code A

SOURCES OF GUIDANCE AVAILABLE TO DOCTORS ON THE USE OF OPIOIDS (eg MORPHINE, HEROIN) IN TERMINAL CARE IN RECENT PUBLISHED SOURCES AS AT JANUARY 2001

Source

Indicative Dose Range (per 24 hours by any route)

British National Formulary no 32 (to March 97)

30 to 900mg

British National Formulary no 33 (from March 97)

30 to 3, 000mg

Typical Hospice (eg Palliative Care Handbook for the Open University K260)

15 to 15, 000mg (smooth progression over dose range)

British Medical Journal Sept 97 (ABC of palliative care)

30 to 15, 000mg (" very few need high doses - most require less than 200mg a day ")

Palliative Care Formulary 1 Twycross etc

One-third of patients need in excess of 200mg and up to 1200mg

Oxford Textbook of Palliative Medicine

15 to 15, 000mg (" whilst most patients require 200mg/day or less some need much higher doses ")

Oxford Textbook of Oncology Vol 2

30-40% of patients

will require more than 200mg

Cancer Pain Management -McGuire etc & Textbook of Pain 3rd Ed Wall & Melzack

400 - 600mg <u>average</u>
requirement - 10%
require <u>more</u> than
2, 000mg <u>intramuscularly</u>
citing Coyle et al (1990)
Journal of Pain Management

Hospice Palliative Consultants on Opioid Overdoses

[&]quot;Even with accidental overdose 5 - 10 times the routine dose, the patient is only likely to become drowsy for a few hours and then recover spontaneously." Dr Kilian Dunphy "There is abundant evidence of people having been given inadvertently 20, 30 and even on one occasion 100 times what had been prescribed. Whilst it can be a tragic error, the patient may wake up 4 hours later to say it is the best sleep that he has had for some time there is no danger in these drugs." Dr Derek Doyle



Cartron House Farm, Ballinakill, Kylebrack, Loughrea, Co.Galway, Republic of Ireland

Telephone: + 353 090 97 45211 / + 353 090 97 45987 Fax: 00 353 509 45987

e-mail:cartronhouse@hotmail.com

Cartron House was built in 1770 and retains a wealth of the original character and style.

Nestling in the lush Galway countryside, there are spacious lawns and fields surrounding

the house which accentuates the air of rural serenity that Cartron House enjoys

As any visitor to Ireland is aware, we have our share of rainy days! With this in mind, we

opened an indoor recreation area at Cartron House for those guests not wishing to

venture out when the weather turns.

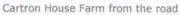
We have now been open to guests for over five years and during that time we have made

so many friends from all over the world, all of whom enjoy the warm informality of Cartron House.

Our guests have use of the sitting room with TV as well as kitchen facilities for tea and

coffee making at any time







The Cottage

home | cartron house | accommodation | dining | the area | special breaks | contact us

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HOME

CARTRON HOUSE

THE ACCOMMODATION

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BREAKDOWN OF EXPENDITURE

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| Professor Forrest | £7957.70 |
| Doctor Anne Naysmith | £23289.35 |
| Doctor Peter Lawson | £26937.80 |
| Doctor Ferner | £33950.05 |
| Irene Waters | £46762.60 |
| Julie Bond (KCT Management) | £1469.90 |
| Mathew Lohn (Field Fisher Waterhouse) | £71492.13 |
| WORM | £23611.35 |
| Doctor Black | £11300.00 |
| Doctor Andrew Wilcock | £29257.50* |
| Doctor Gillespie (X-Ray Expert) | £450.00 |
| Doctor Dudley (Renal Expert) | £1140.00 |

*£17037.50 not included in the print out from E Financials

Gastro Expert not included.

Conferencing, accommodation and travel not included.

Projected total for further work £100,000

Williams, David M

From: Sent:

WATTS, Steve

25 May 2005 19:13

To: Cc: Williams David M: Stephenson Rov.

Code A

Williamson, David

Subject:

RE: Consultant witness interviews.

David,

Thanks for this, further evidence if it were needed of the outstanding determination and dedication of the Rochester team. Im only sorry that I am not part of it for the moment.

Thank you to everyone for what you are doing, this remains the most significant investigation in the Force, and the commitment of the ACPO team is as strong as ever to support you in carrying it through to a successful conclusion (by which I mean a full, impartial and effective investigation that satisfies all parties, most importantly the family members.)

Regards

Steve Watts

From: Sent: To: Williams, David M 25 May 2005 12:30

Stephenson, Roy

Cc:

Code A

WATTS, Steve

Subject: Consultant witness interviews.

Roy/L Code A .all..

Please find attached consultant/clinical assistant list in respect of 3.B's..(Thanks Roy)...

Thanks to all for your continuing work with this.. We are making real progress..there is light at the end of the tunnel..

It seems to me that we can continue to minimise the ongoing effect to the Health Service, by prioritising the key supervising consultant statements to be taken (other than Dr LORD who will be required to comment upon the cases of LAKE, WILSON.SPURGIN, STEVENS in addition to the statement previously supplied in respect of LAVENDER)

Consultant Statements Dr REID (GREGORY) and Dr BANKS (CUNNINGHAM) have been actioned to the able DC GREENALL..

The only other Consultant Statement remaining (Dr TANDY) needs to be taken regarding SERVICE.

<< File: Operation ROCHESTER Key Healthcare Staff 3B'S..doc >>

We will review the ongoing position of Dr LORD with the CPS when we next meet.

By way of update, Roy is in the process of producing a summary of all relevant Healthcare staff statements taken not incorporated into specific 3B investigations.

I have written a week off... week commencing Monday 6th June 2005 to undertake a similar (long awaited) process with all 'other documents'.. (Ant.. To aid the process can you print me off your Disclosure record for other docs)..

At some stage I would like to discuss the position with the 3A's.. I know that we have considered

factoring in similar fact evidence from these upon the basis that they cannot be criminally prosecuted in their own right.. However my thinking is that we will have an abundance of similar fact from the 3B's ..and we may be able to consider NFAing the 3A's.. In the interim Roy will look at the medical notes to determine whether there is anything glaringly obvious that assists either a prosecution case or those in potential jeopardy ..we will also discuss options for disposal with the CPS..

Nigel..

When you are able could you please review the position in respect of cases:-

69 John RITCHIE. 72 Arthur COUSINS 73 Lillian TAYLOR 74 Christina TOWN

They are either Cat 2'S or no scores.. We should be looking to either NFA or forward to GMC and NMC..

Could you also chase up Anne NAYSMITH and Peter LAWSON around:-

89 Alfred LEE... 90 Edith HILL

Thanks..DW.



Operation ROCHESTER.

Category 3B's chronological order of death.

Key Healthcare Staff with a duty of care.

| Patient Details | Ward | Clinical Assistant | Consultant. |
|-----------------------------------------------------|-----------|--------------------|-------------|
| Code A | DRYAD. | Dr BARTON. | Dr TANDY. |
| Elsie LAVENDER Code A Died 06.03.1996. | DAEDALUS. | Dr BARTON. | Dr LORD. |
| Helena SERVICE. Code A Died 05.06.1997. | DRYAD. | Dr BARTON. | Dr TANDY. |
| Ruby LAKE. Code A Died 18.08.1998. | DRYAD. | Dr BARTON. | Dr LORD. |
| Arthur CUNNINGHAM. Code A Died 26.09.1998. | DRYAD. | Dr BARTON. | Dr BANKS. |
| Robert WILSON Code A Died 18.10.1998. | DRYAD. | Dr BARTON. | Dr LORD. |

Enid SPURGIN

Code A

Died 13.04.1999. DRYAD. Dr BARTON.

Dr LORD.

Jean STEVENS

Code A

Died 22.05.1999. DAEDALUS.

Dr BARTON.

Dr LORD.

Elsie DEVINE

Code A

Died 21.11.1999. DRYAD.

Dr BARTON.

Dr REID.

Sheila GREGORY.

Code A

Died 22.11.1999. DRYAD.

DR BARTON.

DR REID.

To Follow Geoffrey PACKMAN.

DW.25.5.05.



Investigator's Notebook

CRIMINAL PROCEDURE INVESTIGATIONS ACT 1996.

6 MARCH 00

information relevant to an investigation, not otherwise recorded in any form, at the time of obtaining or as soon as practicable after that time. Retain means keeping all material obtained in a criminal investigation which may be relevant to the investigation (includes surrounding circumstances of the case) and failure to ensure this, may result in a failed prosecution.

Reveal means ensuring the CPS are aware of all material relevant to the investigation. The CPS will disclose material to the defence if in their opinion it might undermine the case against the accused. Failure to reveal material may result in a failed prosecution.

Reveal

Review, there is a continuing obligation to "4R's" any material that comes to light prior to and during trial.

Review

These books will be issued against signature to all officers engaged on an investigation at its commencement.

At the conclusion of the investigation all books will be surrendered to the Disclosure Officer who will certify their return.

They will be filed with the case papers.

These books should record all notes made, for example:

- conference and other rough notes
- telephone numbers etc.
- notes relating to a witness i.e. statement preparation, the witness name must be linked with those notes.

To assist the Disclosure Officer, an 'S' should be placed in the margin alongside any obvious sensitive entries i.e. Informant, OP's, Police intelligence and Police/witness address/phone numbers. **NO** other document to be maintained except Pocket books, which will still record evidence.



Investigator's Notebook

CRIMINAL PROCEDURE AND INVESTIGATIONS ACT 1996.

Officers have a duty to:

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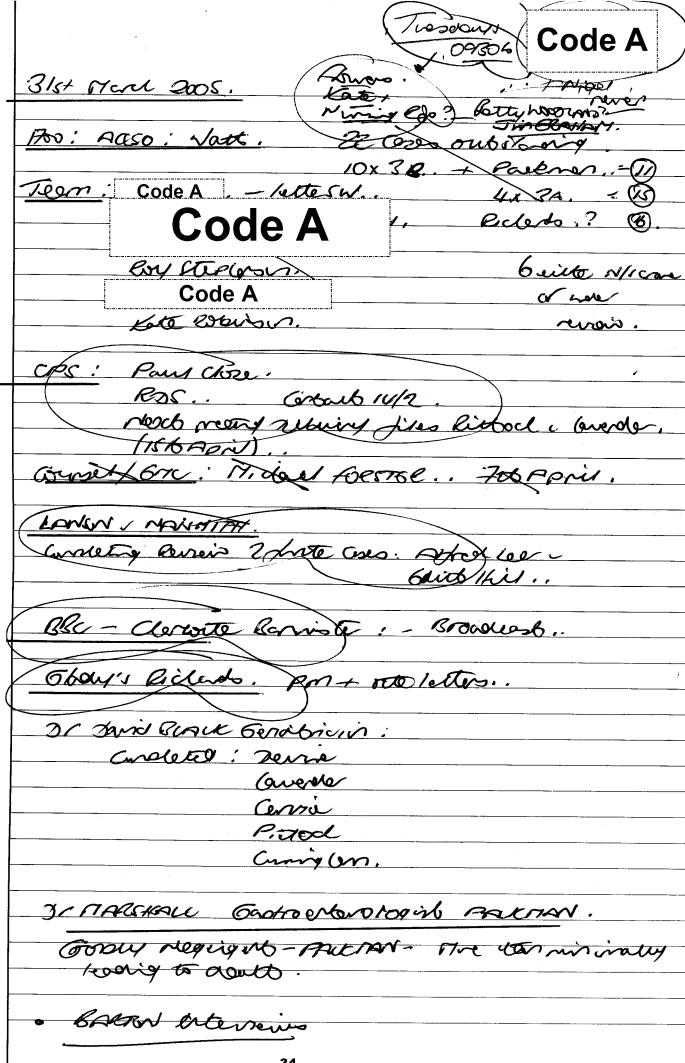
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