S329T(P)

SUMMARY OF CONCLUSIONS

Mr Edwin Carter was a frail 92 year old gentleman who had had multiple medical problems over a number of years. His health started to more rapidly decline and enter a final phase from July 1993. A probable (and in my view likely) diagnosis of carcinoma of stomach was made and he received palliative care in hospital until the time of his death on 24th December 1993.

The dose of Diamorphine and Midazolam started in the syringe driver on 22nd December might be considered to have been excessive; however I believe that this made a negligible contribution to the death of Edwin Carter.

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

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Place

GMC Full registration. No: Code A

Defence Union Medical Defence Union. No: Code A

ORIGINAL

EDUCATION

Leighton Park School, Reading, Berks.	1969-1973
St John's College, Cambridge University.	1974-1977
St Thomas' Hospital, London SE1	1977-1980

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

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4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Edwin Carter (BJC/8)

[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. Mr Edwin Carter was a 92 year old gentleman at the time of his admission to St Mary's General Hospital on 25th October 1993.

5.2. Mr Carter has a long passed medical history including abdominal pain caused by diverticular disease in 1978 (247) (458). He also suffered a left hemiparesis from which he apparently made a good recovery in the same year (252). He had deafness and tinnitus for many years, indeed the deafness going back to the 1940's (252).

5.3. In 1990 he had problems with prostatic symptoms and a urinary tract infection (254). He was due to have a TURP (257) this was postponed (401) because of a fall and a fractured pubic ramus (257). At the same time he was noted to have a raised prostatic specific antigen (17.9) (260) however, as he was never fit enough to have a TURP it was never proven whether or not this represented an early underlying cancer of the prostate gland.

5.4. The same year he was anaemic (271) with multiple faecal occult blood positive samples (368). He was transfused (288) and subsequently a colonoscopy was performed that did not find any serious pathology (360).

5.5. In 1991 he had further urological problems including a hydrocoele (291) and needing to be recatheterised (279 – 280). He also had a cataract operation.

5.6. He had a short admission from 25th April 1992 to the 1st May 1992 with abdominal pain and vomiting (294) that was thought to be a chest infection (299). He was seen in outpatients on 17th June (300) and an elective admission was arranged from the 19th June 1992 – 7th July 1992. He had not walked for 2 weeks and "wanted to die" (301). During this admission he seemed unkeen on rehabilitation, and made little progress, he was still transferring with one, but was really wheelchair dependent. Despite this the residential home was happy to take him back (303) Barthel was 10 (329).

5.7. At an outpatient review in August he was apparently not co-operating with the therapists (305) and he was discharged.

5.8. On 20th July, 1993 he had an emergency admission following a domiciliary visit. The GP had referred on the 7th July (244) because he was deteriorating generally with episodic vomiting with altered blood. The domiciliary visit letter (241-243) documents vomiting and weight loss, feeling fed up and being depressed but he was mobilising indoors. He was discharged on 30th July where as he had not been noted to vomit on the ward but a Barium Meal had been undertaken (238-239). The report of the Barium Meal (407-8) documents an abnormality in the gastric fundus with mucosal irregularity. It was difficult to undertake the procedure because of patient immobility. A gastroscopy to take biopsies is recommended. It was also noted on the abdominal x-ray, that he had abnormal trabecula pattern in the right hemi-pelvis suggestive of Paget's disease. The report of the Barium Meal is suggestive but not diagnostic of gastric cancer.

5.9. A letter from the GP, Dr Robinson, August 1993 (237) notes that Mr Carter is very frail, that there was no question that he could have a gastric operation should cancer be confirmed, that actually undertaking further investigations would be difficult and unpleasant and he suggests that Mr Carter should be just managed symptomatically. The consultant Dr Lord agrees (236) and offers palliative care, if and when, it is needed.

5.10. On 25th October he is admitted as an emergency to St Mary's General Hospital with vomiting and severe back pain. The GP states in his letter that he had already started regular Diamorphine (317). However it is not clear from the GP's letter when it was started and how much the patient was currently on. The GP believes that the patient now needs a syringe driver (317). The admission notes (311-

312) record the fact that Mr Carter had some vomiting and abdominal pain and in the list of drugs after the clerking, the admitting doctor states that he is either continuing or starting (it is not clear) Diamorphine 5 – 10 mgs 4 hourly. I have been unable to find the drug chart for the period of time 25th – 27th October, so cannot comment on the dose of Diamorphine being received.

5.11. Mr Carter is transferred to John Pounds Ward for pain control (44) and is recorded as being on Diamorphine pump (4). A good history and examination is recorded in the notes (323-4) which now documents he does have some mental impairment as well as his deafness. An MTS of 6/10.

5.12. On 29th October (322) he is recorded as being brighter and the notes suggest his Diamorphine is reduced 40 mgs a day and Voltarol is added. Again the drug chart of the Diamorphine prescription on John Pounds Ward appears to be missing from the notes.

5.13. On the 2nd November he is noted to have his pain controlled (322), however he is now completely dependent with a Barthel of 1. His notes state that his son is aware of the prognosis and agrees to Palliative Care. A decision is made to try and convert him to oral medication (morphine slow release 20 mgs twice a day) when the present syringe driver runs out. This is now recorded in the drug charts (34-36).

5.14. On 5th November his family agree to long term care at Gosport War Memorial and it is recorded his pain is well controlled by the oral morphine slow release (MST). He is then admitted on 8th November to Gosport War Memorial for long stay care (320). He is in no pain and does not want to be examined.

5.15. The nursing and medical notes then record between 8th November and 20th December, apart from bouts of nausea, retching, and occasional pyrexia, his pain seems mostly controlled but he is clearly, slowly physically deteriorating. On 20th December it is noted that he was deteriorating further and that sub-cut Diamorphine might be needed (319).

5.16. On 23rd December he is noted to be rapidly deteriorating and that sub-cut analgesia had been commenced the day before. The family

were aware and happy with the management. On 24th December he is recorded as having died peacefully at 12.05 hours.

5.17. Three drug charts are available for comment, the first from 28th October – 8th November (34-39). This demonstrates the MST 20 mgs bd orally was started on the evening of 2nd November and continued until 8th November. As already recorded there is no mention of the Diamorphine.

5.18. The next drug chart goes from 8th November – 22nd December (195 – 203). On the regular prescriptions part, MST 20 mgs bd from 8th November – 13th December and MST 30 mgs bd orally from 13th December – 22nd December are prescribed.

On the as required part ,40 mgs Diamorphine sub-cut in 24 hours is written up on 12th November but is never recorded as being given.

Also on the as required part, Oramorphine 10 mgs in 5 mls, 10 mls 4 – 6 hourly prn is written up on the 11th November. Doses of 10 mgs are given on 13th, 14th, 15th, 16th November and 11th December. Doses of 20 mgs are given on 12th, 13th and 22nd December.

5.19. The third drug chart is a single page (234) which has Diamorphine 80 mgs subcut in 24 hours, Midazolam 40 mgs sub-cut in 24 hours and Hyoscine 200 mcgs sub-cut in 24 hours, all written up on 22nd December and all prescribed on 22nd and 23rd December. On 24th December, Midazolam and Hyoscine both start at the same dose, 08.45 for the Diamorphine, 100 mgs sub-cut in 24 hours is written up and prescribed. This was probably a last minute change of doses as the 80 mg dose is crossed out on the drug chart.

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

6.2. Mr Edwin Carter was a very elderly gentleman at the time of his death who had suffered with multiple pathology including

diverticular disease, cerebrovascular disease, severe deafness, prostatic problems, recurrent problems with indwelling catheters, and explained anaemia, unexplained raised PSA and from 1990 had been living in a residential home.

6.3. He was starting to become frail in 1992, particularly the admission in June where his mobility was declining and possibly his mental state. However, his final illness was certainly apparent by July 1993 when he was having episodes of vomiting, bringing up blood and documented weight loss. To investigate this, a Barium Meal was undertaken. This suggested that he might have a carcinoma of stomach which would be a very likely diagnosis on his symptomatology. However this was never proven by a gastroscopy. 13 years ago it may have been more difficult to get easy access to gastroscopy. The GP, Dr Robinson, suggests and the consultant Dr Lord agrees, that in view of his frailty and declining physical state in someone who was so old, further investigation of a problem that would be untreatable if diagnosed was inappropriate. Both agreed (in particular the GP who knew him very well) that he was coming to the end of his life. Dr Lord agrees to offer palliative care if and when needed. I believe this to have been an acceptable and appropriate management.

6.4. Mr Carter does continue to deteriorate and it is documented that the GP has started him on regular Diamorphine for symptom control, particularly of back pain and distress but we do not know from the notes when this was or what sort of dose. However he is obviously not able to manage him within the community and admits him as an emergency to St Mary's for symptom control and a possible syringe driver. It appears that this does happen, though the drug chart is missing.

6.5. His pain is controlled on the Diamorphine (probably 40 mgs) that he receives in the syringe driver and he is then transferred over to oral medication, Morphine Slow Release (MST). As this is a smaller equivalent dose of morphine to 40 mgs a day of Diamorphine he is on, it is slightly surprising that his pain does become controlled. The dose does need to be increased, in my view appropriately, to 30 mgs bd in December and from the drug chart it is clear that the nursing staff need to give extra doses of Oramorphine on occasion to maintain adequate pain relief. If anything my view is that the dose of Morphine being used may well have been a little bit on the low side, but in someone who has a probable carcinoma of the stomach and recurrent vomiting, often a syringe driver might be a kinder and more effective approach than oral tablets that might well increase the patients

nausea.

6.6. On 20th December he is documented as rapidly deteriorating and on 22nd December is started on a syringe driver. I believe the use of a syringe driver was appropriate and good management. The syringe driver contains Diamorphine, Midazolam and Hyoscine. Diamorphine is started at a dose of 80 mgs sub-cut in 24 hours. In the proceeding 24 hours he had received 60 mgs of MST and 20 mgs of Oramorphine. So a total dose of 80 mgs of Morphine. Normally it would be conventional to convert to Diamorphine at a ratio of 1:2. In other words 40 mgs a day of Diamorphine. Diamorphine is specifically prescribed for pain and is commonly used for the pain of terminal care; it is also very widely used for the distress, without pain, that may occur in patients who are terminally ill from a multitude of causes. However if his symptoms were not controlled then increasing the starting dose by 50% (in this case to a dose of 60 mgs) can be properly justified. 80 mgs might be considered by some as an excessive increase in dosage, with possible risks of over sedation.

Midazolam is widely used subcutaneously in doses of 5 – 80 mgs per 24 hours; it is particularly used for terminal restlessness. Midazolam and Diamorphine can be safely mixed in the same syringe driver. The dose of Midazolam used was 40 mgs for 24 hours which is within current guidelines, although many believe that elderly patients may need a lower dose of 5 -20 mgs per 24 hours (Palliative Care. Chapter 23 in Brocklehurst Text Book of Geriatric Medicine 6th Edition 2003).

6.7. Having received these doses on 22nd to the morning of 24th December a decision is made to slightly increase the Diamorphine to 100 mgs once a day. Although there is no record in the medical dose why an extra increase was needed, this was probably a reasonable clinical decision.

6.8. In my view Mr Edwin Carter died of natural causes almost certainly from Carcinoma of Stomach. His management and decision making was satisfactory. It can be argued that the dose of Diamorphine and Midazolam started in the syringe driver on 22nd December was unnecessarily high, but in my view the only effect might have been very slight shortening of Mr Carter's life by no more than a day or so.

7. OPINION

7.1. Mr Edwin Carter was a frail 92 year old gentleman who had had multiple medical problems over a number of years. His health started

to more rapidly decline and enter a final phase in July 1993. A probable (and in my view likely) diagnosis of carcinoma of stomach was made and he received palliative care in hospital until the time of his death on 24th December 1993.

7.2. The dose of Diamorphine and Midazolam started in the syringe driver on 22nd December might be considered to have been excessive, however I believe that this made a negligible contribution to the death of Edwin Carter.

8 LITERATURE/REFERENCES

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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.
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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: 30/4/06