Annotations made at Con. 6/3/09

Problems noted by Dr Ian R noted 6/3/09

Richard Ian REID (Consultant Geriatrician)

Series of tape recorded interviews with Dr REID in presence of legal representative Will CHILDS under caution 0921hrs – 11600hrs 4.7.06 in respect of Generic Matters Gosport War Memorial and Queen Alexandra Hospitals.

Keypoints:-
Interview Tape Y25.

Dr Reid qualified in 1974; his initial training was conducted in various hospitals in Scotland. After performing Senior Registrar duties in Portsmouth and Southampton Hospitals he was appointed as a Consultant in Geriatric Medicine in 1982.

In March 1998 he took up his current role as Consultant in Geriatric Medicine at Queen Alexandra Hospital, Cosham, he also had the additional responsibility of Medical Director.

His role as Medical Director did not cover General Practice but covered the community hospitals in Fareham, Gosport etc. His role was to provide medical advice and guidance to the Trust Board. He was also the Senior Medical Professional in the Trust.

In 1998/99 he was working half and half as Medical Director and Consultant. His Consultant responsibilities were to Ann Ward (QA), Dryad Ward (GWMH) and clinics at Dolphin Day Hospital and QA.

Interview Tape Y25A.

Dryad Ward would take patients over 65 who were frail and/or had multiple medical problems, slow stream rehabilitation.

His leave entitlement was 6 weeks of which he would take all of it, nobody covered his ward rounds during his absence. Dr Lord, a consultant for Daedalus Ward would have been available should Dr Barton had needed her advice.

As the turnover of the ward (Dryad) was quite low locums were not used as cover.

DR REID performed a weekly ward round on Dryad Ward, on Monday afternoons. DR Barton accompanied him on alternate Mondays as she also attended Daedalus Ward for Dr Lord's round. If Dr Lord was away she would forego the Dryad round. His round lasted about 4 hours, he would spend approximately 12 minutes per patient depending on their conditions. New patients would take longer.

He worked at least 60 hours a week. Clinical Assistants were not in training though they were under the supervision of the Consultant.

Regarding admissions to Dryad most patients would have been seen at QA by one of the Elderly Medicine Consultants and assessed as appropriate for rehabilitation. There were 20 beds on Dryad Ward.

Medical notes were easier to write at Gosport compared to QA as the patients problems were previously well established, they were not 'so medically sick'. He wrote his own notes.

He did not sit down and have regular appraisals with Dr Barton.

In 1998/99 Dryad Ward was for continuing care, assessment for continuing care and Daedalus was for rehabilitation.

Interview tape Y25B.

Dr Barton's role as the Clinical Assistant was to provide 24 hour cover to the wards and to see new patients that came in and attend to any problems. Dr REID was not aware of the Clinical Assistant's Job Description, he had never seen it. He felt that Dr Barton did more than he would have expected in her role in some ways regarding the time she spent at the hospital.

DR REID was satisfied that DR Barton had adequately met the requirements of her job description. He agreed that it was probably the Consultant's responsibility to supervise this.

Patients on Dryad Ward were more medically stable than those on Daedalus, thus she would spend more time there as there were more problems.

Daedalus Ward took patients for rehab, i.e. they would be going back home whereas Dryad took patients for continuing care and whose prospects of getting better were not good.

He had no concerns about either the nursing or medical care.

Patients could be returned to the QA if they became unwell. However if they were unlikely to recover or they were too ill to transfer they would be looked after in a palliative way. Dr Barton usually made those decisions. QA was under huge pressure for beds at that time. It was almost "Well let's send the least suitable patients there" "Well there might be a chance that they might get back on their feet, but it doesn't really look very likely so we'll send them" It's difficult to understate how much pressure there was from QA to fill beds in community hospitals. In an ideal world they would probably have gone to Daedalus Ward. Consequently the turnover of Dryad increased.

Interview Tape Y25C.

On ward rounds typically Dr REID would talk to nursing staff, read medical notes, prescription charts and if appropriate examine patients. They were sometimes conducted with Dr Ravindrane, every other week with Dr Barton and usually with Senior Nursing Staff. Notes would be made if a change in management etc was needed. The purpose of these was for handovers so that others would know what's been happening.

He was not aware of the Wessex Protocols in 1999 or the Palliative Care Handbook. He is not a palliative care expert.

He had not heard of the analgesic ladder in 1999, though its principles were practiced then. Patient's levels of pain are assessed by communication, non verbal clues and clinical observation. The Portsmouth Health Care Trust's policy 'for assessment and management of pain' came about as a consequence of the original GWMH complaints. There was no such policy at Dryad before this.

He was not aware of any policies for prescribing strong opiates at the time. When diamorphine was prescribed the prescribing doctor had responsibility for the patient but ultimately it was the consultant in charge.

It would be very unlikely for Dr REID to have any communication from the hospital about a patient prior to him seeing them on the ward round. In other words a patient could be on the ward for 6 days before he was aware.

Patient notes did not always accompany patients on transfer, though they should have always gone with the patient. It was an option to contact the ward they had come from.

He did not recall either himself or Doctor Barton ever giving patients intravenous infusions. ECG's were carried out on occasions when he or Dr Barton requested them. He couldn't remember anyone having blood transfusions on Dryad Ward.

GWMH was not set up for common medical emergencies, patients would be sent to QA.

He did not remember seeing the 'Operation Policy, Dryad Ward Continuing Care' before (CSY/HF/7). Fundamentally it was the same procedure as when he started.

He remembered that he spoke to Dr Barton on one occasion about her prescribing 20 to 80 milligrams of diamorphine to an unknown patient.

<u>Interview Tape Y25D.</u>

In 1999 Consultants were not regularly appraised, they were regarded as independent medical practitioners and therefore did not need supervision. If somebody had concerns about a Consultant's performance any complaint

would probably have gone to the Chief Executive. Dr REID actually introduced the annual appraisal system for Consultants.

Dr Barton did not have an appraisal system. If she had any problems with the organisation or patients she could seek help from either of the consultants, the hospital manager or the Chief Executive.

Dr REID had no supervisory responsibility for the nursing staff.

Nurses set up syringe drivers and he had no reasons to think they were doing anything other than appropriately. If nurses had reason to, they could speak to appropriate medical or nursing staff regarding prescriptions written up by doctors, similarly with general advice surrounding patient treatment etc. He did not recollect anybody challenging prescribing practice.

Though he and Dr Barton would be responsible for prescribing syringe drivers nurses might suggest it as an option.

Regarding increasing the dose of diamorphine via syringe drivers the guidance was much clearer now, for instance after 24 hours now you would increase by 50%, and then write up a sixth of that for breakthrough pain. In 1999 he would use the BNF advice. The size and age of patients would also influence prescribing. He would use the BNF especially for conversion because that's where the potential for error was.

In general he said that implementing a syringe driver should be written in the medical notes depending on how significant the change in relative dosage was.

<u>Interview tape Y25E.</u>

Explained the prescription chart format etc. He said that he did not recollect when DR Barton started her proactive prescribing, he was only aware of it when he was shown some of the patient notes during the investigation. He recalled that she wrote variable doses. He thinks he was first aware of this early in his time at GWMH.

Described proactive prescribing as prescribing something in the absence of pain and variable where someone was in pain but the nurses are given discretion. He had not seen any policy or guidance as to how large the variance could be. He said that Dr Barton had no authority as such, it was her decision, and she was free to do it though it was not good practice with regards to opiates. She did not speak to him about it.

20 to 40 milligrams was acceptable practice but not 20 to 200. He said you relied on the nurses to start on the starting dose using discretion and common sense.

Regarding patients in pain and who had kidney or liver failure he would check with the BNF before prescribing opiates.

He was shown a copy of CSY/HF/27 'Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion'. He remembered seeing the recording charts but not the rest of it. He read the document but did not recognise it. He was not aware that the nursing staffs were using this at GWMH. He denied that he had drawn the policy up.

He explained the difference between certifying and verifying death. He said that Dr Barton or her partners would be responsible for death certificates; he would not know a patient had died nor would he be notified.

People who had had surgery or an accident within 12 months of death should have that death notified to the coroner. He did not normally see death certificates nor medical causes of death.

Was happy for a doctor to write in the notes 'satisfied for nurses to confirm death' when it's clear that the patient is dying.

Interview Tape Y25F.

On admission of a patient Dr Barton would form a view as to the type of care (e.g. palliative) and so would he. He said that an Elderly Medicine Consultant would have previously written something along the lines of 'Transfer to Gosport for rehabilitation' or 'for further assessment' etc.

Patients conditions could change at or prior to transfer so that the doctor on admission could change the care. He agreed that this should be recorded.

On admission would expect the doctor to record a brief resume, what the patient was transferred with and a management plan. Would not expect as detailed a history as if the patient was being examined from off the street at QA.

Doctors made medical care plans and nurses made the nursing care plans. He did not have great knowledge of the nursing plans, though they would be using information from the medical staff.

Dr Barton was responsible for the initial clerking. There were no policies for completion of notes. He confirmed that medical notes assisted other doctors who might subsequently be called to see the patient.

Described Dr Barton's note keeping as brief but felt that she did record significant changes in condition and management. He said that his busy Mondays did not prevent him from properly writing notes.

When shown CSY/HF/2 agreed that the paragraph concerning accurate and contemporaneous notes was relevant to that time.

Did not raise the issue of note keeping with anybody. He said that when it was difficult for him to follow plans, treatments etc (because of poor notes) he

would speak to the nursing staff to learn what had happened with the patient. He said that this did not happen regularly.

On initial clerking would expect to see Dr Barton to have written a main diagnosis, management plan, to have examined the patient if they were unwell etc.

Could not be specific but recalled that the nursing staff said that in Dr Barton's absence her partners could be reluctant to come in and see patients.

Only remembered one conversation about Dr Barton having concerns about the pressures of her job, this was in early 2000. This centred around the change in patients being sent from QA and causing a higher turnover. Felt that the medical cover was not enough and that a staff grade doctor was required full time. He hoped that this would ~~persuade~~ cause Dr Barton to consider her position so that the money used for her salary would go to the staff grade doctor. Asked why he didn't suggest Dr BARTON to apply for the role he said that her GP role would be far more lucrative.

He said that telephone or verbal prescribing is an accepted practice.

Regarding DR BARTON proactively prescribing diamorphine, oramorph, hyoscine and midazolam he said he had only seen that once, which was the occasion he had spoken to her about it.

Interview Tape Y25G.

Didn't feel that DR Barton kept her notes to the letter of the GMC Guidelines.

Didn't discuss her note keeping with her as she was a senior responsible GP and should know the importance of good note keeping, plus he felt that she did record significant changes.

There would always be a Consultant from Elderly Medicine available on call, but could not remember ever being called by Dr Barton.
Asked if Dr Barton met the standards of his note keeping he said that there were deficiencies.

He was asked about the protocol CSY/HF/27 again. He was also shown a copy of GJQ/HF/39, similar documentation. He agreed that it was documentation emanating from him including a letter regarding a draft protocol which was sent to Dr Barton, Sister Hamblin and others. He agreed that the two were the same documents but in a different font which was why he had not originally recognised it.

It had come about at the same time as the SHIPMAN case and as a consequence of the Gladys Richard case. He felt it appropriate to develop a policy for the management of diamorphine by subcutaneous infusion. He did not relate it to any particular incident at GWMH.

First concerns on prescriptions came about with the Elsie Devine case in March 2000. This involved Fentanyl to Diamorphine prescribed by Dr BARTON. He would have prescribed a smaller dose. The protocol was already in an embryonic stage at this time.

Richard Ian REID (Consultant Geriatrician)

Series of tape recorded interviews with Dr REID in presence of legal representative Will CHILDS under caution 0912hrs – 1410hrs 11.7.06 in respect of Enid SPURGIN.

Keypoints:-
Interview Y25H.

Wrote to a consultant at Haslar agreeing to take over the care of Mrs Spurgin but expressing concern over her hip and to check out that all was well before her transfer on 26th March 1999.

First saw Mrs Spurgin on 7th April 1999. She was in a lot of pain and apprehensive. Increased morphine to 20 milligrams twice daily. Written for x-ray of her right hip as movement painful and there was about a 2 "shortening of her right leg.

She was 92 and very apprehensive so he prescribed a small dose of the tranquilliser (Fluipenthicsal) because fear and anxiety can add to pain.

Next saw patient on 12th April. She was very drowsy and diamorphine infusion had commenced the day before. Dr REID wrote up a reduced dose to 40mgs for 24hrs and should pain re-occur increase to 60 mgs. Wrote that able to move hip without pain but not rousable suggesting that she had been over sedated with diamorphine.

Felt that Dr Barton's clerking in of the patient was brief but contained the salient features.

A fit 50 year old, he would expect to normally rehabilitate. It was a very different matter at 92 particularly someone with a lot of pain in the hip when the chances of rehabilitation were remote.

The term gentle rehabilitation would imply that doctors had considerable doubts about potential to rehabilitate.

In the case of Mrs SPURGIN her chances of mobilisation were very small.

When challenged that Dr BARTON had not properly clerked in the patient Dr REID commented that she was under pressure at the time and as he had said whilst her entries were brief they were salient.

Finally discussion over whether Mrs SPURGIN was capable of carrying her weight on transfer, Haslar said yes, Dr BARTON said no. Stated that Mrs SPURGIN could have deteriorated in the ambulance during transfer, also it was not uncommon for patients condition to be 'over egged' to ensure transfer.

<u>Interview Y25I</u>.

First saw Mrs Spurgin 2 days before she was transferred on 24th March 1999.

Considered that Dr BARTON was more experienced than he in dealing with palliative cases.

Assessed Mrs SPURGIN was suffering hip pain post operatively, not uncommon in elderly patients, thought it important to x-ray the hip.

Stated it was unacceptable that baseline checks such as temperature blood pressure heart and lungs were not recorded at all between the 26th March and 7th April 1999.

It was put that Mrs Spurgin had been on paracetomal until her transfer to GWMH when she was then administered morphine. Agreed that this was quite a jump up the analgesic ladder.

The expectation was that the pain issue would be explored. Following surgery he would get a doctor to examine the hip to see if there were any problems there/ infection.

Deep infection from the hip joint could be difficult to diagnose.

In the case of increasing pain following the successful hip operation something was quite obviously wrong.

In this case it was difficult to know where the long term plan was, did not think he was optimistic about her chances of getting back on her feet.

When asked whether Dr Barton would have access to notes upon transfer of the patient Dr REID commented that it was possible that she had either everything or nothing.

Could not answer why paracetomal was not continued for pain relief upon transfer.

When Dr Barton prescribed ORAMORPH on 26th and 27th March stated that the reasons should have been noted.

Concluded that he did not think it unreasonable to wait and see what happened with analgesia, eg to see how the patient fared over 2 or 3 days with increased amounts and to monitor improvement or not. Lack of progress or increasing pain would be an indication to proceed with further investigation such as x-ray.

Interview Y25J.

At the start of this interview Dr REID handed DC QUADE a document prepared in late 2001 outlining his responsibilities as a medical director of Portsmouth Healthcare Trust. He had ticked his responsibilities in 1999 and had placed 3 crosses against things he was not responsible for in 1999.

Dr Barton had been a regular attendee at consultancy training sessions.

Would have expected Dr Barton to record in notes the patients changing condition.

Highlighted that recent research in the palliative care field had shown there was widespread ignorance around analgesic prescription.

When asked if it was usual for somebody to jump from the bottom to the top of the analgesic ladder commented that it could happen in the event of a patient in a lot of pain.

Regarding Dr Barton's initial prescription of Oramorph, commented that there was probably no alternative.

It was pointed out that Dr BARTON would visit the ward three times a day and had been admitted to GWMH for a total of 18 days, therefore at least 30 visits yet only one entry by Dr BARTON in the medical notes also that

12 days had passed between Dr REID's visit of 7th April and patient admission. No notes had been made by Dr BARTON. Stated that he had access to nursing notes and that he was able to speak to nurses who would record what medical treatment was going on.

Was directing and in overall charge of the patient. Went on to say later in interview that he was appalled there had been no basic record of pulse, temperature and blood temperature (on admission to GWMH) and that was unacceptable.

The issues of Dr REID decreasing the diamorphine infusion from 80 mg to 40 mg per 24hrs was discussed. Had she been on the ward round with him Dr REID would have told her that it was far too much.

The issue of the x-ray instigated by Dr REID was discussed the results would have been available within a couple of days. The nursing note recorded that the results were to be reviewed by Dr REID on his round the following Monday (12th April 1999). Dr REID admitted that he had not reviewed the x ray on the 12th adding that by then it was clear that she was experiencing increasing pain and her skin was breaking down and that these were ominous signs and suggested that he thought that she was pretty close to death. He may not have thought about the x -ray because he felt there were more immediate issues.

Interview Y25K.

By the 12th March 1999 Mrs Spurgin was dying, she was terminally ill.

On admission Mrs Spurgin was prescribed oramorph for pain relief, lactulose for constipation, co-dyromol an analgesic then later diamorphine and hyoscine to dry up chest secretions administered on an as required basis.

Had discussed variable dose prescribing with Dr Barton, she had commented that she was not always immediately available and she did it to ensure that patients received adequate analgesia when they required it.

Trusted the nurses particularly with controlled drugs as there were always two nurses involved in the administration as a safeguard.

In the case of a wide variable dosage 20-200mg Dr REID would expect the nurses to start with the smallest dose.

Could not imagine in this case why the dose of diamorphine was started at 80mg. He had reduced to 40mg.

Interview Y25L.

From the nursing records around the time that the syringe driver started there was a clear indication that Mrs SPURGIN was becoming increasingly distressed and uncomfortable, drowsy at times but then agitated and distressed at other times. This seemed to be an appropriate indication to commence a syringe driver.

Viewed the use of a syringe driver for people regularly receiving small doses as a step up, not a hugely significant event.

Stated that it would have been good practice to have recorded why the syringe driver was started.

Oramorph and morphine had caused vomiting so it was not unreasonable to reduce the strength of the analgesic that was being prescribed to see if the lesser dose would control the pain and at the same time stop the vomiting.

14th July 2006.

Interview Y25M.

Clarified that Mrs SPURGIN received 2 x 20mg doses of morphine tablets on 11th April 1999 before being started on her syringe driver.

Confirmed that he had prescribed Flupenthixol a sedative to Mrs SPURGIN on 7th April but from the prescription sheets he could establish that she had not been administered the drug.

Formed the opinion that Mrs SPURGIN was terminally ill on 12th April 2006 because she was drowsy and irritable this often being a sign that death is very close had not formed that opinion on the 7th April.

Midazolam was prescribed within BNF recommended ranges.

In respect of increasing dosage of Diamorphine and Midazolam commented that it would have been helpful had Dr Barton left written instructions for nurses.

When asked whether he was happy with the variable dose prescribing of 20 – 200mgs of Diamorphine by Dr BARTON, Dr REID stated that he thought the answer was no, he had had a conversation with Dr BARTON, and with hindsight he should have crossed out the prescription and re-written it. The higher level of 200mgs allowed far too much discretion to nursing staff.

The starting dose of 80mgs of diamorphine was too high and it should have been started at a lower level.

Interview Y25N.

Would recommend a lower starting dose. For instance 20mgs and then increase by 50% if the dose insufficient i.e. to 30mgs.

A starting dose of between 25mgs and 45mgs would have been appropriate.

The level of 40mgs that he had reduced the patient to may have still been on the high side but he felt that the lady had been suffering for three weeks he had to make sure that she was not over sedated but at the same time was not going to suffer.

- error!

Did not know why the Midazolam had been increased from 40 to 60 mgs and found it just absolutely amazing particularly an entry an entry on the prescription chart at 1640hrs when the Midazolam was increased

It was difficult to say what cause of death is in a situation where the patients do not have something clearly diagnosable i.e. heart attack or chest infection.

Interview Y25O.

Dr B said this.

The starting dose of 80mgs of Diamorphine prescribed by Dr BARTON was completely inexplicable. Should have spoken to her about it but could not remember if he had.

Cerebral vascular accident is a stroke in laymans terms. There was a reference to Mrs Spurgin 'leaning to the left and having difficulty swallowing' in her nursing notes on 10th April 1999. These could be features of stroke.

There was no written evidence (within the medical notes) to suggest whether Mrs Spurgin had or had not suffered a stroke.

Thought that Mrs Spurgin's death should have been reported to the coroner upon the basis that death had followed within a year of the operation.

In terms of his consultant supervisory duties stated that it consisted of conducting a weekly ward round.

Was working very long hours at the time of dealing with Mrs SPURGIN but this did not affect his ward rounds just the ability to speak with relatives. Latterly he had realised that Dr Barton was very busy, and that GP cover was insufficient with increasing turnover of patients. A Doctor was required Monday to Friday 9-5.

Was not aware of Dr Barton cutting back on anything other than note keeping.

Had approached Dr BARTON towards the end of 1999 and discussed the issue of increasing workload and whether it was possible for her to continue doing her job and shortly after that she tendered her resignation.

Interview 25P.

Confirmed that in layman's terms septicaemia and toxaemia was blood poisoning.

Could not see why analgesics should have been reduced in Mrs Spurgin's case, but agreed that it was appropriate to look at the causes of infection and to be treating them. It was possible that something should have been done in terms of the infection before it was although it was difficult to say in the absence of medical records.

The purpose for getting the x-rays done on 7th April was to see whether there was evidence of infection.

Dr BARTON should have considered speaking to a micro-biologist.

Whilst the pain was being treated nobody addressed what was causing the pain and subsequent increases in pain.

Did not believe that Mrs Spurgin had been overdosed with morphine.

His medical note of the 7th April 1999 was the only note to show that medical assessment had been conducted to exclude potentially reversible causes of the patients deterioration.

Did not recollect a conversation with Mrs Spurgin's nephew on the 12th April 1999 when he was alleged to have said that there was nothing wrong with Mrs Spurgin she was just on a too high dose of diamorphine. Could not imagine saying it.

When asked to explain his comment to Dc Greenhall that Dr Barton and Nurse Hamblin were a formidable pair, he recalled a meeting when he formed the impression that ' this is what we do here, almost this is our patch, you're the new kid on the block and don't interfere. Dr Barton and Nurse Hamblin would make decisions and stick to them without compromise. They were brusque and this attracted complaints. ?

Part of a tape recorded interview with Dr. REID in the presence of legal representative Will CHILDS under caution 1556hrs – 1627hrs 08 08 2006 in respect of Enid SPURGIN

Interview 25X.

Mrs Spurgin's prognosis was for mobilising and eventual return to her home. The patient had been in hospital for about 24 days and during that time she seemed to be in pain from her hip.

There was a possibility of infection or further damage to the hip and that other treatment options may include further discomfort and/or prolonged stay in bed which would be unlikely to restore the lady to full mobility.

The treatment options would be for Mrs Spurgin to return to surgery for examination and the possibility of superficial or deep wound infection. The possible result of further examination may well entail treatment which would render Mrs Spurgin in traction for many weeks or even some months, by which time there would be little chance of her re-mobilising

The x-ray for Mrs Spurgin did not appear to have been done and by the time that Dr. REID saw her 5 days later she was considered to be terminally ill.

It was put to Dr. REID that neither he nor Dr Barton investigated the possible problems of this patient's hip. He stated that he had requested an x ray as previously mentioned, and repeated that when he next saw Mrs Spurgin she was considered to be terminally ill, so pursuance of an x-ray had 'lost it's relevance'.

Confirmed that, according to the medical notes of Mrs Spurgin, she had not been written up as being 'not for 555' (resuscitation). Also that there was no mention that Dr. BARTON was 'happy for nursing staff to confirm death'.

It was put to Dr. REID that in spite of the above, Mrs Spurgin was considered to be terminally ill on 12th April, and Dr. REID agreed that someone should have possibly chased up the x-ray for this patient.

- unlikely to make significant difference.

What would xray show?

- if there were orthopaedic problems (eg crumbly bones) - going back to theatre would have been a disaster. would not alter course

A Superficial wound infection - would have been evident anyway.

Deep wound infect would be devastating for mobility - in the best of patients.

Series of tape recorded interviews with Dr. REID in the presence of legal representative Will CHILDS, under caution between 0907hrs – 1627hrs 08 08 2006 in respect of Geoffrey PACKMAN

Key points:-

Interview Y25Q.

Geoffrey PACKMAN was admitted to Queen Alexandra Hospital suffering from leg ulcers and following an incident at his home where he had become immobile.

He had subsequently been transferred to GWM Hospital for nursing care

He was described as being clinically obese, suffering from pressure sores and arthritis. His life expectancy was described as being poor, but there is nothing recorded to the effect that he was in a terminal phase of life.

In his position he was personally responsible for the care of Geoffrey PACKMAN whilst this patient was in Gosport War Memorial Hospital.

Interview Y25R.

When a patient was admitted to the hospital then that person would be asses by a doctor and nursing staff.

Mr PACKMAN was transferred to Gosport War Memorial Hospital from Queen Alexandra hospital because his major need was for nursing care, at that time he would appear to have been medically stable.

On his transfer to Gosport War Memorial Hospital Mr PACKMAN was prescribed DOXAZIN – 4 milligrams for high blood pressure, FRUSEMIDE (a diuretic) – 80 milligrams per day, CLEXANE – a blood thinning treatment, PARACETAMOL – one gram qds this was his only pain relief.

Mr PACKMAN needed a special bed (large) due to his size.

On a ward round, he would make an overall assessment of what he felt the main issues or patients problems were together with what could be done.

A patient's care plan would change if there was a change in the patient's condition.

Dr Barton was responsible for the treatment of Mr PACKMAN on a day to day basis.
The need arose for Mr Packman's condition to be investigated by means of tests etc. Haemoglobin urea electrolytes and liver function tests, the Haemoglobin tests were to detect any possible bleeding in the bowel.

Any decision making involving a patient should be recorded.

If a doctor was to see a patient then he would expect to see recorded in that patients notes, any interaction, symptoms which the patient may be experiencing together with a record of the results of any examination and treatment.

If a doctor had been called to see a patient for any reason and there had been any significant change in the patient's condition, then he would expect to see this noted in the patient's records.

Initiating any new treatment is significant and should, therefore be recorded

Found nothing in the records of Geoffrey PACKMAN to indicate that this patient was suffering pain.

Was aware of the 'analgesic ladder' and stated "you have to make a judgement about what steps of the ladder you take".

When asked, why Mr PACKMAN who had been on nothing more than one gram of paracetamol 4 times daily and who had no record of documented pain, why there was no record of the reasons for prescribing morphine or other strong opiod to that patient, replied that he was only able to speculate that Dr Barton had felt hat this patient was in sufficient distress caused by a condition which could be relieved by diamorphine.

Did not have any concerns about the care/treatment of Geoffrey PACKMAN.

<u>Interview Y25S.</u>

With regard to keeping up to date with pharmaceutical issues prescribing matters and the fact that he kept himself up to date. The BNF book was described as the 'Bible of Prescribing' and there was usually one on each ward. It was a constant source of information with regards to the possible side effects of drugs and a patient's reaction to new ones.

Had never seen either of the books, Palliative care Formulary or the Nurses Prescribing Formulary.

Mr PACKMAN had not been prescribed any drugs which were new or seldom used that Dr. REID was aware of; he was only ever given drugs which would be used regularly for a patient in Mr. Packman's condition.
Explained the layout of a prescription sheet and that one part is for the actual prescribing by a qualified person whilst the other part was for use by nurses etc. for administration of the drugs / medicines.

Referred to the notes of Geoffrey PACKMAN and listed the drugs prescribed to him as: - Aloperimide for Diarrhoea. On 26th August 1999 at 1800 hours. 10 milligrams of Diamorphine is muscularly prescribed on the basis of a verbal message from Dr. BARTON, with a similar dose on 27th or 28th. Alvine and mepitol dressings for skin wounds, Gaviscon for indigestion, Temazepam 10 – 20 milligrams orally on 24th and 25th August. Doxazosin was given for high blood pressure, Frusemide 80 milligrams administered from 24th through to 31st Clexane (subcutaneous injection) twice daily on 25th and 25th August. Paracetamol 1 gram four times daily, a topical cream and Magnesium Hydroxide 10 mills twice daily.

Was unable to explain the discrepancies in the administration, times and dates as shown on Geoffrey Packman's drugs chart, but said that the range of 40 – 200 milligrams of diamorphine allowed nursing staff discretion to increase the dose in the event of non availability of medical staff.

The range of 40 – 200 milligrams was too large a range at the time when the prescription was written,

Spoke of the side effects of diamorphine with one of them possibly being confusion and that a patient being drowsy may be an indication that the dose is too high.

Proactive prescribing was discussed together with variable dosage which allowed nursing staff flexibility in administering a drug to ease a patient's pain etc.

Agreed the reason for prescribing should always be recorded in the medical notes.

Telephone prescribing and verbal orders, where a nurse might telephone a doctor to explain a patient's current problem and the doctor would give an authority to administer a different drug or an increased dosage.

Nursing staff would prefer to have a written prescription rather than to rely of verbal orders, particularly diamorphine.

Mr PACKMAN was seen by Dr. REID on 1st September and at that time Mr. PACKMAN was on a dose of 40 milligrams of diamorphine, but within hours the dose had been increased, possibly by a nurse (Jill HAMBLIN) when the patient had already been noted as being drowsy on the smaller dose.

Interview Y25T

On 1st September it is recorded that sister Hamblin increased the diamorphine dose of Geoffrey Packman from 40 milligrams to 60 milligrams supposedly to control the patients symptoms, DR. REID was unable to say what these symptoms were because they had not been recorded, even though the patient had been seen by a doctor only hours previously and was noted to have been drowsy but comfortable, the diamorphine dose had been increased by half without explanation.

Relied upon Dr. Barton's knowledge and experience, he trusted her and the nursing staff to care for the patients

Acknowledged the fact that Dr. Barton and Sister Hamblin were more experienced than himself in the actual care of this particular type of patient and for whatever reason Sister Hamblin had seen fit to increase this dose, possibly because the patients condition had changed in the few hours since being seen by the doctor, but the reason for the increase had not been recorded.

Describes Dr Barton and Sister Hamblin as a formidable pair, who knew what they were doing and that they had an established practice of running the ward

Unable to say with any certainty that his clinical opinion was being ignored in this case, but admitted that on a previous occasion he had spoken to ~~medical~~ Dr B X | ~~staff~~ about the range of Diamorphine ~~being too high for a pat~~ient.
Variable

With regard to the use of a syringe driver in the case of Mr Packman, he could only presume that it had taken that level of administration to control the patients symptoms, and because the patient was drowsy and possibly unable to take the drug orally. Was unable to explain why Mr Packman had not been given the drug orally even though he had accepted it orally in the recent past.

Gave no explanation as to why, when Mr Packman had been started on a syringe driver, that the matter had not been recorded or why it had been deemed necessary, even though he accepted that such a matter is a significant change in the patient's condition.

It was Dr. Barton who had prescribed the syringe driver on 26th when Mr Packman was seen and noted to be unwell. Dr Barton had finished the notes with 'keep Comfortable, I am happy for nursing staff to confirm death' but there was no mention at that stage of a syringe driver being commenced. There was a further visit by Dr Barton to Mr Packman but there is no note of the syringe driver commencing. It would then appear that on 30th August a syringe driver was commenced with 40 milligrams of Diamorphine and 20 milligrams of Midazolam and this entry would appear to have been signed by sister Hamblin.

Sister Hamblin would appear to have commenced the syringe driver, in respect of Mr Packman without discussing the matter with a doctor and when

Mr Packman was apparently able to eat and drink a little i.e. he was able to swallow.

It was a 'big decision' to commence a syringe driver' but he was unable to say why sister Hamblin had apparently taken this decision herself, or why she had written in the clinical notes, as opposed to nursing notes.

Mr Packman had been seen by Dr Barton on 26th August, he was noted to be possibly suffering a heart attack and was sufficiently distressed that administration of Oramorph was necessary, therefore Oramorph had been prescribed in two dose strengths of 10 milligrams and up to 20 milligrams.

Mr Packman may have needed Midazolam because he had been stressed or agitated, and that this drug was mostly for mental agitation rather that physical pain.

Interview Y25U.

Diamorphine is an analgesic and included in a group of drugs called opiates which are strong painkillers.

Prior to taking Diamorphine, by referring to the 'analgesic ladder' one would start with Paracetamol and then move up to Coedine and then to extra Coedine and Paracetamol before arriving at drugs which are Opiate related, such as Tramadol. Finally there are the strong Opiates which are known as Morphine and Diamorphine.

Within the analgesic ladder, Diamorphine fits into stage three, which is at the top of the ladder, being the strongest level of painkiller.

Mr Packman had been prescribed Diamorphine in a range of 40 – 200, and this gap / range had been to allow for nursing staff to use their discretion if the starting dose had not been able to control the patient's symptoms.

Midazolam could be used in conjunction with Diamorphine to be administered via a syringe driver and the same range of dosage would be applied in accordance with the analgesic ladder.

Would not expect a nurse to administer the highest range of a drug from the outset, he said that the lower range would be the starting point.

The Diamorphine was prescribed to Mr Packman on 26th August but it had not been actually administered until 30th August, a gap of four days, this was pro-active prescribing.

Mr Packman had originally been prescribed Oramorph as a regular prescription, and the Diamorphine prescription was pro-active in the sense that if the patient was no longer able to take medication orally or that the pain was not controlled then this situation would allow the Diamorphine to be introduced.

Was unable to comment with regard to what circumstances had arisen whereby the patient had been administered the Diamorphine i.e. whether the patient was unable to take oral medication or that the pain was not controlled. Mr Packman was eating small quantities.

Pro-active prescribing policy was not required if a doctor was going to see the patient once a day or was available.

There was nothing in place at that time, as a guide to nursing staff regarding what increase should be made within the prescribed range of 40-200 milligrams. There were no checks or safeguards on this issue other than it was a requirement for two nurses to carry out the procedure of administration of controlled drugs such as diamorphine.

It was difficult to say whether or not Mr Packman was in the terminal phase of his life by the time he was receiving Diamorphine because Dr Barton had written on the notes, 'remains poorly but comfortable, continue with opiates over the weekend' which implied to him that this patient was seriously ill.

A person could be seriously ill but treatable.

In the case of Mr Packman, it was difficult to say from the notes that he was terminally ill at that stage.

He would expect to see written justification for the use of Diamorphine because it was a switch from oral medication to Diamorphine.

An excessive dose of Diamorphine, would vary from patient to patient. Also the fact that a patient may be opiate-naïve but the best answer to this lay with an expert in Pharmacology.

60 milligrams of oramorph converted to a dose of 20 Milligrams of Diamorphine.

Had not advised Dr Barton about her prescribing regime because he had never been asked to. Had not noticed the variance of doses in this case, but said that if he had noticed the variable dosage the he should have said something.

Saw Mr Packman on 1st and noted that he was drowsy but did not feel that he had been overdosed with Diamorphine.

There was no justification in Mr Packman's notes regarding the use of Midazolam.

When he saw Mr. PACKMAN on 1st September he was in the terminal phase of his life, because Mr Packman was taking a fair amount of opiate for pain control, he was passing 'melina stool' and bleeding from the gut, the overall

picture was one in a terminal phase of life. Therefore, despite the apparent symptoms of the patient, he was not referred to another consultant.

Mr Packman was unlikely to have suffered a heart attack and that the main cause of his deterioration was due to the internal bleeding.

Explained the policy of 'not for 555' (not for resuscitation) which was the case for Mr Packman but stated that this did not mean that the patient was not to be diagnosed, treated and possibly cured of the presenting complaints.

Interview Y25V.

Mr Packman is recorded as having died of Myocardial Infarction, and that there is no reference to a heart problem when seen by Dr REID two days earlier.

There was a discussion about the availability of supervision, guidance and study leave for staff, including Dr. Barton if ever that person thought it useful.

It didn't take long to write out patient notes and that to the best of his recollection, there had not been a time when Dr Barton had complained to him about the her work load being too great.

If there was sufficient interaction with a patient then it should be noted.

Had there been any adverse reports with regards to Dr Barton then he would have tackled her on any relevant issues, but from his understandings, she was regularly on the wards in accordance with her contract and more, sometimes two or three times a day.

Explained his personal method of ward rounds and days it was carried out.

When he saw Mr Packman on 1st September, he was dying and was suffering a GI bleed for which he would not be treated for. The patient was to be made comfortable and allowed to pass away peacefully.

Mr Packman was suffering a GI Bleed as opposed to MI because of the huge drop in haemoglobin in a short time. Also the patient was passing black stools caused by bleeding in the upper gut.

Interview Y25W.

On 23rd August, the day Mr Packman arrived at Gosport War Memorial Hospital, he is seen by Dr. Ravindrane and assessed. It is noted that, as on previous occasions, Mr Packman may be suffering a GI bleed. Dr. REID stated that a GI bleed is a life threatening medical emergency, which is treatable but with difficulty, explained some treatments.

The symptoms of being pale, clammy and unwell are very consistent with GI bleeding, and he was sure of this by 1st September following the results of the check. Nothing further was done because a decision had to be made as to whether or not it was in the patient's best interest to transfer to another hospital for the necessary treatment / blood transfusion etc. and whether or not a patient in this condition would even survive the transfer.

There was no evidence, other than Dr Barton's note entry to support the fact that Mr Packman was not fit for transfer, but Dr. REID stated that it was a judgement which had to be made at the time.

When Mr Packman arrived at Gosport War Memorial Hospital, he was not in immediate expectation of death, despite his obesity and presenting complaints. He may well have been 'on the slippery slope' but he could not tell at that time if Mr. PACKMAN would survive one week or six months.

There was anything in the medical notes where Mr Packman's wife was made aware of his condition and the decision not to transfer him for further treatment or blood transfusion.

Persons charged with looking after MR. PACKMAN had a duty of care to him and his wife, but on looking at the notes, it would seem that little was done in respect of either.

Did speak with Dr Barton about variable dose prescribing but he was unable to recall as to what particular patient it was regarding.

There were no set safeguards to prevent a patient being administered an unintentional dose other than the expectation of nursing staff to start with the lowest dose.

Interview Y25X.

Agreed that on 27th August the patient's condition would appear to have stabilised, and that there should have been sufficient time to obtain the haemoglobin results from the check on the previous day.

Unable to give an explanation as to why Mr Packman had not been transferred for treatment to another hospital when his condition would appear to have improved.

Mr Packman's condition was not discussed with a gastroenterologist or the on-call medical team.

Mr Packman had complained of left sided abdominal pain on 29th August. It would be unusual for the cause of such pain to be Myocardial Infarction.

Mr Packman was started on a syringe driver on 30th, when he is noted to have slept for long periods the previous night. He would appear to have complained

of left abdominal pain and there is a 'query' indigestion'. Unable to give an explanation as to why Sister Hamblin started this patient on a syringe driver at that time.

He was not certain if the syringe driver was appropriate at that time, because there is no record of it being required for use at that particular time.

Agreed it appeared, that a nurse had made a decision to start Mr Packman on a syringe driver, but there is no record of that nurse having discussed it with Dr Barton, so was not able to say as to whether or not it was a satisfactory situation.

There was some discussion regarding the haemoglobin test and the fact that the result, although available, was not received for some time, and whether or not there would have been an alternative route for the treatment of Geoffrey PACKMAN, either through his verbal wishes or the requirements of his wife and the ethics of it all.

Didn't know if Dr Barton had at any stage made the correct diagnosis of Mr Packman.

Not able to say as to whether or not Dr Barton had ever acted on the results of the haemoglobin check results, even though she had seen them.

As far as he was concerned he had fulfilled his duty of care in respect of Mr Packman, he was aware that discussion had taken place between medical staff and Mrs Packman about her husbands condition and the management of it, he had to take some things on trust, such as what others had recorded, and these factors would influence him in his decision with regards to the treatment of this patient.

In hindsight, there should have been better documentation in the case of Mr Packman. In his opinion Mr Packman died from a Gastro-Intestinal bleed and if
he was to certify Mr Packman's death today he would put the cause of death as being a Gastro-Intestinal bleed.