Portsmouth Hospitals NHS
NHS Trust

Our Ref: RIR/ij
Your Ref: BSPK/4007152-0002/BJZM

Division of Medicine for Older People

Gosport War Memorial Hospital
Bury Road
GOSPORT
PO12 3PW

Code A

Mr Stuart Knowles
Consultant
Mills & Reeve LLP
78-84 Colmore Row
BIRMINGHAM
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Date: 13th January 2009

Dear Mr Knowles Stuart

Re: **Gosport Inquests (Joint instruction)**

Thank you for your letters of the 4th December 2008 and 6th January 2009 and our subsequent telephone conversation.

You have asked me to make comments in relation to three areas. Firstly comments on the statements provided by the two expert witnesses, Dr Andrew Wilcock and Professor David Black Secondly you have asked me to comment on the difference between prescribing practice now and in 1999 and thirdly you asked me to comment on Dr Barton's practice in 1999.

1. With regard to the comments of the expert witnesses it is notable that there are two main issues – inadequate note keeping and prescribing practice, particularly in relation to opiates.

Dr Wilcock also felt that in relation to two of the cases, Enid Spurgin and Geoffrey Packman, there was a case to be answered that the care was grossly negligent. This did not appear to be the view of Professor Black.

In relation to note keeping, best practice would dictate that every encounter with a patient is documented. A particular criticism is that on occasions opiates were prescribed or the dose increased without any apparent justification in the medical records. This is fair comment.

The second criticism is of prescribing practice, particularly opiates. Dr Wilcock's view would appear to be one of marked caution particularly in prescribing for the very elderly and would appear at times not to be set in context ie on some occasions his view would appear to be ensuring safe prescribing and not necessarily effective prescribing, given that in at least one of the patients the nursing documentation is littered with references to the patient being in pain.

Dr Wilcock specifically criticises me for not reducing the dose of Diamorphine enough (or stopping it). I can provide a detailed response to this if you wish.

Continued/...

**Gosport Inquests (Joint instruction) - continued**

Thirdly in relation to the case to be made for gross negligence I feel that in both patients, Enid Spurgin and Geoffrey Packman, Dr Wilcock has failed to take account of, or has not recognised the prognosis of both of these patients in his comments on their management. In my view both of these patients had an extremely poor prognosis which Dr Wilcock appears not to have recognised, ie his views on the management of these two patients have not been set in context. It is perhaps of note that he is a palliative care physician with an interest in medical oncology and I believe that one would have to question how much experience he has had in managing patients like Mrs Spurgin and Mr Packman. It is notable that Professor Black who practices in geriatric medicine, and who almost certainly has extensive experience of dealing with such patients, felt that both these patients had an (extremely) poor prognosis.

I also believe that Dr Wilcock's views on what would have been optimal management of these patients reflects academic palliative care practice and does not even reflect mainstream palliative/hospice practice today, eg Dr Wilcock refers to measuring respiratory rate and oxygen saturations. This would not be practised within the Rowans Hospice locally, according to the senior consultant there, Dr Huw Jones, to whom I spoke recently. Also Dr Wilcock refers to administering Naloxone to reverse the effects of opiates. This is not without problems, ie causing significant pain !!

2. Next you asked me to comment in the difference between prescribing practice then and now.

I think that medical and nursing staff within our department are now much better informed, about prescribing of opiates, in particular, than they were in 1999.

In 1999 I was not aware of the existence of the Wessex Palliative Care Protocols nor, would I suspect, were (most of) my consultant colleagues. I also suspect in 1999 there was low awareness of good prescribing practice of opiates within General Practice.

In 2009, while prescribing practice of opiates within the Department of Medicine for Older People is good, I do not believe that that knowledge extends far beyond our own department (and the Palliative Care Service). Many junior staff come into our department poorly educated in the prescribing of opiates. My local consultants in palliative care tell me that palliative care (opiate) prescribing in primary care (General Practice) is still poor.

As you are aware, Diamorphine and other drugs were prescribed with a (wide) dosage range in 1999. I do not believe that this would happen today, certainly within the Division of Medicine for Older Persons, but two of my colleagues in Portsmouth, Dr David Jarrett and Dr Jane Tandy have told me that they quite clearly remember opiates being prescribed in a variable dose in other hospitals within Portsmouth (including the acute hospital) when syringe drivers were first introduced (sometime before 1999).

It is also of note that even today the Wessex Palliative Care Protocols refer to the fact that it may be necessary to administer between 20mg and 200mg of Diamorphine to relieve pain and it may have been from this source that variable dose prescribing arose.

3. Lastly you asked me to comment on Dr Barton's practice. Was this common in 1999?

In relation to note keeping it has been my experience when visiting community hospitals where GP's provide day-to-day care that note keeping was of a standard not dissimilar to that of Dr Barton.

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**Gosport Inquests (Joint instruction) - continued**

In 1999 I had recently moved to Portsmouth from Southampton and had experience of note keeping in Romsey Hospital and to a lesser extent Fenwick Hospital and Lymington Infirmary, where note keeping was of a similarly brief nature, much as would have been the case within GP records in primary care at that time.

I think it would be important to point out that on transfer to a community hospital one would not expect the same detail of clerking and note keeping as would be undertaken on admission to an acute hospital. (On occasions I have seen patients in community hospitals who have had nothing recorded in their notes on admission!!)

My impression was that while Dr Barton's notes were usually brief, she had usually captured the essence of the reason for transfer in her notes and recorded important changes in patients' condition.

In relation to prescribing in GP community hospitals and in primary care, my experience and that palliative care consultant colleagues in Southampton, was that it was generally poor in 1999 and remains poor today.

I hope these comments are helpful. If you would like me to elaborate further should be very happy to do so.

Yours sincerely

Code A

Dr R I Reid
Consultant Geriatrician

Portsmouth Hospitals NHS
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Mr Stuart Knowles
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Date: 16th January 2009

Dear Mr Knowles

**Re: Gosport Inquests (Joint instruction)**

Further to our telephone conversation I am writing to expand on the comments in my earlier letter in relation to one of the expert witnesses, Dr Andrew Wilcock, whom the coroner proposes to call to the inquest to give evidence.

In relation to the care of Enid Spurgin, on page 38 of his statement (first paragraph, first line) Dr Wilcock records that "in my view Mrs Spurgin was not anticipated to be dying ---".

Fractured neck of femur incurs a very high mortality (up to 25%). Mortality will be even higher in patients who are more elderly (Mrs Spurgin was 92) and who develop complications following their operation (as Mrs Spurgin did), and who also have existing medical conditions as Mrs Spurgin did – ischaemic heart disease, mild memory impairment. Continuing pain after an operation for fractured neck of femur is, in my view, a very poor prognostic fact for survival.

Dr Wilcock doubts the cause of death as laid out in the death certificate but offers no further opinion on cause of death.

In respect of Geoffrey Packman, on page 47 (paragraph 2, line 11) of his statement Dr Wilcock records that (Mr Packman) "--- had no known underlying life-threatening illness, death was not anticipated ---".

This view is grossly erroneous.

Marked obesity itself confers a significantly reduced life expectancy. Mr Packman had gross arthritis of both knees and had become immobile. Immobility further reduces life expectancy. Very significantly he had extensive pressure sores which would put him at risk of sepsis (and increased mortality). In addition he was incontinent of urine and faeces. This would inevitably contaminate his pressure sores making sepsis and its complications stress peptic ulceration, gastrointestinal haemorrhage and death.

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The statements by Dr Wilcock would lead me to question how much experience he has in managing elderly patients who have sustained a fractured hip with complications and elderly patients with gross obesity, immobility and extensive pressure sores.

I note that his curriculum vitae states "---includes experience in health care of elderly (acute medicine and rehabilitation) ---". This would appear to have been at junior doctor level and is likely to have been four to six months at the most. He would not appear to have had any experience at consultant level in dealing with such patients.

This, and the statements above, which no doubt reflect his lack of experience in elderly medicine, would lead me to question his suitability as an expert witness at an inquest, the primary purpose of which is to determine cause of death.

Yours sincerely

**Code A**

Dr R I Reid
Consultant Geriatrician