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ABD/DEJ

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Private & Confidential

Code A

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Dear Stuart

RE: Gosport War Memorial Hospital Inquests

Thank you for asking me to read through and comment on the expert reports of Dr Andrew Wilcock and Professor David Black, prepared as part of the police inquiry into the deaths at Gosport. Following is a summary of my thoughts.

For background information, I have been a Consultant Geriatrician in Portsmouth for nineteen years and I am currently the Divisional Clinical Director for Medicine for Older People. Although I have worked in many areas of the service, I have never had clinical responsibility for the inpatient beds at Gosport War Memorial Hospital.

I felt a number of themes emerged from reading the expert reports, which I have summarized below. In addition I have attached my comments on particular areas of the reports as an appendix, which is referenced by page number of each particular report. These comments are made without the benefit of reading the hospital records and purely on the expert statements.

On the evidence presented in the witness reports, there would appear to have been poor documentation of assessments and rationale behind decision making about treatment plans and this is a recurring theme from both experts in all the cases.

Most of the patients were transferred to Dryad Ward and some of the reports state the patients were being transferred for rehabilitation, which may suggest that patients were fitter than they actually were. Dryad was a continuing care ward; NHS continuing care is for those most frail whose needs are complex and intense. It is not uncommon for this group of patients to be at the end of their life.

On many occasions the starting doses of Diamorphine and Midazolam may have been higher than I would use myself in clinical practice. Also wide dose ranges were used, which again may not be common practice. Saying this, the context must be borne in mind. These patients were in Gosport War Memorial Hospital about ten years ago and like many community hospitals at the time, there was relatively limited medical presence with day-to-day medical input for inpatients provided from the general practice, primarily Dr Barton in this case, and this work would be fitted in around her day-to-day work as a general practitioner.

Cont/d..............

Patients on Dryad Ward were often extremely frail and the proportion would be at the end of their life. Although people can die without symptoms, many do develop symptoms as part of their terminal illness. There are a number of drugs commonly used for end of life symptoms, which include Diamorphine, Midazolam and Hyoscine and these can be prescribed if needed so that a patient is not suffering in distress at the end of life whilst awaiting the attendance of a doctor who is not working on site. It would be more usual just to have intermittent doses prescribed if required rather than a syringe driver with these medications. Nevertheless one can see the rationale behind this.

The striking feature of the reports is that the two expert witnesses often came to different conclusions about whether patients were at the end of their life. In particular Dr Wilcock felt that there was doubt in the case of Elsie Lavender, Enid Spurgin, Geoffrey Packman and Elsie Devine about whether they were at the end of their life and, therefore, whether the medication and management could have significantly contributed to death. In all of these cases, Professor Black's assessment was that these patients were terminally ill and that medication may have had a minimal impact, shortening life by no more than hours to days at most. This partly highlights the difficulty even for experts in identifying when somebody is at the end of their life. It may also reflect their areas of expertise. Palliative care consultants often see a significant number of patients with cancer, which has a very different disease trajectory to the frail elderly with multiple co-morbidities. Cancer patients often maintain a good functional status for some time after diagnosis and then have a relatively rapid functional decline at the end of their life. The disease trajectory for the frail elderly with multiple co-morbidities is a more chronic fluctuating downward trend. This makes it much harder to identify the terminal phase of life. Geriatricians see many such patients and are, therefore, more likely to identify this end of life phase.

It is also of note that although both experts agreed that by and large starting doses were often higher than one might expect, Professor Black felt that in all but the case of Robert Wilson, the impact of medication and management was likely to have been minimal on life expectancies and certainly no more than hours or days. The one case where he felt medication may have had a significant contribution, the other expert Dr Wilcock felt that drugs were likely to have had a minimal impact. This again highlights difficulties around decision making, as a number of factors need to be taken into account when deciding doses of medication including symptom severity, other co-morbidities of the patient, age, size etc.

I hope this overview and the attached appendix highlighting my thoughts on some of the statements made in the expert reports is helpful. If you require any further information, please do not hesitate to contact me, otherwise I am sure we will have the opportunity to discuss this more fully at the meeting on 6th March 2009.

Yours sincerely

Dr A B Dowd, FRCP
Divisional Clinical Director

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APPENDIX

Code A

a) Dr A Wilcock

P3 – "If pain was a problem, it was not recorded or assessed". The statement does say however that pain was documented in the nursing notes (right wrist and generalized).

P3 – Last paragraph – Diamorphine may contribute to agitation in which case it would be appropriate to reduce the dose. However, agitation may also be due to pain, in which case an increase in Diamorphine dose would be appropriate.

P11 – "Also increasing anxiety and agitation, ? sufficient Diazepam, ? needs opiates" – This entry indicates that Dr Barton had considered both whether drug withdrawal or pain might be causing agitation.

P11 – Code A stated that he had generalized pain". This indicates his pain was not controlled by Arthrotec.

P12 – "Condition remains very poor. Some agitation was noticed when attended to" – This could suggest pain was a factor in his agitation and therefore an increase in Diamorphine may be appropriate.

P13 – "Remains distressed on turning". Again supports the possibility that pain is causing distress and so requires an increase in analgesia.

P14 – The syringe driver had constant doses of medication for 48 hours before death i.e. death did not occur shortly after the Diamorphine dose was increased.

P21 – "Why the Arthrotec was stopped or why a 'weak' opiod like codeine was not felt appropriate". If Arthrotec had not controlled pain, it is very possible that Codeine also would not have controlled pain, in which the next step would be opiates.

P23 – Code A painful right hand held in flexion .... it may have been tetany. This is extremely rare and unusual to see in clinical practice. A painful wrist is much more common due to arthritis of some sort.

P23 – "Hypocalcaemia is reported to cause mood disturbance such as anxiety and agitation, it would have been particularly relevant to consider". These features were described as being present on admission to Mulberry Ward and felt by the Psychiatrist to relate to his depression.

P24 – "If opioids were being suggested for his painful hand, this would be inappropriate". It would be appropriate if weaker analgesics had failed to control symptoms (he had already had Arthrotec).

P30 – "It is not usual in my experience for such decisions to be left for nurses to make alone"

- the nurses did have input from Dr Barton as several entries document
- what is Dr Wilcock's experience of delivering palliative care either in a cottage hospital 10 years ago or in the patients own home – nursing staff have a large part to play.

b) Prof David Black

Based on the expert witness statement of Prof Black, it would seem documentation was poor and a higher than normal starting dose of Diamorphine was given.

P18 – "This would again suggest that the patient was being given a higher dose of Midazolam than would usually be required for symptom relief". However, he was a previous user of Benzodiazepines and therefore would be likely to need a higher dose of Midazolam (supported in Dr Wilcock's statement).

P19 – "The combination of the high doses of Diamorphine, the high doses of Midazolam and the high doses of Nozinan are in my view likely to have caused excessive sedation". There are entries in the nursing notes on 15th, 16th 17th and 18th about agitation on movement and symptoms difficult to control. This implies that rather than being over sedated, his distressing symptoms were not fully controlled.

2) ELSIE LAVENDER

a) Dr Andrew Wilcock

P21 – "Particularly as her neurological findings could also be in keeping with cervical spinal cord and nerve root trauma"

- cervical root damage would not give upgoing plantars
- cervical spine damage is more likely to give bilateral signs, not unilateral as stated
- unilateral weakness and upgoing plantar most commonly seen in a stroke

P21 – Cervical spine X-ray would have shown bone injury but not neurological damage

P30 – "As the pain got worse despite increasing the morphine, consideration should have been given to the fact that the pain was not responding to morphine". Dr Black previously stated that incident pain is difficult to control and may need doses of morphine that cause sedation at rest.

P31 – "Such decisions should not be left to a nurse" – nursing staff have a large part to play in a cottage hospital or if a patient is dying at home.

Dr Wilcock expresses doubt in the conclusion that this lady was terminally ill. Prof Black's assessment is different, that this lady had complex problems and was seriously ill.

b) Prof David Black

I have not seen patient records to judge further. Prof Black describes a lady with multiple and complex problems, increasing physical dependency causing very considerable patient distress. This is a very different picture from that given in Dr Wilcock's statement.

P15 – Dr Wilcock's summary of notes suggests unilateral neurological signs, which would be consistent with a stroke.

P18 – Although Prof Black and Dr Wilcocks both feel the starting dose of Diamorphine excessive, they have differing views of what would be the expected starting dose.

3) <u>HELENA SERVICE</u>

a) <u>Dr A Wilcock</u>

P3 - Mrs Service's behaviour remained challenging at times despite the use of Thioridazine could suggest her agitation/distress had not been adequately addressed prior to transfer.

P17 - A gallop rhythm suggests this lady was still in heart failure.

P19 - Nursing notes record "failed to settle – very restless and agitated" – the staff had therefore been trying to use non drug means to settle her agitation until the early hours of the morning. It could be argued it would have been wrong to leave Mrs Service in an agitated state for the rest of the night.

P19 – I would agree that doing blood tests in a terminally ill patient is not indicated. However, they do demonstrate her renal function had deteriorated again within 2 weeks of stopping her intravenous fluids. This would indicate frailty and support the notion that she was entering a terminal phase of life.

P27 – Dr Wilcock surmises from the notes that although Mrs Service may well have been in heart failure, this did not appear to be as severe as on her admission to F1 where Midazolam and opioids were not used. There was poor record keeping on Dryad Ward and so it is difficult to support this assumption.

P29 – Dehydration and low potassium could have contributed to worsening confusion. However, Mrs Service had variable confusion/agitation throughout her hospital stay/even when her renal function was better.

P34 – There is clearly a difference of opinion from two 'experts' about the doses of diamorphine.

P37 – haloperidol and benzodiazepines both have advantages and disadvantages and both are commonly used in clinical practice for agitation. I am unaware of a good evidence base that haloperidol is significantly better than benzodiazepines.

Dr Wilcock does not mention what Prof Black identified from the nursing notes that on 2nd June she remained continuously breathless and needed to be nursed upright all night. This suggests acute heart failure, for which diamorphine would be indicated.

b) Prof Black

Prof Black clearly identifies a lady in a terminal illness, which Dr Wilcock has not.

P6 – 20mg midazolam and 20mg diamorphine are both felt to be within a reasonable range, albeit at the higher limit for an older person.

P7 – "the dose of 20mg diamorphine combined with the 40mg dose of midazolam was higher than necessary". However, Dr Wilcock commented that nursing notes indicated Mrs Service remained restless on the syringe driver of 20mg midazolam, suggesting the need to increase medication to address symptom control.

4) RUBY LAKE

b) Dr Wilcock

P3 – Dr Wilcock describes a lady of 84 with multiple medical problems, a fractured femur and difficult post operative course. He does not comment on the high mortality and morbidity in such patients. He also comments that she appeared to be progressing rather than deteriorating. Although she had started to stand with help, she had ongoing confusion in the evening and had fever prior to transfer to Gosport despite a previous course of antibiotics for a chest infection, which indicates a lady with frailty and ongoing health problems, not one who was significantly improving.

P4 – "No justification given for the prescription of morphine or the drugs administered in the syringe driver". The nursing notes record chest pain and a 'bubbly' chest and there is previous evidence of heart disease. Diamorphine is commonly used for heart pain and hyoscine for a 'bubbly' chest to dry the secretions.

P13 – Dr Lord, Consultant Geriatrician in her assessment supports the picture of a frail lady who may be at the end of her life – "it is difficult to know how much she will improve".

P27 – "Morphine is indicated for the relief of pain, breathlessness or cough. In patients with cancer this is generally when underlying causes have been treated". However it is commonly used first line for severe chest pain related to the heart.

P29 – "a starting dose of diamorphine 10mg/24h would have been more appropriate". However Prof Black's assessment is that "it is probably reasonable to have started with 20mg diamorphine in the syringe driver over the first 24 hours.

P32 – "it is possible that Mrs Lake had naturally entered the terminal phase of her life ..... generally heralded by a more gradual decline over several days or weeks". A fall in an older person is a marker of increasing frailty and functional decline. Additionally there is a significant morbidity and mortality attached to hip fracture.

c) Prof Black

Prof Black points out the often poor outcome after hip fracture in older people and the fact that her fever never actually settled prior to transfer.

5) ARTHUR CUNNINGHAM

a) Dr Wilcock

Concludes that Mr Cummingham was dying in an expected way and the use of diamorphine, midazolam and hyoscine were justified. The starting doses used and the doses subsequently received of diamorphine, midazolam and hyoscine were not unusual and had been arrived at in a stepwise fashion.

P27 – "it does not appear as though Dr Lord necessarily anticipated that Mr Cunningham was imminently dying". As Prof Black point out in his statement, it is unusual for a Consultant to write "poor prognosis" unless they believe the patient is terminally ill. The history prior to his admission to Dryad Ward also shows a downward spiral in an already frail man.

b) Prof Black

P1 – Prof Black also indicates that Mr Cunningham was coming to the end of his life and the decision to use a syringe driver was appropriate.

6) ROBERT WILSON

a) Dr Wilcock

P32 – Regular oral morphine was prescribed for pain in his left arm….."this is against the general expectation that pain from a fracture would have been improving over time". However, earlier in his report Dr Wilcock states that nursing records show throughout his stay that pain had been variable and often severe. The transfer letter (P30) also states that "he still has a lot of pain in his arm". There is also a comment that Mr Wilson refused paracetamol as it was not working, indicating the need for stronger analgesia.

P41 – "when diamorphine is used for acute pulmonary oedema it is usually given iv". Although it is usually given iv, this does not mean it has no effect given subcutaneously.

P45 – It is important to note Dr Wilcock's conclusion that although the dose of morphine may well have contributed to his reduced level of consciousness, it is difficult to say with any certainty that this contributed more than minimally, negligibly or trivially to his death because the heart and liver failure could also have done this.

b) Prof Black

P1 – "the dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th – 16th October". This conclusion is at odds with the expert opinion of Dr Wilcock who acknowledges that the features may well be consistent with heart and liver failure. Prof Black notes on P11 that Mr Wilson has markers of serious alcoholic liver disease with a poor long-term prognosis.

P13 – "the first clinical deterioration is on the night of 15-16th October, not the night of the 14th – 15th October". This appears to be a criticism of the regular oramorph given on 14th October. However, Dr Wilcock's interpretation of the nursing record for that day was that morphine was given for pain relief. The syringe driver was not started until the next day when there appears to be worsening heart failure.

P16 – The weight increase of 11kg is noted and this will be almost entirely fluid retention. He feels this is not adequately managed. The treatment for fluid retention is diuretics. Dr Wilcock's assessment of the notes suggest he did receive these (P17). It is important to note that earlier in his admission his diuretics had to be stopped for a time due to renal failure. Treatment for heart failure can worsen renal failure and vice versa and often indicates end stage disease with multi-organ failure.

P17 – Prof Black indicates that the use of strong opiates on 15th October was negligent. However Dr Wilcock's summary of the nursing record is that Mr Wilson's pain was variable and often severe. Indeed this is commented on in the transfer letter. Mr Wilson himself is quoted as saying paracetamol did not work. This contradicts Prof Black's comment that weaker analgesics had controlled his symptoms the previous week.

P17 – "while it is possible that Mr Wilson has gone into heart failure…………" It is almost certain that Mr Wilson had gone into pulmonary oedema (acute heart failure) given the documented weight gain, peripheral oedema and 'bubbly' chest with copious secretions. This can precipitate hepatic encephalopathy in someone with severe liver disease. This would also appear to be Dr Wilcock's assessment.

P18 – "Apart from the comments about secretions in the nursing cardex, there is no rationale for the increase in dose of diamorphine or the addition of midazolam". There certainly appears to be poor record keeping but Dr Wilcock does note a comment in the nursing cardex of 17th October (P20) that 'requires assistance to settle at night" suggesting some distress or agitation. If a person has so much fluid on their lungs that they need regular suction, it is often a very distressing symptom causing breathlessness and fear. Opiates help to relieve the sensation of breathlessness and midazolam is often used to relieve anxiety/fear.

7) ENID SPURGIN

a) Dr Wilcock

P3 – "Mrs Spurgin was a relatively fit and independent 92 year old widow....." However, this does not match the picture given by her past medical history of multiple fractures (were these related to falls which are a marker of frailty), heart attack and depression. Prof Black's assessment is of a "very elderly lady with a number of chronic conditions and becoming increasingly frail".

P3 – "Mrs Spurgin was not anticipated to be dying". Dryad Ward was a continuing care ward i.e. for those most frail and dependent who may be at the end of life. Also 25% of people with a hip fracture do not survive.

P4 – "symptoms and signs were in keeping with a potentially reversible septicaemia/toxaemia arising from an infection". However, she had been given 2 antibiotics and deteriorated despite this.

P4 – "use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death". Prof Black's assessment is that a starting dose of 40mgs diamorphine would seem appropriate (although 80mgs was started, this was reduced to 40mgs by Dr Reid). Also although many believe older patients may need a lower dose of 20mg midazolam, 40mgs is still within current guidelines.

P26 – "at no point did Mrs Spurgin receive regular analgesia............One explanation for this apparent discrepancy...........relatively comfortable at rest. However the summary of the nursing entries do not support this with regular comments about pain throughout her stay. It is more likely her pain had been inadequately addressed prior to transfer to GWMH.

P27 – "the exact course of Mrs Spurgin's deterioration is unclear". The death certificate states a cerebrovascular accident, which may produce the symptoms and signs listed.

P28 – "it would have been reasonable for a doctor to have assessed respiratory function e.g. respiratory rate and pulse oximetry". This would not be a widespread practice in end of life care in hospital wards/hospice or for patients dying at home.

P32 - ...."if increasing pain was associated with a wound infection...........this would require appropriate antibiotics rather than morphine". She had been given 2 antibiotics i.e. the infection treated but it would also be good practice to address pain, which may require morphine.

P32 – Dr Wilcock criticises the use of regular morphine. However, this starting dose clearly did not control her pain and was increased appropriately in a stepwise fashion.

P34 - ...."in my opinion, Mr Spurgin was not anticipated to be dying..........." This assessment is in contradiction to Prof Black's assessment (P16)...as there is no doubt in my view that Mrs Spurgin was now dying". Prof Black also quotes a reference (P17) explaining that prediction of how long a terminally ill patient will live is virtually impossible and even palliative care experts show enormous variation.

b) Prof Black

P2 – The use of Oramorph on a regular basis is criticised because of not considering other possible analgesic regimes. However, prior to transfer to Gosport she had received intermittent doses of morphine and Paracetamol, yet had ongoing record of pain. In addition, even when she did start regular oramorph, the starting dose did not control her pain.

8) GEOFFREY PACKMAN

a) Dr Wilcock

P15 - ......"pain needs to be controlled" is stated in the nursing notes, but not in the medical notes. This is likely to represent poor documentation rather than a lack of pain. Pressure sores are usually exceedingly painful, particularly on movement.

P30 – Dr Barton reported to be 'not well enough' to transfer to the acute unit. Dr Wilcock is unable to understand this comment and feels emergency transfer to the acute unit should have taken place. The decision to keep Mr Packman at Gosport is most likely to have been made due to his poor prognosis. Prof Black identifies this on P15 + 16 of his statement. To stop any bleed an intervention would have to be undertaken – at a minimum an endoscopy and more likely surgery. Mr Packman is unlikely to have survived this given his morbid obesity, significant pressure sores and physical dependence. It was appropriate therefore to manage him conservatively with symptom control (supported in Prof Blacks statement – P15).

P33 – I would agree that this man's deterioration was due to a gastro-intestinal haemorrhage rather than a myocardial infarct.

P37 – "He had been transferred to Dryad Ward for rehabilitation and had no known underlying life threatening illness........" Firstly Dryad Ward is a continuing care ward and not a rehabilitation ward i.e. it provides assessment and care for those who are most frail and with complex needs, often at the end of their life. Secondly Dr Wilcock does not seem to appreciate the very poor prognosis of a man with morbid obesity, severe pressure sores and functional decline. This type of patient may be more commonly seen in Geriatric Medicine than general palliative care. Prof Black in his statement identifies the poor prognosis.

P37 – "...........gastrointestinal bleed is unknown, one of the commonest causes is a peptic ulcer which can be cured with appropriate treatment". This statement deserves further qualification. The fact that Mr Packman passed melaena (blood in stool) but did not have blood in his vomitus raises the possibility that the bleeding was coming from below the level of stomach/duodenum in his gastrointestinal tract. To stop bleed at this level would have required surgery, which he would not have survived. At a minimum he would have required endoscopy.

P39 – Dr Wilcock questions the presence of pain and the need for strong analgesia as there is limited documentation about pain apart from 27th August in the nursing notes – 'some discomfort this afternoon – especially when dressings being done'. This is most likely to be due to poor documentation rather than lack of pain. Usually pressure sores are extremely painful.

P42 – The dose of diamorphine started in the syringe driver is questioned and felt to represent a 33 – 100% increase in dose. However, if pain is not controlled, it is not uncommon to increase the dose of opiate by 50%.

P43 – The increasing doses of diamorphine and midazolam in the syringe driver are questioned. However, Dr Wilcock indicates that the nursing kardex explains this as 'previous dose not controlling symptoms'.

b) Prof Black

Without access to the drug charts and notes, Prof Black's assessment seems fair and balanced.

P17 – Of note – he does not feel that the doses of diamorphine used although higher than might have been conventional at the start, were required to control Mr Packman's symptoms and did not contribute in any significant fashion to his death.

9) ELSIE DEVINE

a) Dr Wilcock

P3 – "....based on the medical and nursing records, there is reasonable doubt that she had entered her terminal stage". This lady was frail with chronic progressive diseases – renal failure and a rapidly progressing dementia. Her prognosis was poor. This is supported by Prof Black's assessment (P18, P19).

P9 - ....a score of 9/30 on a mini mental state examination (a score of less than 17 suggests definite cognitive impairment). This statement is slightly misleading, as dementia may be present with scores well above 17. A score of 9/30 indicates a more severe/advanced dementia. Dementia is a terminal illness.

P9 – It would be useful to see the actual entry in the notes for Dr Jayawardena who is said to have thought her suitable for rehabilitation at Gosport. Given her cognitive impairment, it is highly unlikely she had rehab potential (you need to have reasonable recall short-term memory to learn and progress from one therapy session to the next). Additionally Dryad Ward was a continuing care ward and not a rehabilitation ward.

P19 – Dr Wilcock felt that Mrs Devine was not typical of patients dying from chronic renal failure. However, this lady also had a vascular dementia which usually has a stepwise deterioration (as explained by Dr Wilcock on P13 of his report)

P21 – Dr Wilcock critisises the use of fentanyl patch. I agree that this is not a typical management and the reasons for its use should have been documented. However, sometimes agitation occurs in patients with dementia because of pain. This is why diamorphine and midazolam are often both prescribed for terminal agitation (see Prof Blacks statement P19). The day before fentanyl was administered, Prof Black's summary of the notes is that she had become more restless and aggressive and was refusing medication. If she were felt to be agitated due to pain, fentanyl patches would be a way of addressing symptoms without relying on the oral route.

b) Prof Black

10) SHEILA GREGORY

a) Dr Wilcock

P5/6 – He feels that opiates are not indicated for non-specific treatment of distress. However, it is commonly used for this in end of life care. This is supported by Prof Black in his statement (P15). Also it is clearly documented that the morphine successfully helped her distress.

b) Prof Black