

**RESTRICTED**

Statement number: S329J

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STATEMENT PRINT

Surname: BLACK

Forenames: DAVID ANDREW

Age: Date of Birth: **Code A**Address: **Code A** Postcode: **Code A**

Occupation: CONSULTANT PHYSICIAN GERIATRIC MEDICINE

Telephone No.: **Code A**

Statement Date: 30/10/2005

Appearance Code: Height: Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

## SUMMARY OF CONCLUSIONS

Mr Geoffrey PACKMAN was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastrointestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

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There are a number of weaknesses in the clinical care provided to Mr PACKMAN:

- gastro-intestinal haemorrhage is suspected in Portsmouth, but although never disproven he is continued on his anticoagulant.
- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.
- on assessment on 25<sup>th</sup> August a further bleed does not lead to medical attention.
- on 26<sup>th</sup> August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.
- a difficult clinical decision is made without appropriate involvement of senior medical opinion.
- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.
- a higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is my opinion that Mr PACKMAN died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

## 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

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on the part of individuals or groups.

## 3. CURRICULUM VITAE

Name Professor David Andrew BLACK  
 Address   
 Telephone  E-mail:   
 DOB   
 Place Windsor, England.  
 GMC Full registration. No:   
 Defence Union Medical Defence Union. No:

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

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## PRESENT POST

Dean Director of Postgraduate Medical and Dental Education  
 Kent, Surrey and Sussex Deanery. 2004-present  
 Honorary Chair in Medical Education. Brighton & Sussex  
 Medical School. 2005  
 Consultant Physician (Geriatric Medicine) 1987-present  
 Queen Mary's 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 Mary's 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

## PUBLICATIONS

Acute Extrapramidal Reaction to Nomifensine  
 DA BLACK, IM O'Brien  
 Br Med J, 1984; 289; 1272

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## DOCUMENT RECORD PRINT

Transit Time in Ulcerative Proctitis

DA BLACK, CC Ainley, A Senapati, RPH Thompson

Scand J Gastro, 1987; 22; 872-876.

Lingual Myoclonus and Dislocated Jaw

DA BLACK, S Das

Br Med J, 1986; 292; 1429

Endoscopic Sclerotherapy for Bleeding Oesophageal Varices in the Elderly

DA BLACK, RPH Thompson

J Clin and Exper Gerontol, 1987; 9: 131-138

Mental State and Presentation of Myocardial Infarction in the Elderly

DA BLACK

Age and Ageing, 1987; 16; 125-127

Hyperbilirubinaemia in the Elderly

DA BLACK, I Sturgess

J Clin and Expt Geront, 1987, 9, 271-284

Malabsorption: Common Causes and their Practical Diagnosis

DA BLACK

Geriatrics 1988, 43, 65-67

Pseudotumour Cerebri in a patient with Castleman's Disease

DA BLACK, I Forgacs, DR Davies, RPH Thompson

Postgrad Med J, 1988; 64; 217-219

Non-Surgical Intervention; A First Choice in obstructive Jaundice

DA BLACK

Geriatric Medicine, 1988; 18(4); 15-16

Endoscopy: Investigation of choice for many Elderly GI Problems

DA BLACK

Geriatric Medicine, 1988; 18(9); 14-16

Hepatic Stores of Retinol and Retinyl Esters in Elderly People

DA BLACK, E Heduan and WD Mitchell

Age and Ageing, 1988; 17; 337-342

Elderly People with low B12 Levels do need Treatment

DA BLACK

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## DOCUMENT RECORD PRINT

Geriatric Medicine 1989, 19(1); 21-22

NSAIDS and Ulcer disease in Old Age

DA BLACK

Geriatric Medicine (special supplement) April 1989; 4-5, 8-11

The Independent Living Fund

DA BLACK

Br Med J (editorial) 1989, 298; 1540

Ischaemic Hepatitis

DA BLACK

Geriatric Medicine, 1989, 19(9); 92

Laparoscopic cholecystectomy: not without pitfalls in the elderly

DA BLACK

Geriatric Medicine 1991 21(10); 21

The successful medical management of gastric outflow obstruction associated with the use of non-steroidal anti-inflammatory drugs in the elderly

RJ Geraghty, DA BLACK and SA Bruce

Postgrad Med J 1991; 67; 1004-1007

Bronchodilator response to nebulized salbutamol in elderly patients with stable chronic airflow limitation

RJ Geraghty, C Foster, DA BLACK & S Roe

Respiratory Medicine 1993 23(5); 46-57

The reality of community care: a geriatricians viewpoint

DA BLACK

In: Care of elderly people. South East Institute of Public Health 1993; 81-89

Accidents: a geriatrician's viewpoint

DA BLACK

In: Care of elderly people. South Thames Institute of Public Health. 1994; 53-58.

Community Care Outcomes

DA BLACK

Br J of Clin Pract 1995 49(1); 19-21

Choice and Opportunity

DA BLACK

Geriatric Medicine 1996 26(12) 7.

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## DOCUMENT RECORD PRINT

Emergency Day Hospital Assessments

DA BLACK

Clinical Rehabilitation. 1997; 11(4); 344-347

Geriatric Day Hospital. A future?

DA BLACK

Opinion in General and Geriatric Medicine. 1997, 1.1, 4-6.

The Health Advisory Service

DA BLACK

JAGS 1997; 45; 624-625.

The Rhetoric and Reality of Current Management Training for NHS Clinical Directors

DA BLACK

MBA dissertation. 1997. University of Hull.

Community Institutional Medical Care- for the frail elderly.

DA BLACK &amp; CE Bowman

Br Med J. (Editorial). 1997, 315; 441-442.

Remains of the day.

DA BLACK

Health Services Journal. 1998. 19 Feb. p32.

Nutritional problems in old age

DA BLACK

Opinion in General and Elderly Medicine. 1998. 2(1): 12-13.

Constipation in the elderly :causes and treatments.

DA BLACK

Prescriber. 1998; 9(19); 105-108.

Intermediate not Indeterminate Care

CE Bowman &amp; DA BLACK

Hospital Medicine. 1998; 58; 877-9

Improving geriatric services

DA BLACK

JRColl Physicians Lond 1999; 33: 113. (also p152)

General internal medicine and speciality medicine- time to rethink the relationship.

JM Rhodes, B Harrison, D BLACK et al.

JR Coll Physicians Lond 1999, 33: 341-347.

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## DOCUMENT RECORD PRINT

Iron deficiency in old age

DA BLACK & CM Fraser.

British Journal of General Practice. 1999; 49; 729-730

A systems approach to elderly care

DA BLACK, C Bowman, M Severs.

Br J Health Care Management, 2000, 6(2), 49-52

The Modern Geriatric Day Hospital

DA BLACK.

Hospital Medicine. 2000.61(8);539-543

Complaints, Doctors and Older People

DA BLACK

Age and Ageing. 2000; 29(5):389-391.

NSF Overview

DA BLACK

Geriatric Medicine 2001; 31(4):11-17 & 31(5)

Anaemia

D Sulch, DA BLACK

Geriatric Medicine 2001; 31(6): 46-49

Professional Review Mechanism. Chapter in: Clinical Governance Day to Day.

DA BLACK.

British Association of Medical Managers 2002; 41-56.

Induction for newly appointed consultants

DA BLACK

Clinician in Management. 2002; 11(1); 9-13

Average length of stay, delayed discharge and hospital congestion.

DA BLACK and M Pearson

BMJ 2002;325:610-611

An audit of outcomes in day hospital based crisis interventions.

David A BLACK

Age Ageing 2003; 32; 360-361

Quality Improvement in the UK

DA BLACK

Chapter 119 In: Brocklehurst's Textbook of Geriatric Medicine. 6<sup>th</sup> Edition Ed: Tallis and Fillit.



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## DOCUMENT RECORD PRINT

2003.

The new NHS framework for handling performance concerns.

David A BLACK

Hospital Medicine 2004; 65 (2): 112-115

Not because they are old- revisited

DA BLACK

Age and Ageing. 2004;33; 430-432

## BOOK

British Geriatrics Society compendium of policy statements and statements of good practice. Edited by

DA BLACK &amp; A Main. First Edition. 1995.

## RECENT SIGNIFICANT PRESENTATIONS

Secondary care as part of the whole system. Laing &amp; Buisson conference on intermediate care. April 2001

The impact of the NSF on everyday Clinical Care. Conference on Clinical governance in elderly care . RCP May 2001

The Geriatricians view of the NSF. BGS Autumn Meeting 2001

The Organisation of Stroke Care. Physicians and managers working together to develop services. Professional training and clinical governance in geriatric medicine. All at Argentinean Gerontological Society 50<sup>th</sup> Anniversary meeting. Nov 2001

The future of Geriatric Medicine in the UK. Workshop: American Geriatrics Society May 2002

Liberating Front Line Leaders. Workshop: BAMB Annual Meeting June 2002

Revalidation - the State of Play. A Survival Guide for Physicians. Mainz July 2002

Medical Aspects of Intermediate Care. London Conference on building intermediate care services for the future. Sept 2002

Developing Consultant Careers. Workshop: BAMB Medical Directors Meeting. Nov 2002

Lang and Buisson. Update on Intermediate Care Dec 2002

Intermediate Care Update: London National Elderly Care Conference. June 2003.

Appraisal- an update. GMC symposium on revalidation. Brighton. June 2003.

Innovations in emergency care for older people. HSJ Conference. London July 2003.

Emergency Care &amp; Older People: separate elderly teams? RCP London March 2004

Professional Performance &amp; New Consultants. London Deanery Conference April 2004

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## DOCUMENT RECORD PRINT

Mentoring as part of induction for new consultants. Mentoring in Medicine Conference. Nottingham. April 2004

The Future of Chronic Care- Where, How and Who? CEO & MD conference. RCP London. June 2004

Mentoring as part of consultant induction. Surviving to Thriving. New Consultant Conference, London June 2004

360 Degree Appraisal. Chairman National Conference. Nottingham June 2004

Maintaining Professional Performance. BAMM Annual Summer School. June 2004

Chronic Disease management. BGS Council Study Day. Basingstoke. July 2004

MMC post FP2. BGS Study Day. Basingstoke. July 2004

Designing care for older peoples. Emergency services conference. London July 2004.

The Modern Geriatric Day Hospital. Multidisciplinary Day. South East Kent hospitals. Sept 2004

Geriatricians and Acute General Medicine. BGS Autumn Meeting . Harrogate Oct 2004

#### 4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Geoffrey PACKMAN (BJC/34)

[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.'

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5. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence).

5.1 Geoffrey PACKMAN a sixty eight year old gentleman in 1999 was admitted as an emergency on the 6<sup>th</sup> August 1999 to Portsmouth Hospitals NHS Trust following an attendance at A&E (40,42).

5.2 Mr PACKMAN had suffered from gross (morbid) obesity for many years, he had also had venous leg ulceration for at least five years (44), he was hypertensive and had a raised prostatic specific antigen, suggesting prostatic pathology. (8)

5.3 Following a fall at home he was completely immobile on the floor and two ambulance crews were needed to bring him to accident and emergency (42). He was currently receiving District Nursing three times a week for leg ulcer management(255). He had become increasingly immobile complicated by the fact that his wife who lived with him and provided care was being investigated for breast cancer. The admission clerking showed that he not only had leg ulcers but he had marked cellulitis, was pyrexial and in atrial fibrillation. Cellulitis was both in his groin and the left lower limb (45). He was totally dependent needing all help (143) with a Barthel of 0 (163). His white cell count was significantly raised at 25.7 (48), his liver function tests were abnormal with an AST of 196 and his renal function was impaired with a urea of 14.9 and a creatinine of 173 (47). These had all been normal earlier in the year. He was treated with intravenous antibiotics (45) in a special bed (187).

5.4 He appeared to make some progress and on 9<sup>th</sup> August his cellulitis was settling (48) . A Haemolytic Streptococcus sensitive to the penicillin he had been prescribed was identified (225). On 11<sup>th</sup> August the nursing cardex (134) stated that there appeared to have been a deterioration of his heel ulcers with a "large necrotic blister on the left heel". His haemoglobin on 12<sup>th</sup> August (211) was 13.5.

5.5 On 13<sup>th</sup> August white count was improved at 12.4 (50,52), his U's and E's were normal and the notes recorded a planned transfer to the Gosport War Memorial Hospital on 16<sup>th</sup> August.

5.6 Later on the 13<sup>th</sup> black bowel motion is noted but the doctor who examines him records a

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brown stool only. It is not clear whether he has had a gastro intestinal bleed (52). On 16<sup>th</sup> August no comment is made on the possible gastrointestinal (G.I) bleed , but on 20<sup>th</sup> August his haemoglobin is noted to be 12.9 (53) no further black stools have been reported so he is planned for transfer on 23<sup>rd</sup> August. Albumin at this stage is now reduced at 29 (190).

5.7 On 17<sup>th</sup> August sacral sores are now noted in the nursing cardex (118) which by the 20<sup>th</sup> are now recorded as "deep and malodorous" (125).

5.8 He is transferred to the Gosport War Memorial Hospital on 23<sup>rd</sup> August (54). A reasonable history and examination is undertaken which notes that there was a history of possible melaena, the clinical examination recorded suggests that he is stable. Blood tests are requested for the next day. The drug chart (168) suggests that his weight is 148 kgs but it is not clear if this is an estimate or a measurement. He is very dependent with a Barthel of 6 and a Waterlow score of 18, putting him in high risk. His haemoglobin on 24<sup>th</sup> is 12 (207). The nursing cardex on the 24<sup>th</sup> notes the multiple complex pressure sores on both the buttocks and the sacrum (96-100).

5.9 On 25<sup>th</sup> August the nursing cardex reports that he is passing blood rectally and also vomiting (62,82).

5.10 On 26<sup>th</sup> August a doctor (Dr BARTON ) is asked to see him and records that he is clammy and unwell. (55) The notes suggest that he might have had a myocardial infarction and suggests treating him with Diamorphine and Oramorphine overnight. It records that as an alternative there might be a G.I. bleed but this is recorded as unlikely because he has not had haematemesis. It also notes that he is not well enough to transfer to an acute unit and he should be kept comfortable, including "I am happy for the nursing staff to confirm death". His Clexane (an anticoagulant given to prevent pulmonary embolus) is now stopped. The nursing cardex (62) on the same day records further deterioration throughout the day with pain in his throat and records a verbal request for Diamorphine. A full blood count is taken (this fact is not recorded in the notes) but the result is filed in the notes recording a haemoglobin markedly reduced at 7.7 (205). It also states "many attempts were made to phone Gosport War Memorial Hospital but no response from switchboard". These significant results are not commented on at any stage in the nursing or clinical notes.

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5.11 On 27<sup>th</sup> August (63) the nursing notes record some improvement in the morning but discomfort in the afternoon especially with dressings. On 28<sup>th</sup> August both the medical (55) and the nursing records (63) are noted to be very poorly with no appetite. Opiates are to continue over the weekend. 29<sup>th</sup> August he is sleeping for long periods (63) and on 30<sup>th</sup> he is still in a very poor clinical condition but eating very small amounts of diet. He is re-catheterised the same day (55).

5.12 On 31<sup>st</sup> he is recorded as passing a large amount of blood rectally (83) and on the 9<sup>th</sup> September (55 and 64) he is reviewed by a consultant Dr REID who notes that he is continuing to pass melaena stool, there are pressure sores across the buttocks and posterior aspects of both thighs, he is now significantly confused. Dr REID records that he should be for TLC only and that his wife is now aware of the poor prognosis. Nursing notes (64) note that the dose of drugs in the syringe driver should be increased; the previous doses were not controlling his symptoms. The nursing notes of the 2<sup>nd</sup> September (62) record the fact the Diamorphine is again increased on the 2<sup>nd</sup> to 90mgs and on 3<sup>rd</sup> September he dies at 13.50 in the afternoon (55, 64).

5.13 Drug Chart review: There are two drug charts. Chart 1 (174-178) confirms his original admission to Portsmouth Hospital Trust in particular the appropriate use of the antibiotics, Penicillin, Flucloxacillin and the prescription of the anticoagulant Clexane. This goes from 6<sup>th</sup> August - 23<sup>rd</sup> August.

5.14 The second drug chart (168-172) goes from his admission to the Gosport War Memorial Hospital on 23<sup>rd</sup> August to his death on the 3<sup>rd</sup> September. The once only part of this drug chart on 26<sup>th</sup> August states Diamorphine IM 10 mgs verbal message given 18.00 hours. Then there is two days later on 28<sup>th</sup> August, Diamorphine IM 10 mgs signed Dr BARTON. This is never given, this may be a retrospective attempt to legitimise the prescription given verbally 2 days before.

5.15 On the 'as required' part of the drug chart only Gaviscon and Temazepam are written up. On the regular side of the drug chart Doxazosin, Frusemide, Clexane (until 25<sup>th</sup> August) Paracetamol, Magnesium, Metoclopramide and Loperamide are all written up. Though some of these drugs like the Magnesium appear to have been given in a "as required" fashion. Oramorphine though written up regularly is never given. Diamorphine 40 - 200 mgs subcut in 24

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hours is prescribed and appears to have been given 40mgs on 28<sup>th</sup>, 29<sup>th</sup> and 30<sup>th</sup> 60 mgs on 1<sup>st</sup> September and 90mgs on 2<sup>nd</sup> September. The drug chart is extremely confusing (171) as these prescriptions have not been properly put in the day and date boxes required, and the nursing staff appear to be putting two days of prescribing into a single day box. Midazolam 20 - 80 mgs subcut in 24 hours is written up and Midazolam is given 20 mgs on the 28<sup>th</sup> and 29<sup>th</sup> August, 40mgs on 30<sup>th</sup> August, 60mgs on 1<sup>st</sup> September and 80mgs on 2<sup>nd</sup> September.

5.16 However, on the next regular page of the drug chart (172) Diamorphine 10-20mgs 4 hourly is written up and is signed up to Have been given for 4 doses on 27<sup>th</sup>, 28<sup>th</sup> and 29<sup>th</sup> August. I cannot tell from the drug chart whether 10mgs or 20mgs is given. It is also totally unclear whether this was given at the same time as the syringe driver, at least on the 28<sup>th</sup> and 29<sup>th</sup> August, or whether the drug chart was completely misunderstood as to how it should be used. This will need to be clarified with Dr BARTON and the nursing staff. My assumption is that Mr PACKMAN only actually received 40 mgs of Diamorphine on the 28<sup>th</sup> and 29<sup>th</sup> August and not 80mgs as might be implied. Oramorphine is written up 20mgs at night and given on 26<sup>th</sup>, 27<sup>th</sup>, 28<sup>th</sup> and 29<sup>th</sup> August. Hyoscine is written up but never given, although it is prescribed as a regular prescription.

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

6.2 Mr PACKMAN had a number of chronic diseases prior to his terminal admission. The most serious was his gross (morbid) obesity which led to severe immobility and non-healing leg ulcers.

6.3 He then develops an infection (cellulitis) of his leg ulcers which has spread to his groin causing his high white count, his pyrexia, then his total immobility requiring appropriate

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admission to the Portsmouth Hospitals NHS Trust. On admission he is recognised to be at high risk of pressure sore development and appears to have been put on a special bed.

6.4 He appears to make reasonable progress from the point of view of his cellulitis and is treated with appropriate antibiotics, however is noted to have developed buttock and sacral pressure sores by 17<sup>th</sup> August which are in a serious condition by 20<sup>th</sup> August.

6.5 In the meantime, a black stool is noted on 13<sup>th</sup> August and the question of whether this is melaena (blood leaking from the upper gastro-intestinal tract which turns black when passing through the gastro-intestinal tract) and whether he has a gastric or duodenal ulcer. Normally this would be investigated with an endoscopy. However this would be quite a major procedure on such a dependent gentleman. Although in retrospect it is easy to say that this was the first bleed, it would not have been clear at the time, the lack of further melaena and the fact that haemoglobin does not significantly fall over the next week, suggests that conservative management was appropriate. However, he is not put on any prophylactic anti-ulcer medication and his anticoagulant is continued. In retrospect both of these decisions may have contributed to his subsequent problems.

6.6 He is transferred to the Gosport War Memorial Hospital on 23<sup>rd</sup> August. The prognosis for a patient with gross obesity, who is catheterised, and who has recent deep and complex pressure sores is terrible. In my experience such patients almost invariably deteriorate despite the best efforts of staff and die in hospital. He is appropriately clerked on admission and indeed appropriate investigations carried out including haemoglobin which is now 12. Although by itself this is a normal haemoglobin his level of haemoglobin has very slowly drifted down and again in retrospect suggests that he was starting to bleed slowly.

6.7 On 25<sup>th</sup> August the nursing staff note that he is passing blood rectally and he is vomiting, although the medical staff do not appear to have been asked to see him. However on the 26<sup>th</sup> August he is seen when he is unwell, very cold and clammy. Dr BARTON suggests the likeliest diagnosis is a myocardial infarction, although appropriately she does think of a gastro-intestinal bleed. No examination is recorded in the notes, nor are some simple and appropriate investigations undertaken (for example an ECG), to try and differentiate these two problems. However a blood count is sent to the laboratory and haemoglobin has now fallen to 7.7. Mr

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PACKMAN has had a massive gastro-intestinal bleed, this is now a re-bleed and in itself would be a marker of significant risk of death. Proven re-bleed needing more than 4 units of blood would in a previously fit patient over 65 be an indication for an emergency operation. However as the laboratory cannot inform the hospital of this result, no-one would appear to have brought it to medical or nursing attention.

6.8 Despite this there is an important decision to be made on the 26<sup>th</sup> August. Whatever the cause, Dr BARTON identifies that the patient is seriously ill and the acute problems whether a G.I. bleed or a myocardial infarction would not be appropriately managed in a community hospital. Dr BARTON makes the decision that the patient is too ill for transfer and should be managed symptomatically only at Gosport. In my view this is a complex and serious decision that should be discussed with the consultant in charge of the case as well as with the patient and their family if possible. I can find no evidence of such a discussion in the notes. It is my view however, that in view of his other problems it is within boundaries of a reasonable clinical decision to provide symptomatic care only at this stage. The chances of surviving any level of treatment, including intensive care unit and surgery were very small indeed.

6.9 Mr PACKMAN deteriorates further in the evening and is prescribed a single dose of Diamorphine as a result of a verbal request. In paragraphs 5.13 - 5.16 I have identified significant failings in the way the drug chart has been used and written up. Controlled drugs are given on at least one occasion based on a verbal request and the prescription apparently written 2 days later. Regular drugs are written up and never given. There may or may not be confusion over the prescribing of Diamorphine on a regular basis particularly on the 28<sup>th</sup> and 29<sup>th</sup> August and the drug chart is used in a most irregular fashion over that period of time. I do not believe that the standards of medical prescribing or nursing delivery meet the expectations of regulations on the prescription in the use of controlled drugs.

6.10 From the 26<sup>th</sup> August Mr PACKMAN is dying and after a single dose of Diamorphine on the 26<sup>th</sup> August, receives regular Diamorphine and Midazolam until his death. Diamorphine while specifically prescribed for pain is commonly used to manage the stress and restlessness of terminal illness. Diamorphine is compatible with Midazolam and in itself is particularly used to terminal restlessness, and can be mixed in the same syringe driver. It is very difficult to assess the starting dose of Diamorphine. This would be complicated in this case by the massive obesity



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which might well effect the absorption of the Diamorphine from subcutaneous injection, together with his serious pressure sores which would be extremely painful on being dressed. He appears to have been started on 40mgs of Diamorphine in 24 hours with 20mgs of Oramorphine (equivalent to another 10mgs of Diamorphine) at night together with 20mgs of Midazolam. In my view this is a higher dose than most clinicians would start with which would be more likely to be 10-20 mgs in the first 24 hours. However I can find no evidence that there was any significant side effects from the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes.

6.11 He is reviewed by a consultant (Dr REID) on 1<sup>st</sup> September where it has now become absolutely clear that it is a gastro-intestinal haemorrhage which is causing his death on top of his other problems. Dr REID is happy with the management and later in the day the Diamorphine is increased because the previous dose is no longer controlling his symptoms. Further increase of 50% in dosage occurs on 2<sup>nd</sup> September and he dies the following day.

6.12 In my view, based on the evidence in the notes 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.

6.13 In my view a death certificate should read:

1a Gastro-intestinal haemorrhage

Pressure sores and morbid obesity

## 7. OPINION

7.1 Mr Geoffrey PACKMAN was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

7.2 There are a number of weaknesses in the clinical care provided to Mr PACKMAN:

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- gastro-intestinal haemorrhage is suspected in Portsmouth but although never disproven, he is continued on his anticoagulant.
- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.
- on assessment on 25<sup>th</sup> August a further bleed does not lead to further medical attention.
- on 26<sup>th</sup> August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.
- a difficult clinical decision is made without appropriate involvement, of senior medical opinion.
- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.
- a higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is my opinion that Mr PACKMAN died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

## 8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
- 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, 6<sup>th</sup> Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002;1:129
6. The Palliative Care Handbook. Guidelines on Clinical Management, 3<sup>rd</sup> Edition. Salisbury Palliative Care Services, May 1995.

## 9. EXPERTS' DECLARATION

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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

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complete professional opinion.

Signed: D A BLACK

Signature witnessed by: