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STATEMENT OF DR JANE BARTON

RE: HELENA SERVICE

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mrs Helena Service. Unfortunately, at this remove of time I have no recollection at all of Mrs Service. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mrs Service.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998.

I confirm that these comments are indeed a fair and accurate summary of the position then.

4. The demands on my time were probably only marginally less in 1997 than the position which then pertained in 1998 and beyond. Certainly by 1997 there had been a significant increase in dependency, increase in bed occupancy, and consequent decrease in the ability to make notes of each and every assessment and review of a patient. These difficulties clearly applied to both myself and my nursing staff at the time of our care of Mrs Service. Similarly I had by this stage felt obliged to adopt the policy of pro-active prescribing to which I have made reference in my previous statement to you, given the constraints and demands on time.

5. From Mrs Service's medical records it is apparent that in 1981 she had a partial gastrectomy and cholecystectomy for what appeared initially to be a malignant stomach ulcer, but on histology this turned out to be benign. An x-ray report in October 1984 revealed that her heart was enlarged, and she was admitted in December of that year to St Mary's Hospital with a right sided cerebro-vascular accident and left sided hemiparesis in consequence. Following extensive physiotherapy she made a very good recovery and was discharged home.

6. In August 1987 she was admitted to hospital having sustained rib fractures after a fall at home. She was noted to be in controlled atrial fibrillation, but at that time there were no signs of cardiac failure. Chest x-ray again confirmed enlargement of the heart.

7. In December 1992 Mrs Service was admitted to the Queen Alexandra Hospital having suffered another cerebro-vascular accident. She had a

left hemiparesis, but again appears to have made a good improvement and was discharged.

8. Following a request by her General Practitioner, Mrs Service was then seen by Dr Althea Lord by way of a domiciliary visit on the 9th January 1995. The letter from her GP in this regard shows that Mrs Service had been increasingly short of breath over the proceeding two weeks in spite of an increase in diuretic medication she was receiving, and also had pitting oedema of her knee. Her GP suspected that she might need an ACE inhibitor. The pro forma domiciliary visit record for Dr Lord appears to indicate the GP's view that Mrs Service was in heart failure.

9. Dr Lord then carried out a domiciliary assessment on the 10th January, writing to her GP on the 13th January 1995. Dr Lord observed that Mrs Service's pulse was irregular, that she had a pan systolic murmur at the apex that radiated towards the axilla, and she agreed that Mrs Service had congestive cardiac failure due to mitral regurgitation and possible atrial fibrillation. Dr Lord felt that her diuretics should be increased in the first instance to 80mgs of Frusemide daily. She did not feel that ACE inhibitors should be started immediately as there was a need to ensure that renal function was normal first, Dr Lord had apparently made arrangements for monitoring that with the proprietor of the Rest Home at which Mrs Service was resident.

10. Subsequently, renal function was established to be normal. Mrs Service apparently remained breathless on exertion and her mobility was said to be quite limited. In her report to Mrs Service's GP, Dr Lord stated on the 17th January 1995 that she was arranging for her to be admitted to the Queen Alexandra Hospital for an ACE inhibitor to be commenced. On examination in hospital, Mrs Service was said to be peripherally cyanosed

and dyspnoeic on minimal exertion. Atrial fibrillation, a JVP which elevated to her ears, and a mitral regurgitant murmur that radiated to the axilla were also noted. She was given a trial of an ACE inhibitor,being started on Lisinopril in additional to 80mgs of Frusimide daily, and was subsequently discharged on the 25th January 1995.

11. Mrs Service was admitted to hospital again the following year. She was complaining of pain in the wrist, and was thought to have been hitting her wrists against the wall persistently. A diagnosis of gout was made.

12. Unfortunately, in May 1997 Mrs Service deteriorated, and the Residential Home became unable to cope with her needs. A care plan for the 12th May 1997 recorded that her GP, Dr Rees had visited and that she had diagnosed as being in heart failure. At that stage Mrs Service was described as "very poorly". Admission was arranged to the Queen Alexandra Hospital. In her referral letter, Dr Rees indicated that MrS Service had recently developed a urinary tract infection, which had responded initially to antibiotics, but Mrs Service had now become increasingly short of breath, confused and disorientated.

13. On admission to the Queen Alexandra Hospital Mrs Service was found to have atrial fibrillation, and a possibility of chest infection/bronchial pneumonia was also raised. It was felt there was evidence of left ventricular failure. An ECG was performed which showed Q waves inferiorally, consistent with ischaemia, and a chest x-ray showed patchy consolidation consistent with the pneumonia. Mrs Service was treated aggressively with antibiotics and fluids, and her atrial fibrillation was controlled with Digoxin. The Senior Registrar reviewed Mrs Service following admission confirming the impression of left ventricular failure,

and noted that she was not for "555", meaning that her condition was such that she was not suitable for resuscitation.

14. Mrs Service's condition improved a little over the following days. It seems the nursing staff contacted the Rest Home on the 22nd May 1997 and were informed that she needed to be able to transfer with the assistance of one person in order to return to the home. Referral to the Social Services would therefore have been necessary in case a nursing home was required.

15. Mrs Service's antibiotics were completed on the 23rd May 1997 and the intravenous fluids were to be discontinued. The following day she then developed a floppy left hand and became unaware of the hand with reduced tone, giving the impression of a cerebro-vascular accident or a transient ischaemic accident.

16. It appears then that the Rest Home declined to take Mrs Service back as she was unable to weight bear and had a left sided weakness. A referral was then made to Social Services on the 27th May 1997 by the Senior Registrar on the ward round. At this point Mrs Service's Barthel was 4, and Social Services apparently indicated that she had to be referred to Elderly Services as she was too dependent for them to place. In consequence of this it appears that Mrs Service was then referred back to the Geriatricians.

17. Consequent on that referral, Mrs Service was seen by Dr Ashbal, Locum Geriatrician, on the 29th May 1997. Dr Ashbal noted that there had been a further episode of left ventricular failure, and she was still "congested", by which I anticipate he meant she was still in congestive cardiac failure, though he noted that she was better. His entry in the

notes for the 29th May indicates that he was to transfer Mrs Service to the Gosport War Memorial Hospital.

18. Mrs Service then remained at the Queen Alexandra Hospital waiting for a bed to become available at the GWMH. The fact that immediate transfer was not possible is probably an indication that there was very high bed occupancy at GWMH at the time. An entry for a ward round on the 2nd June 1997 indicates that a bed was still awaited, and Mrs Service was said to be "well". The nursing records, however, suggest a rather different picture of Mrs Service being dysnoeic on exertion, a condition which had persisted throughout her stay at the hospital. The night staff on 2nd June recorded that there were no signs of confusion, but Mrs Service was said to be very demanding over night, shouting out constantly.

19. Mrs Service was then transferred to GWMH the following day, 3rd June. She was recorded as being 99 years old, with atrial fibrillation and confusion. Medication on transfer consisted of Melleril, 25mgs nocte, Lisinopril 2.5mg BD, Bumetanide, 1mg once a day, Asprin 75mgs once a day, Allopurinol 100mgs nocte, and Digoxin 125~~mgs~~ mcgs once a day.

20. My expectation is that Mrs Service would have been transferred from the ward at the Queen Alexandra Hospital to the Transfer Lounge, waiting there until it was possible to bring her to Gosport. This would understandably have been a stressful experience for an elderly lady suffering with heart failure. In any event, on arrival, I carried out an assessment, and my record in her notes reads as follows:-

"3-6-97 Transfer to Dryad Ward
Recent admission 17-5-97
Confusion

Off legs
URTI
NIDDM
CCF
Gout
came from a Rest Home
O/E slightly breathless plethoric lady
HS I and II + gallop
Bases clear
ankles ✓✓
needs palliative care if necessary
I am happy for nursing staff to confirm death"

21. As my note indicates, Mrs Service was now no longer able to mobilise - hence the reference "off legs", and she was confused. I recorded the fact that she was a non-insulin dependent diabetic and that she had had an upper respiratory tract infection. I also recorded that she was in congestive cardiac failure. My note indicates that I undertook examination, recording that she was breathless and plethoric, by which I meant that she had purple/blue colouring of the extremities, indicating cyanosis, consequent on the heart failure. I listened to her heart sounds. I was able to hear a 'gallop' - a third heart sound, indicating that the heart was struggling to cope, and that she was clearly in heart failure.

22. In my view, Mrs Service was very unwell. I believed she was probably dying and indeed might well die shortly. She had probably reached the stage of multi system failure. Blood test results revealed a high sodium level probably brought about dehydration due to powerful diuretics, which were vital in treating her heart failure. She had low potassium, and high urea and creatinine levels. At the time of my assessment, I considered Mrs Service would have been more appropriate for care at the Queen Alexandra Hospital, but a return transfer in an ambulance

was very probably not in her best interests. She had probably deteriorated consequent upon the transfer to the GWMH, and would have further deteriorated through a transfer back to the Queen Alexandra Hospital. No doubt her bed there would have been allocated to another patient and she might well have had to wait on a trolley whilst another bed was found. In all the circumstances, we had to do the best we could to care for her.

23. Having assessed Mrs Service I then wrote up appropriate medication on her drugs chart. Concerned that she was in congestive cardiac failure I recorded a PRN prescription for 5 to 10mgs of Diamorphine to be administered intramuscularly. I prescribed Bumetanide 1mg once a day as a diuretic, Lisinopril 2.5mgs twice a day for her heart failure, being the ACE inhibitor, Allopurinol 100mgs daily for her gout, Lanoxin 125~~mgs~~ mcgs daily for the atrial fibrillation, and 75mgs daily of Aspirin to help prevent a further cerebro-vascular accident.

24. In addition to that medication, I also prepared a prescription for Diamorphine 20 - 100mgs subcutaneously over 24 hours, Hyoscine 200 - 800mcgs subcutaneously over 24 hours, and Midazalam 20 - 80mgs subcutaneously over the same period. If Mrs Service's condition deteriorated and she developed pulmonary oedema consequent on the cardiac failure, the Diamorphine would assist in relieving the pulmonary oedema. Pulmonary oedema can cause a sensation of drowning which would be profoundly distressing for a dying patient in such circumstances. The Diamorphine and Midazolam would have the effect of relieving the significant distress and anxiety produced from that sensation, with the Hyoscine being available to dry chest secretions.

25. A Barthel assessment carried out on the 3rd June revealed a zero score, indicating that Mrs Service was now totally dependent. The nursing records noted her admission and it was recorded that her buttocks were very red and sore with broken skin. A pressure relieving "Spenco" mattress was made available.

26. The nursing records go on to indicate that over night Mrs Service failed to settle and was very restless and agitated. Quite appropriately, 20mgs of Midazalam was given via syringe driver in accordance with my prescription. Whilst ordinarily I believe the nursing staff would contact me when making use of such an anticipatory prescription this would ordinarily be in the event of provision of Diamorphine. In circumstances in which Midazalam only was given and at this time, I anticipate the nursing staff properly administered the Midazalam without further reference to me.

27. Sadly, it was felt the following morning that Mrs Service's condition had deteriorated overnight. She remained restless. The nursing notes record that she was seen by me the following morning and the syringe driver was re-charged this time with 20mgs of Diamorphine, and 40mgs of Midazalam. Mrs Service's nephew was contacted to inform him of her poorly condition.

28. Unfortunately, I have not made an entry of my assessment of Mrs Service on this occasion, for reasons I have indicated previously - that I would simply have had no opportunity to do so through the need to attend to all my various patients. I anticipate that the agitation and restlessness observed overnight had been due to continuing cardiac failure, and that this deterioration was further apparent when I reviewed Mrs Service on the morning of 4th June. Given that she was in

my view now terminally ill with heart failure, and distressed and agitated in consequence of that condition, it was in my view entirely appropriate to administer the Diamorphine and Midazalam in the hope of reducing the pulmonary oedema brought on by the heart failure, and the distress and agitation from the drowning sensation of the pulmonary oedema.

29. Sadly, Mrs Service continued to deteriorate and she was recorded as having passed away at 3.45am on the morning of 5th June 1997.

30. The Diamorphine and Midazalam were prescribed and in my view administered solely with the intention of relieving Mrs Service's agitation and distress, with the Diamorphine having the additional beneficial affect of treating the pulmonary oedema from her heart failure. At no time was any medication provided with the intention of hastening her death.