ELSIE LAVENDER

SUMMARY OF EVIDENCE

CASE OF ELSIE LAVENDER

Background/Family Observations

Elsie Hester LAVENDER nee BRYANT was born on Code A She married at the age of 22 and had one child Alan William LAVENDER. She became a widow in 1989 and had one brother who died in 1993/4. She continued to live alone in the family home in Gosport until she died at the Gosport War Memorial Hospital on 6th March 1996 at the age of 84 years.

Mrs LAVENDER was diagnosed as suffering with diabetes in 1982 and was insulin dependant; her only other medical conditions were that she had slight rheumatism and was partially blind due to the diabetes. Apart from this she was a strong, healthy and independent woman who coped with her housework, washing and was very family orientated. She did have a home help and a nurse would assist with her insulin regime twice a day. She had been admitted to hospital on a couple of occasions when she became 'hypo' but the hospital would stabilise her and send her home.

In February 1996 Mrs LAVENDER had a fall at home and was found by her home help, Frances DOHINI, and was taken to Haslar Hospital. It was several days later before the family was informed she had suffered a brain stem stroke, although she was sat up in bed from the start. Mrs LAVENDER was in pain not only from the stroke but from the fall as well albeit she had not fractured any bones but had cut her head.

Mrs LAVENDER remained in Haslar for two or three weeks and made excellent progress so much so that her Occupational Therapist and physiotherapist were preparing her for home. She had learned to walk with the assistance of a frame and an adjustable walking stick was being arranged. She was talking to others coherently and understanding what was being said to her.

Mrs LAVENDER was transferred to Daedelus Ward at Gosport War Memorial Hospital for rehabilitation and was placed in a room on her own. She easily passed a mental test conducted by a nurse just after she arrived.

Her son Adam LAVENDER and his wife visited daily and after two or three days spoke with Dr BARTON. Adam LAVENDER asked Dr BARTON when his mother would be going home as he would have to get rid of the cat if she was going to get a warden controlled flat.

Dr BARTON replied, "You can get rid of the flat" and added, "You do know that your mother has come here to die".

Mr LAVENDER was stunned as he believed his mother was at the War Memorial Hospital for rehabilitation and he could not believe the cold and callous way Dr BARTON had broken the news to him. He felt as if his mother's death had been predetermined.

Shortly after this conversation Mrs LAVENDER was placed on a syringe driver and her health quickly deteriorated. Code A

On 6th March 1996 Mr LAVENDER received a call from the Gosport War Memorial Hospital informing him that his mother had died. Her death certificate was certified by J A BARTON BM and gave the cause of death as cerebralvascular accident diabetes mellitus.

Mrs LAVENDER was an elderly lady and at that time was one of the longest standing insulin dependant people. She appeared to be making a full recovery from the stroke, was alert, lucid and only had a little pain in her shoulder. It was not until her final day that Mr LAVENDER was told that diamorphine was being administered through the syringe driver.

Police Investigation

Following the publicity in respect of the Police investigation of the case of Gladys RICHARDS who died at the Gosport War Memorial hospital in, a number of relatives of other patients who died at the same hospital reported to the Police that they had concerns in respect of the medical treatment of their relatives and requested Police investigations. Amongst these relatives were those of Mrs LAVENDER.

The medical records of Mrs LAVENDER were obtained by the Police, copied and submitted to the key clinical team for review. The key clinical team considered that Mrs LAVENDER'S treatment at the Gosport War Memorial hospital was negligent and the cause of death was unclear.

As a result of the key clinical team's findings the medical records of Mrs LAVENDER have been examined by Police in order to identify all persons who were concerned in her medical and nursing treatment. All medical and nursing staff identified have made statements explaining those entries, in the medical records of Mrs LAVENDER, made by them or to which they made some contribution.

Case papers and the medical records of Mrs LAVENDER have been analysed by a further set of independent experts, Dr's WILCOCK and BLACK.

<u>Medical history of Elsie LAVENDER.</u>

(The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes, 'M' in front are the microfilm notes).

The Gosport notes record that Mrs LAVENDER was an insulin dependent diabetes mellitus since the1940's (53). She is referred to the Diabetic Service because of more troublesome hypoglycaemia in 1984 (65). In 1985 she is known to have a mild peripheral neuropathy (73).

By 1988 she has very poor eyesight (47M). She is also documented to have high blood pressure in 1986 (29).

Elsie LAVENDER was admitted to Haslar hospital on 5th February 1996 through A&E having had a fall at home (H15, H16). She is recorded as having right shoulder tenderness (H25) is moving all four limbs and her cervical spine is thought to be normal, written as (CX spine√) (H16). The notes record that x-rays were taken of her skull and both shoulders (H24). In a subsequent neurological examination, she is noted to have reduced power 3/5, cannot move her right fingers and has an extensor right plantar (H24). A Barthel on the 5th (H631) is recorded as 5/20.

Her past medical history is noted as insulin dependent, diabetes mellitus for 54 years (age 29) appendicectomy and a hysterectomy. She is noted to have previous collapses in the past (H47) but without weakness, although her clerking in 1995 (H48) suggested that she might have had some sensory loss and a mild diabetic peripheral neuropathy. Her Barthel in 1995 was 14/20 (H495) and she was able to mobilise at that stage with a walking stick (H497). She had diabetes, eye disease, was registered blind in 1988 (H 97). She had hypoglycaemic episodes going back many years (H 71) and pneumonia in 1985 (H317).

On transfer to the ward, both her legs are noted to be weak 4/5 (H35) no sensory loss is noted. The notes also state she does not normally go upstairs and her bed is downstairs (H29). However, her son stated that a large pool of blood was found at the top of the stairs (H37). She apparently goes out once a week with her son is forgetful but not confused (H39).

Following admission, she is seen by a physiotherapist (157) who notes pain in both shoulders, can only stand with two people and is now having to be fed, washed and dressed, when previously independent.

No further neurological examination is recorded by the Haslar medical team and she is referred to Dr Lord on 13th February (H159). Dr Lord sees her and confirms that she still has bilateral weakness of both arms and legs (H163) and finds that her left plantar is extensor (H163) confirmed in his letter (H253) but is not sure about the right plantar which has previously been found to be extensor.

The importance of this finding is that it suggests that she has a bilateral neurological event in the brain or brain stem somewhere above the lumbar spine.

Dr LORD records "probable brain stem CVA"........ "she has had her neck x-rayed, I assume it was normal" (H167).

Dr LORD notes her mild anaemia of 9.7 with an MCV of 76.5 (H17) and says that she will consider investigation into anaemia later (H164). Abnormal blood tests are also available in the notes on 9th February (H609) an albumin of 32, a Gamma GT 128 and Alkaline Phosphatase of 362. No investigations are done to determine whether these are a hepatic effect of her diabetes or a mixture of problems with the raised alkaline phosphatase potentially coming from a fracture.

On the 20th February Mrs LAVENDER is again seen by a physiotherapist (H165), her bilateral shoulder pain is again documented and she needs two to transfer. Reviewing her drug charts (H684 and H690) she receives regular analgesia comprising Co-proxamol and Dihydrocodeine all through her admission.

Events at Gosport War Memorial Hospital.

The medical notes in Gosport (45M) 22nd February 1996 state that she "fell at home from the top to the bottom of the stairs and had lacerations on her head". It also states that she has Code A leg ulcers. Once in Gosport there is no rigorous clerking of the patient and no examination recorded. In some of the nursing cardex there is a series of assessments confirming that this lady is highly dependent. She has no mobility and bed rest is maintained all through her stay (100 -101). She has leg ulcers both legs (107 - 109). She is catheterised throughout, although there is no suggestion that she had a catheter prior to her admission to hospital (111). She has a sacral bed sore noted; "a red and broken sacrum on 21st February" (115) Code A Code A She is thought to be constipated on an assessment, Code A Code A

Barthel is documented at 4/20 on 22nd February (165) (i.e. grossly dependent). Her mental test score is normal 10/10 on the same date (165). Lift handling score (171) also confirms high dependency.

Investigation tests reported on 23rd February 1996 find that she has a normal haemoglobin of 12.9 with a slightly reduced mean cell volume of 75.6 and gross thrombocytopenia (a low platelet count) of 36,000 (57M). The report on the film (58M) shows that this is a highly abnormal full blood count with distorted red blood cells and polychromasia. A repeat blood film is suggested. This is repeated on 27th February (57M) and thrombocytopenia is now even lower at 22,000. The urea is normal at 7.1 on 23rd February but has increased and is abnormal at 14.6 on 27th February (187). Her alkaline phosphatase is 572 (over 5 times the upper limit of normal) her albumin is low at 32 (187). No comment is made on

any of these significantly abnormal blood tests in any of the Gosport notes, though the low platelet count is noted in nursing summary on 23rd February (151). The platelet count had been normal at 161 on admission to the Haslar (H17).

An MSU (59M) sent on 5th February showed a heavy growth of strep faecalis there are no other MSU or other blood culture results in the notes.

Medical progression (documented on pages 45M and 46M) is of catheterisation and treatment for a possible U.T.I on 23rd February. On 26th February, a statement that the patient is not so well and the family were seen regarding progress. Nursing cardex reports (153) a meeting with the son occurred on the 24th February and state "son is happy for us just to make Mrs Lavender comfortable". "Syringe driver explained".

The medical notes on 5th March say deteriorated further, in some pain, therefore start subcutaneous analgesia. On 6th March "analgesia commenced, comfortable overnight I am happy for the night staff to confirm death". It is then confirmed at 21.28 hours on 6th March.

The nursing care plan first mentions significant pain on 27th February (95) and describes pain on most days up until 5th March where the pain is uncontrolled and the patient is distressed, at which point a syringe driver is commenced (97).
Morphine slow release (MST) (67M) was started at 10 mgs bd on the 24th February and is given until 26th February when MST 20 mgs bd (145) is started, this continues until the 3rd March. On 4th March Oramorph 30 mgs bd is written up and given during 4th March (139). On 5th March Diamorphine is written up 100 – 200 mgs subcut in 24 hours (137). 100 mgs is prescribed and started at 08.30 in the morning, together with Midazolam 40 mgs (137) (61M). Midazolam had been written up at 40 – 80 mgs subcut in 24 hours. Diamorphine and Midazolam pump is filled at 09.45 hours (61M) on 6th March together with another 40 mgs of Midazolam.

The notes document (for example page 65M) Dr Lord was the consultant responsible for this patient although the patient only appears to have been seen medically at any stage by Dr Barton, and a different consultant Dr Tandy saw the patient in the Haslar Hospital.

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Elsie DEVINE was a Clinical Assistant, Dr Jane BARTON. As such her role in caring for patients is governed by Standards of Practice and Care as outlined by the General Medical Council. This advice is sent to all doctors on a yearly basis and includes the following statements

Good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination.

In providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed.

Good clinical care must include – taking suitable and prompt action necessary.

Referring the patient to another practitioner, when indicated.

In providing care you must – recognise and work within the limits of your professional competence...

Prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patient's health and medical needs.

In reviewing the medical records of Mrs LAVENDER it is apparent that Dr BARTON has not made entries in the medical records when she has visited her patient. There is lack of explanation as to the treatment being offered to Mrs LAVENDER and the reasoning behind the various prescriptions of drugs. Ranges of drugs are prescribed which appear to fall outside recognised parameters.

Expert analysis

Dr Andrew WILCOCK

The medical records were examined by two independent experts. Dr Andrew WILCOCK in his review of the standard of care afforded to Mrs LAVENDER reported specifically:-

i) The notes relating to Mrs LAVENDER's transfer to Daedalus Ward are inadequate. On transfer from one service to another, a patient is usually re-clerked highlighting in particular the relevant history, examination findings and planned investigations to be carried out.

ii) The cause of Mrs LAVENDER's urinary retention was not assessed.

iii) Mrs LAVENDER was treated for a urinary tract infection with the antibiotic trimethoprim. Neither a diagnostic urine specimen nor a check urine specimen (to see if the infection had cleared) were sent for microbiology. It is therefore unclear if the urinary tract infection was successfully treated or not. This should have been considered when Mrs Lavender was noted to be 'not so well' (see point v).

iv) There is a lack of medical notes relating to the pain or its assessment and the commencement of morphine (MST 10mg) twice a day on the 24th February 1996.

v) On the 26th February 1996 the medical notes report Mrs LAVENDER to be 'not so well over weekend'. There is a lack of detail that explains in what way she was not so well. There are no records that an appropriate history, examination or investigations had been undertaken to try and determine the reason for Mrs LAVENDER feeling less well. Instead, without any assessment of the pain, the MST was increased to 20mg twice a day and a syringe driver prescribed to be used 'as required' that contained diamorphine and midazolam in doses that would be excessive to Mrs LAVENDER's needs.

vi) Blood tests from the 27th February 1996 revealed a low platelet count and deteriorating kidney function. There is no mention of this in the medical notes, and no action was taken.

vii) On the 29th February 1996 there is no mention in the medical notes that Mrs LAVENDER's blood sugars were high requiring additional doses of insulin. The fact that this could have been due to an untreated infection does not appear to have been considered. Despite entries in the nursing care plan and summary sheets relating to Mrs LAVENDER's pain there is no mention of this in the medical notes.

viii) Code A There is no mention of this problem in the medical notes or consideration of the possible significance of this symptom given Mrs LAVENDER's history of trauma.

ix) The morphine was increased again on the 4th March 1996. There is no pain assessment or entry in the medical notes that relates to this increase.

x) The entry in the medical notes of the 5th March reports that Mrs LAVENDER had deteriorated over the last few days. It is not clear in what way she had deteriorated. There is no history or examination that considers the possible reasons for her decline.

xi) Mrs LAVENDER's pain appeared poorly controlled on the night of the 4th March but there is no assessment of the pain in the medical notes prior to a syringe driver containing diamorphine 100mg and midazolam 40mg being commenced. The doses of diamorphine and midazolam used in response to Mrs LAVENDER's worsening pain, are excessive for her needs, even if it were considered that her pain was morphine responsive and she was dying from natural causes.

Dr David BLACK

Dr BLACK is an expert in Geriatric medicine. His review of the standard of care afforded to Mrs LAVENDER reported specifically:-

i) Mrs Elsie LAVENDER provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.

ii) The major problems in this lady's case are the apparent lack of medical assessment and the lack of documentation. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical care must include – taking suitable and prompt action necessary"... "referring the patient to another practitioner, when indicated"..... "in providing care you must – recognise and work within the limits of your professional competence....".... "prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs". The major gaps in the written notes, as documented in my report, represent poor clinical practice to the standards set by the General Medical Council. In this case, I believe that the overall medical care received between Haslar and Gosport Hospital was negligent in that an inadequate assessment and diagnosis of this lady's conditions was made. If it was, it was never recorded. The lack of any examination at Gosport, the lack of any comment on the abnormal blood test make it impossible to decide if the care she subsequently received was sub optimal, negligent or criminally culpable. It seems likely to me that she had several serious illnesses, which were probably unlikely to be reversible, and therefore, she was entering the terminal phase of her life at the point of admission to Gosport Hospital. However, without proper assessment or documentation this is impossible to prove either way.

iii) The initial symptomatic management of her terminal illness was appropriate. The prescription of the Diamorphine on the 26th February (never given) and the excessive doses of medication used in the final 36 hours was, in my view, sub optimal drug management. These may have been given with the intention of shortening life at the final phase of her terminal illness. However, I am unable to prove beyond reasonable doubt this did hasten death by anything other than a short period of time (hours to a few days).

Interview of Dr Jane BARTON

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified as a registered medical practitioner in 1972. In addition to her GP duties she took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 24th March 2005 Dr BARTON, in company with her solicitor, Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Elsie LAVENDER at the Gosport War Memorial hospital. The interviewing officers were DC Code A and DC Code A.

The interview commenced at 0917hrs and lasted for 22 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/4.

This statement dealt with the specific issues surrounding the care and treatment of Elsie LAVENDER.

Expert response to statements of Dr BARTON

Operation ROCHESTER

Elsie LAVENDER.

KEYPOINTS May 2005.

Elsie Hester LAVENDER Born Code A.

Diabetic and insulin dependant since the 1940's when she was 53.

Generally strong healthy and independent, other than poor eyesight and recorded high blood pressure in 1986.

February 1996 suffered a fall at her Gosport home address from the top to the bottom of the stairs, suffering head lacerations found by her home help.

She was admitted to Haslar Hospital on 5th February 1996.

Following admission noted to suffer pain in her shoulders, she received regular analgesia comprising Co-Proximal and Dihydrocodeine.

Examined by Doctor LORD on 13th February 1996, who confirms bilateral weakness of both legs.

Transpired that she had suffered a brain stem stroke, made excellent progress towards recovery and being prepared for release, walking with a frame, talking coherently (according to next of kin her son)

On 22nd February 1996 transferred to Daedelus Ward, Gosport War Memorial Hospital for rehabilitation.

Noted that Mrs LAVENDER suffering severe Code A leg ulcers.
Is catheterised throughout, suffering bed sores assessed as grossly dependent, mental test score normal.

On 24th February Nursing records report a meeting with Mrs LAVENDERS son, comment that' son is happy to make Mrs LAVENDER comfortable, and syringe driver explained'. Slow release morphine 10mgs was commenced.

In response to a question from Mrs LAVENDERS son about the timing of her release, DR BARTON allegedly told him 'you can get rid of the cat , you do know that your mother has come here to die'.

On 26th February it is noted on medical records that the patient is 'not so well', Oral morphine is increased to 20mgs.

On 27th February the nursing plan first mentions significant pain, describes pain on most days until 5th March when pain is uncontrolled and the patient is distressed.

On the 4th March Oramorph increased to 30mg and administered.

On 5th March notes indicate that the patient has deteriorated further and to start syringe driver analgesia. 100-200mgs with 40mgs of midazolam (pro-actively prescribed).

Mrs LAVENDER died on 6th March 1996.

Cause of death recorded and certified by Dr BARTON as 'cerebral-vascular accident diabetes mellitus.'

Case assessed by multidisciplinary key clinical team 2004.

Elsie LAVENDER. 83. 22nd February 1996 – 6th March 1996. Head Injury or brain - stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. It was possibly musculoskeletal pain from a fall downstairs. Other forms of analgesia such as anti-inflammatory drugs or hot/cold packs might have worked. The most worrying aspect is the large dose escalation when converting Morphine to Diamorphine via syringe driver (Five fold increase). The cause of death is unclear and the dose escalation might have contributed.

Dr Jane BARTON. From Caution interview with Police 24th March 2005.

Workplace demands were substantial and a choice had to be made between detailed note making or spending more time with patients.

Felt obliged to adopt a policy of pro-active prescribing given constraints/demands on her time.

Consultant Geriatrician DR TANDY had recorded in a letter on 16th February that Mrs LAVENDER had most likely suffered a brain stem stroke leading to the fall. Dr TANDY confirmed atrial fibrillation on examination but heard no murmurs. Made mention of iron deficiency anaemia and stroke and agreed to take the patient to Daedalus Ward for rehabilitation as soon as possible.

Dr BARTON entered on the transfer assessment of 22nd February details of the fall, head laceration, leg ulcers, Code A needing a catheter, Code A Code A needing help to dress and feed, she adds that the patient was profoundly dependent.

The prognosis for the patient was not good her being blind, diabetic, with brain stem stroke, and immobile. The hope was for rehabilitation.

Prescribed for congestive cardiac failure, diabetes, anaemia, asthma, and dihydrocodeine for pain relief.

The following day prescribed for a urinary tract infection.

On 24th prescribed morphine sulphate in addition to dihydrocodeine for pain relief.

Increased dosage for pain relief on 26th February, Code A Pegasus mattress arranged for pressure sores.

No recollection of meeting with the son of the patient on the 26th February.

The circumstances of the fall with pre-existing illness can have a serious and deleterious effect on health leading to death. May have mentioned to son that his mother was dying, believe would have discussed options for pain relief.

Might have explained that administration of proper pain relieving medication might have the incidental and undesired effect of hastening death.

Following discussion with son wrote up a proactive prescription for further pain relief for diamorphine, would have anticipated that the nursing staff would contact her so that she could authorise administration as necessary within the dosing range.

Saw the patient on 29th February and 1st March, to review condition which was slowly deteriorating.

Next saw on 4th March Oramorph slow release increased.

Reviewed again on 5th March, pain relief clearly inadequate, Mrs LAVENDER had had a poor night and was distressed, diamorphine and midazolam authorised via syringe driver, considered doses appropriate in view of uncontrolled pain.

On 6th March Mrs LAVENDER comfortable and peaceful, medication successful in relieving the significant pain and distress, Dr BARTON aware that she was dying, and content for a nurse to confirm death.

<u>Expert Dr Andrew WILCOCK (</u>Palliative medicine and Medical Oncology) comments:-

- Notes inadequate.
- Cause and treatment of Mrs LAVENDER'S urinary tract infection not properly assessed/treated.
- Morphine may have been inappropriate or excessive to the type of pain experienced and the possible role this played in her deterioration was not considered.
- Treatments were continued that may have aggravated her condition ie the diuretic.
- Excessive doses of diamorphine/midazolam from 26th February 1996.
- Blood tests of 27th February 1996 revealed low platelet count and deteriorating kidney function, not reflected in the notes and no action taken, not discussed with a consultant or specialist advice.
- On 29th February 1996 no mention of high blood sugar requiring high doses of insulin. No mention of pain in medical notes therefore inconsistent with nursing notes.
- No pain assessment recorded against increase in morphine of 4th March 1996.
- The reported deterioration mentioned in the notes of 5th March is not explained.
- There is reasonable doubt that Mrs LAVENDER had reached her terminal phase. Causes of her decline may have been reversible with appropriate treatment.
- Ultimately excessive doses of diamorphine and midazolam could have contributed more than minimally trivially or negligibly towards her death, Dr BARTON leaves herself open to the accusation of gross negligence.
- Cause of death registered as cerebrovascular accident, validity difficult to comment upon but final deterioration does not seem typical of cerebrovascular accident, more likely immobility from fall leading to infection.

Expert <u>Dr David BLACK</u> (Geriatrics) reports that Mrs LAVENDER represents the most complex and challenging problems of geriatric medicine.

- Patient suffered long standing multiple medical problems, after admission found to be Code A totally dependent, suffering constant pain to shoulders and arms and found to have serious abnormalities in various blood tests.
- Increasing physical dependency and increased patient distress.
- Doctors and consultants failed to make adequate medical assessment and diagnosis of her condition.
- Dr BLACK believes Mrs LAVENDER was misdiagnosed and had suffered a quadriplegia from a high cervical spinal cord injury secondary to her fall.

- Abnormal blood tests could have represented systemic illness such as cancer of the bone marrow, the test should have been commented upon by the doctor in charge of the case as to their relevance.
- The lack of examination and comment on abnormal blood tests make it impossible to assess the care as sub optimal, negligent or criminally culpable.
- Likely she had several serious illnesses and entering the terminal phase of her life.
- Mrs LAVENDER received a negligent medical assessment both at Haslar and Gosport War Memorial Hospital, in particular not examined on admission to Gosport. No medical diagnosis made for pain, which would fit with spinal cord fracture. Without appropriate assessment impossible to plan appropriate management.
- The two options were to either get further specialist opinion or provide palliative care. Would have been wise to obtain specialist opinion, probably from the consultant in charge of the case. There is no evidence that this was done.
- Unusually large dose of diamorphine written up on 26th February 1996, and subsequent excessive dose reported on 5th March 1996, together with high dose of Midazolam likely to cause excessive sedation and respiratory depression.
- Cannot say beyond all reasonable doubt that life was shortened.

Evidence of other key witnesses.

Alan William LAVENDER Son of the deceased. Spoke of his mother making an excellent recovery at Haslar Hospital following her fall, and the occupational therapist speaking of preparing her to return home. Mother coherent, and walking with the assistance of a frame. Within a couple of days of admission to Gosport War Memorial Hospital DR BARTON told him that 'his mother has come here to die', she deteriorated rapidly, he was not aware that his mother was being administered syringe driver diamorphine until the day prior to death.

Dr Althea LORD Community Geriatrician responsible for the ward rounds at Daedalus Ward of Gosport War Memorial Hospital. Was on annual leave from 23rd February 1996 – 18th March 1996 as a consequence had no input into the treatment or care of the patient Elsie LAVENDER. No formal arrangements in place for arranging locum cover, although this may be done in respect of long periods of absence (There is no evidence of Consultant supervision of this patient)

Sheelagh JOINES Registered Nurse GWMH Daedalus Ward, 1973-1997.. consisted of 8 stroke beds and 14 geriatric long stay beds, working to consultant Dr LORD and clinical assistant DR BARTON. Only Doctors authorised syringe drivers, which did not accelerate the process of dying. In 4 years at Daedalus only one family denied syringe driver treatment. It was agreed by Dr BARTON, DR LORD and Nurse JOINES that prescriptions would be written up in advance (pro-active prescribing) to enable use on a patient need basis. Ms JOINES wrote in notes that Dr BARTON had discussed Elsie LAVENDERS prognosis and the issue of syringe driver with the

son's wife, and that pain was not being controlled by DF 118 and as a result DDR BARTON prescribed further pain relief.

Yvonne ASTRIDGE Senior Staff Nurse made various entries onto the nursing care plan referring to condition of the patient and nursing care afforded. On 6th March 1996 wrote on medical notes that 'medication other than through syringe driver discontinued as patient un-rousable'

Christine JOICE Registered Nurse noted requirement for increased analgesia following Physio- exercises on 4th March 1996, Morphine sulphate tablets/Oramorph increased in dosage as a result.

Patricia WILKINS Registered Nurse delivered nursing care, bed bath, catheter and dressings.

Margaret COUCHMAN Registered Nurse entered on medical notes 1.3.1996 that patient 'complaining of pain in shoulders' this nurse commenced syringe driver diamorphine 100mg and midazolam 40mg on 5th March 1996 she explained that she had been informed by overnight staff that the patient had suffered a poor night distressed with uncontrolled pain, and had conformed to DR BARTON and Sister JOINES written instructions to commence syringe driver analgesia. Administered as the lowest amounts written up by Dr BARTON.

Code A Registered Nurse, nursing note entries regarding general nursing care.

Code A Senior Staff Nurse, has written on notes 6th March 1996 'Death Verified', explains that she would have checked heart and breathing before verifying. Given that there was no 24hr doctor, it was common for nurses to verify death.

Operation ROCHESTER.

Additional evidence summary.

Relating to the deaths of :-

Robert WILSON.

Elsie LAVENDER.

Leslie PITTOCK.

Robert WILSON.

Grant HEATLIE (Senior House Officer Queen Alexandra Hospital) dealt with hospital admissions and accordingly admitted Robert WIILSON as an emergency patient on 17th January 1997 following transfer from accident and emergency unit. Presented with chest pain associated nausea and shortness of breath. Admitted consuming one bottle of spirits a week. Mr WILSON was discharged to his home address on 5th March 1997.

Nolan GHEEVES (Senior House officer accident and emergency Queen Alexandra Hospital) Explains medical notes in respect of examinations of Mr WISLON between 1st October 1998 and 13th October 1998 including liver function test results.

Arumugam RAVINDRANE (Consultant Physician Elderly Medicine Queen Alexandra Hospital) addition to statement of 25.11.05 attempts to explain why he ceased to prescribe co-drydromol to patient WILSON.

Anthony KNAPMAN (Clinical assistant cover for Dr BARTON Gosport War Memorial Hospital) further to statement 20th January 2006 explains reason for small dose of diamorphine administered 16th October on the instructions of Dr BARTON, did not take issue with this.. thought may have suffered silent heart attack..

Code A (Staff Nurse Q/A hospital) made entries on nursing notes 6th/9th October 1998 re nursing issues.

Pauline MUNDY (Hospital Social Worker) Produced client notification and assessment forms. Did not actually see the patient.

Interview Transcript Dr Jane BARTON 0918hrs – 1452hrs 19th April 2006 + copies of documentary exhibits referred to within the interview.

Elsie LAVENDER.

Ewenda PETERS. (General Practitioner) Details Mrs LAVENDER's medical history particularly of Diabetes since 1982. Also suffered irregular heartbeat, overweight, swollen ankles, heart failure, impaired vision, chronic bronchitis in 1995 and admitted to Haslar Hospital with a stroke in February 1996.

Walter MELIA (Consultant Physician/ Gastroenterologist Haslar Hospital) commented that Mr LAVENDER had been a diabetic for many years saw the patient on 8th February 1996 suffering from a diabetic condition. Suffered painful shoulders from a fall for which she was admitted and was prescribed an analgesic.

Patrick CONNOR (Consultant Physician) comments that Mrs LAVENDER was admitted on 5th February 1996 following a fall on stairs and suffering pain to her to her shoulder and a laceration to her head. At 2150hrs the same day Dr CONNOR order two hourly blood sugar levels to be taken and hourly neuro-observations.

Rodney TAYLOR (Consultant Physician and Gastroenterologist) General background re admissions procedure and appraisal of the care afforded to Mrs LAVENDER at Royal Naval Hospital Haslar before her transfer to Daedalus War at Gosport War memorial Hospital. She was registered blind and diabetic admitted following a fall at home. After examination it was believed she had suffered a small brain stem stroke which had caused her to collapse, she needed stitches as a result of the fall. She was stabilised medically and accepted she was not able to go home. She was stabilised then referred and accepted for continuing care by GWMH.

Simon HAMBLING (General Practitioner) Saw Mrs LAVENDER variously between the 6th February 1996 and 16th February 1996 general medical note entries, describes as a frail elderly lady who had significant medical problems suffered a fall, was admitted and stabilised and transferred for continuing care.

Clare ATKINSON (Senior House Haslar Hospital) Wrote to consultant elderly medicine on 13th February 1996 summarising patients condition and asking for opinion further entries dating to 21st February 1996. Describes Mrs LAVENDER as an 83 year old woman with several significant medical problems, Dr ATKINSONS involvement was with regards to her diabetes and mobility, transferred to GWMH for rehabilitation.

Jane TANDY (Consultant Geriatrician) Reviewed Mrs LAVENDERS condition 16th February 1996 making detailed medical note entry and referring her to

Daedalus Ward GWMH. Then wrote to Surgeon Commander TAYLOR on 20th February 1996 detailing her findings and transfer recommendation to GWMH.

Code A (Detective Constable) Produces transcript of taped interviews with Dr BARTON of 24th March 2006)

William EDMONDSTONE. (Consultant Physician) Negative statement.

Leslie PITTOCK.

Rosemary BAYLY (Locum Registrar Psychogeriatrics GWMH) under Dr BANKS in 1996. Penned detailed discharge letter from Mulberry Ward 8th November 1995 to GP Dr ASBRIDGE highlighting Mr PITTOCKS depression. Mr PITTOCK readmitted to Mulberry Ward 13th December 1995 following depressive deterioration. Dr BAYLY details care throughout December 2005 until 3rd January 1996 when he was transferred to the elderly care ward.

John ALLEN (Nurse elderly mental health) Review Mr PITTOCKS behaviour September 1995.

Janet DAOUD (Consultant in old age psychiatry) Reviewed Mr PITTOCK on 20th December 1995. Reported deceased mobility, displaying Parkinson features and depressed. Prescribed Thioridazine an anti-psychotic and Procyclidine an anti choligenic.

Code A (Detective Constable) Seized cremation certificate.

Code A (Detective Constable) Produces transcribed taped interviews of Dr BARTON of 3rd March 2005.

Code A

D.M.WILLIAMS.
Detective Superintendent 7227.
Operation ROCHESTER.
22ND August 2006.

PCO000308-0020

C.51 1/99

Identification Ref. No. DB/2010

Court Exhibit No.

R - v -

Description
A certified copy of a Death Certificate (LAVENDER)

Time/Date Seized/Produced
19TH May 2005

Where Seized/Produced
Office for National Statistics

Seized/Produced by D. BURGESS

Signed

Incident/Crime No. Operation Rochester.

Major Incident Item No. X 617

Laboratory Ref:

PLEASE ATTACH WITH TAPE

GLOUCESTERSHIRE CONSTABULARY

Station.

J1 No. Item No.

O.I.C.

Identification Ref No.

Court Exhibit No. DB 2010

R-v-

Description
A CERTIFIED COPY OF A DEATH CERTIFICATE

Time / Date Seized / Produced
19TH May 2005

Where seized / Produced
Office for National Statistics

Seized/ Produced By
DAVID BURGESS

Signed Code A

Incident Crime No. Operation Rochester

Major incident item No.

Laboratory Ref

P27B (Rev 2/02)

Code A

Note (1) Births and Deaths.

This certificate is issued in pursuance of the Births and Deaths Registration Act 1953. Section 34 provides that any certified copy of an entry purporting to be sealed or stamped with the seal of the General Register Office shall be received as evidence of the birth or death to which it relates without any further or other proof of the entry, and no certified copy purporting to have been given in the said Office shall be of any force or effect unless it is sealed or stamped as aforesaid.

Note (2) Births.

A name given to a child (whether in baptism or otherwise) before the expiration of twelve months from the date of registration of its birth, may be inserted in Space 17 of the entry in the birth register under the procedure provided by Section13 of the Births and Deaths Registration Act 1953. If the parents or guardians wish to avail themselves of this facility at any time, they must deliver a certificate of baptism or of naming to the registrar or superintendent registrar having the custody of the register in which the birth was registered. This certificate must be in the prescribed form and can be obtained on application to any registrar.

STATEMENT OF DR JANE BARTON - RE: ELSIE LAVENDER

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 Elsie Lavender. 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 Lavender.

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 bartel 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.

Code A

4. Whilst the demands on my time were probably slightly less in 1996 than the position which then pertained in 1998 and beyond, certainly even by 1996 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 both to me and the nursing staff at the time of our care of Mrs Lavender. 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. Mrs Lavender aged 83 was transferred to Daedalus Ward at GWMH on 22nd February 1996 under the care of consultant Geriatrician Dr Althea Lord. Her Past Medical history was of diabetes for over 40 years, and she had been registered blind since 1988. She had apparently lived alone since the death of her husband and had a son living in Warsash who would do her shopping. She had fallen down the stairs at home two weeks previously and been admitted to a medical bed in Royal Naval Hospital Haslar with general weakness and immobility. She was referred to Dr Jane Tandy consultant Geriatrician at Portsmouth Healthcare Trust by her consultant physician, Surgeon Commander Taylor although I do not have the benefit of the referral letter nor any of her Haslar notes. Dr Tandy had seen her on ward A4 at Haslar and dictated a letter to Surgeon Commander Taylor on 16th February 1996.

6. Dr Tandy had recorded that she had examined Mrs Lavender. She felt the most likely problem was a brain stem stroke which had led to the fall. In addition, she had noted Mrs Lavender had insulin dependent diabetes mellitus, was registered blind, was now immobile and had atrial fibrillation.

There was weakness in both hands and Mrs Lavender had been unable to stand, though was able to do so with physios. She was 'a bit battered' and had pain across her shoulders and down her arms. She still required 2 people to transfer her. She had longstanding stress incontinence and mild iron-deficiency anaemia. Dr Tandy had confirmed the atrial fibrillation on examination, but had heart no murmurs. She had made mention of further investigation of her iron deficiency anaemia and her stroke but had agreed to take her over to Daedalus ward for "rehab" as soon as possible.

7. To assist with the transfer, one of the nursing staff on Ward A4 completed a nursing referral form on 21st February recording that Mrs Lavender's main problem was now immobility. She confirmed the pain in the arms and shoulders, and recorded that Mrs Lavender had ulcers on both legs. At that stage all pressure areas were said to be in tact Code A Code A The referral form also set out the various medications Mrs Lavender was receiving at the time of discharge to GWMH.

8. I then admitted Mrs Lavender to Daedalus Ward the following day. Unfortunately, given the very considerable interval of time I now have no real recollection Mrs Lavender, but my entry in her records for the assessment on her admission reads as follows:

"22-2-96 Transferred to Daedalus Wd GWMH
PMH fall at home top to bottom of stairs
laceration on head
leg ulcers
Code A
IDDM needs Mixtard Insulin bd

regular series B.S.

transfers with 2

Code A

help to feed and dress. Barthel 2

Assess general mobility

? suitable rest home if home found for cat"

9. A nurse apparently recorded that Mrs Lavender had a barthel score of 4, but the difference with my assessment is of no real significance - Mrs Lavender was clearly profoundly dependent. A Waterlow pressure sore score on admission was recorded at 21, a score of 20 or more being 'very high risk'. Mrs Lavender's prognosis in view of her condition, being blind, diabetic, with a brain stem stroke and being immobile was not good, but the hope was that we might be able to rehabilitate her.

10. Following the information in the referral form in relation to Mrs Lavender's medication, I prescribed Digoxin for her atrial fibrillation, Co-amilofruse (a Frusemide and Amiloride combination) for congestive cardiac failure, Insulin Mixtard for her diabetes to be given in the morning if the blood sugar was above 10 and the same medication at night at a slightly different dose, again if her blood sugar was above 10. I also prescribed Ferrous Sulphate for her anaemia, Becomethasone as an asthma preventer, and Salbutamol as an asthma reliever.

11. I do not know now if Mrs Lavender was receiving pain relieving medication whilst at Haslar, but in view of the pain she was experiencing on admission, I also prescribed Dihydrocodeine, two 30mg tablets, 4 times a day.

12. I saw Mrs Lavender again the following day, probably in the morning, and would have reviewed her condition again. My note on this occasion reads as follows:

"23-2-96 Catheterised last night 500ml residue
blood & protein Trimethoprim"

13. The nursing note for the previous day in fact recorded that 750mls of urine had been catheterised, but the important feature was that the subsequent urine test revealed the presence of blood and protein in the urine, suggestive of a urinary tract infection. I therefore prescribed an appropriate antibiotic, Trimethoprim, on a precautionary basis in case of infection.

14. Bloods had been taken on 22nd February, and the nursing notes for the following day suggest that the platelet level was found to be abnormal and that the blood sample was too small. I was apparently informed of this and was to review the position in the morning.

15. The nursing notes record that I did see Mrs Lavender again the following morning, Saturday 24th February, and that her pain was not controlled by the Dihydrocodeine. The nursing notes show that she had a red and broken sacrum. I therefore prescribed Morphine Sulphate, 10mgs twice a day, in addition to the Dihydrocodeine. Although I did not normally see patients at GWMH over weekends, when others were usually on duty, I may have been on duty the previous night, and would have been concerned to attend to Mrs Lavender if she was in pain at the time.

16. The nursing notes suggest that in consequence of the Morphine Sulphate Mrs Lavender had a comfortable night, but had deteriorated again by the following evening. It was said that she appeared to be in more pain, screaming "my back" when moved, though she was uncomplaining when not. Mrs Lavender's son apparently wanted to see me. The nursing notes also indicate that the sacral area was now weak Code A Code A and broken areas.

17. I would have reviewed Mrs Lavender's condition again on the Monday morning, 26th February. In view of the fact that the previous dosage of Morphine Sulphate had become insufficient for Mrs Lavender's pain, I increased the dose to 20mgs twice a day, again with the Dihydrocodeine continuing. Code A I was concerned that she should have a Pegasus mattress in the hope of reducing pressure sores. I was probably made aware of the fact that Mrs Lavender's son wanted to see me and arranged to return to GWMH at 2pm for that purpose.

18. The nursing notes record that I saw Mr Lavender and his wife at the hospital that afternoon. I have no recollection of this meeting, but I anticipate he was understandably concerned at the fact that his mother had been suffering in pain over the weekend. I think that by this stage Mrs Lavender's appetite was poor. I would probably have explained that pain relief was becoming more difficult, that there was skin breakdown, and that his mother was deteriorating.

19. Sadly it is the case that in elderly frail people with pre-existing illness, such as Mrs Lavender, significant events such as a major fall with transfer to one

hospital and then another can in themselves have a very serious deleterious effect on their health, leading to death.

20. It may be the case that in the circumstances I indicated to Mrs Lavender's son that his mother might be dying, this simply being a feature of what can happen to elderly people in such circumstances, with the trauma of stroke, a major fall, and transfer to one hospital and then another. I believe I would have discussed the options for pain relief with Mrs Lavender's son and probably explained that it might become necessary to use a syringe driver and administer Diamorphine if the pain continued to be inadequately controlled. I think I would have explained that it was possible the administration of proper pain relieving medication might have the incidental and undesired effect of hastening death.

21. I believe Mrs Lavender's son was concerned that his mother should have adequate, proper pain relief, including medication administered via syringe driver if necessary, so that his mother was free from pain.

22. In any event, my note for 26th February in Mrs Lavender's notes reads as follows:

"26-2-96 not so well over w/e
family seen and well aware of prognosis
and treatment plan
Code A needs Pegasus mattress
institute sc analgesia if necessary"

23. I think that following my discussion with Mrs Lavender's son, I wrote up a proactive prescription for further pain relief should Mrs Lavender experience uncontrolled pain when I was not immediately available. I prescribed Diamorphine in a dose range of 80 - 160mgs, together with Midazolam 40 - 80mgs and Hyoscine 400 - 600mcgs. I would have anticipated that the nursing staff would contact me in such an event, so that I could then have authorised administration as necessary within that dose range.

24. I believe that I would have seen Mrs Lavender again the following morning, though I have not made an entry in her records. The nursing notes record that bloods were taken. Code A
Code A

25. I would have seen Mrs Lavender again the following day, 28th February, but again I did not make an entry in her notes on this occasion. The nursing notes show that the black areas - on the sacrum - were covered with Inadine. It appears that over the period 26th - 28th February Mrs Lavender had required no insulin in the morning and 20 units in the evening, suggesting poor nutritional intake.

26. Again, although I do not believe I had an opportunity to note it, I would have seen Mrs Lavender on 29th February, and 1st March, to review her condition. Sadly, I think she was slowly deteriorating over this period. The nursing notes suggest that on 29th February, Mrs Lavender's blood sugar was elevated and that I was contacted, ordering a quick acting insulin to be administered. I would not then have seen her again until the following Monday, 4th March.

27. Unfortunately, Mrs Lavender was again suffering in pain by 4th March. The drug chart and the nursing notes show that I therefore increased the Morphine Sulphate, in the form of Oramorph slow release tablets, to 30mgs twice a day. I think the Dihydrocodeine was still continued at this stage.

28. I would have reviewed Mrs Lavender again the following morning, and it was clear that the pain relief was again inadequate. The nursing notes record that Mrs Lavender's pain was now uncontrolled. She had had a very poor night and was said to be distressed. She was now not eating or drinking and had deteriorated over the last few days. In the circumstances I felt that it was necessary now to set up subcutaneous analgesia via syringe driver and to administer Diamorphine together with Midazolam in order to relieve Mrs Lavender's pain and distress. I recorded the medication on her drug chart, with the Diamorphine in a range of 100 - 200mgs over 24 hours, Midazolam in a range of 40 - 80mgs over the same period, and Hyoscine at 400 - 800mcgs.

29. The syringe driver was then set up at 9.30am that morning, with the Diamorphine and the Midazolam at the lower end of the range, 100mgs and 40mgs respectively. It was not necessary to administer Hyoscine at that stage as there were no secretions. I considered these doses appropriate in view of the fact that Mrs Lavender's pain was now uncontrolled and she was reported to be in distress. In spite of the previous increases, it had become necessary to increase the medication still further. A further reasonable increase to the level prescribed by me was now necessary to ensure that Mrs Lavender was now free from pain and distress in circumstances in which it was clear that she had continued to deteriorate and was now likely to be

dying. This medication was given solely with the aim of relieving that pain and distress.

30. My note on this occasion in Mrs Lavender's medical records reads as follows:

"5-3-96 Has deteriorated over last few days
not eating or drinking
In some pain ∴ start sc analgesia
Let family know"

31. As suggested in my note and confirmed by the nursing records, Mrs Lavender's son was contacted by telephone and the situation explained to him.

32. The medication appears to have been successful in reliving the pain and distress. The following day the nursing notes indicate that the pain was well controlled and the syringe driver was renewed at 9.45am. I reviewed Mrs Lavender again that morning and my note reads as follows:

"6-3-96 Further deterioration
sc analgesia commenced
comfortable and peaceful
I am happy for nursing staff to confirm death"

33. As indicated, Mrs Lavender was now comfortable and peaceful. It was apparent that the medication had been successful in relieving the significant pain and distress which she had suffered. Aware that she was dying, I indicated that I was happy for nursing staff to confirm death and that it

would not be necessary for a duty doctor to be asked to attend for this purpose.

34. It appears then that Mrs Lavender died in the course of the evening of 6th March, and she was found to have passed away peacefully shortly before 9.30pm.

Signed [signature] 24-3-05
handed to Dr Yates.

Code A