ROBERT WILSON

SUMMARY OF EVIDENCE

CASE OF ROBERT WILSON

Background/Family Observations

Robert WILSON was born on Code A in Glasgow and at 15 years of age joined the Navy serving for 22 years. During this time he met his wife who was a Wren although in 1982 after 32 years of marriage they divorced after having seven children one of whom was adopted.

He remarried in 1985 and lived with his wife in Fareham and Sarisbury Green. He fully retired at 65 years but would smoke 80 cigarettes a day and drink heavily. He gave up smoking after being admitted to Queen Alexandra Hospital following a suspected heart attack in 1997 but at that time was drinking a bottle of scotch a day.

In September 1998 whilst his wife was away Mr WILSON collapsed in his bedroom and was admitted to the Queen Alexandra Hospital, at first he appeared extremely ill, had a fracture to his left shoulder and had lost the will to live. After time Mr WILSON improved considerably and after approximately 3 ½ weeks it was decided he would go to the Gosport War Memorial Hospital for rehabilitation.

On Monday 11th October 1998 Mr WILSON was transferred to the Gosport War Memorial Hospital. The trip was via a mini-bus and took an hour and a half. On his arrival he was clearly tired out. He was seen by a lady doctor who stated that she would give him something to calm him down from the trip. Mr WILSON was lucid at this time.

The following day Mr WILSON was found with food all over him and incomprehensible when spoken to. When Mrs WILSON asked to see someone in authority she was told by the Ward Sister 'your husband is dying'. Later that evening Mr WILSON went into a coma from which he did not recover. He was being given drugs to remove his pain by some sort of drip.

Mr WILSON died at about 2340 hrs on Sunday 18th October 1998.

Given the fact that Mr WILSON had gone to the Gosport War Memorial Hospital for rehabilitation how come he slipped into a coma so quickly and why was he put on Diamorphine.

Mr WILSON's death certificate shows a cause of death as congestive cardiac failure, renal failure and liver failure and was signed by Dr PETERS.

Medical History of Robert WILSON

Robert WILSON a 74 year old gentleman in 1998 attended Queen Alexandra Hospital, Portsmouth A&E Department on the 21st September 1998 with a fracture of the left femoral head and tuberosity.

Mr WILSON had suffered many years before with Malaria and Diphtheria but was first noticed to be abusing alcohol at the time of an endoscopy in 1994. In 1997 he was admitted to hospital with a fall, epigastric pain and was found to have evidence of severe alcoholic liver disease. During the 1997 admission, an ultra sound showed a small bright liver compatible with cirrhosis and moderate ascites. His Albumin was very low at 19 and a bilirubin was 48. All these are markers of serious alcoholic liver disease with a poor long term prognosis. His weight was 100 kgs. There is no record of follow up attendance.

When he attends A&E it is originally intended to offer him an operation on his arm, which he refuses. However, he is kept in A&E overnight for observation. It becomes apparent by the next day that he is not well, is vomiting and he is needing Morphine for pain. His wife is on holiday and it is not thought possible for him to go home so he is transferred on 22nd September to the Care of the Elderly team at the Queen Alexandra Hospital.

The day after admission he is no longer thought fit enough to have an operation on his arm, although he would now be prepared to. He is recognised to have been an extremely heavy drinker with considerable oedema and abdominal distension on admission. He has abnormal blood tests on admission including a mild anaemia of 10.5 with a very raised mean cell volume of 113 and his platelet count is reduced at 133. Five days later his haemoglobin has fallen to 9.7 and the platelet count has fallen to 123. There are no further full blood counts in the notes, although his haemoglobin was normal with haemoglobin of 13 in 1997.

He is noted to have impaired renal function with a Urea of 6.7 and a Creatinine of 185 on admission and on 25th September Urea of 17.8 and a Creatinine of 246. He is started on intravenous fluids on 27th September and his renal function then continues to improve so that by the 7th October both his Urea and Creatinine are normal at 6.1 and 101.

His liver function is significantly abnormal on admission and on 29th his albumin is 22, his bilirubin 82 (he would have been clinically jaundice) there is then little change over his admission. On the 7th October is albumin is 23 and his bilirubin also 82. His AST is 66.

His vomiting within 24 hours of admission may have been due to alcohol withdrawal but he had also been given Morphine for pain. He is started on a Chlordiazepoxide regime as standard management plan to try and prevent significant symptoms of alcohol withdrawal. This has some sedative effects as well.

His physical condition in hospital deteriorates at first. He is noted to have considerable pain for the first 2 – 3 days, he is found to have extremely poor nutritional intake and has eaten little at home. His renal function deteriorates as documented above. He is communicating poorly with the nursing staff and is restless at night on 30th September. His Barthel deteriorates from 13 on 23rd September to 3 on the 2nd October, his continued nutritional problems are documented by the dietician on 2nd October. In the nursing cardex he is vomiting, he has variable communication problems, he is irritable and cross on 1st October. On 4th October his arm is noted to be markedly

swollen and very painful and it is suggested he needs Morphine for pain. The following day he knocks his arm and gets a laceration.

There is ongoing communication with his family which is complicated by inter-family relationships between his first wife's family and his current wife. The plan by 6th October is that he will need nursing home care when he leaves hospital and his Barthel at this stage is 5. However on the 5th the nursing cardex note that he is starting to improve although, he remains catheterised and has been faecally incontinent on occasion.

On 7th October is now more alert and is now telling the staffs that he wishes to return home. The nursing staff notes that he is now much more adamant in his opinions. However on 8th he had refused to wash for 2 days. He is then reviewed at the request of the medical staff by a psycho-geriatrician. The opinion is that he has early dementia, which may be alcohol related and depression. He is noted to be difficult to understand with a dysarthria. He is started on Trazodone as an antidepressant and as a night sedative, he is still asking for stronger analgesics on 8th October. The letter also mentions rather sleepy and withdrawn ..... his nights had been disturbed.

On the 9th October an occupational therapy assessment is difficult because he is reluctant to comply and a debate occurs about whether he is capable of going home. By the 12th October his Barthel has improved to 7 so Social Services say that he no longer fits their criteria for a nursing home and he should now be considered for further rehabilitation (21). The nursing cardex notes that his catheter is out he is eating better but he still gets bad pain in his left arm. His arms, hands and feet are noted to be significantly more swollen on 12th October. His weight has now increased from 103 kgs on 27th September to 114 kgs by 14th October. However his Waterlow score remains at "high risk" for all his admission. A decision is made to transfer him for possible further rehabilitation, although the medical review on 13th October states in view of the medical staff and because of his oedematous limbs, he is at high risk of tissue breakdown. He is also noted to be in cardiac failure with low protein and at very high risk of self neglect and injury if he starts to take alcohol again. He currently needs 24 hour hospital care.

Gosport War Memorial Hospital

On 14th October he is transferred to Dryad Ward and the notes say "for continuing care". The notes document the history of fractured humerus, his alcohol problem, current oedema and heart failure. No examination is documented. The notes state that he needs help with ADL, he is incontinent, Barthel 7, he lives with his wife and is for gentle rehabilitation.

The next medical notes are on 16th October and state that he had declined overnight with shortness of breath. On examination he is reported to have a weak pulse, unresponsive to spoken orders, oedema plus plus in arms and legs. The diagnosis is "? silent MI, ? liver function" and the treatment is to increase the Frusemide. The nursing cardex for 14th October confirms he was seen by Dr BARTON, that Oramorphine 10 mgs was given and he was continent of urine. On 15th October the nursing notes state commenced Oramorphine 10 mgs 4 hourly for pain in left arm, poor condition is explained to wife. On 16th on the nursing cardex he is "seen by Dr KNAPMAN am as deteriorated overnight, increased Frusemide". However the nursing care plan states for 15th October, settled and slept well, Oramorphine 20 mgs given 12 midnight with good effect, Oramorphine 10 mgs given 06.00 hours. Condition deteriorated overnight, very chesty and difficulty in swallowing medications. Then on 16th it states has been on syringe driver since 16.30

hours. As will be seen from the analysis of the drug chart, Mr WILSON received the Oramorph at midnight on 15th and then 06.00 hours Oramorph on 16th. The first clinical deterioration is on the night of 15th – 16th October not the night of the 14th – 15th October.

The next medical note is on 19th October which notes that he had been comfortable at night with rapid deterioration and death is later recorded at 23.40 hours and certified by Staff Nurse Code A The nursing cardex mentions a bubbly chest late pm on 16th October. On the 17th Hyoscine is increased because of the increasing oropharyngeal secretions. Copious amounts of fluid are being suctioned on 17th. He further deteriorates on 18th and he continues to require regular suction. The higher dose of Diamorphine on the 18th and Midazolam is recorded in the nursing cardex.

Dr Jane BARTON

The medical care provided by Dr BARTON to Mr WILSON following his transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council, Good Medical Practice, October 1995, (pages 2–3)

Dr BLACK reports

There is weakness in the documentation of his condition, in particular on the admission to the Gosport War Memorial Hospital on 14th October, and on the15th October when the regular oral strong opiate analgesia is commenced. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must provide clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatments provided". The lack of clinical examination on admission and on the day of 15th October when the decision was made to start regular strong oral opiate analgesia represents poor clinical practice to the standards set by the General Medical Council.

In Dr BLACK's opinion he further comments:-

It is my belief that the prescription of a total of 50 mgs of Oramorphine on the 15th October following the 20 mgs that were given on the 14th October was not an appropriate clinical response to the pain in Mr WILSON's left arm. In my view this dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th-16th October, in particular, his rapid mental state deterioration. In my view this treatment was negligent, and more than minimally contributed to the death of Mr Robert WILSON on 19th October.

Dr WILCOCK reports

Mr Wilson was a 74 year old man who was admitted to hospital after falling over and fracturing the greater tuberosity of his left humerus. He had multiple serious medical problems; alcohol-related cirrhosis leading to liver failure and encephalopathy, heart failure and kidney failure. Other

problems included early dementia, depression and a high level of dependency. Although the care he received at Queen Alexander Hospital led to Mr Wilson being mentally more alert and returned his kidney function to normal, he continued to become increasingly oedematous despite the re-introduction of his diuretic therapy which was considered due to heart failure. The pain he experienced from his fracture progressively improved as anticipated and during his time at Queen Alexander Hospital, his daily analgesic requirements reduced from the equivalent of 20mg to 3mg of oral morphine. Nevertheless, given the time it takes for a fracture to heal, it was not surprising that pain on movement was still present at the time of his transfer. There are no concerns regarding the care proffered to Mr Wilson at the Queen Alexander Hospital.

On transfer to Dryad Ward, the care proffered to Mr Wilson by Dr Barton and Dr Knapman fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient (Dr Barton and Dr Knapman) and providing treatment that could be excessive to the patients needs (Dr Barton). No pain assessment was carried out on Mr Wilson, but his only regular analgesic, paracetamol, was discontinued and prescribed p.r.n. (as required). Instead of his usual codeine 15–30mg p.r.n., approximately equivalent to morphine 1.5–3mg, he was prescribed morphine 5–10mg p.r.n. for pain relief. He received two doses of 10mg (a total of 20mg/24h) and the next day commenced on regular morphine 10mg every 4h and 20mg at night. In total he received 50mg of morphine in this 24h period, representing a larger dose than that he received in the initial 24h after his fracture. This is against the general expectation that pain from a fracture would have been improving over time and, without a clearly documented pain assessment, it is difficult to justify. However, the impact of this dose of morphine on Mr Wilson is impossible to judge because he deteriorated rapidly in the early hours of the 16th October 1998. The nature of his rapid decline and subsequent death were in keeping with worsening heart failure with or without a sudden event such as a heart attack. This, combined with his liver failure, could easily have precipitated his terminal decline. His reduced level of consciousness could have been due to a hepatic coma precipitated by the morphine or by a reduced level of blood oxygen secondary to the excess fluid on the lungs (pulmonary oedema) due to the heart failure. Later that day a syringe driver was commenced containing diamorphine 20mg/24h and increased over the next 48h to 60mg/24h, equivalent to oral morphine 120–180mg/24h. This increase in dose appears difficult to justify, as Mr Wilson was not reported to be distressed by pain, breathlessness or the secretions and was likely to be excessive for his needs. However, because heart and liver failure could also have led to a reduced level of consciousness, in my opinion, it is difficult to state with any certainty that the doses of morphine or diamorphine he received would have contributed more than minimally, negligibly or trivially to his death

Dr Jonathan MARSHALL a specialist Gastroenterologist states:-

Mr Wilson entered a terminal phase at or around the 16th October 1998. There is an entry in the notes that he had declined overnight with SOB (shortness of breath). On examination at that time he had a weak pulse, was unresponsive to spoken commands and had oedema ++ in arms and legs.

The impact of regular morphine administration to Mr Wilson is likely to have hastened his decline. It's sedative effects would worsen hepatic encephalopathy which he undoubtedly had throughout his hospital stay and would cause rapid deterioration as indeed happened between the 14th and the 18th October.

Mr Wilson's received 10mg of morphine on 14th October and then was commenced on 10mg morphine 4 hourly from then on. No dose reductions appear to have been made as recommended by standard prescribing guides. Doses escalated upwards until syringe drivers containing diamorphine 40mg with hyocine and midazolam 20mg were administered [278]. These are 'terminal care' doses from which recovery could not be expected with advanced liver disease and hepatic encephalopathy

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Interview of Dr Jane BARTON

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified 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 19th May 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 Robert WILSON at the Gosport War Memorial hospital.. The interviewing officers were DC Code A and DC Code A Code A

The interview commenced at 0902 and lasted for 28 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/6.

This statement dealt with the specific issues surrounding the care and treatment of Robert WILSON

Expert response to the statement of Dr BARTON

Dr BLACK reports having read Dr BARTON's statement it does not effect the conclusions in his report.

Professor BAKER who conducted a statistical study of the mortality rates at Gosport War Memorial Hospital which is included in the generic case file has also commented upon the care of Mr Robert WILSON at the GWMH and reports as follows:-

I have studied the copies of the records provided to me by Hampshire Constabulary in order to consider three issues – the certified cause of death, the prescription of opiates and sedatives, and whether Mr Wilson fell into the category of patients who might have left hospital alive.

With respect to death certification, I have concluded that the certificate was inaccurate in that Mr Wilson did not have renal failure, and had liver dysfunction but not failure. He probably did have

heart failure, although I believe the initiation of opiate medication was an important factor in leading to death.

With respect to the prescription of opiate drugs, I have concluded, on the evidence available to me, that the initiation of opiate medication on transfer to Dryad ward was inappropriate; I have also concluded that the starting dose was too high. The prescription of hyoscine and midazolam was justified by the use of opiates.

With respect to leaving hospital alive, I have concluded that Mr Wilson was in the category of patients who might have left hospital alive if he had not been commenced on opiate medicate on transfer to Dryad ward.

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Operation ROCHESTER.

Key Points June 2006.

Robert Caldwell WILSON. Born Code A

Robert Wilson served 22 years in the Navy leaving in 1964. He was married with 7 children before divorcing in 1981 he had suffered malaria and diphtheria.

His ex wife describes his latter days as being an alcoholic it was not uncommon for him to drink 17 pints of beer in a day, by 1997 he is said to have been drinking a bottle of whisky a day.

Medically Mr WILSON was first noticed to be abusing alcohol at the time of an endoscopy in 1994.

In 1997 he was admitted to hospital with a fall demonstrating markers of serious alcoholic liver disease with a poor long term prognosis

On the 21st September 1998, Mr WILSON collapsed in his bedroom suffering a fracture to left shoulder. He was admitted to the Queen Alexandra Hospital where he refused to be operated upon. His physical condition initially deteriorated with alteration in mental state, renal impairment and subsequent gross fluid retention.

His wife was away on holiday at the time and unable to care for him, as a consequence Mr WILSON was transferred to the care of the elderly team at the Q/A hospital on 22nd September 1998.

Mr WILSON was clearly unwell. By the 22nd September he agreed to an operation but no longer thought fit enough.

He was recognised to have been an extremely heavy drinker with considerable oedema and abdominal distension his blood tests were found to be abnormal, he was suffering from mild anaemia, impaired renal function and was vomiting within 24hrs of admission probably due to alcohol withdrawal.

His physical condition deteriorated and he was noted as being in considerable pain during the first 2-3 days of his admission. He was noted as being in poor nutritional condition, irritable and suffering communication problems.

Regular Co-dydramol starts on 25th September until 30th September when it is replaced by 4 times a day regular Paracetamol which continues until his transfer.

In summary, his pain relief for the last week in the Queen Alexandra is 4 times a day Paracetamol and occasional night time dose of Codeine Phosphate.

By the 4th October 1998, his arm had become markedly swollen and it was suggested that he needed morphine for the pain.

By the 6th October 1998 it was recognised that he would need nursing home care, it had been noted the previous day that his condition was starting to improve although he remained catheterised and faecally incontinent.

On the 7th October 1998 it was noted that Mr WILSON was more alert and telling staff that he wished to go home, he was assessed by a psycho-geriatrician who's opinion was that that he had early dementia which may be alcohol related and depression. Mr WILSON was prescribed and administered 'Trazodone' as an antidepressant and as a night sedative he is still asking for stronger analgesics on 8th October. Mr WILSON was noted as sleepy and withdrawn and suffered disturbed nights.

On the 9th October an occupational therapy assessment was described as difficult because he is reluctant to comply and it was debated whether Mr WILSON was capable of going home .

By the 12th October Mr WILSONS Barthel score had improved to a level (7) that Social Services took the view that he no longer fitted their criteria for a nursing home and he should be considered for further rehabilitation.

The nursing notes comment that his catheter was out he was eating better but still suffered 'bad pain' in his left arm. His arms, hands and feet were noted to be significantly more swollen on 12th October, but his weight had increased from 103 kgs on 27th September to 114 kgs by 14th October 1998.

A decision was made to transfer Mr WILSON for possible further rehabilitation, although a medical review on 13th October stated that because of his oedematous limbs, he was at high risk of tissue breakdown. He was also noted to be in cardiac failure with low protein and at very high risk of self neglect and injury should he take alcohol again. He was assessed as requiring 24 hour hospital care.

On 14th October 1998 Mr WILSON was transferred to Dryad Ward at Gosport War Memorial Hospital, for 'continuing care'.

Mr WILSON was seen by Dr BARTON who prescribed Oramorphine 10 mgs.

On 15th October the nursing notes state that Oramorphine 10 mgs was commenced 4 hourly for pain in the left arm and that Mr WILSONS poor condition was explained to wife.

On 16th October the nursing notes comment that Mr WILSON was 'seen by Dr Knapman a/m as deteriorated overnight, increased Frusemide'.

This position seems to be contradicted by the nursing care plan which states 'for 15th October, settled and slept well, Oramorphine 20 mgs given 12 midnight with good effect, Oramorphine 10 mgs given 06.00 hours. Condition deteriorated overnight, very chesty and difficulty in swallowing medications, then on 16th it states that Mr WILSON had been on syringe driver since 16.30 hours.

Analysis of the drug chart indicates that Mr Wilson received the Oramorph at midnight on 15th and then 06.00 hours Oramorph on 16th. The first clinical deterioration is on the night of 15th – 16th October not the night of the 14th – 15th October.

Nursing notes mention a 'bubbly chest' late pm on 16th October and on the 17th Hyoscine is increased because of the increasing oropharyngeal secretions. Copious amounts of fluid are being suctioned on 17th. He further deteriorates on 18th and he continues to require regular suction (266). The higher dose of Diamorphine on the 18th and Midazolam is recorded in the nursing cardex (266).

The next medical note is on 19th October noting that Mr WILSON had had a comfortable night but had rapidily deteriorated.

Death was recorded at 23.40 hours on the 18th October and certified by Staff Nurse Code A

<u>Case assessed by a multi-disciplinary clinical team 2004.</u>

<u>Robert WILSON.</u> 74. Died 18th October 1998 four days after admission to Gosport War memorial Hospital, he is recorded as having a high alcohol intake and poor nutritional status. He was admitted with a fracture of the left humerus.

During his last days on Dickens ward, he was on regular paracetomal and codeine as required needing one dose of codeine most days. On transfer to dryad, he received 2 doses of oramorph and was then put on a moderate dose of oramorph every 4 hours with paracetomal as required. Liver and kidney problems make the body more sensitive to the effects of oramorph. He had both of these problems. He deteriorated, and was converted to a syringe driver at a dose, which was a close conversion from the oramorph dose.

Over the next 2 days the dose was increased without obvious indication. Death was presumably from overdose of opiates, in a man with a poor opiate metabolism, and reduced tolerance.

Unless the decision had been taken to treat pain 'regardless' then this was negligent. The initial dose of Morphine was inappropriate in a person with known alcoholic liver disease. A rapid increase in body weight was documented in notes, with no apparent clinical response.

Dr Jane BARTON from caution interview with police on 19th May 2005.

Within a prepared statement Dr BARTON commented that she had no recollection of Mr WILSON due to the remove of time. However with the benefit of referral to notes she was able to comment on his medical history and admission to the Queen Alexandra hospital on 21st September 1998 with a fracture to the left humerus.

In particular Dr BARTON referred to Mrs WILSON condition on 29th September 1998, impaired renal function, liver function abnormal and suffering alcoholic hepatitis. It had also been recorded that Mr WILSON was 'not for resuscitation in view of poor quality of life and poor prognosis'.

On the 14th October 1998 Mr WILSON was transferred to Gosport War Memorial Hospital Dryad ward being assessed by Dr BARTON on admission. She had noted that he had been transferred for continuing care having suffered a fractured left humerus. In summary she noted Mr WILSON's alcohol problems, recurrent oedema and congestive cardiac failure.

Following her assessment she wrote Mr WILSONS prescriptions on his drug chart mirroring the medication recorded on his referral form consisting of vitamin nutrition for alcoholism, drugs for constipation, diuretics to reduce oedema, drugs for depression, parecetamol analgesia and increased pain relief Oramorph due to continued pain in his arm.

Additionally Dr BARTON wrote up a proactive regime of Diamorphine, Midazolam and Hyoscine, pain relief and medication available in case of deterioration of the patient.

It was her expectation that in the usual way nursing staff would endeavour to make contact with her or the duty doctor before commencement of the medication which would be at the bottom end of the dose range.

Dr BARTON prescribed further Oramorph on 15th October 1998, subcutaneously given his difficulty in swallowing medication.

Diamorphine was commenced on 16th October 1998 the reason being explained to the patients wife, she was also informed of his continued deterioration.

On the 17th October the patient was seen by Dr PETERS who recorded that Mr WILSON was comfortable but there was a rapid deterioration. He added that nursing staff could verify death if necessary.

There followed an increased dosage of Diamorphine, Hyoscine and Midazolam which might have been done with reference to Dr PETERS note, or with reference to Dr BARTON.

Dr BARTON commented that the patient suffered increasing secretions producing a sensation of inability to breath, diamorphine can assist in relieving agitation and distress and reducing oedema from cardiac failure. Furthermore there may have been a concern that Mr WILSON might become tolerant to opiates and according the increase might be required.

On the 18th October 1998 Dr PETERS attended speaking to Mrs WILSON and authorising an increase in Hyoscine beyond the range prescribed by Dr BARTON.

Mr WILSON continued to deteriorate and the nurses recorded that he died peacefully at 1140pm in the presence of members of his family.

Expert Witness Dr Andrew WILCOCK (Palliative medicine and medical oncology) comments:-

Mr WILSON was a 74 year old man who was admitted to hospital after falling over and fracturing the greater tuberosity of his left humerus. He had multiple serious medical problems; alcohol-related cirrhosis leading to liver failure and encephalopathy, heart failure and kidney failure. Other problems included early dementia, depression and a high level of dependency.

Although the care he received at Queen Alexander Hospital led to Mr WILSON being mentally more alert and returned his kidney function to normal, he continued to become increasingly oedematous despite the re-introduction of his diuretic therapy which was considered due to heart failure.

The pain he experienced from his fracture progressively improved as anticipated and during his time at Queen Alexander Hospital, his daily analgesic requirements reduced from the equivalent of 20mg to 3mg of oral morphine. Nevertheless, given the time it takes for a fracture to heal, it was not surprising that pain on movement was still present at the time of his transfer.

There are no concerns regarding the care proffered to Mr WILSON at the Queen Alexander Hospital.

On transfer to Dryad Ward, the care proffered to Mr WILSON by Dr BARTON and Dr KNAPMAN fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient (Dr BARTON and Dr KNAPMAN) and providing treatment that could be excessive to the patients needs (Dr BARTON).

No pain assessment was carried out on Mr WILSON, but his only regular analgesic, paracetamol, was discontinued and prescribed p.r.n. (as required).

Instead of his usual codeine 15–30mg p.r.n., approximately equivalent to morphine 1.5–3mg, he was prescribed morphine 5–10mg p.r.n. for pain relief. He received two doses of 10mg (a total of 20mg/24h) and the next day commenced on regular morphine 10mg every 4h and 20mg at night. In total he received 50mg of morphine in this 24h period, representing a larger dose than that he received in the initial 24h after his fracture.

This is against the general expectation that pain from a fracture would have been improving over time and, without a clearly documented pain assessment, it is difficult to justify. However, the impact of this dose of morphine on Mr Wilson is impossible to judge because he deteriorated rapidly in the early hours of the 16th October 1998.

The nature of his rapid decline and subsequent death were in keeping with worsening heart failure with or without a sudden event such as a heart attack. This, combined with his liver failure, could easily have precipitated his terminal decline.

His reduced level of consciousness could have been due to a hepatic coma precipitated by the morphine or by a reduced level of blood oxygen secondary to the excess fluid on the lungs (pulmonary oedema) due to the heart failure.

Later that day a syringe driver was commenced containing diamorphine 20mg/24h and increased over the next 48h to 60mg/24h, equivalent to oral morphine 120–180mg/24h. This increase in dose appears difficult to justify, as Mr Wilson was not reported to be distressed by pain, breathlessness or the secretions and was likely to be excessive for his needs. However, because heart and liver failure could also have led to a reduced level of consciousness, in my opinion, it is difficult to state with any certainty that the doses of morphine or diamorphine he received would have contributed more than minimally, negligibly or trivially to his death.

Expert Witness Dr David BLACK (Geriatrics) comments:-

Mr Robert WILSON a 74 year old gentleman with known severe alcoholic liver disease who was admitted with a complex and painful fracture of the left upper humerus. His physical condition deteriorates at first in hospital, with alteration in mental state, renal impairment and subsequent gross fluid retention.

He then starts to improve and is transferred to the Gosport War Memorial Hospital for further assessment and possible rehabilitation or continuing care. He is started on regular oral strong opiate analgesia for pain in his left arm and rapidly deteriorates and dies within 5 days of admission.

There is weakness in the documentation of his condition, in particular on the admission to the Gosport War Memorial Hospital on 14th October, and on the15th October when the regular oral strong opiate analgesia is commenced.

If clinical examinations were undertaken they have not been recorded.

General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must provide clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatments provided".

The lack of clinical examination on admission and on the day of 15th October when the decision was made to start regular strong oral opiate analgesia represents poor clinical practice to the standards set by the General Medical Council.

It is Dr BLACK's belief that the prescription of a total of 50 mgs of Oramorphine on the 15th October following the 20 mgs that were given on the 14th October was not an appropriate clinical response to the pain in Mr WILSON's left arm.

This dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th-16th October, in particular, his rapid mental state deterioration. In Dr BLACK's view this treatment was negligent, and more than minimally contributed to the death of Mr Robert WILSON on 19th October.

Professor Richard BAKER (Clinical Governance)

Studied the records provided by Hampshire Constabulary in order to consider three issues – the certified cause of death, the prescription of opiates and sedatives, and whether Mr Wilson fell into the category of patients who might have left hospital alive.

With respect to death certification the expert concluded that the certificate was inaccurate in that Mr Wilson did not have renal failure, and had liver dysfunction but not failure. He probably did have heart failure, although the expert believed the initiation of opiate medication was an important factor in leading to death.

With regard to the prescription of opiate drugs the expert concluded that on evidence available, that the initiation of opiate medication on transfer to Dryad ward was inappropriate. The expert also concluded that the starting dose was too high. The prescription of hyoscine and midazolam was justified by the use of opiates.

Dr BAKER had referred in a previous report commissioned by the Chief Medical Officer to the potential of patients leaving hospital alive, he concluded that Mr Wilson was in the category of patients who might have left hospital alive if he had not been commenced on opiate medicate on transfer to Dryad ward.

In the experts opinion, Mr Wilson had liver dysfunction but not full blown failure. His liver dysfunction did not cause death. In the presence of other life-threatening conditions, the liver dysfunction may impair the ability to recover, and it would have been reasonable to mention on the death certificate that Mr Wilson had chronic liver disease. The cause of his liver disease – alcohol – was not mentioned on the certificate.

Mr Wilson did not have renal failure. He did have abnormal blood test results after his admission to hospital, but these improved with re-hydration. Mr Wilson probably did have cardiac failure. There may have been other conditions as well. Haemoglobin estimations during his admission to Queen Alexandra Hospital had indicated mild anaemia. If this condition had deteriorated, the heart failure would also have become worse. However this was rather unlikely since he was being closely observed in Queen Alexandra Hospital and signs of increasing anaemia would almost certainly have been recognised. Evidence of bleeding would have been noted if it had occurred. There is no convincing evidence in the records to confirm a diagnosis of myocardial infarction such as history of chest pain, raised cardiac enzymes or ECG evidence. One could also speculate about possible occurrence of some unsuspected condition.

However, despite all these speculations, it has to be acknowledged that his decline was associated with the regular administration of morphine, and was responded to by administration of diamorphine by syringe driver.

The reason for commencing Oramorph is not recorded in the medical notes [179]; in particular, the reasons for not using a non-opiate drug for pain relief are not given. Even if Mr Wilson did have pain from the fracture that was not controlled by paracetamol, regular does of 10mg of oral morphine would not have been the appropriate treatment. Other non-opiate or weak opiate medication should have been used first. If these medications had failed to adequately reduce

the pain, a low dose of morphine (2.5-5mg) as had been used in the early days of his admission might have been reasonable. Although Mr Wilson did have congestive cardiac failure, therefore his death would have been hastened by opiate administration and the path to death may well have been initiated by the commencement of Oramorph on 14/10/98.

It is important to note that the general standard of completion of death certificates is unsatisfactory. For example, in a review of 1000 counterfoils of certificates in one teaching hospital in 1999-2000, only 55% of certificates had been completed to a minimally accepted standard (Swift and West, 2002). Of the remaining certificates, 25% had incomplete data, in 11% the part II section had been used inappropriately, and 9% were illogical or inappropriate. In her third report from the Shipman Inquiry, Dame Janet Smith observed: *A further problem with the current system is that the quality of certification is poor. Doctors receive little training in death certification.* (paragraph 17, page 4, Shipman Inquiry). The standard of completion of the death certificate in Mr Wilson's case should therefore be regarded as fairly typical. Although Mr Wilson did not have renal failure, the history of recent abnormal renal function tests prompted use of this diagnosis; the mention of liver failure was probably a convenient way of describing the impaired liver function.

Expert Witness Dr Jonathon MARSHALL (Gastroenterologist)

Mr WILSON was suffering with chronic liver failure due to alcoholic cirrhosos in 1997.

Mr WILSON entered terminal phase on or about 16th October 1998 there was a clearly marked deterioration between 12th/13th of October and the 16th.

The management of Mr Wilson's liver condition following the time of initial admission was not perfect but reasonable. He should have received Pabrenex to prevent *Wernickes'* encephalopathy in addition to lactulose to treat *hepatic* encephalopathy.

Mr Wilson was assessed by a psychogeriatrician who did not detect any of the classical signs of Wernickes' encephalopathy. During most of his admission as well Mr Wilson was generally alert and so the omission of lactulose or other anti-encephalopathy treatment cannot be cited as a major omission. In real-life I suspect Mr Wilson would have refused to take lactulose for presumed encephalopathy because of its taste and laxative effects.

Mr Wilson was clearly an un-well man whose life expectancy was short. His previous record demonstrates that he would have been likely to return to drinking on discharge from hospital. The administration of high doses of morphine whilst an in-patient on Dryad however must be considered reckless. Warnings about morphine usage in the context of liver disease are readily available in standard prescribing guides such as those cited from the BNF.

No attempt appears to have been made to justify the use of opiates in this at risk patient group. There also does not appear to have been any attention paid to appropriate dose reduction and/or monitoring in Mr Wilson's case.

The outcome was predictable in the clinical context of cirrhosis and escalating opiate dosage that Mr Wilson could not have survived.

The impact of regular morphine administration to Mr WILSON is likely to have hastened his decline. Its sedative effects would worsen hepatic encephalopathy which he undoubtedly had throughout his hospital stay, and would cause rapid deterioration as indeed happened between the 14th and 19th October./

Mr Wilson's cause of death is given as (1) Congestive Cardiac Failure (2) Renal failure and (3) Liver failure. The experts understanding was that this was a clinical diagnosis as opposed to a post-mortem finding.

Congestive cardiac failure was unlikely to be the primary cause of death in Mr Wilson's case. Mr Wilson had oedema and the *commonest* cause for oedema is as a consequence of heart failure. However oedema also occurs in cirrhotic liver disease and in the experts view this was far more likely cause of oedema and ultimate demise than heart failure.

Mr Wilson had cirrhosis and therefore cause of death (3) 'liver failure' was reasonable. Mr Wilson had signs of *chronic* liver failure throughout his hospital stay including oedema and probable hepatic encephalopathy. The experts view is that he died of *acute chronic* liver failure precipitated by opiate medication.

Renal failure is a common secondary consequence of liver failure.

While there is limited evidence to support a diagnosis of 'renal failure' it is a common complication of liver disease. Mr Wilson is likely to have had the 'hepatorenal syndrome.' This means reversible renal failure as a direct consequence of the liver failure. If the liver injury can in some way be reversed then the renal failure will correct.

<u>Evidence of other key witnesses.</u>

<u>Mollie EDWARDS</u> first wife of Robert WILSON, describes husband as a fit active navy man until 1964. However was a heavy smoker 60-80 a day and would drink heavily regularly 17 pints a day. Divorced in 1981.

Saw Mr WILSON when admitted to Queen Alexandra Hospital, he had refused painkillers was lucid and able to speak clearly. Next visited on his second day at Gosport War Memorial Hospital. He was in a coma and she was told by the nurse that he had travelled badly. Did not see him against prior to death.

Gillian KIMBERLEY second wife of Robert WILSON married in 1885. WILSON retired at 65 in quite good health. A heavy smoker 40 a day. Drank half a bottle of scotch a day. He was 5'6' tall and about 12 stone. Sufferd suspected heart attack in Febraury 1997 hospitalised for 3 weeks and stopped smoking.

Husband suffered a fall in September 1998 whilst she was staying with relatives in Plymouth. She visited him 6 days later. He was transferred to Gosport on 14th October for rehabilitation. Seemed OK prior to transfer.

On arrival a female Doctor said she would give him something to calm him down from the trip. The following day he looked dreadful was a mess with food all over him and incomprehensible. Spoke with the ward sister who told her bluntly that he was dying. He could die at any time but they were not giving him longer than a week. Has always had concerns about Roberts death.

Iain WILSON son of deceased. Father a heavy smoker form the age of 11 but quit five years prior to death. Drank a bottle of whisky a day after giving up smoking.

When initially admitted to Queen Alexandra hospital with fractures left shoulder he was told by a doctor that his father had given up the will to live.

The evening prior to leaving the Queen Alexandra hospital Mr WILSON was happy sat up in bed, having a joke and aware of his surroundings. Nurse said they new he was on the road to recovery because he was arguing with them.

Father transferred to Gosport War memorial hospital on the 14th October by minibus a 90 minute journey. Saw father following day on the bed in an almost paralysed state, distressed and confused. Saw father on 16th almost in coma and on syringe driver.

Mr WILSON concerns:-

- Why did he go downhill so quickly after leaving Q/A?
- Why was he placed on diamorphine when earlier had been refusing painkillers?
- If he was ill why move for rehabilitation, and why not by ambulance?
- What was the cause of renal and liver failure?

Keran Lynn WILSON daughter of deceased - family history and visits made to father at Q/A and Gosport War memorial Hospital.

Neil WILSON step - son of deceased. Background and hospital visits. Unhappy with fathers treatment at Gosport War Memorial Hospital and challenged staff. Tried to meet doctor in charge but unable to do so despite several attempts.

Leslie CLARKE Daughter of deceased. Family history and visit to Gosport War memorial hospital on 17th/18th October 1998.

David HUNTINGTON Son of deceased. Background, visted father at Queen Alexandra hospital September 1998, seemed to be well and looked after, clean and tidy was in a wheel chair following fall but seemed lucid and happy with where he was, spoke about going home.Next saw father the day prior to his death. Totally shocked at his decline.

Tracy HUNTINGTON Daughter of deceased. Family background.Visted Dryad ward 14th or 15th October, father was completely unconscious, did not register that she was in the room.

Robert LOGAN Eldest son of deceased. Background. Visited once at Gosport War Memorial Hospital was not conscious, seemed poorly and clearly heavily sedated.

Anthony MOWBRAY General Practitioner retired. Mr WILSON a patient at his Sarisbury Green practice. In March 1997 prescribed drugs and multi-vitamins for oedema (fluid on the legs) ascites (fluid abdominal cavity) and liver failure. Patient felling better by April 1997. May 1997 troubled by swelling to right leg, in July 1997 he was taking small amounts of alcohol, told to take more exercise. Blood tests consistent with high alcohol dependency.

Timothy TAYLER Doctor, Sarisbury Green practice. Saw Mr WILSON in July 1996 noted abnormal liver function and alcohol excess. Commissioned liver tests . Saw again in August 1996, test indicated abstinence from alcohol and improving liver.

Dierdre DURRANT General Practitioner saw Mr WILSON in November 1993 suffered inflammation of the stomach due to alcohol abuse. Failed return to see doctor in 3 weeks as requested.

Christopher HAND Doctor Queen Alexandra Hospital. Examined Mr WILSON for his fractured left humerus 21st September 1998. WILSON refused an Operation.

Christian BIRLA Doctor Queen Alexandra Hospital. Explains an entry re 'resuscitation' status on 23rd September 1998. Having observed Mr WILSON between 23rd and 29th September 1998 she decided that due to his physical condition (he was an alcoholic) he would not be resuscitated if he stopped breathing at any point. General re condition of Mr WILSON whilst at QAH and analgesia applied.

The BNF notes that if a patient's liver is damaged caution has to be exercised in the administration of opiates.

Mrs WILSON'S state of physical health was such through alcohol abuse that if his health deteriorated to the extent that he were to die, it would not be unexpected in the near future.

Arumugam RAVINDRANE Consultant Physician specialist registrar Dickens Ward, Queen Alexandra Hospital 1998. Examined Mr WILSON 25th September 1998, noted dehydrated and drowsy. Renal function slightly better by 30th September. Stopped all sedatives but continued fluids. By 2nd October 1998 Mr WILSON still very sleepy, indications of malnutrition and diseased liver. Stopped I/V fluids and gave high protein drinks.

Listed patient for long term continuing care. Wrote a letter to psychiatrist indicating his alcoholism liver disease, clinical depression and withdrawn attitude.

9th October 1998 noted gross oedema but eating well, Barthel index 5 which was low indicating very poor mobility. Asked for nursing home placement with social services.

Last enrty in notes dated 13th October 1998 stating Mr WISLON needed both nursing and medical care. In danger of falling and risk would remain until fully mobilised. His special needs included attending to swollen arm.

Does not recall Mr WILSON but having read notes he was unwell, he may have stabilised and maintained some level of health, equally he could have died suddenly or quickly due to his condition. His liver function was abnormal.

Kathryn TAYLOR-BARNES Senior House Officer Queen Alexandra Hospital 1998 examined Mr WILSON 24th September 1998. Examined fractured shoulder and checked for further damage. Produced five point plan to ensure proper management. Content that diamorphine 5mg was adequate for pain relief.

Rosie LUZNANT Consultant in old age psychiatry. On 8th October wrote entry in medical notes, presented with a low mood, a wish to die and disturbed sleep. Believed to be suffering from early dementia and depression.

Mini mental state examination score of 24/30. (30/30 is good memory. 5/30 is poor memory)

Wrote to referring doctor GRUNSTEIN on 15th October

Code A Nurse, working Dickens Ward Queen Alexandra Hospital 28th September 1998 was first day as a trained nurse. Made several entries in the patient's daily living notes between 28th September and 6th October 1998.

Ruth CLEMON Nurse Dickens Ward, Queen Alexandra Hospital head of nursing team. Made entries in nursing notes between 24th September 1998 and 13th October 1998, final entry 13th October reads 'Reviewed by medical team, continues to require special medical/nursing care as oedematous limbs at high risk of breakdown (right foot already about to break down) this is due to increased oedema secondary to cardiac failure and low protein. Also high risk of self neglect and injury if starts to take alcohol again. Needs to have 24hr hospital care until arm healed.

On 24th September Mr WILSON in severe pain addressed with diamorphine slow either intravenous or subcutaneous 2-5mgs. Morphine given 3 times during initial 24hrs.

Code A Entries to nursing notes between 23rd September 1998 and the 1sr October 1998 whilst at Queen Alexandra Hospital.

Code A Nurse.. entries to medical notes including transfer on 13th October 1998.

Althea LORD Consultant Geriatrician. Had no contact with the patient at Dryad Ward, was on leave from 12th October to 23rd October.

Ewenda Jay PETERS GP Forton Road Medical Centre, GOSPORT, employed as clinical assistance at Royal HASLAR Hospital, GOSPORT 1995 – 2000 and provided cover for Dr BARTON at Gosport War Memorial Hospital. Made entry on medical notes 18th October 1998 reading 'comfortable but rapid deterioration nursing staff or night sister to verify death if necessary'.

On 18th October increased the patients dosage of Hyoscene an anti nausea drug also used to dry up secretions

Anthony Charles KNAPMAN GP Forton Road Medical centre. Provided cover for Dr BARTON at Gosport War Memorial Hospital.

Made entry in Mr WILSON's medical notes on 16th October 1998 'decline overnight with shortness of breath, fluid in chest, weak pulse, oedema arms and legs, silent MI/, indicates that he may have had a heart attack or deterioration of his liver.

Dr KNAPMAN prescribed Mr WISLON an increase in Frusemide a diuretic due to his fluid retention, the only drug written up by Dr KNAPMAN.

Dr KNAPMAN did not feel that drugs written up by Dr BARTON were excessive.

Gillian Elizabeth HAMBLIN Senior sister Dryad Ward responsible for the 24hr care of the patients on the ward. Dr BARTON would visit the ward each morning 0730hrs Monday to Friday to see every patient before returning to her own practice.
Dr BARTON prescribed the drugs required by each patient.
Nurse HAMBLIN has no doubts about the use of syringe drivers.
Following admission Nurse HAMBLIN has written the following diagnosis.
Broken left upper arm.
Congestive cardiac failure.
Renal failure.
Liver failure.
Treatment /recommendation syringe driver 16.10.1998.
The diagnosis obtained through her review of the medical records.

Nurse HAMBLIN noted from the notes that Mr WILSON suffered multiple organ failure and she made the prognosis that he was being admitted for terminal care at Dryad Ward.
At 1550hrs on 17th October Nurse HAMBLIN increased dose of Diamorphine to 40mgs and Hyoscine increased to 800 mcgs.She added 20 mcgs of Midazolam.
On 18th October Diamorphine increased from 40mg to 60mg to control pain, multi organ failure and fractured arm. Midazolam increased 20-40mg due to patient suffering liver failure.

Nurse HAMBLIN Further statement cannot recall conversation with nurse Shirley HALLMAN who was her senior nurse on Dryad WARD. Reiterated that the dosage increases in diamorphine to Mr WILSON were necessary to deal with his pain and anxiety, this was not always recorded in the notes but was self evident. Would always inform a doctor of the change, sometimes afterwards.

Lynne BARRETT Staff nurse Dryad Ward. Discusses training and use of syringe drivers and background re ward procedures. Made single entry on Mr WILSONS notes.

Code A Staff nurse Dryad Ward. Witnessed use of diamorphine on patient WILSON 16th and 18th October via syringe driver.

Code A Staff nurse Dryad Ward. Administered Oramorph to Mr WILSON 14TH October and witnessed Nurse Code A administer Oramorph on 15th and 16th October prescribed by Dr BARTON.

Code A Staff nurse Dryad Ward, administered Oramorph to Mr WILSON ON 15TH October .

Code A Nurse Employed Daedalus ward occasionally covered Dryad. On 17th October administered 20mg of Diamorphine to Mr WILSON.

Code A Nurse Dryad Ward, witnessed staff nurse Code A administer 20mg Diamorphine on 17th October 1998.

Freda SHAW Staff nurse Dryad Ward. Witnessed Oramorph oral solution administered by Nurse HAMBLIN on 15th October 1998. Explains other general nursing note entries.

Code A Staff nurse Sultan Ward providing cover for Dryad. Administered Oramorph 20mg 15th October 1998 and 10mg on 16th October.

Code A Staff nurse Dryad Ward. Explains the 'five rights' procedure for syringe driver use. Only involvement with Mr WILSON was to verify death at 2340hrs on 18th October 1998.

Shirley HALLMAN Staff nurse Dryad Ward. Administered Diamorphine and Oramorph to Mr WILSON, does not believe dosage excessive in her experience.

Code A Healthcare support worker. Witnessed administration 10mg ramorph 15th October 1998.

Jacqueline SPRAGG. Produces cause of death certificate stub 23170 re Robert WILSON.

Detective Constables Code A and Code A. Tape recorded interviews Dr BARTON 19th May 2005.

Code A

D.M.WILLIAMS
Det Supt 7227
8th June 2006.

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..

Susan WEBB (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.

HAMPSHIRE CONSTABULARY

C.51 1/99

Identification Ref. No. DB/2002

Court Exhibit No.

R - v -

Description

A CERTIFIED COPY OF A DEATH CERTIFICATE (WILSON

Time/Date Seized/Produced

19TH MAY 2005

Where Seized/Produced

OFFICE FOR NATIONAL STATISTICS

Seized/Produced by DAVID BURGESS

Signed

Incident/Crime No. OPERATION ROCHESTER

Major Incident Item No. X 609

Laboratory Ref:

PLEASE ATTACH WITH TAPE

GLOUCESTERSHIRE CONSTABULARY

Station.

J1 No. Item No.

O.I.C.

Identification Ref No.

Court Exhibit No. DB 2002

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: ROBERT WILSON

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, Mr Robert Wilson. 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 Mr Wilson.

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. I confirm that these comments are indeed a fair and accurate summary of the position in 1998 when I was involved in the care of Mr Wilson.

4. Unfortunately, at this remove of time I have no recollection of Mr Wilson. With the benefit of the notes however, it is apparent that Mr Wilson was a 74 year old gentleman who was admitted to the Queen Alexandra Hospital on the 21st September 1998 following a fall at home during which he had sustained a fractured greater tuberosity of the left humerus. Mr Wilson had been admitted the previous year with epigastric pain which was diagnosed as left lobar pneumonia and alcoholic gastritis with grossly abnormal liver enzymes. He was found to have a small bright liver compatible with alcohol liver disease, and indeed it seemed that he had been consuming excessive alcohol for a number of years. In the course of this admission in 1997 Mr Wilson was treated with antibiotics and diuretics but was unco-operative about diet. He was discharged after three weeks with a planned follow up in out-patients.

5. It appears that Mr Wilson spent the night of the 21st September 1998 on the A & E ward. He complained of pain, and the relevant A & E record shows that he received 10mgs of morphine intravenously at 9pm that evening.

6. Mr Wilson was then assessed in the fracture clinic the following day. He was reported as not being keen to undergo surgical intervention, and following this he was admitted to Dickens Ward in the Elderly Medicine Department of the Queen Alexandra Hospital. It appears that on admission Mr Wilson's analgesia was not sufficient, and intravenous Morphine, 2 - 5mgs was prescribed, together with 30mgs of Codeine Phosphate 6 hourly as required.

7. Although not seemingly recorded on the prescription chart, a nursing entry records that the medication was subsequently altered so that the Morphine was given by a subcutaneous injection, with the addition of the Codeine Phosphate.

8. A Barthel score assessment was made on the 22nd September following his admission, a score of 5 being recorded.

9. Although there appears to be no entry in the prescription charts, the medical notes record that on 24th September Mr Wilson was given 5mgs of Diamorphine, though an examination following that administration the area from the shoulder to the elbow was said to be very painful. Indeed, the nursing records show that an initial 2.5mgs of Diamorphine was given with little effect, seemingly requiring a further 2.5mgs about half an hour later.

10. It seems that Mr Wilson may have had oedema, and on 24th September diuretics in the form of Frusemide and Spironolactone were prescribed. On 25th September Mr Wilson was recorded as still being in pain, and indeed he appears to have continued to have been throughout much of his stay on Dickens Ward in pain in spite of the administration of Morphine and Codeine Phosphate from time to time. On 1st October for example his left arm was said to be "painful +++ on movement", though he had no apparent pain at rest, and that continued generally. On the 4th October he was said to be still in great pain, and the humerus was elevated slightly on the pillow to help reduce the swelling.

11. On the 11th October the pain was said to remain "quite bad in his L arm", and then again on the 12th the nursing notes record that he remained "in a lot of pain when being cared for".

12. It appears on the 29th September Mr Wilson had become very dehydrated and his renal function had deteriorated. His diuretics were stopped and he was commenced on IV fluids. A medical entry that day records that Mr Wilson had impaired renal function, that his liver function was abnormal and he had alcoholic hepatitis. It was also recorded that Mr Wilson was "not for resuscitation in view of poor quality of life and poor prognosis". I do not know who made this entry in the records, but clearly one of the medical team considered that Mr Wilson was significantly unwell with a poor prognosis, to the extent that resuscitation would not be appropriate.

13. Mr Wilson's arm became swollen through oedema. Consultant Surgeon, Mr Hand appears to have reviewed Mr Wilson at a clinic on the 6th October and reported to Dr Durrant the GP that the left arm was grossly swollen, Mr Hand suspecting that this was secondary to immobilisation as well as fluid retention. On the 8th October it is also recorded that his ankles were very oedematous. On 9th October diuretics were recommended in view of the gross oedema, with Bendrofluazide being added.

14. A Barthel score was recorded as only 3 on the 2nd October, by 6th October this had risen to 5.

15. It appears that Mr Wilson had become depressed in consequence of stopping alcohol, and on the 2nd October referral was made to Dr Lusznat, Consultant in Old Age Psychiatry. The note of referral in the medical records stated specifically that he was "very withdrawn and depressed".

16. Dr Lusznat carried out an assessment on the 8th October and recorded her impression that Mr Wilson was suffering with early dementia, possibly alcohol related, together with depression. She prescribed Trazodone as an anti-depressant. In a subsequent letter to Dr Grunstein, Consultant in Elderly Medicine, Dr Lusznat stated that physically Mr Wilson was obese with his left arm in a sling and his left hand still grossly swollen and bruised. She also noted that there was also marked oedema of both legs. In relation to his mental state she recorded that he was subjectively low in mood and objectively easily tearful. Although he had no active suicidal ideas or plans, he had said that there was no point in living. Dr Lusznat confirmed her impression that Mr Wilson had developed an early dementia which could well be alcohol related although alternatively this might be an early Alzheimer's disease or vascular type dementia. Further, on her assessment record Dr Lusznat noted that Mr Wilson had a lot of pain in his left arm, and admitted feeling low and wishing to die. He wanted to go home.

17. Unfortunately, it seems that Mr Wilson had an unrealistic expectation of his position. The records show that an assessment was carried out the following day, 9th October and it was felt Mr Wilson required help with all the activities of daily living, generally by two people. Specifically his "conception of discharge" home was said to be "totally unrealistic", and he was felt to be too much at risk at that time to be managed at home.

18. On the 11th October a further Barthel assessment was carried out, producing a Barthel score of 7.

19. It appears that Mr Wilson's condition remained essentially unchanged. Attempts were made without success for him to have a convalescent

bed, and arrangements were then made for him to be transferred to the GWMH. Mr Wilson was seen on a ward round on the 13th October and it was agreed that he still needed both nursing and medical care. It was felt that a short spell in a long-term NHS bed would be appropriate. He was still very oedematous and his albumin was very low. Frusemide was added to his diuretics and renal function was to be reviewed. The nursing notes also record that he continued to require special medical/nursing care given his oedematous limbs were at high risk of breakdown, and indeed his right foot was apparently already having started to breakdown.

20. A referral form was completed on the 13th October with Mr Wilson recorded as continuing to be in a lot of pain, and indeed the prescription chart shows he had been receiving Codeine Phosphate over the previous days. The referral form also confirmed that Mr Wilson's legs were very oedematous with high risk of breakdown, and secondary to cardiac failure and low protein.

21. Mr Wilson was then transferred to Dryad Ward at the GWMH the following day, 14th October. I believe I assessed Mr Wilson on his admission, and my note in his records reads as follows:-

"14-10-98 Transfer to Dryad Ward continuing care 75

HPC # humerus L 27-8-98

PMH Alcohol problems
Recurrent oedema
CCF
needs help c ADL
hoisting
continent
Barthel 7
Lives c wife Sarisbury Green
plan gentle immobilisation"

22. As will be apparent I inadvertently recorded the date of the fracture as the 27th rather than the 21st September. Although I also recorded the Barthel score as 7, assessment done the same by the nursing staff in fact gave a score of only 4. My notation "CCF" meant that I understood Mr Wilson to have congestive cardiac failure, apparent from his significant oedema, and indeed confirmed by the referral form which had specifically recorded cardiac failure. I do not know what records would have been available to me at the time, but I anticipate some form of records would have came with the patient on transfer.

23. Following my assessment I wrote up prescriptions on Mr Wilson's drug chart, mirroring the medication which had been recorded on the referral form. Specifically, I prescribed Thiamine 100mgs once a day - a vitamin given for nutrition due to alcoholism, multi vitamins once a day for the same purpose, Senna and Magnesium Hydroxide for constipation probably brought on by the opiate medication given for pain relief Frusemide 80mgs in the morning and Bendrofluazide 25mgs once a day both as diuretics to reduce the oedema, together with Spiranolactone 50mgs twice a day as a diuretic which increases the efficacy of the Frusemide. I also prescribed Trazodone 50mgs once a day for Mr Wilson's depression, and Paracetamol as recorded on the referral letter.

24. Although the referral letter made no mention of the codeine phosphate which had clearly been given to Mr Wilson over the previous days, I had felt it appropriate to provide further pain relief of medication beyond the Paracetamol in circumstances in which the referral letter made clear that Mr Wilson continued to have a lot of pain in his arm. Accordingly I prescribed Oramorph, 10mgs in 5mls at a dose of 2.5mgs - 5mls as needed, 4 hourly.

25. The nursing notes confirm Mr Wilson's admission, with a history of the fractured humerus, the long history of heavy drinking and left ventricular failure, with chronic oedematous legs. The nursing notes also record that following my assessment Mr Wilson was given 10mgs of Oramorph for pain control.

26. The prescription charts also contain prescriptions for Diamorphine in a dose range of 20 to 200mgs subcutaneously, together with Hyoscine 200/800mcgs and Midazolam 20 to 80mgs via the same route. I do not know when I wrote this up but I anticipate it may have been at the time of my assessment on Mr Wilson's admission. I anticipate I would have been concerned to ensure that there was a pro-active regime of pain relief and medication available in case of deterioration and with the potential for Mr Wilson to become inured to the opiate pain relief which was clearly necessary at that stage. It would have been my expectation in the usual way that the nursing staff would endeavour to make contact with me or the duty doctor before commencement of that medication - if Mr Wilson's medical condition warranted it and indeed it would be commenced at the bottom end of the dose range.

27. I anticipate that I would have seen Mr Wilson again the following day, 15th October, though clearly I have no recollection of this. I have not made an entry in his clinical notes but did I record a further prescription for Oramorph, with 10mgs to be given 4 hourly at 6am, 10am, 2pm and 6pm and a further 20mgs at 10pm in the hope of ensuring that Mr Wilson did not experience pain and distress in the course of the night.

28. The nursing note for the 15th October confirmed that Oramorph was commenced 4 hourly for pain in Mr Wilson's left arm. Mrs Wilson was then seen by Sister Hamblin who apparently explained that her husband's condition was poor. 20mgs of Oramorph was apparently given at midnight with good effect but it appears that Mr Wilson then deteriorated over night becoming 'very chesty' with difficulty in swallowing medications.

29. I believe I was absent from the Hospital on Friday 16th October. I think I attended at a meeting in Portsmouth at the Health Authority in the morning and would not have been contactable. It is clear though from the records that one of my partners, Dr Knapman, came to see Mr Wilson on 16th October in my absence. Dr Knapman has recorded that Mr Wilson had declined overnight with shortness of breath and that on examination he was 'bubbling' and had a weak pulse. He was said to be unresponsive to spoken orders. Dr Knapman recorded oedema in the arms and legs and suspected that Mr Wilson had suffered a silent myocardial infarction. He increased the dose of Frusemide in an attempt to reduce the oedema.

30. From the nursing records it appears that Mrs Wilson was informed of her husband's deterioration, and later that day Mr Wilson was said to have a very bubbly chest. A syringe driver was then commenced with 20mgs of Diamorphine and 400mgs of Hyoscine. It is not clear if the diamorphine was commenced following discussion with Dr Knapman or any other doctor then on duty, or indeed if it might have been discussed with me. It is possible that nursing staff might have made contact with me if I had been available later on 16th October, but equally Dr Knapman or one of my other partners would have been available on duty.

31. The 20mgs of Diamorphine was in effect broadly commensurate with the Oramorph which had been administered, 50mgs of Oramorph having been given the previous day. In view of the reported difficulty Mr Wilson had in swallowing medications, a switch to the equivalent subcutaneous medication appears to have been sensible, together with the Hyoscine to help reduce or 'dry' the chest secretions.

32. A nursing note later on the 16th October records the commencement of the Diamorphine and that the reason for the driver was explained to the family, with Mrs Wilson being informed of her husband's continued deterioration. Later that evening, at approximately 10.30pm, Mr Wilson was recorded as being a little "bubbly" with more secretions during the night, but it was also said that Mr Wilson had not been distressed and appeared to be comfortable.

33. It appears that the following morning, 17th October, the Hyoscine was increased to 600mcgs as pharyngeal secretions had been increasing overnight. The Diamorphine was maintained at 20mgs. It appears that my partner Dr Peters then saw Mr Wilson in the course of the day, recording in the notes that he was comfortable but there was a rapid deterioration. Dr Peters was probably on duty that weekend. Dr Peters also noted that the nursing staff could verify death if that proved necessary. Clearly Dr Peters' expectation was that Mr Wilson might die shortly. It appears that in the course of the day the Diamorphine was then increased to 40mgs, and Hyoscine to 800mcgs, with the addition of 20mgs of Midazolam. I do not know if that increase might have been with reference to Dr Peters either when Dr Peters visited or otherwise, or indeed separately with reference to me.

34. The effect of secretions which were reported to be increasing, can be very unpleasant for a patient, producing a sensation of inability to breath, and the administration of a drug such as Diamorphine can assist in relieving the significant agitation and distress which can be experienced from such a sensation, and indeed reduce oedema from cardiac failure. This may have been a factor in the decision to increase the Diamorphine. The nursing note immediately preceding the reference to the increase in Diamorphine refers to suction being required very regularly to remove copious amounts of secretions. Further, there may well have been a concern that Mr Wilson might become tolerant of the opiates and that increase might be required accordingly.

35. Fortunately, although noisy secretions continued at night, it seems then the medication was indeed successful in relieving any distress. Specifically the secretions were said not to be disturbing him, and he appeared comfortable.

36. Although Dr Peters has not made a separate entry in the medical records the following day, 18th October, it seems that Dr Peters attended again at the hospital, there being a ~~significant~~ specific MAG entry in the nursing records that Mrs Wilson had remained overnight and that Dr Peters spoke with her. There was said to have been a further deterioration in Mr Wilson's already poor condition. The syringe driver was apparently renewed at 2.50pm with an increase in the Diamorphine to 60mgs, Midazolam to 40mgs, and Hyoscine at 1200mcgs. That latter prescription was in excess of the dose range I had previously authorised, and Dr Peters made a further specific prescription as a verbal order to enable that to be given.

37. Sadly, it appears that Mr Wilson's condition continued to deteriorate and the nurses later recorded that he died peacefully at 11.40pm in the presence of members of his family.

19-5-05

Agreed Code A and handed to Dr Code A.

Code A