PCO000318-0001

HELENA SERVICE

Police officer witness statements
Transcript suspect interviews

CASE OF HELENA SERVICE

Background/family observations

Helena SERVICE was born on Code A in Watford. She worked in an auctioneers until she married in 1929. They didn't have any children and when her husband retired they moved to Stubbington to live. Her husband died shortly afterwards and Mrs SERVICE lived alone. Apart from being deaf she had no past medical history of any significance until 1990 when she suffered a stroke and lost some use in her left hand.

In 1993 her GP recommended that Mrs SERVICE needed additional care and she moved into Willow Cottage Nursing Home. She enjoyed the home, was mentally alert and active and would do the Daily Telegraph crossword each day.

In 1997 she became very ill and was admitted to the Queen Alexandra Hospital via her GP. During her stay at QA Mrs SERVICE did not appear ill and was bright, alert and witty. As she didn't need a medical bed at the QA and the nursing home could not provide the sort of care that Mrs SERVICE required she was transferred to Gosport War Memorial Hospital.

When Mrs SERVICE was visited the following day at Gosport War Memorial Hospital she was found lying on her back with her mouth wide open and didn't respond when her hand was squeezed. When questioned about her condition a nurse said "A lady of this age, we have to give her something to make the journey more comfortable for her for the journey".

Mrs SERVICE never woke up and she died on the 5th June 1997. Her death was unexpected and she had never complained of being in any pain although she was frail. She was subsequently cremated.

Her death certificate stating that she died of Congestive Cardiac Failure.

Medical history of Helena SEVICE

Events at Queen Alexander Hospital, May 17th–June 3rd 1997

Mrs Helena Service, a 99 year old woman who lived in a rest home, was admitted to Queen Alexander Hospital on the 17th May 1997 at 14.00h. A junior doctor (House Officer) clerked Mrs Service and noted that she was very deaf, confused, disorientated and unable to carry out a mini-mental test. Because it was impossible to obtain a history from Mrs Service, this was taken from the General Practitioner's referral letter. This noted that she had recently developed a urinary tract infection, initially responding to antibiotics but was now short of breath, confused, disorientated and that the rest home were unable to cope. A past history of gout, non-insulin dependent diabetes mellitus (NIDDM) and congestive cardiac failure (CCF) was also noted.

Review of the recent rest home (Willow Cottage) notes revealed that Mrs Service had been prescribed thioridazine at night to help her to sleep on the 21st April 1997; paracetamol on the 1st May 1997 for pain in her back due to osteoporosis; antibiotics on the 6th May 1997 for a chest infection and stronger pain killers for her back pain (no details given); her lisinopril dose was increased on 12th May 1997 because of heart failure; she was noted to be very restless on the 14th May 1997 and had developed a bed sore; on the 17th May 1997 she was described as poorly and admitted to hospital.

In 1981 she underwent a cholecystectomy and gasterectomy for gastric ulcers, in October 1984 suffered a cerebrovascular accident (a 'stroke') affecting especially her left hand and wrist. She recovered well but residual weakness remained; her heart failure was longstanding - a chest x-ray in 1984 revealed that her heart was enlarged; in 1988 had polymyalgia rheumatica, treated with steroids that precipitated her diabetes mellitus; in August 1989 she fell and fractured her ribs, a chest X-ray again revealing signs of heart failure; in 1990 had a cataract removed; in 1992 was admitted with a chest infection, diarrhoea and vomiting and found to be in atrial fibrillation, later that year she had a further stroke with good improvement); in January 1995 heart failure was a problem, she was peripherally cyanosed and short of breath on exertion, had an elevated jugular venous pressure, a heart murmur of mitral regurgitation and oedema to her thighs. She was admitted to commence an ACE inhibitor treatment for heart failure (going home on lisinopril 5mg at night), her digoxin was also discontinued; in January 1996 she was admitted for gout affecting her wrist. History was unavailable on admission because her hearing aid wasn't working and she was profoundly deaf. Her urea was 17.6mmol/L (normal 3–7.6mmol/L), creatinine 167micromol/L (45–90micromol/L) and uric acid 0.45mmol/L (0.13–0.36mmol/L) (page 177 of 401) and she was treated with IV antibiotics and fluids. Her Barthel score was 3 on admission and 6 on discharge, she was slightly breathless on exertion, occasionally woke at night and was prescribed temazepam 10mg p.r.n..

Mrs Service's current medication consisted of lisinopril 2.5mg twice a day, bumetanide 1mg once a day (both for heart failure), aspirin 75mg once a day (to thin the blood), allopurinol 100mg once a day (for gout) and thioridazine 25mg at night as required 'p.r.n.' (an antipsychotic sedative). During the examination Mrs Service vomited. She was alert but disorientated, confused and dehydrated (+++). Other main findings were an irregular pulse (due to atrial fibrillation), crackles in her chest (suggestive of either excess fluid or infection) and mild swelling of her ankles. She was unable to cooperate with a neurological examination. The initial impression was that Mrs Service was deaf with increasing confusion possibly due to a urinary tract ± chest infection. She also had atrial fibrillation.

A number of investigations were carried out including blood tests, blood, urine and sputum cultures (to look for infection), blood gases, chest and abdominal x-rays and an electrocardiogram (ECG). These tests confirmed that Mrs Service was dehydrated (sodium of 149mmol/L (normal range 135–146mmol/L), urea of 14.4mmol/L (normal range 3–7.6mmol/L) and creatinine 151micromol/L (normal range 45–90micromol/L); had a low level of oxygen in her blood stream (PaO_2 6.7kPa, normal 11.3–12.6kPa; oxygen saturation 88.5%, normal 95–98%); had patchy shadowing on her chest x-ray, was constipated and confirmed to be in uncontrolled atrial fibrillation at a rate of 135 beats per minute. Her full blood count was normal.

The initial treatment plan consisted of intravenous fluid and encouraging oral fluid intake, intravenous antibiotics (cefuroxime), oxygen and digoxin to slow the rate of the atrial fibrillation. Mrs Service's oxygen saturation was to be monitored, her general observations recorded every 4h and blood sugars checked twice a day.

Her other medication was continued unchanged. Mrs Service took thioridazine 25mg on the 24th, 25th, 26th, 27th, 28th, 30th, 31st of May and the 1st and 2nd June, generally between 22–23.00h. She was also prescribed paracetamol 1g p.r.n. but received only one dose at 08.25h on the 25th May.

That evening she was reviewed by a more experienced doctor (senior registrar) who considered that the chest x-ray and crackles were suggestive of left ventricular failure. This is a failure of the left side of the heart to pump properly, causing a build up of pressure in the veins in the lungs which in turn allows fluid to collect on the lungs (pulmonary oedema). The senior doctor did not think Mrs Service appropriate for more intensive therapies nor cardiopulmonary resuscitation and agreed with the treatment plan outlined above. The nursing care plan noted that Mrs Service was very confused and this continued into the night. The nursing notes record that she was breathless. Subsequent entries on the 21st–23rd, 25–26th, 28th May–2nd June note that Mrs Service was breathless on exertion but do not record that she was breathless at rest.

On the 18th February 1997, Mrs Service was reviewed by the consultant, Dr Miller, and it was noted that she was more alert, her pulse rate had slowed to 80 beats per minute, blood pressure 125/80 and her chest was clear. The nursing care plan recorded that Mrs Service seemed less confused, with confusion only apparent when 'patient was unable to hear what is being said to her.' The night entry recorded 'remains confused, slept for periods'.

On the 19th May she was noted to be 'very deaf! But much better, sitting in a chair and talking ++'. Blood tests revealed an improvement in her hydration state; sodium 146mmol/L, urea 7.9mmol/L and creatinine 114micromol/L. Full blood count revealed a slightly elevated white blood count $11.2x10^9$/L (neutrophils $8.2x10^9$/L). The plan was to discontinue the intravenous fluids when oral intake adequate and change to oral antibiotics and to repeat her blood tests. The nursing notes record that she remained 'confused at times but at times very lucid' and at night 'remains confused'.

On the 20th May 1997 she was noted to be sleeping in the chair with some shortness of breath at rest. She remained apyrexial with a blood pressure of 120/80 and pulse rate of 88. Examination revealed her to be in atrial fibrillation and slightly dry. Nursing notes recorded 'sleepy and confused after an active night; slept most of the afternoon despite numerous attempts to remain awake by staff; drowsy early evening and slept most of the night'.

Full blood count on the 21st May 1997 revealed a persistently raised white blood cell count $13.3x10^9$/L (neutrophils $10.1x10^9$/L). Nursing notes recorded 'asleep much of morning but lucid when awake; some confusion pm. Drowsy night time, remains confused, slept for short periods only'.

On the 22nd May she was noted to be apyrexial, to have a pulse rate of 80, blood pressure 120/80 and a few crackles at the bases of her lungs. The plan was to push more fluids, continue antibiotics until tomorrow and aim for home. The nursing notes recorded 'lucid and very demanding this am. Bowels open++; night time remains confused'.

On the 23rd May 1997 she was apyrexial, comfortable at rest with a blood pressure of 120/70 and pulse of 88. Thyroid function tests were normal. The plan was to continue intravenous fluids until oral intake improved, to check her digoxin level (1.8mmol/L, normal 0.9–2.6mmol/L and plan for home the following week. The IV cannula was pulled out, but as she was drinking well the IV fluids were not resumed. Nursing notes recorded 'no change. Night time: remains noisy at times'.

On the 24th May 1997 the nursing notes recorded 'remains confused at times'.

On the 25th May 1997, her biochemistry revealed continued improvement; sodium, potassium, urea were normal and creatinine 111micromol/L (normal 45–90micromol/L). Nursing notes report that she was confused at times and noisy at night.

On the 26th May 1997 she was seen by the on-call doctor at the nurses request who noticed that Mrs Service was not weight bearing and her left hand was weak. Mrs Service herself was unaware of any problem with her left hand. On examination she appeared to be using her left arm less and although more floppy was able to move it. The strength of the muscles were reduced and the reflexes were increased in the left arm and it was considered that she may have had a cerebrovascular accident (a 'stroke') or a transient ischemic attack (a 'stroke' that resolves quickly and completely). The nursing notes reported that she remained confused at times. There were problems with the hearing aid and the battery was changed and the ear piece cleaned that improved Mrs Service's ability to hear. That night the nursing notes recorded 'when hearing aid is in place understands the question and answers appropriately. Quiet most of the night, only asking a couple of times to be sat up'.

When reviewed on the 27th May it was noted that her left arm was weak and she was referred to Social Services. To return to the rest home, Mrs Service needed to be able to transfer with only one nurse, but she required the help of two. Nursing notes record no problems with confusion in the day or overnight.

On the 28th May 1997 it was noted that her Barthel score was 4 and she was referred to the geriatricians for continuing care, the referral note recording that Mrs Service had presented with left ventricular failure that had improved and that her 'Humphrey' hearing aid was needed to speak to her. The nursing notes reported that she was 'very demanding...wanting to get in/out of bed. Confusion due to hearing problems. Less confused overnight'.

On the 29th May 1997 she was seen by a locum consultant geriatrician, Dr Ashbal. The letter summarising his review of Mrs Service reads 'thank you very much for asking me to see this delightful lady, whom I saw on the ward today. She has longstanding cardiac failure and was admitted again because of breathlessness and general deterioration. She was found to be in heart failure. She is deaf and uses a deaf aid. Although clinically she is better, she is still in a degree of heart failure. She is normally in a rest home, but I doubt whether they can manage her. I will put her on the list for Gosport War Memorial Hospital for assessment, with a view to considering continuing care'. The nursing notes recorded 'remains very demanding today. At night: no change, remains quite noisy at times'.

Entries in the medical notes for the 30th May and 2nd June 1997 noted that she was well and her condition unchanged. Over this time the nursing notes record 'not confused but is quite agitated at times. At night less confused (30th May); less confused, noisy at times; slept well, less noisy (31st May); no signs of confusion but very demanding at times during the day and night (1st June); no signs of confusion. Very demanding overnight, shouted out constantly' (2nd June).

On the 3rd June 1997 she was seen by Dr Miller, noted to be well and due to transfer to Gosport that day. The nursing transfer letter from F1 ward to Dryad Ward summarised that Mrs Service had been admitted with atrial fibrillation and confusion, a chest infection and had received IV fluids, IV antibiotics, oxygen therapy and digoxin; that she was very deaf (wears hearing aid in right ear, known as Humphrey (this was now working well, required all care with eating and drinking and took two people to transfer. Treatment was listed as thioridazine 25mg at night, lisinopril 2.5mg twice a day, bumetamide 1mg once a day, aspirin 75mg once a day, allopurinol 100mg at night and digoxin 125microgram once a day. The medical discharge summary from F1 noted that Mrs Service had been admitted because of shortness of breath and confusion, treated with intravenous fluids, cefuroxime, oxygen and digitalisation for pulmonary oedema secondary to left ventricular failure and dehydration. It listed the medication as lisinopril, bumetamide, aspirin, allopurinol and digoxin but not the thioridazine

Events at Gosport War Memorial Hospital, 3rd–5th June 1997

3rd June 1997

The medical notes entry reads 'Transferred to Dryad Ward, recent admission 17th May 1997, confused, off legs, URTI (upper respiratory tract infection), NIDDM, CCF (congestive cardiac failure), gout, came from a rest home. On examination slightly breathless plethoric lady, heart sounds 1 and 2 + gallop, bases clear, ankles √√ (possibly indicates no swelling (oedema)), needs palliative care if necessary. I am happy for nursing staff to confirm death'.

The nursing summary notes recorded 'admitted today from F1 ward QA. Helena is a very pleasant lady. She has a normal diet but needs assistance at meal times. Code A Code A. Her skin is quite dry. She has 2 superficial grazes on her spine. Skin on lower arms is discoloured. Helena uses a Humphrey hearing aid which has a microphone. She is able to respond to questions. Helena is a non-insulin dependent diabetic, has congestive cardiac failure, suffers from confusion, has upper respiratory infection also gout. Code A Code A First swabs of MRSA screening sent (which were negative). Helena has not eaten supper this evening but has had a drink of water. Her Barthel score was 0.

The medication chart reveals she continued her bumetamide, lisinopril, allopurinol, digoxin and aspirin as before. However, Mrs Service was not written up for thioridazine 25mg p.r.n. that she had been taking most nights. She was also prescribed diamorphine 20–100mg SC/24h, hyoscine 200–800microgram SC/24h and midazolam 20–80mg SC/24h all p.r.n.. On the once only and pre-medication drugs section diamorphine 5–10mg IM was also prescribed, but not apparently given.

The nursing summary entry for the night of 3rd June 1997 records 'Spenco mattress in situ, nursed on alternate sides overnight. Zinc and castor oil to sore sacrum. Not passed urine. Oral fluids encouraged and taken fairly well. Tongue dry and coated – mouth care given.

4th June 1997

The nursing notes at 02.00h record 'failed to settle – very restless and agitated, midazolam 20mg given by a syringe driver (started at 02.15h) over 24 hours with some success'.

Nursing summary entry reads 'condition appears to have deteriorated overnight – remains restless. Seen by Dr Barton. Driver recharged with diamorphine 20mg, midazolam 40mg at 09.20h...Rang nephew to inform him of poorly. There was no medical notes entry but a blood test was undertaken. This revealed that Mrs Service was dehydrated with sodium 156mmol/L (normal range 135–146mmol/L), urea 13.2mmol/L (3–7.6mmol/L) and creatinine 126micromol/L (45–90micromol/L). There were low values of potassium 2.7mmol/L (3.5–5mmol/L), albumin 29g/L (37–50g/L) and calcium 1.97mmol/L (2.25–2.70mmol/L).

5th June 1997

Nursing summary entry at 04.00h reads 'condition continued to deteriorate and died very peacefully at 03.45h. Nephew informed.

On Mrs Service's death certificate the cause of death was given as 1a (disease or condition directly leading to death) congestive cardiac failure with an approximate interval between onset and death given as two days.

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Helena SERVICE was a Clinical Assistant Dr Jane BARTON. The medical care provided by Dr BARTON to Mrs SERVICE following her 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, General Medical Council, October 1995, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination.
- in providing care you must keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs
- in providing care you must be willing to consult colleagues.

The medical records were examined by two independent experts. Dr Robert BLACK in his review of Dr BARTON's care reported specifically:-

Mrs Service's hospital notes go back for 16 years prior to her death. They document that she has heart disease with an irregular heartbeat (atrial fibrillation) in 1981 and heart enlargement in 1984 (229). She also has two previous strokes documented in both 1984 and 1992. The natural history of heart disease is in general for progressive decline over time, with a very poor prognosis once serious heart failure has developed, as documented on this lady in 1995.

She is also profoundly deaf which leads to communication difficulties and makes a patient more likely to get acute confusion. She suffers from Diabetes Mellitus, which is unmasked when she receives steroid treatment for polymyalgia rheumatica, she is also thought to have had an episode of gout and has been dehydrated with impaired kidney function on at least two occasions.

Despite her noted physical frailty she eventually makes a good recovery from a stroke in 1984. By 1995 she has moved into a residential home. We do not know what precipitated this, however in 1995 her Barthel is documented at only 10/20 meaning that she required considerable help with her routine activities of daily living.

In 1996 she is admitted with gout, and is found to be profoundly dependent on admission with a Barthel of 3/20, which improves to 6/20 on discharge. Very poor mobility is noted and she has a Waterlow score which is a risk score for pressure sores (12) of 30 putting her into a very high-risk category. There is no doubt that this lady would normally be

cared for in a nursing home, with this level of dependency, or even in NHS continuing care if she had not already been living in a residential home that was committed to her care.

By the time she is admitted on 17th May 1997 she has been progressively failing in the residential home. It seems unlikely that this was a dramatic change in function, but the end point of a slow deterioration of her multiple illnesses, including her progressive heart disease, her cerebro-vascular disease and of course the physiological frailty of an age of 99 years,

When admitted to hospital she was found to be both dehydrated and in again heart failure. This is often a combination suggesting poor prognosis. She has acute confusion (delirium) and this does not resolve, although it does fluctuate, during all her time in the Queen Alexander Hospital. Investigations on admission found she is dehydrated with a raised creatinine of 151 but she is also markedly hypoxic (low oxygen in the blood) with a PO2 of 6.7 kPa (normal range 12.7+0.7) with a PCO 5.6 kPa (normal range 5.3+0.3) She is now very unwell, and highly dependent with a Barthel at best 4/10 (162). On the basis of the nursing notes she makes very little improvement in her confusion or her breathlessness and indeed things take a turn for the worse when she probably has a new stroke on 26th May (116) (303). She remains totally dependent after this.

She is seen by a locum consultant geriatrician, Dr Ashbal on 29th May. His assessment is that she will not return to her residential home and that he is transferring her to Gosport "with a view to considering continuing care". By this he probably means an assessment as to whether this lady is dying or will improve enough to be discharged into a nursing home, or perhaps to simply remain in an NHS continuing care bed until she does die. However, this is not spelt out in the letter or the notes.

The medical notes make very little further comment on her clinical condition at the Queen Alexander Hospital, however, the nursing notes on the 2nd June comment she is very demanding overnight, shouting out continuously, suggesting that she is acutely delirious again and that she is so breathless that she has to sit up all night on the night of the 2nd June. I believe this lady is now physically deteriorating, but it is impossible to tell if this is progression of heart failure, a pulmonary embolus, or chest infection on top of her other problems. I have little doubt that she was entering a terminal phase of her illness.

On the 3rd June she is transferred to Gosport War Memorial hospital where she is noted to have a buttock bedsore. The recorded medical assessment is brief but does include an examination, which although it notes that she has a tachycardia and is very breathless, fails to give an overall impression of her status and whether this is acute, chronic or acute on chronic, and fails to record her pulse and blood pressure. A thorough objective assessment of this lady's clinical status is not possible from the notes that are made on admission, and would appear to be below an acceptable standard of good medical practice.

It seems likely though that the doctor recognises that this lady was seriously ill as the only comment under the examination is "needs palliative care if necessary". There is no record in the notes of this being discussed at this stage with the nurses or the family.

. The drug chart is written up with all the usual medication from Queen Alexander Hospital and this is given on both the 3rd and 4th June.

Diamorphine with Midazolam and Hyoscine are written up PRN on admission. The Midazolam is usually used for terminal restlessness and is widely used subcutaneously in doses from 5 – 80 mgs per 24 hours for this purpose. 20 mgs is within current guidance but at the top end for elderly patients. Elderly patients usually need a dose of between 5 – 20 mgs per 24 hours.

Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. It can be difficult to predict exactly the starting dose of Diamorphine to give in a syringe driver but many would give between 5 – 15 mgs of Diamorphine in the first 24 hours, in this case the 20 mgs is at the upper limit.

Mrs Service becomes extremely restless and agitated on the night of 4th June (probably similar to the previous night at the Queen Alexander hospital). Midazolam is now started via a syringe driver at 20 mgs. The restlessness is probably being caused by her severe breathlessness and heart disease and Diamorphine at this stage might well have been the drug of choice, but it is difficult to criticise the use of Midazolam.

She continues to deteriorate over night and the Midazolam is now replaced with Diamorphine 20 mgs a day and Midazolam 40 mgs. She then deteriorates further and dies 15 hours later.

There is no evidence in the notes that any other medical assessment was done prior to the starting of the Diamorphine and Midazolam in the syringe driver, nor is there any evidence at all that at any time after her admission to Gosport was further advice obtained from the consultant who was presumably responsible for this patient's care. It is not clear from the notes if the locum consultant (Dr Ashbal) was responsible for the patient's care once they had transferred to Gosport Hospital and it would have been good medical practice for the doctor at Gosport to have sought further advice from their consultant when a patient was transferred, apparently so seriously ill, and immediate palliative care was being considered.

It is also possible to criticise the care at Queen Alexander. All to often when a patient is not obviously going home and a bed elsewhere has been found, the pressure is to move the patient at the first opportunity, even when it may not be in their best interest. It seems likely to me that her condition was deteriorating in the Queen Alexander Hospital and the stress of an ambulance transfer would not have helped this lady's care.

The cause of death in Mrs Service was multifactorial. In my view the dose of 20mg Diamorphine combined with the 40mg dose of Midazolam was higher than necessary in this very elderly and frail lady's terminal care and the medication may have slightly shortened life, although this opinion does not reach the standard of proof of "beyond reasonable doubt". However, I would have expected a difference of, at most, no more than a few hours to days, if a lower dose of either or both of the drugs had been used instead.

Dr Andrew WILCOCK reports:-

Mrs Helena Service was a 99 year old woman who was admitted to the Queen Alexandra Hospital on the 17th May 1997, confused and disorientated most likely as a result of a chest

infection ± a fast irregular pulse (atrial fibrillation) precipitating a worsening of her cardiac failure. Mrs Service was appropriately assessed, investigated and managed and her condition improved relatively quickly; she was more alert, her heart rate was controlled and her renal function improved. She remained confused at times and noisy at night. On the 26th May it is likely that Mrs Service had a further cerebrovascular accident (a stroke) affecting the left side of her body, particularly the left arm and hand and she became more dependent on the nursing staff to transfer her. As a result, she was unable to return to the rest home and she was referred to the geriatricians. Mrs Service was seen by Dr Ashbal who agreed to take her to Gosport War Memorial Hospital for assessment with regards to continuing care. Mrs Service's behaviour remained challenging at times, particularly at night. However, apart from the regular use of thioridazine as a night time sedative, Mrs Service's behaviour was managed by the nursing staff using non-drug means. On the day of her transfer to Dryad Ward, Mrs Service was seen by consultant physician Dr Miller, and was noted to be 'well'. There are no concerns regarding the care proffered to Mrs Service at the Queen Alexander Hospital.

On Dryad Ward, there was an inadequate assessment of Mrs Service's current symptoms and cardiovascular status. Mrs Service's medication was mostly continued unchanged except the thioridazine was omitted. She was prescribed diamorphine 20–100mg SC/24h, hyoscine (hydrobriomide) 200–800microgram/24h and midazolam 20–80mg SC/24h all p.r.n. (as required). Diamorphine 5–10mg IM was prescribed as a stat dose, but not apparently given. There is inadequate justification documented in the notes for the prescription of these drugs in these doses. Midazolam 20mg SC/24h was commenced on the first night Mrs Service spent on Dryad Ward because she 'failed to settle'. Mrs Service was however, elderly, very deaf, confused/prone to confusion, had been moved to unfamiliar surroundings with unfamiliar staff and her usual night sedative had been omitted. Thus, there were many reasons why Mrs Service could have been restless on her first night on Dryad Ward. The following day, there was no documented assessment of Mrs Service's condition, but the midazolam was increased to 40mg SC/24h and diamorphine 20mg SC/24h added to the syringe driver. The increase in midazolam appeared to be in response to Mrs Service's persistent restlessness. There is no justification in the notes as to why the diamorphine was considered necessary but in her statement Dr Barton reports that in her view Mrs Service was terminally ill with heart failure'. However, blood tests were taken from Mrs Service on the same day and these would not be indicated in patients who were imminently dying and the fact that they were carried out suggests that doubt existed.

The blood test result confirmed that Mrs Service had renal impairment and a low potassium, possibly due to her medication and/or an inadequate fluid intake. These could have contributed to worsening confusion and were potentially reversible with appropriate treatment. There is no documentation relating to these results and why it was not considered appropriate to act on them.

If it were that Mrs Service was not actively dying, as the notes on her transfer to Dryad Ward suggest, then the failure to rehydrate her, together with the use of midazolam and diamorphine could have contributed more than minimally, negligibly or trivially to her death. If it were considered that Mrs Service was actively dying, then it would have been reasonable not to have rehydrated her and the use of diamorphine and midazolam could be justified. However, in my opinion, the starting dose of diamorphine was likely to be excessive to her requirements and access to smaller doses of diamorphine (and midazolam) p.r.n. would have been a more appropriate way of initially addressing Mrs Service's symptoms, identifying her dose requirements and justifying the need for regular dosing and subsequent dose titration. Given that elderly, frail patients with significant medical morbidity can deteriorate with little or sometimes no warning, it could be argued that it is

difficult to distinguish with complete confidence which of the above scenarios was most likely for Mrs Service.

He further states specifically;-

i) There was insufficient assessment and documentation of Mrs Service's symptoms and physical (particularly cardiac) state on her transfer to Dryad Ward on the 3rd June 1997.

ii) On the day of her transfer, Mrs Service was prescribed a stat dose of IM diamorphine and diamorphine and midazolam by syringe driver p.r.n. in dose ranges that would be excessive to her needs.

iii) The use of midazolam in a syringe driver, appears an excessive response to Mrs Service's 'failure to settle' on her first night in a new environment.

iv) There was insufficient assessment and documentation of Mr Service's clinical condition when she was restless on the 4th June 1997.

v) Mrs Service received a starting dose of diamorphine that was likely to be excessive for her needs.

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 27th October 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 Helena SERVICE at the Gosport War Memorial Hospital. The interviewing officers were DC Code A and DC Code A.

The interview commenced at 0911hrs and lasted for 23 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/10. This statement dealt with the specific issues surrounding the care and treatment of Helena SERVICE.

Operation ROCHESTER.

Key points July 2006.

Helena SERVICE born 2nd February 1898.

Helena SERVICE was 99years of age when she died at Gosport War Memorial Hospital on the 5th June 1997 two days after her admission.

Born in Watford, Helena married in 1929 and moved to the Stubbington area of Hampshire upon her husband's retirement.

Following her husbands death shortly after his retirement Mrs SERVICE lived alone (she had no children) until 1993 when she moved to a nursing home.

She had suffered gastric ulcers in 1981 a stroke in 1984 and fractured ribs following a fall in 1989. During the 80's and 90's she is recorded as suffering increasing heart problems and gout for which she was admitted to hospital both in January 1995 and January 1996.

During 1997 Mrs SERVICE became very unwell at the nursing home suffering back pain, a bed sore and a chest infection and was admitted to the Queen Alexandra Hospital, COSHAM on the 17th May 1997 confused, disorientated and most likely suffering a chest infection precipitating worsening of cardiac failure. She was very deaf, and because of this it was impossible to take a history from Mrs SERVICE herself, this was provided by way of a GP referral letter.

Initially Mrs SERVICE was appropriately assessed and managed by hospital staff resulting in an improvement in her condition, she was more alert and her heart rate improved as did her renal function. However she was suffering left ventricular failure, a failure of the left side of the heart to pump properly, causing a build up of pressure in the veins in the lungs and fluid on the lungs.

Nursing notes between the 21st May 1987 and 2nd June 1997 indicate that Mrs SERVICE was 'breathless on exertion' and variously describe her as demanding and confused,

On the 26th May 1997 it is likely that Mrs SERVICE suffered a stroke, as a result she became more dependant and was unable to return to her nursing home.

On the 28th May 1997 Mrs SERVICE was referred to geriatricians for 'continuing care'.

On 29th May Consultant Geriatrician Dr ASHBAL examined Mrs SERVICE reporting her longstanding cardiac failure breathlessness and deafness. He reported improvement that 'clinically she was better but in a degree of heart failure'.

Entries in medical notes for 30th May and 2nd June 1997 report that she was well and her condition unchanged. The nursing notes comment that she was 'not confused but quite agitated at times' Mrs SERVICE is recorded as being 'very demanding and shouting constantly overnight' on 2nd June 1997.

On 3rd June 1997 she was seen by consultant Dr MILLER who noted her to be 'well' and due for transfer to Dryad Ward at Gosport War Memorial hospital that day.

The nursing transfer letter summarised that Mrs SERVICE had been admitted with atrial fibrillation, confusion a chest infection and was very deaf.

She had received intravenous fluids and antibiotics, oxygen therapy and digoxin. Treatment was listed as thioridazine 25mg at night, lisinopril 2.5mg twice a day, bumetamide 1 mg once a day, aspirin 75mg once a day. Allopurinol 100mg at night, and digoxin 125 microgram once a day.

Dr Jane BARTON conducted the admission assessment of Mrs SERVICE on the 3rd of June 1997. She described her as no longer able to mobilise, ie 'off her legs' and was confused. Dr BARTON recorded that she was a non – insulin dependent diabetic and that she had upper respiratory tract infection and congestive cardiac failure. Under examination Mrs SERVICE was 'breathless and plethoric' this meaning that she was of purple/blue colour to the extremities indicating cyanosis consequent on the heart failure. Dr BARTON listened to her heart concluding that it was struggling to cope and that she was clearly in heart failure was very unwell and was probably dying.

Dr BARTON reports that Mrs SERVICE had deteriorated upon transfer and prescribed opiate analgesia.

On assessment at Dryad Ward Mrs SERVICE was prescribed diamorphine hyoscine and midazolam and administered in increasing doses over the first two days.

Midazolam was commenced at 20mg subcutaneously over the first 24 hours upon the basis that she was failing to settle during her first night at the hospital.

The following day the 4th June 1997 she was administered double the amount of midazolam and additionally 20 mg diamorphine per 24ours via syringe driver, Dr BARTON considering that it would have the effect of relieving pulmonary oedema and the significant anxiety and distress produced from that sensation.

The Hyoscine was to be available to dry the chest secretions.

The terminal prognosis was not consistent however with the results of blood tests carried out the same day (according to consultant palliative care expert Dr WILCOCK)

A Bartel assessment carried out on the 3rd June revealed a 'zero score' meaning that Mrs SERVICE was totally dependent.

Mrs SERVICE continued to deteriorate and passed away at 3.45am on the morning of the 5th June 1997. Her cause of death was recorded by Dr BARTON as congestive cardiac failure.

Clinical Team assessment.

Mrs SERVICE was very old, and had many medical problems including diabetes, heart failure, confusion and sore skin.

She was 'agitated' in the Queen Alexandra hospital but they accepted it and used thioridazine orally. Upon transfer to Gosport War Memorial Hospital, she was placed on sedation via a syringe driver at night. She became less well the next day and diamorphine was added to the driver (she had not required analgesia other than paracetomal at the Q.A.H). Mrs SERVICE died the following day.

Medication could have contributed towards her death, the need for such medication was not clear.

Account Dr Jane BARTON from interview with police 27th October 2005.

Within a prepared statement Dr BARTON commented that by 1997 there had been a significant increase in dependency, increase in bed occupancy and consequent decrease in the ability to make notes of each and every assessment and review of a patient these difficulties applying at the time of her care of Mrs SERVICE.

Dr BARTON reported Mrs SERVICE'S medical history in particular her heart problems and her GP Dr REES recording on 12th May 1997 that she had been diagnosed as being in heart failure.

Dr BARTOIN summarised Mrs SERVICE'S treatment at the Queen Alexandra hospital following her admission and that a senior registrar confirmed left ventricular failure and that her condition was not suitable for resuscitation.

Dr ASHBAL noted on 29th May that he was to transfer her to Gosport war memorial hospital. That it was not done immediately was probably an indication that there was high bed occupancy at the time, confirmed in notes of 2nd June indicating that a bed was still awaited.

On transfer on 3rd June 1997 Dr BARTON carried out an assessment Mrs SERVICE was clearly in heart failure and very unwell and probably dying. She had probably reached 'multi-system' failure. Care would have been more appropriate at Queen Alexandra hospital but a transfer by ambulance would not have been in her best interests.

Dr BARTON prescribed medication including diamorphine, hyoscine and midazolam.

A barthel score of zero on 3rd June indicated total dependency.

Mrs SERVICE was administered the opiates but continued to deteriorate and her nephew was contacted to inform him of her poorly condition.

She was suffering terminal heart failure and was distressed and agitated as a consequence.

The diamorphine and midazolam were prescribed and administered solely with the intention of relieving Mrs SERVICES agitation and distress with the diamorphine having the additional affect of treating the pulmonary oedema from her heart failure.

At no time was any medication provided with the intention of hastening her death.

<u>Expert Witness Dr Andrew WILCOCK (Palliative medicine and medical oncology) comments:-</u>

Mrs SERVICE was a 99year old woman who was admitted to the Queen Alexandra Hospital on the 17th May 1997 confused and disorientated most likely as a result of a chest infection, and a fast irregular pulse precipitating a worsening of her cardiac failure.

She was appropriately assessed investigated and managed and her condition improved relatively quickly, she was more alert, her heart rate was controlled and her renal function improved. She remained confused at times and noisy at night.

On 26th May it is likely she suffered a stroke affecting the left side of her body.

She was seen by Dr ASHBAL who agreed to take her to Gosport War memorial hospital for assessment with regards to continuing care.

On the day of her transfer she was described as 'well' by Consultant Physician Dr MILLER.

Her behaviour remained challenging particularly at night however apart from the regular use of thioridazine as a night time sedative Mrs SERVICE's behaviour was managed by the nursing staff using non-drug means.

On Dryad Ward there was an inadequate assessment of Mrs SERVICE's current symptoms and cardiovascular status. Her medication continued mostly unchanged other than the thioridazine.

She was prescribed diamorphine, midazolam and hyoscine with inadequate justification for the dosage.

Dr BARTON reports that in her view Mrs SERVICE was terminally ill with heart failure, however blood tests were taken from her on the same day and these would not be indicated in patients who were imminently dying and the fact that they were carried out suggests that doubt existed.

The blood test confirmed renal impairment and low potassium possibly due to her medication and/or inadequate fluid intake. These could have contributed towards a worsening condition and were potentially reversible with appropriate treatment.

If it were that Mrs SERVICE was not actively dying as the notes on her transfer to Dryad Ward suggest then the failure to re-hydrate her together with the use of midazolam and diamorphine could have contributed more than minimally negligibly or trivially to her death.

If it were considered that Mrs SERVICE were actively dying then it would have been reasonable not to have re-hydrated her and the use of midazolam and diamorphine could have been justified.

However, in the opinion of Dr WILCOCK the starting dose of diamorphine was likely to be excessive to her requirements and access to smaller doses would have been a more appropriate way of initially dealing with her symptoms.

Given that elderly frail patients of significant morbidity can deteriorate with little or sometimes no warning it could be argued that it is difficult to distinguish with complete confidence which of the above scenarios was the most likely for Mrs SERVICE.

The opinion of a cardiologist should be sought on Mrs Service's likely prognosis, scope for optimising her heart failure therapy and the role of opioids in chronic heart failure in 1997.

<u>Expert Witness Dr Michael Charles PETCH Consultant Cardiologist:-</u>

Dr PETCH reported that Mrs SERVICE at the time of her death had a long medical history with evidence of heart disease by 1989 and heart failure by 1995. The average survival of patients with this sort of heart failure is 2 years

hence her terminal decline in 1997 was not unexpected. Once the decision had been made that she was not for resuscitation as it was in the Queen Alexandra hospital in May 1997, then the palliative care with increasing doses of diamorphine and midazolam was appropriate. These drugs were administered in accordance with cardiological practice in 1997.

Mrs SERVICE remained unwell despite corrective treatment (at Queen Alexandra hospital). Opiates, notably diamorphine are standard drugs for the alleviation of shortness of breath and distress associated with pulmonary oedema and are particularly helpful at night. The administration of diamorphine has been standard practice for cardiologists for decades.

Mrs SERVICES prognosis was hopeless. The administration of diamorphine together with midazolam was reasonable given the circumstances as described by Dr BARTON.

Expert Witness Dr David BLACK (Geriatrics) comments:-

Mr SERVICE was admitted to Queen Alexandra Hospital on 17th May 1997 at the age of 99 at the request of her GP to hospital with confusion, disorientation and progressive failure for the rest home to be able to cope with.

She had been progressively failing in the residential care home, unlikely that this was dramatic change in function but the end point of slow deterioration of her multiple illnesses including her progressive heart disease, her cerebro – vascular disease and the physiological frailty of an age of 99 years.

She was diagnosed to have a combination of dehydration and left ventricular failure and recorded as having long standing congestive cardiac failure.

On the basis of her nursing notes she makes very little improvement in her confusion or her breathlessness and indeed things take a turn for the worse when she probably has a new stroke on 26th May, she remains totally dependent after this.

She is seen by a locum consultant geriatrician Dr ASHBAL on the 29th May his assessment is that she will not return to her residential nursing home and that he is transferring her to Gosport with a view to considering continuing care. By this he probably means an assessment as to whether this lady is dying or perhaps to simply remain in an NHS continuing care bed until she does die.

By the 2nd June Mrs SERVICE is deteriorating, she is very demanding overnight shouting continuously suggesting that she is acutely delirious and so breathless that she has to sit up all night on the 2nd June.

I believe that this lady is now physically deteriorating but it is impossible to tell if this is progression of heart failure, a pulmonary embolus, or chest infection

on top of her other problems. I have little doubt that she was entering a terminal phase of her illness.

Mrs SERVICE was transferred to Gosport War Memorial Hospital on 3rd June Code A The recorded medical assessment is brief but does include an examination which although notes that she had tachycardia and is very breathless, fails to give an overall impression of her status and whether this is acute, chronic or acute on chronic and fails to record her pulse and blood pressure.

A thorough objective assessment of this lady's clinical status is not possible from the notes made on admission and would appear to be below an acceptable standard of good medical practice.

The cause of death in the view of the expert was 'multi-factorial'. The dose of 20mg of diamorphine combined with the 40mg dose of midazolam was higher than necessary in this very elderly and frail lady's terminal care and the medication may have slightly shortened life although this opinion did not reach the standard of proof of beyond all reasonable doubt. The expert would have expected a difference (of survival) of at most no more than a few hours or days had a lower dose been used.

Evidence of other key witnesses.

Alexander TUFFEY (Nephew of deceased) General family and medical background as relates to Mrs SERVICE, speaks of her developing a bad cough in 1997 leaving her frail and weak.

Elsie TUFFEY Details family history. Although unwell at the age of 99 the family expected her to recover.

Florence TUFFEY Visited Mrs SERVICE four times at Queen Alexandra Hospital. She seemed to be recovering, was chatty and cheerful. Also visited at Gosport War Memorial Hospital, she was very 'dopey' and did not realise that Mrs TUFFEY was there, surprised at her death.

Delia KEENE (Personal friend of deceased) Close detail of her recent medical history and increasing dizzy spells precipitating her admission to 'willow cottage' rest home. Admitted to Q.A.H following a cough and seemed to be improving. Transferred to GWMH visited on 4th June 1997, seemed to be unconscious.

Jean KENNEDY (home help and friend) Post 1991 describes Mrs SERVICE as very sound in mind but of frail body. Describes Mrs SERVICE as alert bright and witty at Q.A.H and was shocked at her condition at G.W.M.H. She was told by a nurse that 'she had to be given something to make the journey more comfortable'.

Geoffrey WHITE (Proprietor Willow Cottage Guest house) describes her medication and care plan for 1997. Mrs SERVICE was diagnosed by Dr REESE as being in heart failure on 12th May 1997 her next of kin were informed.

Elaine WHITE (Co-proprietor) information as above. Describes how Mrs SERVICE became increasingly frail over the years. In May 1997 she was diagnosed with heart failure, became breathless and poorly.

Judith REES (General practitioner) Details medical history and the fact that Mrs SERVICE had suffered heart problems since 1984. Dr REES details considerable visits during the 1990's. On 12th May her drowsiness had increased she had ankle swelling and her chest infection appeared to have exacerbated her heart failure symptoms. She was very unwell and in her judgement was dying.

James MILLAR (Consultant general medicine) Conducted ward round at Q.A.H on 18th May 1997. Noted Mrs SERVICE temperature normal but she was mildly dehydrated. Her clear chest sounds suggested an improvement in the function of her heart. X-rays showed classic indications of left heart failure. Subsequent examinations showed improvements in heart and breathing functions but attempts to mobilise her proved difficult. On 28th May 1997 her referred her to the elderly care medical team at G.W.M.H asking for continuation of the measures for continuing care. His final assessment of 3rd June 1997 was that she was well.

James MILLAR (Further statement) Describes medication and rational for prescription.

Grant HEATLIE (Consultant Cardiologist) In 1997 a senior house officer at Q.A.H. His role to see new admissions. Jointly examined Mrs SERVICE with Dr MEEKING. Her ECG and X-ray showed heart failure, not reversible. Noted condition improving by 21st May 1997, and wrote referral letter on 28th May for considering continuing care.

Code A (Nurse Q.A.H) Explains nursing note entries between 17th and 30th May 1997.

Code A (Nurse Q.A.H) Explains her nursing note entries in particular a nursing transfer note to G.W.M.H.

Al-Ashbal Saleh (Consultant Physician) specifically assessed Mrs SERVICE whilst at Q.A.H for continuing care and wrote transfer letter.

Code A (Nurse Dryad Ward G.W.M.H) The admitting nurse at G.W.M.H on 3rd June 1997.. describes as a pleasant lady normal diet but needed assistance with meals, Code A skin broken, skin quite dry superficial grazes on spine and skin on lower arms discoloured.

Sharon RAY (Senior staff night nurse G.W.M.H) Explains nursing entries overnight 3rd June 1997 including that she had failed to settle and was very restless and agitated, as a consequence 20mgs of Midazolam administered at 0200hrs over 24hrs via syringe driver.

Code A (Staff nurse Dryad Ward G.W.M.H) Wrote patient summary on 4th June 1997 'condition appears to have deteriorated overnight, remains restless. Seen by Dr BARTON. Driver re-charged with diamorphine 20mgs midazolam 40mgs in 50 millimols hourly. Rang Mr TUFFEY (nephew) to inform him of poorly condition. Nurse RING confirms that she administered the midazolam and diamorphine.

Freda SHAW (Nurse G.W.M.H) Catheterised Mrs SERVICE on 4th June 1997 and explains associated nursing notes.

Code A (Nurse G.W.M.H) at 0440hrs on 5th June 1997 wrote on the nursing notes that Mrs SERVICE had died peacefully at 0345hrs.

Janice HOGGARTH (Social worker) re referral summary.

Natalie LISTER (House physician Q.A.H) spoke to referring GP on 17th May 1997.. and conducted initial examination of Mrs SERVICE..explains detailed notes made between 17th and 23rd May 1997.

Darryl MEEKING (Senior registrar) completed admissions entry on 17th May 1997. ECG and X-ray indicated findings of heart failure. Dr MEEKING instructed that Mrs SERVICE should be resuscitated if her heart was to stop beating given that the probability of success was remote due to her age, history and heart disease.

Jason HEWETT (Locum house officer Q.A.H) examined Mrs SERVICE on 26/27th May 1997.. suffered a small stroke.

Detective Constables Code A and Code A Interviewed Dr BARTON on 27th October 2005 and received from her a prepared statement ID ref: JB/PS/10.

D.M.WILLIAMS
Detective Superintendent 7227.
19th July 2006.

C.51 1/99

Identification Ref. No. DB|2014

Court Exhibit No.

R - v -

Description

A certified copy of a death certificate (Service)

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 621

Laboratory Ref:

PLEASE ATTACH WITH TAPE

GLOUCESTERSHIRE CONSTABULARY

Station.

J1 No. Item No.

O.I.C.

Identification Ref No.

Court Exhibit No. DB 2014

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.

Copy

STATEMENT OF DR JANE BARTON

RE: HELENA SERVICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25. A Barthel assessment carried out on the 3rd June revealed a zero score, indicating that Mrs Service was now totally dependent. The nursing records noted her admission Code A Code A A pressure relieving "Spenco" mattress was made available.

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

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

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

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

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

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