David?

Dr David BLACK

Dr BLACK is an expert in Geriatric medicine. His reporting comments on the standard of care afforded to Mr Pittock and his expert opinion reports specifically:-

> Mr Leslie Pittock was an extremely ill, frail and dependent gentleman on his admission to Gosport War Memorial Hospital and was at the end point of a chronic disease process of depression and drug related side effects that had gone back for very many years.
>
> The major problem in assessing Mr Pittock's care is the lack of documentation. Good Medical practice (GMC 2001) states that good clinical care must include an adequate assessment of the patient's condition, based on history and symptoms and if necessary an appropriate examination".... "In providing care you must keep clear accurate legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any other drugs or other treatments prescribed". The major gaps in the written notes, the lack of evidence of appropriate examinations, use of unusual drug regimes without adequate documentation in the medical notes, changes in

prescription without proper documentation, all represent poor clinical practice clinical practice to the standards set by the General Medical Council. However, by itself, these do not prove that the medical or nursing care provided to Mr Pittock was sub-optimal, negligent or criminally culpable.

In my view the drug management as Gosport was sub-optimal. There was no written justification at any stage for the high doses of Diamorphine and Midazolam written up in the drug charts and subsequently prescribed to Mr Pittock. The notes and the drug charts leave confusion as to whether at one stage there may have been three syringe drivers being used. The dose of Nozinan may have been prescribed by verbal prescription and not written up in the drug chart. Combinations of the higher than standard doses of Diamorphine and Midazolam, together with the Nozinan were very likely to have caused excessive sedation and may have shortened his life by a short period of time, that in my view would have been no more than hours to days. However, this was a dying man, the family appeared to have been appropriately involved and the patient did eventually die without distress on 24th January. While his care is sub-optimal I cannot prove it beyond reasonable doubt to be negligent or criminally culpable.

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

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

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

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

Interview of Dr Jane BARTON

a chest infection, that could have been appropriately treated. It is therefore possible that her physical state had deteriorated in a temporary or reversible way and that with appropriate medical care she would have recovered.

- If it were that Mrs Lake had naturally entered the terminal phase of her life, at best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mrs Lake a peaceful death, albeit with what appears to be an inappropriate use of medication due to a lack of sufficient knowledge. However, given the lack of medical and nursing records to the contrary, reasonable doubt exists that Mrs Lake had definitely entered her terminal stage.

- Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lake by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lake by failing to adequately assess her physical state at the time of her transfer and when she complained of chest pain, failing to take suitable and prompt action when necessary and if her physical state had deteriorated in a temporary or reversible way exposing her to the inappropriate use of diamorphine and midazolam in doses that could have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton leaves herself open to the accusation of gross negligence.

Expert witness Dr David BLACK (Geriatrics) comments:-

- Ruby Lake an 84-year-old lady with a number of chronic diseases, suffered a fall and a fractured neck of femur in August 1998. She is admitted to hospital and has operative treatment but develops post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorates and dies in the Gosport War Memorial Hospital.

- Mrs Lake had a number of chronic diseases prior to her terminal admission following a fractured neck of femur. She had cardiac disease with known atrial fibrillation, aortic sclerosis and heart failure, documented in 1993. She also had not just osteoarthritis but an auto-immune arthritis that was thought variously to be either rheumatoid arthritis or variant auto-immune arthritis (the CREST syndrome). She also had problems as a result of her long-standing varicose swelling of her lower limbs, with many years of unresolved and very painful leg ulcers. Finally she had impaired renal function, developed mild acute renal failure when she was given on occasion, non-steroidal anti-inflammatory drugs.

- As is all too common, she subsequently has a fall and suffers a fractured neck of femur. She is admitted to the Haslar Hospital for

operative repair. There is always a very significant mortality and morbidity after fractured neck of femurs in old people, particularly in those who have previous cardiac and other chronic diseases.

- She is seen by Dr Lord who does a thorough assessment and arranges for an appropriate transfer to Gosport War Memorial Hospital. It is clear though from the notes that on the day of transfer she is still not right. She had been pyrexial the day before, she had been confused the night before transfer and she is more breathless needing oxygen on the day of transfer. It might have been wiser not to transfer her in this unstable clinical state.

- When she is transferred to the Gosport War Memorial Hospital she is seen by Dr Barton who fails to record a clinical examination, apart from a statement regarding her functional status, that she is catheterised, needs two to transfer and needs help with ADL and documents a Barthel of 6. An opportunity to assess her apparent unstable clinical state appears to have been missed. The nursing cardex states the Bartel is 9 (373) and that in the nursing cardex, she can wash with the aid of one and is independent in feeding.

- The continuation notes of Dr Barton (77) then mention rehabilitation with a statement about being happy for the nursing staff to confirm death. There are no further medical notes at all and in view of the subsequent changing clinical condition documented in the nursing cardex on 19th August and that the nurses contacted the doctor (388) this is a poor standard of care. It also makes it very difficult to assess whether appropriate medical management was given to Mrs. Lake.

- On admission the regular drugs being prescribed at Haslar were continued but the Paracetamol and Tramadol she had received in the Gosport War Memorial Hospital only a month before were not prescribed, nor was any other milder analgesia such as Paracetamol. The only analgesia written up was Oramorphine on the 'as required' part of the drug prescription. While it is probably appropriate for somebody who might have been having episodes of angina and left ventricular failure while in Gosport to have a Morphine drug available for nurses to give, it is very poor prescribing to write up no other form of analgesia, particularly if a doctor is not on site. The nursing staff could have no alternative but to go straight to a strong opioid analgesia.

- On her first night she is documented as anxious and confused. This is then treated by giving a dose of Oramorphine despite there being no record in the medical or nursing cardex that it was pain causing this confusion. It should be noted this was probably no different from her

evenings in Haslar which did not need any specific medication management. In my view this is poor nursing and medical care in the management of confusion in the evening.

- On 19th August an event happened at 11.50 in the morning with the nursing notes recording that she had marked chest pain and was grey around her mouth. This could have been a heart attack, it could have been a pulmonary embolus, it could have been another episode of angina, it could simply have been some non-specific chest pain. No investigations are put in train to make a diagnosis, she does not appear to have been medically assessed, or if she was it was not recorded in the notes and would be poor medical practice. However, if the patient was seriously distressed, it would have been appropriate to have given the Oramorphine 10 mgs that was written up on the 'as required' side of the drug chart. The first aim would be to relieve distress while a diagnosis was made.

- Later on 19th August s syringe driver is started containing Diamorphine 20 mgs and 20 mgs of Midazolam. The only justification for this is recorded in the nursing notes (394) where it says pain is relieved for a short period. I am unable to find any records of observations, for example, pulse or blood pressure while the patient continues to have pain.

- The syringe driver is continued the next day and Hyoscine is add and the dose of Diamorphine, Midazolam and Hyoscine all increase during the afternoon of the 20th and again when the syringe driver is replaced on 21st. Mrs Lake dies peacefully on 21st August.

- Diamorphine is specifically prescribed for pain, is commonly used for pain in cardiac disease as well as in terminal care. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Diamorphine subcutaneously after oral morphine is usually given at a maximum ratio of 1 to 2 (up to 10 mgs of Diamorphine for 20 mgs or Oramorphine). She had received 20 mgs of Oramorphine on 19th and appears to have been in continuing pain so I think it is probably reasonable to have started with 20 mgs of Diamorphine in the syringe driver over the first 24 hours.

- Midazolam is widely used subcutaneously as doses from 5 – 80 mgs per 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 20 mgs for the first 24 hours, which is within current guidance, although many believe that elderly patients need a lower dose of 5 – 20 mgs per 24 hours (palliative care). (Chapter 23 in the Brocklehurst's Text Book of Geriatric Medicines 6th Edition 2003).

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

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".

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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.

unresponsive, the diamorphine dose was halved, however the midazolam dose was doubled.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to the use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Expert Witness Dr David BLACK (Geriatrics) comments:-

Mrs Enid Spurgin presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture.

The prognosis after such a fracture, particularly in those with impairments of daily living before their fracture is generally poor both in terms of mortality or morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and complications.

A significant problem in Mrs Spurgins case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, '(GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include – taking suitable and prompt action when necessary"..... "referring the patient to another practitioner, when indicated"..... "in providing care you must recognise and work within the limits of your professional competence"..... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

There are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport, the failure to address the cause of this lady's pain or to consider any other actions from 26th March until 7th April, the use of Oramorphine on a regular

basis from admission without considering other possible analgesic regimes.

Subsequent management of Mrs Spurgin's pain was within current practice with the exception of the starting dose of Diamorphine (80mg in the syringe drive is at best poor clinical judgement). However, the expert was unable to satisfy beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

Expert Consultant Orthopaedic Surgeon Dr Daniel REDFERN comments:-

Mrs Spurgin suffered a relatively complex hip fracture as a result of her fall on March 19th 1999. The decision to operate and the implants and operative technique employed were appropriate.

The expert was unable to comment on the quality of the fixation of the fracture in the absence of radiographic record or post mortem findings.

The patient had a significant bleed into her thigh in the early stages post-operatively, and the possibility of compartment syndrome was raised. It is of grave concern that no further action can be identified in relation to this potentially serious and reversible diagnosis. Consequently, it is not possible to confirm that she had a compartment syndrome from the medical record.

Due consideration of the significance of her symptoms of pain and her inability to mobilise was not given consistently at either Haslar or at Gosport War Memorial Hospital. Specifically she did not undergo a further x-ray examination at either hospital, and she was not referred back to Haslar from Gosport War Memorial Hospital. The differential diagnosis should have included implant failure and uncontrolled infection. These complications would have been reversible.

Evidence of other key witnesses.

Carl JEWELL Nephew, background in respect of deceased. Visited Aunt at Haslar hospital impressed by level of care, Mrs SPURGIN seemed OK in herself and was lucid.

Visited aunt four or five times after transfer to Gosport War memorial hospital. She seemed fine.

Visited Aunt on 12th April 1999 she was unconscious and unrousable. Dr REID told him that she was on too high a dose of morphine. Doctor told nurse to reduce aunts diamorphine, he said she would be alright.

Received call at 0130hrs 13th April and informed that she had died.

Helen McCORMACK(formerly Helen MEARS) Psychiatric Consultant saw Mrs SPURGIN on 11th November 1997 depressed and becoming increasingly frail, intellectual and with it but did not want to socialise. Failing eyesight and

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 where she is noted to have a buttock bedsore. 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'.

- In patients with cancer, the use of diamorphine and other sedative medications (e.g.midazolam, haloperidol, levomepromazine) when appropriate for the patients needs, do not appear to hasten the dying process. This has not been examined in patients dying from other illnesses to my knowledge, but one would have no reason to suppose it would be any different. The key issue is whether the use and the dose of diamorphine and other sedatives are *appropriate* to the patients needs. Although the principle of double effect could be invoked here, it remains that a doctor has a duty to apply effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose of strong opioid that was *appropriate* and not excessive for a patient's needs.

- There appears little doubt that Mr Cunningham was 'naturally' coming to the end of his life. His death was in keeping with a progressive irreversible physical decline, documented over at least 10 days by different clinical teams, accompanied in his terminal phase by a bronchopneumonia. Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mr Cunningham a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge, illustrated, for example, by the reliance on large dose range of diamorphine by syringe driver rather than a fixed dose along with the provision of smaller 'as required' doses that would allow Mr Cunningham's needs to guide the dose titration.

- Dr Barton could also be seen as a doctor who breached the duty of care she owed to Mr Cunningham by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Cunningham by unnecessarily exposing him to potentially receiving excessive doses of diamorphine. In the event, however, such large doses were not administered, and in my opinion, the use of diamorphine, midazolam and hyoscine in these doses could be seen as appropriate given Mr Cunningham's circumstances.

Expert Witness Dr David BLACK (Geriatrics) comments:-

- Mr Arthur Cunningham a 79 year-old gentleman, suffers from long-standing Parkinson's disease with multiple complications followed by a fairly rapid decline in health leading to his first admission to the Gosport War Memorial Hospital on 21st July, 1998 and a final admission 21st September, 1998.

- Mr Cunningham receives terminal care including subcutaneous Diamorphine and Midazolam through a syringe driver and dies on 26th September 1998.

- Arthur Cunningham is an example of a complex and challenging problems in geriatric medicine. He suffered from multiple chronic diseases and gradually deteriorated with increasing medical and physical dependency. It is always a challenge to clinicians to identify the point at which to stop trying to deal with each individual problem or crisis, to an acceptance the patient is dying and that symptom control is appropriate.

- In my view, Mr Cunningham was managed appropriately, including an appropriate decision to start a syringe driver for managing his symptoms and agitation as part of his terminal illness in September 1998.

- My one concern is the increased dose of Diamorphine in the syringe driver on 25th and 26th September 1998, as I was unable to find any justification for this increase in dosage in either the nursing or the medical notes. In my view this increase in medication may have slightly shortened life for at most no more than a few hours to days, however, I am not able to find evidence to satisfy myself that this is to the standard of "beyond reasonable doubt".

Evidence of other key witnesses.

Charles Rodney STEWART- FARTHING stepson of Arthur CUNNINGHAM, describes him as a blunt and difficult man who had alienated most of his family. Describes him as cheerful on admission to Dryad Ward Gosport War memorial hospital and suffering a bedsore on his behind. Mr STEWART –FARTHING was surprised to be told by Sister HAMBLIN that he suffered the worst bedsores she could remember seeing and that he could not survive them.

Was informed by sister HAMBLIN that Mr CUNNINGHAM had become rude and difficult on 22nd September and that he had been given something to calm him down. By Lunchtime on Wednesday 23rd September he was shocked to find Mr CUNNINGHAM totally unconscious and being administered drugs via syringe driver.

He was appalled and demanded removal or interruption of the syringe driver, Sister HAMBLIN refused saying that this could only be authorised by a doctor.

Later informed by Dr BARTON that Mr CUNNINGHAM was dying due to poison emanating from his bedsores, the drugs were required to ensure that he was not discomforted.

Was shocked to note that the cause of death had been registered as Bronchopnuemonia, and demanded a post mortem. Cause of death was confirmed by post mortem, and the pathologist with whom Mr FARTHING spoke.

Mr FARTHING felt that there was a conspiracy afoot extending to the coroners office.

The next drug chart goes from 7th October – 17th November. Regular medication includes Thyroxine, Fluoxetine, Aspirin, Paracetamol, Senna, Lactulose, Thioridazine and Temazepam. She receives 3 days of antibiotics from 1st November – 3rd November.

On the as required part Oramorphine, 10mgs in 5mls 2.5 -5mls orally four hourly prn is written up and one dose is given on 11th November. Metoclopromide and Gaviscon Loperamide are also written up.

The final drug chart goes from the 18th November up unto her death. On the regular side Oramorphine 10 mgs in 5mls is written up and 2.5mls (i.e.5mgs) is given 6 hourly on 18th and 19th November and on the morning of 20th November. Thyroxine, Fluoxetine continue to be given regularly up until 21st November.

Diamorphine 20 – 80 mgs subcutaneously in 24 hours, together with Hyoscine, Midazolam and Cyclizine are all written up on the as required part of the drug chart on 18th November. Diamorphine 20 mgs in 24 hours with 50 mgs of Cyclizine is given in an infusion pump. The first one starting on 20th November and the second on 21st November.

Dr Jane BARTON

The doctor on a day to day basis for the treatment and care of Shelia GREGORY was a Clinical Assistant. As such her role in caring for patients is governed by Standards of Practice and Care as outlined by the General Medical Council. The medical care provided by Dr BARTON to Mrs GREGORY during 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, October 1995, (pages 2–3)

The medical records were examined by two independent experts.

Dr David BLACK reports :-

Sheila GREGORY a 91 year old lady with a number of serious chronic diseases suffers a fall and fractured neck of femur in August 1999. She is admitted to the Haslar Hospital and making little rehabilitation progress, with a very poor prognosis she is transferred to the Gosport War Memorial Hospital.

There is some weakness in the documentation of her condition in particular on her admission to the Gosport War Memorial Hospital and on the 18th November when her definitive final clinical deterioration is documented. 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 clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patient's and any drugs or other treatment prescribed". The lack of clinical examination both on admission and more important Mrs GREGORY's care deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above I am satisfied that Mrs GREGORY's death was of natural causes and that her overall clinical management in Gosport was just adequate.

Dr Andrew WILCOCK's report is awaiting completion although he has reviewed Mrs GREGORY's medical notes and reports :-

- In summary, pain did not appear to be a major problem for Mrs Gregory at the time of her transfer to Dryad Ward. Any pain present appeared satisfactorily controlled with p.r.n. doses of co-dydramol 2 tablets, twice a day at most. During Mrs Gregory's time on Dryad Ward, she appears to have experienced a number of pains. Apart from the pain in the right wrist, no medical assessment is documented and their underlying cause is unclear. Nevertheless, they were generally treated with paracetamol only. Thus, in my opinion, from a pain point of view, there was no justification for the prescription of diamorphine, hyoscine and midazolam to be given in a syringe driver on the day that she was transferred to Dryad Ward and when the drug chart was rewritten on the 18th November 1999. However, she did not receive any diamorphine until 20th November 1999. One obvious conclusion, that should be explored further, is that the use of these drugs, in these doses, was part of a 'standard' approach, that had little, if any, immediate consideration or relevance to an individual patient. The reasoning behind such an approach should be identified.
- In my opinion, from a pain point of view, there was no justification for the prescription of the regular oral morphine on the 18th November 1999 and the indication for its use needs to be determined. If it was for anxiety, as the nursing notes suggest, this in my opinion is not an appropriate use of morphine. However, opioids are indicated for the relief of symptoms other than pain, e.g. cough and breathlessness, and Mrs Gregory did have breathlessness. In my experience, morphine is widely used to relieve breathlessness (generally occurring at rest) in patients with cancer. It is used less in non-cancer conditions causing breathlessness, although this practice may be increasing. Nevertheless, it is generally used for symptomatic relief of breathlessness that persists despite the optimal treatment of the underlying cause. In this regard, there is a lack of documentation in the medical notes that an assessment was made of Mrs Gregory's medical condition around the times that breathlessness seemed a particular problem, e.g. 17th and 19th November 1999. If a thorough medical assessment of Mrs Gregory's breathlessness on the 17th November 1999 had considered it to be due to heart failure, then appropriate management of her heart failure could be seen as a more appropriate response to her episodes of breathlessness and anxiety rather than the use of morphine per se. On the 19th November 1999, a stat dose of frusemide 40mg was given IM at 15.45h because of breathlessness. In my experience, it is generally the case that a patient who is considered to be a degree of heart failure sufficient to warrant parenteral frusemide, also warrants a medical review. Given this occurred at 15.45h, I would have considered it appropriate for Dr Barton/the doctor on call to have assessed Mrs Gregory as soon as was possible the same day, and not to have left until the following morning. Even so, there was no medical notes entry for 20th November 1999, although regular oral frusemide 40mg once a day was presc\\ribed. I am not a cardiologist however, and the opinion of one could be sought if considered necessary regarding the above.

unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.

Expert Witness Dr David BLACK (Geriatrics) comments:-

Mrs Gregory had a number of chronic diseases prior to her terminal admission following a fractured neck of femur. She had severe lung disease documented to going back to at least 1990, and in his view was extremely lucky to survive the admission in December 1998 at the age of 90 years. She also had documented heart failure, atrial fibrillation and heart cardiac valvular disease going back to at least 1995. It seems likely that she had cerebral vascular disease following the episode of diplopia in 1995 and the confusion that was subsequently documented is probably evidence of mild to moderate multiple infarct disease.

As is all too common, a very frail elderly lady had a fall and she suffered a fractured neck of femur. She was admitted to the Haslar Hospital for operative repair. There is always a very significant mortality and morbidity after fractured neck of femurs in old people, particularly in those who have had previous cardiac and other chronic diseases.

In the post operative period in Haslar she remained doubly incontinent of both urine and faeces and had considerable confusion, especially at night. She made very little rehabilitation progress. All of these are very poor prognostic signs at the age of 91.

She was subsequently assessed by the geriatric team and appropriately transferred to Gosport Hospital. The comment in the notes in Haslar, "will get home?" suggest that a consultant view was that even at this early stage, significant improvement was very unlikely, a view agreed by Dr BLACK.

When transferred to the Gosport War Memorial Hospital Mrs Gregory was seen by Dr Barton who failed to record a clinical examination apart from some short statements about her past medical history and her functional history. However, Mrs Gregory appeared to have been in a relatively stable clinical condition and no harm seemed to befall her as a result of this failure to examine her.

However, she was examined three days later by a different doctor when she had been noted to have a left sided facial droop and it seems quite likely that she had a further small stroke at this time as part of her multiple infarct disease.

Essentially she made no improvement in rehabilitation during her two months in Gosport War Memorial. She remained extremely dependent, eating very little and reliant on very considerable nursing input. There was ongoing discussion about the possibility of a long term nursing home

The lack of clinical examination both on admission and more important Mrs Gregory care deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above Dr BLACK was satisfied that Mrs Gregory's death was of natural causes.

Evidence of other key witnesses.

Janet Martin-Rogers (Mrs GREGORY'S daughter) Detailed medical history and background as known. His mother was heavy smoker, smoked 40 cigarettes a day. Following fractured hip in April 1999 mother was admitted to Queen Alexandra and then Gosport War memorial hospital. Seemed to be making progress but worsened after her bout of diarrhoea.

Pauline GREGORY (granddaughter) Details family history, following her admission to Haslar hospital in 1999 Pauline asked for a move to Gosport War Memorial hospital because she felt that she would receive rehabilitative treatment. Her grandmother was initially very happy she thought the nurses were lovely and she made progress. Then declined, not eating or drinking much and staying in bed. On 20th November Mrs GREGORY was happy bright alert and lucid, did not complain of any pain. By 21st November she was lying on her side and appeared drowsy.

Dean GREGORY (great grandson) General background information made several visits to Mrs GREGORY at GWMH. Was telephoned by a nurse on 22nd November to 'come in and say good-by', does not know why she died, she was a strong fit woman who had broken her hip.

Luci GREGORY (great granddaughter) Background as above.

Trudi JACKSON (granddaughter) Background.

Wendy HARRISON (G.P retired) Principal in general practice at Bury Road Surgery, GOSPORT. Mrs GREGORY a patient since 1984. Initially attended infrequently but then every four months between 1996 and 1999.
Mrs GREGORY was on long term medication for an under active thyroid gland and a hypnotic as she was an insomniac. She was suffering fromchronic obstructive pulmonary disease secondary to smoking, valvular heart disease and mild anxiety leading to insomnia. As a result her routine medicine was:-
Thyroxine- For under-active thyroid.
Salbutomal, Beclaforte inhaler and Atrovent – for chronic obstructive pulmonary disease.
Zimovane-for insomnia.
Attended Mrs GREGORY's home address 15th December 1998 breathless and could not lay down, diagnosed pneumonia in left lung and left ventricular failure and arranged admission to Queen Alexandra Hospital forthwith.

placement.

On 15th November she is noted to be quite unwell, the diagnosis was not entirely clear and Dr BLACK wondered whether something was actually starting on 1st November when there was an episode of vomiting. The patient was examined and that examination is recorded in the notes. However, by 18th November, she had very rapidly deteriorated and Dr Barton made a record in the notes that because of her deterioration in general condition, oral opiates should be started in a small dose. Based on the nursing assessment of her distress and breathlessness, this was an appropriate response to someone who has an extremely poor prognosis, multiple chronic illnesses and making no significant progress after 3 months in hospital. A symptomatic response to this lady's problems was a reasonable clinical decision.

She received 5 mgs 6 hourly of Oramorphine on the 18th and 19th December, which Dr BLACK believed to be an appropriate dosage and therapeutic regime. No improvement was made and she started on a Diamorphine pump at 20 mgs on 20th November. It would appear that the decision to start this was a nursing one, as no specific medical note was made on that day, however Dr BLACK believed this to have been a reasonable decision for a patient who was dying.

Diamorphine was specifically prescribed for pain and is commonly used for pain /cardiac disease. However, it is also widely used for the distress and agitation that may be associated with terminal illness. Diamorphine can be mixed with Cyclizine (to prevent vomiting) in the same syringe driver. Diamorphine subcutaneously after Oramorphine is usually given a maximum ratio of 1 to 2 (for example up to 10 mgs of Diamorphine for 20 mgs of Oramorphine). On this occasion Sheila Gregory had been receiving 20 mgs of Oramorphine a day on 18th and 19th where an absolute minimum dose of Diamorphine would have been 10 mgs in the syringe driver over the first 24 hours. However the increased to 20 mgs over 24 hours after 2 days of 20 mgs of Oramorphine would be within the range of acceptable clinical practice.

Seen on the 22nd, she was very ill with a rapid pulse, a rapid respiratory rate with a clear sounding chest. This suggests to Dr BLACK that the agonal event may well have been a pulmonary embolus. However, this would not be surprising after a long period of poor mobilisation, following a fractured neck of femur.

A remaining concern regarding the clinical management was the anticipatory prescribing of strong opioid analgesia on both the first and second drug charts written between 3rd September and 17th November. Except where this would be useful as part on normal clinical management (for example after a heart attack), there appears to be no clinical justification for this prescribing pattern. However, although this may represent poor clinical practice, no harm came to Mrs Gregory as a result of it.

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

Dr Andrew WILCOCK reports:-

There was insufficient assessment and documentation of Mr Packman's clinical condition when he became less well on the afternoon of the 26th August 1999.

There was insufficient assessment and documentation of Mr Packman's clinical condition when he became acutely ill on the evening of the 26th August 1999.

Mr Packman was considered to have experienced either a myocardial infarction or a gastrointestinal haemorrhage, yet advice was not sought from other colleagues nor was he transferred to an appropriate place of care.

Mr Packman received regular oral morphine that may have been excessive to his needs and prescribed a syringe driver, as required, with upper dose ranges of diamorphine and midazolam likely to be excessive to his needs.

Over the days that followed, there was a continued lack of an appropriate medical assessment of Mr Packman's condition; the results of blood tests that would have indicated a gastrointestinal bleed were either not obtained or acted upon.

Mr Packman received increasing doses of diamorphine and midazolam that were likely to be excessive to his needs.

Dr BLACK further states

Both Dr Barton and Dr Reid had a duty to provide a good standard of medical practice and care. In this regard, Dr Barton and Dr Reid 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, providing treatment that could be excessive to the patients' needs and willingness to consult colleagues.

Mr Packman was admitted for rehabilitation and it was not anticipated that he was likely to die. Although Dr Barton considered a myocardial infarction more likely than a gastrointestinal haemorrhage, the latter would have been confirmed as the more likely if the haemoglobin result was obtained that evening or the following day. A gastrointestinal haemorrhage (or a myocardial infarction) is a serious medical emergency and requires appropriate and prompt medical attention. The cause of Mr Packman's gastrointestinal bleed is unknown. However, as the most common cause is a peptic ulcer which can be cured with appropriate treatment, it is possible that Mr Packman's deterioration was due to a potentially reversible cause that could have been managed by transfer to the acute hospital for appropriate resuscitation with intravenous fluids, blood transfusion and further investigation. This view is in keeping with the opinion of a gastroenterologist, Dr Jonathan Marshall (report of 1st April 2005).

Dr Barton considered Mr Packman too unwell to move. In this regard it seems odd that a patient becoming acutely unwell at Gosport War Memorial Hospital would be at a disadvantage compared to if they had become acutely unwell at home. I see no reason that a patient could not be transferred by emergency ambulance if this was in their best interests. When possible they should be medically stabilised beforehand, but the lack of ability to do this should not be the reason not to attempt transfer at all. Even if one accepted the view that Mr Packman was too unwell to move, advice should have been sought on his management from the on-call physicians/geriatricians or cardiologists.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mr Packman by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Packman by failing to adequately assess his condition and taking suitable and prompt action. Mr Packman could have had a potentially treatable and reversible medical condition, which presented with a serious complication (i.e. bleeding). He should have been urgently and appropriately assessed and transferred to an acute medical unit. He was not appropriately assessed, resuscitated with fluids, transferred or discussed with the on-call medical team. In my view, there was no obvious reason why it was not appropriate to provide Mr Packman with this usual course of action.

Morphine and diamorphine are safe drugs when used correctly. The key issue is whether the use and the dose of diamorphine and other sedatives are *appropriate* to the patients' needs. Although some might invoke the principle of double effect (see technical issues), it remains that a doctor has a duty to apply effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose of strong opioid that was *appropriate* and not excessive for a patient's needs. The stat doses of diamorphine could be seen as appropriate for the relief of severe pain. However, in my opinion, the ongoing use of regular morphine and subsequent use of diamorphine and midazolam were inappropriate; their use was not obviously justified and the doses were likely to be excessive to Mr Packman's needs. In my opinion, it is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Dr Jonathan Marshall a specialist Gastroenterologist specifically reports that :-

Mr PACKMAN was likely to have experienced a significant GI bleed approximately 3 days after transfer to GWMH. He was assessed as being unwell and was managed with escalating doses of opiate analgesia until he died on 3-9-99.

He further states that transfer for endoscopic therapy should have been considered in Mr PACKMAN's case, although this can only take place after resuscitative measures have been taken such as I/V fluids, oxygen etc. Endoscopic therapy allows accurate diagnosis of the site and cause of bleeding. It also allows further procedures to try and stop the bleeding and is 'bread and butter' emergency gastroenterology available in any endoscopic unit.

The critical determinant would be how fit Mr Packman was after resuscitative measures for the ambulance transfer to endoscopy.