Mr Robert Wilson born Code A **– and died 18.10.1998**

Iain Wilson gave evidence that his father had joined the Royal Navy at the age of fifteen and had done twenty two years service. He was divorced after thirty two years of marriage and took it very badly. He moved to Saresbury Green in lodgings and it was acknowledged that Dad was an alcoholic. He formed another relationship and they married and lived some two hundred yards from the club where Mr Wilson use to drink.

In 1997 he was admitted to hospital after a fall and on discharge was told to stop drinking at which point he changed from rum to whiskey.

In October 1998 he was admitted to hospital whilst his wife was in Cornwall and no one knew he was there. Apparently he had not been eating, been drinking heavily and it was when he didn't turn up at the club for his normal drink that they became concerned and he was found at home having had a fall. He had put on an enormous amount of weight.

He was taken by ambulance to QA and it was not until he had been in there for a week that the family discovered from the bar staff at the club that he had been admitted.

Iain Wilson went to the hospital and was shocked at what he found. He looked as if he had died there and then. He didn't want to talk or eat or drink and at that stage he was told his father's condition was not life threatening that he had a broken shoulder and required surgery but that he was too ill to undergo that at that time. He believes his father had given up the will to live.

Over the following week his condition improved he was taking food and drink and was more alert.

When it came to discharge Social Services said that he could not go home and his wife refused to have him there.

Neil Wilson

Dad smoked 80 a day & drank heavily

? 10 pints a day

Confirms admission to QA in 1996

Had treatment for shoulder & was put on a

Died 5'7" & 18 Stone

Not until Sept 98 he discovers Dad

is in hospital & only finds out through

the social club where he drinks

Neil is told to send id all round - Mr W's

wife is not communicating with the

Mr W's children

Confirms Dad in procedural @ QA

Dad spirals down - making plans for his

funeral - then things begin to look

up & the doctor of name of GWMH

is told by Dr Hand Dad needs some life

changes Move to GWMH 14.10.98

Neil down to discuss matters with Dr

but she was speaking to Gill Nicholson

b. The inappropriate combined subcutaneous administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients, leading to death;

c. Confusion amongst staff about whether patients were being admitted for palliative or rehabilitative care;

d. A failure to recognise the potential adverse effects of prescribed medicines;

e. A failure of clinical managers to routinely monitor and supervise care on the ward.

9. It was not within CHI's remit to determine whether the said failures caused or contributed to any individual death.

10. In relation to staffing, CHI found that there was inadequate supervision of the clinical assistants providing medical support on the hospital wards (until July 2000), including a lack of review of any prescribing (pp29 and 33).

11. CHI's key conclusion was that there was a failure of trust systems to ensure good quality patient care in that:

a. There were insufficient local prescribing guidelines in place governing the prescription of power pain relieving and sedative medicines;

b. There was a lack of routine and rigorous review of pharmacy data, that led to high levels of prescribing on wards not being questioned;

c. The absence of adequate supervision and appraisal systems meant that poor prescribing practices were not identified;

d. There was a lack of adequate assessment of care needs of patients on admission (Executive Summary, vii).

12. HM Coroner has elected to conduct inquests in relation to 10 patients who died at the hospital. The criteria for the selection of those deaths are not clear at this stage. The Coroner is invited to note that Blake Lapthorn have been contacted by a number of other relatives of those dying at the hospital in the relevant period, who are keen for the deaths of their relatives to be considered.

One or more inquests

13. From the information currently available, it would appear that there are a number of generic issues that would apply to the Coroner's investigation of all 10 deaths. They include the lack of clarity as to whether palliative or rehabilitative care was required for patients, the prescription and administration of strong opiates, and the lack of

Apparently he was not ill enough for a Nursing Home and so he went to Gosport War Memorial Hospital whilst the family looked for care from a ex navy establishemt.

On the night before he transferred to Gosport he seemed fit and well was quite lively and when Mr Wilson left him he was chatting, talking, eating sweets although he was concerned about the travelling the following day.

On the day of the move he was collected from QA at 10.00am by passenger transport and did not get to Gosport until about 2pm.

Iain sees his father on 15th October and is horrified at the change in his condition. He was unable to move, could not speak and when Iain questioned this Mrs Wilson said that he had not travelled well and that they had spent some four hours in the transport. He was advised that the Sister had said that he was seriously ill and was going to die.

Because he could not talk to anyone in his own words he kicked off and was told he would be arrested if he did not leave. That seemed to be a significant breakdown in relationships because from then on the staff would not talk to him. The following day 16th October he finds his father in a coma as he puts it with the syringe driver in position although he did not know what that was for. He was then advised by telephone that his father has died on 18th October and unfortunately seems to have been excluded from the funeral arrangement.

In response to Mr Jenkins he said that he was not aware that his father had fluid overload and congestive cardiac failure. He was concerned that he was not in the group of people being spoken to and that he had effectively been excluded. He believed that the drugs caused the deterioration in his fathers condition.

In response to Mr Sadd he said that he believed QA were doing what they should have been doing whilst he was with them. He was aware that his father had multiple problems.

N G L Wilson

The statement of **Christian Birla** was then read. He confirmed that he was Senior House Officer in Medicine at QA from 1st April 1998 to 30th September 1998.

He confirmed that Mr Wilson was admitted to QA on 22nd September 1998 with a fractured left humerus. He remained there until 14th October

He then keeps contact with Dad although
id is divorced with Marlene but they have
Dad over for tea
Then Jay with Dad 17/10/98 but he dies
shortly after they leave to go home

d. Blake Lapthorn are content to represent the interested of any/all of the deceased, but that will be a matter for the individuals concerned;

e. Various documents (identified below) will be required and it is anticipated that most of the witnesses should give live evidence. Early and full disclosure is invited;

f. The inquest should take place in a convenient venue that is able to accommodate the large number of interested persons/witnesses;

g. It is probably premature for an accurate time estimate, but a working estimate of 6 weeks is considered appropriate.

Factual summary

5. The 10 deceased whose deaths fall to be investigated by HM Coroner were patients at the Gosport War Memorial Hospital ("the hospital"). Police investigations took place into an alleged unlawful killing of a patient at the hospital in 1998. Expert evidence was obtained in respect of 5 deaths. Although the police decided not to proceed with any prosecution, they were sufficiently concerned about the care and treatment of frail and elderly people at the hospital that they referred the issue to the Commission for Health Improvement ("CHI") for investigation. CHI duly investigated and reported in July 2002, in a report entitled "Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital" ("the CHI report").

6. Hampshire Constabulary also referred the experts' reports to the General Medical Council and the Nursing and Midwifery Council, amongst others.

7. CHI's terms of reference were to consider whether, since 1998, there had been a failure of trust systems to ensure good quality patient care. The investigation focused on a number of areas, including the arrangements for the prescription and administration of drugs and staffing, accountability, supervision and training (para 1.4). CHI's remit specifically excluded the investigation of any particular death or the conduct of any individual (Executive Summary, vii). CHI's investigation centred on the 3 wards at the hospital providing general medical care for patients over 65: Dryad, Daedalus and Sultan wards.

8. In relation to the administration of medications, CHI noted the concerns of the experts to include the following (p12):

   a. A lack of evidence of trust policy to ensure the appropriate prescription and dose escalation of strong opiate analgesia as the initial response to pain;

when he was transferred to Gosport. That transfer was for continuing care.

He takes the view between 23rd and 29th September 1998 because of Mr Wilson's physical condition he would not be resuscitated if he stopped breathing at any point.

He confirms that he was given 5mgs of morphine on 23rd September and 24th September.

The last morphine he had was 5mgs on 3rd October. He then describes the analgesic ladder and he then describes from the notes problems with Mr Wilson's renal function that his kidneys were not working properly and his liver function was affected. He says specifically 'not for resuscitation in view of poor quality of life and poor prognosis' and he noted that he was suffering from alcoholic hepatitis.

He refers to an assessment undertaken by Dr Lusznak who confirms that he is suffering from early dementia and depression and he says that death would not be unexpected in the near future.

Dr Lusznak's statement was read and she confirmed she was a consultant in old age psychiatry. She has no personal recollection of Mr Wilson so her memory comes from the notes. She noted that in addition to his fractured humerus he had low mood, a wish to die, disturbed sleep pattern secondary to pain. She recalled that he was suffering from early dementia which was alcohol related and that he was suffering from depression. She prescribed an anti depressant for him and she says that in an ideal world nothing would have been prescribed for him because of his impaired liver function.

She writes to the Consultant in elderly medicine at QA confirming that Mr Wilson's mood was low he was tearful with no delusions or hallucinations but felt there was no point in living. He was physically obese, left arm in a sling, left hand grossly swollen and bruised with marked oedema of both legs.

Collette Billows statement was then read. She gives evidence as to the transfer from QA to Gosport confirms that at that point Mr Wilson's barthell score was seven. He had much pain in his arm and required specialised nursing.

Gillian Hamlyn similarly had a statement that was admitted in writing. She confirms that on admission Mr Wilson had a fractured left humerus end stage congestive cardiac failure, renal failure, liver failure and it was noted that he had a syringe driver from 16th October 1998.

From the notes she understood that he had multi organ failure and she understood that he was being admitted for terminal care.

It is she who decides to increase a dose of diamorphine from 20 to 40mgs and to add a further 20mgs of medazalam and to increase the dose of hiascine.

She notes that the dosage of hiascine was not controlling Mr Wilson's secretions and she therefore says that she increased the dose to 600mcgs.

Similarly she says that on 17th October she increased the dose of diamorphine from 20mgs to 40mgs at 3.30 in the afternoon and the hiascine was increased from 600 to 800mcgs. She also added 20mgs of medazalam she says quite specifically that the diamorphine was increased because of the pain and the medazalam was administered to relieve anxiety.

She notes a further deterioration in his condition. She does not know why the diamorphine dose was increased but can only presume it was due to pain level not being controlled by the previous dose.

She notes on 18th October that there is a further deterioration and the syringe driver is renewed at 14.50 hours with diamorphine 60mgs medazalam 40mgs and hiascine 1200mcgs.

She refers to consulting Dr Peters because there would have been an increase in the hiascine and that could only be authorised by a doctor.

She then went on to describe how oral doses of morphine were administered.

She confirms that on 17th October 1998 40mgs of diamorphine was administered and that was doubling up from the previous 20mgs. Her statement says that the standard practice was to double up the dosage of diamorphine although that does not accord with other nursing notes.

She does note that at 15.50 on 17th October an increased dose of diamorphine to 40mgs hiascine to 80mcgs and 20mgs medazalam were

administered by syringe driver although there is no written record as to Mr Wilson's pain and anxiety.

The statement of **Marjorie Wells** was read. She worked between 1997 and 1998 as a Grade D Staff Nurse on Driad Ward.

She recalls from the notes that she administered 10mgs of oramorph at 6pm on 15th October.

She noted that on 16th October Mr Wilson was seen by Dr Knapman and was noted to have deteriorated over night.

She also detailed that at night the dose would be doubled to enable the patient to get a more settled night sleep. As nursing staff she would give the prescribed dose. She could not omit it and could not increase it without reference to others. That may be another nurse or it may be the doctor concerned.

She is quite clear that if medication did not control pain there would be a change/increase in medication.

Dr Knapman statement was read and he was one of Dr Barton's partners who would have been out of hours cover for Gosport during Dr Bartons down time. He records on 16th October that Mr Wilson declined over night with shortage of breath, fluid in the chest, weak pulse, irresponsive to spoken order, oedema in arms and legs, a question of a silent myocardial infarction, deterioration in liver function and an increase in diuretic.

She comments that he was transferred to a syringe driver 16th October 1998 and that on 17th October his dose was increased from 20mgs to 40mgs and then to 60mgs on 18th October.

Dr Barton had set the parameters at 20mgs to 200mgs and the maximum that was ever given to Mr Wilson was 60mgs.

Dr Knapman gave a statement that was read in which he said that he was a General Practitioner and his role was to administer appropriate medication to patients at Gosport. He considered that Mr Wilson may have had a silent heart attack and felt the most appropriate course of action was to make him comfortable and for that reason he prescribed two doses of oramorph at 10mgs.

Dr Barton then gave evidence. She has no memory of him and any recollection is from the notes.

She details the previous care at QA and Dr Luszant assessment but she says very particularly that Mr Wilson was given an unrealistic expectation as to his prognosis.

On his admission to Driad ward she notes in the records transfer to Driad ward continuing care, fractured humerus, left 27th August 1998 previous medical history, alcohol problems, recurrent oedema, congestive cardiac failure, needs help with all daily living, hoisting continent barthell seven lives with wife Sarisbury Green, plan gentle immobilisation.

The date of the fracture is not recorded correctly in that it should have said 21st September. She also records the barthell scale as seven whereas the nurses recorded it as four.

She says that because of the continuing pain in Mr Wilsons arm she prescribed oramorph over and above the codeine phosphate that he had been given at QA. Her oramorph was prescribed at 10mgs at a dose of 2.5mgs to 5mgs as needed four hourly.

The doctor further confirms that on 15th October 20mgs of oramorph was given at midnight with good effect but then Mr Wilson then deteriorated over night becoming very chesty and with difficulty in swallowing.

She confirmed that the syringe driver was commenced on 16th October overnight with 20mgs diamorphine and 40mgs hiascine although the doctors statement actually says 400mgs. She says that the hospital records are clear that the matter was discussed with the family but clearly not Mr Iain Wilson.

The same situation with Dr Booth then seems to have arisen that Dr Peters one of Dr Bartons partners was on duty for the weekend and Dr Peters was of the opinion that Mr Wilson was likely to die.

It seems that Dr Peters attended again on 18th October and he spoke at that stage to Mrs Wilson. Diamorphine had been increased to 60mgs medazalam to 40mgs and hiascine to 1200mcgs. That was in excess of the prescription that she had given but Dr Peters specifically authorised that.

He took the view that to prescribe the three drugs was perfectly in order in the terminal phase but he would not have use a syringe driver. He would adjust the dosage as the pain is assessed. Again there is a lack of note to justify the position.

It is significant in assessing Mr Wilson's condition that he did not appear distressed and they were able to put a catheter into the back of his throat to suction secretions without any adverse reaction.

It was suggested that Professor Black had said that oramorph had contributed to Mr Wilson's death and whilst Dr Wilcock understood how he reached that view he could not agree with it because of the pulmonary oedema.

If on 16th October the sole finding was the drowsiness and coma this could be a drug related death but the heart failure and pulmonary oedema don't follow on from alcoholic serosis and represent a different condition.

He did comment that the secretions were greater than might be expected if this was just pulmonary oedema that that was as likely to cause death as hepatic coma.

He did not consider that the dosage of drugs disregarded Mr Wilson's safety and that was how it was put to him.

In response to you and whether there was any treatment for the encephalopathy he said in terms that the condition was not reversible. The conditions from which he was suffering were not correctable. There may be things to do to relieve the burden but the burden benefit balance had to be considered.

Dr Barton then gave evidence with regard to Mr Wilson and recountered the history. She undertook the assessment of Mr Wilson on transfer on 14th October 1998. On her examination she noted the fractured humerus, the alcohol problems, recurrent oedema, congestive cardiac failure, the fact that he needed help with daily living, hoisting, that he was continent and had a barthell of 7. The plan for him was gentle mobilisation.

You may recall that I was concerned that Mr Wilson had been discharged from QA without the arm injury being resolved and that in itself would involve a great deal of pain. Dr Barton confirmed that and that she prescribed oramorph 10mgs at a dose of 2.5mgs four hourly.

She also confirmed that she wrote up diamorphine 20 to 200mgs subcutaneously together with hyacine and medazalam 20 to 80mgs but does not recall when she wrote that up. She anticipates that it may have been when she undertook her examination on the basis of the proactive regime.

On 15th October she sees Mr Wilson again and give another prescription of oramorph at 10mgs four hourly and another 20mgs at night. The 20mgs is given at midnight on 15th October going to 16th. But overnight she confirms that Mr Wilson's condition deteriorates and you will recall that she is away from the hospital on 16th October and it is Dr Knapman who sees Mr Wilson. Further she does not consider that she was on duty that weekend and therefore her understanding of Mr Wilson's condition is from the notes of others.

It is however significant that she confirms Dr Peters sees Mr Wilson on 18th October and it is he who increases the diamorphine, medazalam and hyacine. The hyacine to a level in excess of that originally prescribed by Dr Barton.

She was questioned by Mr Sadd generally about the history of her appointment which is generally dealt with in Dr Barton's evidence she confirmed that she was essentially the person with the expertise in geriatric and continuing care and if in doubt her partners would seek her opinion. However they were all Doctors all underwent continuing education and were all use to care of patients at Gosport.

She said that she was supported by Dr Lord and Dr Tandy as the Consultants in charge of Didalus and Driad respectfully until Dr Tandy became pregnant and left on maternity leave in April 1998. She then had no Consultant support for the rest of 1998 until the arrival of Dr Reid in 1999. Responsibility rested on her shoulders and she understood that she was responsible for the clinical management. She said that proactive prescribing palliative care was the only practical way of dealing with the problem and you may remember that Dr Wilcock used a similar practice although in different circumstances. She then gave details of her daily routine. She would attend Gosport War Memorial Hospital before she started her day. She would attend again at lunch time to do any clerking in and she would attend in the evening as required to see families or if anyone required her attention. The situation was becoming more difficult because of the increased dependence of the patients and you may remember that I asked her about continuing care and whether the nature

of the ward had changed to become a medical ward and she confirmed that it had.

She was led very much by Mr Sadd into the consideration of whether her practice put the patients at risk. She initially replied no and went on to say I certainly hope it didn't subject patients to risk.

She then explained about the introduction of syringe drivers in 1998 and the necessity for pre-prescribing arose about 1990 because there were not enough people available to undertake prescriptions and so they had to be available. She said that within the parameters of the prescription she had given her partners were quite content to change the dosage.

In 1998 we were pre-prescribing. We had a very good pharmacist that attended weekly and would express any concerns that she had. In addition the Consultant would review medication on ward rounds she certainly did not feel that her prescriptions put any of her patients at risk. The nursing staff had input and some of the nurses had worked with Dr Barton for ten years. It was a mutually trusting working relationship.

She worked closely with Sister Hamblin and she could always have recourse to the notes subject to the constraints on nursing time.

Often the medication would be changed and the nursing staff would tell Dr Barton after the event. She said that she relied heavily on their assessment of the patient.

Dr Barton was quite clear that the combination of diamorphine, medazalam and hyacine was part of her palliative care process.

She was quite clear that in 1998 nursing staff did not think of the ward as a terminal care ward.

The first assessment was on clerking in when Dr Barton would note the relevant points and she would then form a view of what should be prescribed and she would hope at that stage have the notes that would enable her to make an assessment.

On most occasions she would have the notes when the patient was admitted and it was she and the nursing staff that had access to the notes.

Generally she would read the notes and highlight the relevant factors to the senior nurse. She did not take blood pressure etc and would rely on the nursing staff to do that.

He initial examination would give a clear indication of the degree and that would be relevant to the prescription which she would then write up.

Mr Wilson was clerked in at lunchtime on 14th October. Dr Barton has no memory of him. He had some improvement in his condition and his medication from 30th September was paracetamol, some codeine and some codeine phosphate. He was at level 2 on the analgesic ladder, he was still in a lot of pain and at the time of his admission had spent four hours in the mini bus travelling to Gosport.

Dr Barton was clear that she had taken some of her observations from he examination and some from the nursing notes. It was put to her that she had as much time as she wanted to do the clerking in but that may be a slightly unfair assessment.

It was clear that at QA he had been immobile and that he was having pain on movement. She was quite clear that it was the level of pain that he was suffering that caused her to give the stage 3 analgesia.

She was aware of his alcohol problem and that his liver function was compromised. However she was in no doubt that he had to have the appropriate dose analgesia for the particular problem.

Whilst Professor Black considered that there was no justification for the change in medication she considered that that was theoretical and that she was dealing with the patient himself.

Dr Barton said that she was aware of the problems with opioids in liver disease but Mr Wilson had seen to tolerate the medication well and he settled well and became comfortable. She certainly felt that the 50mgs of oramorph for the following twenty four hours was justified.

Despite what his son says on 15th October the nurses were able to administer to him and he was comfortable. She noted that Dr Wilcock felt that he had been overdosed but she did point out that Dr Wilcock was not actually treating the patient.

On 15th October there is a change of medication and Dr Barton says that that confirms that se reviewed the medication. She accepted that there

was no mention in the notes of the risks of liver damage with morphine but she was aware of the problem and did not feel that it was necessary to document it. She was quite adamant that she would not have reviewed the medication without some kind of review.

Despite Sister Hamblyn's statements that Mr Wilson had been admitted for terminal care she was quite clear he was for continuing care.

The dose of oramorph on 15th October was not unsafe. Dr Barton said she was aware of the risk and she took a positive decision.

Despite Professor Black's comments Dr Barton did not note any deterioration in Mr Wilson's mental state and he was certainly more comfortable on oral morphine. That was given at 10mgs every four hours.

His deterioration on 15th October she was quite convinced was physical and not mental. Dr Knapman considered that he had had a myocardial infarction and he was certainly in decline by then.

Any increase in diamorphine at that stage would depend upon Mr Wilson's pain and distress. He was effectively drowning in his own secretions.

The diamorphine she said was increased on 17th October but not until late in the day. There was concern from the nursing staff that Mr Wilson may be developing tolerance to the opioids but any adjustment to the dose she said was done with their approval.

Mr Townsend asked Dr Barton about Sister Hamlyn that the spell summary was made out after the patient had died. Dr Barton said it was the nurses view of the doctors comments.

She confirmed that oramorph 2.5mgs in 5mlts four hourly was prescribed prn and 2x10mgs twice over twenty four hours and the nurses would check out the patient.

In response to Mr Jenkins Dr Barton confirmed that she had applied for the job at Gosport in 1988 and it comprised four sessions and she was the only applicant for the position. She gave a clear indication that she was working far in excess of that for which she was being paid but said that she loved the job and the people she worked with.

Her use of the syringe driver was to make the life of her patients more comfortable. It was not just intended for those who could not swallow and it was not just intended for those that were terminally ill.

Mr Wilson had a broken arm and she said that there was absolutely nothing that they could do with it or that they were going to do with it. She saw him first on 14th October after he had had four hours in transport. In addition to the fracture he was suffering from congestive cardiac failure and oedema. She noted that he was for gentle mobilisation.

On her initial assessment there was no mention that the nursing staff could certify death because she had no indication that he was going to die. The first mention of that is in Dr Peters note of 17th October.

There was no doubt that his heart was failing to pump and that was effectively the congestive cardiac failure. He had a fluid on his lungs and limbs. He had put on 11kgs all of fluid.

Initially she wrote up paracetamol prn then oramorph prn. The situation with Mr Wilson's transfer on 14th October was a general view and a snap shot of his condition at that point. She did not consider his previous analgesia relevant and she had to treat the condition of the patient as she found him.

On 14th October she assessed his discomfort and felt that doses of oramorph of 2.5 in 5mlts to 10mgs in every 5mlts prn to be appropriate. The nurses would only offer it if they felt that it was needed.

She noted that he got 10mgs at 2.45 that day and again nine hours later. The nursing staff would clearly have felt that that was appropriate.

She also wrote up paracetamol prn.

She said that all pain killers may cause liver problems form aspirin, paracetamol, cocodamol and morphine. Her duty she considered to be adequate pain relief.

By 15th October Mr Wilson was receiving regular oramorph although it had been prn.

On 16th October Dr Knapman considers that he has suffered a silent MI and she noted that it was he who deals with the adjustment to the medication. She did not see him from then.

Professor Black gave evidence and said that Robert Wilson was a 74year old with known severe alcoholic disease. He was admitted with a complex and painful fracture and his condition deteriorated first in hospital with alteration in mental state, renal impairment and subsequent close fluid retention but he then starts to improve and is transferred to Gosport for further assessment and possible rehabilitation.

He says that the documentation is weak but by 15th October there is regular oral strong opiate analgesia. He is concerned that the dose of 50mgs of oramorph on 15th October following 20mgs on 14th October was not appropriate there is concern that if the notes do not address that particular issue then there is no explanation for that increase. However he confirms that on admission Mr Wilson is fit for the operation to resolve his shoulder problem but by the following day he has deteriorated to such an extent that he is not fit for surgery. There is a continued deterioration clinically although the particular increase in dosage cannot be explained.

Dr Baker's statement which was read to you refers to death certification the prescription of opiates and the prospect of Mr Wilson leaving hospital alive. He concluded that Mr Wilson had liver dysfunction but not full blown liver failure and that the cause of the liver disease mainly alcohol was not mentioned in the certificate. He takes the view that oramorph may well have contributed to the death but that was not started at Gosport but rather at QA. He also takes the view that Mr Wilson's prospects of recovery were very questionable.

Professor Black considered that Mr Wilson died of alcoholic liver disease and that would be appropriate certification. He does not believe that the congestive cardiac failure and renal/liver failure are supported by the evidence that he sees.

Dr Wilcock gave evidence and gave a short history of Mr Wilson's condition. Again he commented on the absence of note keeping and patient records and the absence of a pain assessment. He had been on paracetamol as regular analgesia but that was discontinued and prescribed prn.

He had been receiving codeine 15 to 30mgs prn which is roughly the equivalent to morphine of 1.5 to 3mgs but he is then prescribed morphine 5 to 10mgs prn for pain relief.

He gets two doses of 10mgs and the next day is commenced on regular morphine 10mgs every four hours and 20mgs at night. He therefore gets

50mgs of morphine in the twenty four hour period which is more even than when the fracture first happened.

Dr Wilcock could not assess the impact of that because of the rapid deterioration Mr Wilson suffers on 16th October 1998. He says that is in keeping with his heart failure with or without a sudden event such as a heart attack. That in conjunction with the liver failure could have precipitated the terminal decline.

He does say that the reduced level of consciousness could have been due to a hepatic coma precipitated by the morphine or it could be as a result of the reduced level of blood oxygen due to the pulmonary oedema.

On that day the syringe driver is commenced at 20mgs of diamorphine which increases over the next forty eight hours to 60mgs and again he finds the increase in dose difficult to justify. Mr Wilson was not reported as being distressed by pain, breathlessness or the secretions. Whatever the position he is confident that the doses of morphine or diamorphine would not have contributed substantially to death.

He was quite clear that the oedema was due to the heart and liver failure. The fracture would cause considerable pain although he indicated that the need for analgesia would reduce it.

He was concerned that Mr Wilson was written up for morphine 5 to 10mgs prn but the 5mgs were never tried and he went straight on to 10mgs.

It is considered that Mr Wilson may have had a silent heart attack and that would account for his rapid decline. Whilst his increase in diamorphine was fairly rapid from 20 to 60 that did not contribute to his death.

In response to Mr Jenkins Mr Wilson's condition was poor and he deteriorates on the nights 15/16th October and he is seen by Dr Knapman.

There is no doubt that the rapid deterioration is a terminal event and therefore the object was to make him comfortable. His weight gain is all body fluid.

He was then questioned by Mr Sadd and confimed that at QA the dose of morphine he was given was appropriate. He did not have pain at rest but he did have pain on movement.

There needed to be caution with opioids because of the state of his liver. The 2.5 dose intravenously was appropriate.

Dr Luszant prescribed the antidepressant and she refers specifically to liver problems that could be aggravated by medication.

On 13th October Mr Wilson's weight gain is a significant problem and he had put on something in the region of 10kilograms all of which was body fluid.

It is impossible to look at the heart failure and liver failure separately because they go hand in hand.

On 13/14th October there is no pain recorded but he is given codeine phosphate and that seems to be effective together with the regular paracetamol. Dr Wilcock could see no reason to change the medication and there was nothing in the notes to indicate why that had happened.

Dr Wilcock did not understand why Mr Wilson had been transferred because his condition clearly was not stable. He did not think Mr Wilson was likely to die within a couple of days but there was no doubt that his prognosis was poor and he was likely to die soon.

Mr Wilcock was clear that whether this was continuing care or terminal care was irrelevant and it was the need for opioid medication that needed to be assessed. There was no pain assessment undertaken.

He is unable to say why the oramorph was prescribed on 14th October because there is nothing in the notes to confirm that. Further he could not agree that the dosage should be 2.5mgs.

The encephalopathy was as a result of the live disease. He was confused by 14th October and that is no doubt the reason for it.

People in liver failure could be imbalanced and could tolerate opioids notwithstanding the indications in the brief. From his interpretation of Professor Black's report it was clear that morphine passed through the liver and if the liver was not working properly then the effects of opiate doses was greater. He accepted that there were certain drugs to avoid in liver cases but again that it was a question of balance. He agreed that overdose of opiates may precipitate coma and hepatic impairment and in those circumstances you would reduce the dose or avoid all together.

However the national formulary did make it quite clear that some patients tolerated opioids well. He had been on codeine for intermittent pain relief. When he went on to oramorph 2.5mgs Dr Wilcock felt it was important to check that the patient was not becoming drowsy. He would not have prescribed more than 2.5mgs of oramorph and he was therefore concerned that Mr Wilson was getting 10mgs. As ever he was concerned that there was nothing in the notes to support that or explain it. He said that the side effects may be sedation or hepatic encephalopathy but in Mr Wilson's case we did not know because something happened acutely that can never be answered clearly.

It was suggested that Mr Wilson had been taken directly from stage 1 to stage 3 in the analgesic ladder that was not correct because he had been started on paracetamol stage 1 then codeine stage 2 then morphine stage 3. He did not necessarily think that opioids were wrong but he did question the dosage.

He had been on codeine and codridamol both of which had been stopped and he became more alert. However he was then not pain free and was put back on occasional codeine. He did question why the regime was changed when he was transferred to Driad and again commented on the lack of justification.

It was put to Dr Wilcock that Mr Wilson had said that when he sees his father on 15th October he is almost paralysed, distressed and confused and Dr Wilcock said could be as a result of the oraorph.

Dr Knapman's diagnosis of a silent myocardial infarction on 16th October may well be correct he would not have put him on continuing dosage.

Dr Wilcock felt that if Mr Wilson's sole problem was the confusion and drowsiness then it could be drug related but it is not. He had a bubbly chest, noisy breathing and secretions. Something else had happened but Dr Wilcock did not think it was a liver death.

He felt that Mr Wilson's pulmonary oedema was not typical and there was no doubt that he had heart failure. There could be any number of causes but that there was no doubt at that stage that Mr Wilson was dying.

To prescribe the diamorphine, hyacine and medazalam the view must have been taken that Mr Wilsons was dying and that is almost certain. However on transfer on 14th Ocotober that was not the case.