Geoffrey Packman died on 3rd September 1999

Mr Packman's daughter Vicky confirmed that her father was a big man, that he had worked latterly as a taxi driver but retired in 1989 and did not work again. He was a big man and his legs and feet became extremely swollen and he found it increasingly difficult to get around. During the last three years of his life his legs were so bad that the skin would break open and weep. The District Nurse came to the house two or three times a week to change the dressings on his legs. On 6th August 1999 the District Nurse makes the decision that Mr Packman has to be admitted to hospital and after some difficulty is taken to A&E at QA although she was not aware of the reason for the admission.

Her father made good progress and the condition of his legs seemed to improve and he looked the best she had seen him for years. He was happy and chatty and keen to go home.

Because of his lack of mobility he was to go to Gosport for rehabilitation and remobilisation.

After two weeks at QA she told us that her father was moved to Gosport where all was well until after three or four days he suddenly appeared 'spaced out', his eyes were glazed, his head nodded about, he was propped up on pillows and she believed that he was catheterised.

She saw him daily but he drifted in and out of consciousness and by 1st September 1999 he did not move or stir.

He died on 3rd September 1999 and the only treatment she was aware of was of his legs and she understood that he was due to be at Gosport for remobilisation although she never saw him out of bed.

She did report a conversation between her mother and 'the lady doctor' but she was not aware of the content of that conversation.

Sister Hamblin statement was then read. She has no personal recollection of Mr Packman but from the notes she tells us that on 25th August 1999 he was found to be passing fresh blood per rectum and his medication was to be withheld pending review by Dr Barton. He was also

vomiting. The next entry that she makes says that he had a fairly good morning no further vomiting. He was not for resuscitation. At lunch time he is unwell, his colour is pale and he is feeling unwell. He has further deterioration in the afternoon with indigestion and vomits again. There is a verbal instruction from Dr Barton to start the diamorphine 10mgs which is given at 6pm. Mrs Packman is advised of her husband's condition. Because of his presentation she queries whether he is having a heart attack.

Until 30th August Mr Packman is given oramorph notwithstanding that he had been written up for diamorphine and medazalam. Those are not given until 30th August.

She does the conversion of oral morphine to diamorphine and she calculates it as 10mg six times daily equating to 20mgs of diamorphine. The oral morphine was not controlling the pain and so she puts him on 40mgs of diamorphine in a syringe driver. She says that she would have called Dr Barton and that would have been agreed.

There is some query about an entry on 1st September 1999 but from Sister Hamblin's statement it appears that the syringe driver was renewed at 19.15 that day with 60mgs of diamorphine and 60mgs of medazalam as the previous dose was not controlling the symptoms. Mrs Packman had visited and was aware of her husband's poor condition and in view of the fact that she was to be admitted for surgery the following day contact would was to be with Mr Packman's son but not during the night. On 2nd September the diamorphine is increased to 90mgs and that was approved by Jeanette Florio and Shirley Hallman.

During this time Mr Packman has several smelling sores to his buttocks and between his thighs and blistered areas to both feet and heels. Those are treated continuously but essentially the skin had broken down.

The statement of **Shirley Hallman** was then read and she confirmed that she had been trained at St Mary's Hospital Portsmouth between 1968 and 1971 and that she qualified as a State Registered Nurse. She then went on to obtain further qualifications and amongst other things she then started work in January 1998 as a Staff Nurse at Gosport.

She was appointed as Deputy Manager under Jill Hamblin but that was not a comfortable position.

She was concerned that alternative medication was not being tested with patients and she expressed her concerns to Jill Hamblin and on one occasion to Dr Barton. She said that she and Freda Shaw, Lynn Barrett and Sharon Wring as well as Barbara Robertson expressed their misgivings about syringe drivers. She says that she never had a satisfactory answer from Jill Hamblin as to the use of syringe drivers, she was concerned with the care of Mr Packman and noted that on 1st September 1999 he appeared with no breath sounds no heart rate ausculated no radial pulse felt pupils fixed and dilated rip death verified.

She then went on to note that son notified and that the minister was to notify Mrs Packman.

Going backwards she then noted that on 23rd August 1999 she confirms that Mr Packman was admitted from Anne Ward following an episode of immobility and sacral sores. He was catheterised and he was on a profile bed and for hoist only.

She notes that on 6th August 1999 Dr Barton was in attendance and confirmed that Mr Packman was to receive oramorph four hourly and she saw Mrs Packman and explained Mr Packman's condition to her and the medication.

She says that the oramorph was given orally and that 10mgs were given on 27th August at 6.00am, 10.00am, 2pm and 6pm and a further 20mgs at 10.00pm to cover the night time.

10mgs were also given on 28th August at 6.00am, 10.00am, 2.00pm, 6.00pm and 20mgs were then given at 10.00pm.

Again on 29th August 10mgs given at 6.00am, 10.00am, 2.00pm and 6.00pm with the 20mgs to cover the night dose at 10.00pm.

The only dose given on 26th August was at 10.00pm 20mgs and on 30th August 10mgs were given at 6.00am and 10.00am.

She did note on 28th August 'remains very poorly, no appetite, has refused all food, wife visited very distressed as she is having surgery this coming week QA Thursday'.

She did say that she remembered Mr Packman, that he had dreadful pressure sores. She said that he believed he'd been stuck on the toilet and the sores were in the shape of a toilet seat. They were yellow and pusey.

They were extremely difficult to dress and in her own words they were the worse she had ever seen.

Beverly Turbull then gave evidence and confirms that she was involved with nursing Geoffrey Packman and does remember him because of his sacral sores and on 28th August 1999 she noted oramorph given as prescribed condition remains poorly and variable, drinking well, dressings remain intact.

She then notes on 31st August appeared to have a comfortable night, continues to pass tarry black faeces.

She assumed from that that he was either on iron tablets or was having an internal bleed.

On 1st September 1999 she notes 'incontinent of black tarry faeces unsettling, peaceful night all care given, syringe driver satisfactory'.

She had not set up the syringe driver but she checked it and it was in order.

She then noted on 27th August 1999 oramoph given as prescribed, comfortable night, not complaining of any chest pain and she then notes on 28th August oramorph given as prescribed, condition variable, drinking well, appears hydrated, slept long periods.

She confirms the prescription for oramorph.

On 2nd September 1999 she notes incontinent of weak tarry faeces unsettling, nursed on side, peaceful night, strong radial pulse, opens eyes when spoken to. Her final entry is for 31st August when she notes catheter drained satisfactory.

In response to Mr Leper she said that she was aware of the analgesic ladder.

That with opioudes there was a risk of drowsiness, constipation and there could be evidence of a confused state.

She had been concerned that the analgesic ladder was not being adhered to in 1991.There had been concerns but they had been resolved.

In response to Mr Jenkins she said that her experience on syringe drivers was comparatively new and she had training on the job.

Mr Sadd queried that and she confirmed that her worries were from 1991 and they had all been resolved.

In response to questions you asked she said that she would not have administered the dose of medication if she had not been happy with it. That had happened in the past but not with diamorphine.

Dr Reid then gave evidence and confirmed the history. He confirmed that diamorphine had been prescribed by Dr Barton on 26th August at a dose of 10mgs and that was to be repeated on 27th/28th August.

He was prescribed alvine and mepitol dressings for his skin wounds gavescon for indigestion tamazapam 10 to 20mgs orally on 24th/25th August and he was given doxazosin for high blood pressure and frusemide 80mgs administered from 24th to 31st August. He also had clexane as a subcutaneous injection twice daily on 25th August and he also had paracetomol and various creams.

He confirmed that the prescription of 40 to 200mgs of diamorphine as a proactive description of which he approved although one of the side effects of diamorphine was confusion and drowsiness.

He saw Mr Packman on 1st September at which time he was on a dose of 40mgs of diamorphine although the dose had been increased probably by Sister Hamblin notwithstanding the patient was already drowsy.

On 1st September it is noted that Sister Hamblin increases the diamorphine from 40mgs to 60mgs although Dr Reid is unable to say the reason for that because it was not recorded. Some hours before Mr Packman had been noted as being comfortable.

However he relied on Dr Barton's knowledge and experience as to patient management.

He would assume that the dosage was increased because the patient was in some difficulty and he relied on Sister Hamblin's view of that.

He did point out that the diamorphine had been prescribed for Mr Packman on 26th August but that it had not actually been administered until 30th August.

From his notes prepared by Dr Barton he was in no doubt that Mr Packman was in the terminal phase of his illness.

He saw Mr Packman on 1st September and did not feel that he had been overdosed. He thought he was in the terminal phase of his life because he had had a fair amount of opiate medication for pain control. He was passing Melina stools and the overall picture was a man in the terminal phase of life. It was not felt appropriate to refer him on to another consultant.

He felt it was unlikely that Mr Packman had suffered a heart attack and that his deterioration was due to the internal bleed.

He felt that Mr Packman had suffered a gastro intestinal bleed (which seem to be a matter of fact) and his cause of death was that as opposed to the myocardial infarction. That view is supported by the drop in haemoglobin over a short period.

Dr Barton gave oral evidence and dealt with the history of the case. On admission to Gosport Mr Packman had a barthell of score of 0 and he was totally dependent.

He was admitted to Gosport on 23rd August 1999 with his problems noted as obesity, arthritis, immobility and pressure sores. There was also a note of the episode of Melina on 13th August. On admission his barthell was noted as 6 on 23rd August. That seemed to indicate that he had improved to a degree from his time in QA.

Dr Barton sees him on 24th August and prescribes temazapam for him.

On 25th August there is a not that he had passed blood per rectum and his prescription was at that stage changed by Dr Beasley who was the on call doctor.

Because of a deterioration in his condition Dr Barton was called to see him on 26th August and she finds him pale, clammy, unwell and that suggested a myocardial infarction. She felt that there should be treatment with diamorphine and oramorph overnight. He may have had a GI Bleed but there was no vomiting of blood. He was not well enough to transfer to an acute unit. It was said that he should be kept comfortable and that at that stage Dr Barton was happy for nursing staff to confirm death. She was quite convinced that he was very ill and it was inappropriate to

transfer him. She felt that such a transfer was likely to have a further deleterious effect on his health.

On 26th August there is a further deterioration and there is a significant drop in his haemoglobin levels which would support the diagnosis of a GI Bleed.

She sees him again 7pm on 26th August because of his pain and distress and prescribes 10 to 20mgs of oramorph four times per day with 20mgs at night.

Proactively she then writes up a prescription for diamorphine 40 to 200mgs subcutaneously over twenty four hours together with 20 to 80mgs of medazalam. The records show that she saw Mrs Packman and explained Mr Packman's condition to her and the medication that they were using.

There then seems to have been an improvement and that Mr Packman was tolerating oramorph although he was still experiencing some discomfort especially when his dressings were being changed.

However he remained poorly.

On 28th August Dr Barton sees him again and notes that he remains poorly but comfortable and she asks that the opiates should continue over the weekend.

His condition deteriorates and on 30th August he is set up on a syringe driver to deliver 40mgs of diamorphine and 20mgs of medazalam and she assumes from that that he was continuing to experience pain.

She considers at that stage that he is terminally ill and her concerns shift to ensuring that he did not suffer pain and distress. He had received 60mgs of oramorph with the preceding three days and the administration of 40mgs of diamorphine over twenty four hours did not represent a significant increase.

She continues to see him she presumes daily during the week and note that on 1st September he has five separate pressure sore areas and a barthell score of only 1. He is seen by Dr Reid and is noted for TLC.

It is noted later that day that the syringe driver is renewed at 7.15pm with 60mgs of diamorphine and 60mgs of medazalam. It seemed that Mr

Packman was suffering yet further pain and discomfort and Dr Barton presumes that she would have been contacted by the nursing staff and she would have consented to the increase in medication.

That night Mr Packman was incontinent of black tarry faeces. You may remember that she felt that was a continuation of the original bleed as opposed to my suggestion that there was a continuing bleed.

On 2nd September his diamorphine was increased to 90mgs and medazalam to 80mgs presumably because of the continuing pain and distress.

Mr Packman died on 3rd September at 1.50pm and Dr Barton considered that that was consequent upon a myocardial infarction.

Professor Black gave evidence that Mr Packman was a 68year old man with numerous chronic problems in particular gross obesity. He had leg ulcers and severe cellulites. That led to an increasing risk of pressure sores.

He developed possible gastric or duodenal ulcer and continued with a slow bleed. He then seems to have had a massive gastrointestinal haemorrhage at Gosport which Professor Black considers to be the terminal event.

He observes that there was no further medical intervention after the GI Bleed although on questioning he was not sure what treatment there could have been and if that had involved a transfer that would have been an adverse indicator. His view was that any decision relating to Mr Packman should have been multi disciplinary and that does not seemed to have happened.

Notwithstanding he considers that Mr Packman died of natural causes and that there was effectively no change to the outcome.

Dr Wilcock gave evidence and after a brief history says that when Mr Packman becomes acutely unwell on 26th August 1999 it is likely that he suffered a significant gastro intestinal bleed. He is in no doubt that Mr Packman should have been transferred to the acute hospital but that did not happen. He was also concerned that the blood test results were not picked up and that could have produced significant results. Again he believes that the diamorphine and medazalam were excessive and if diamorphine was being given for a heart attack then it would not be

regular doses it would be a one or two off. He was concerned that the cause of the bleed had not been determined on admission Mr Packman was not terminally ill and the condition was probably controllable.

In response to Mr Jenkins he confirmed that Professor Black felt that the diamorphine was required but Dr Wilcok disagreed. He felt there should have been treatment for the underlying condition.

He accepted that discussions took place with Mrs Packman without the root cause of the problem being dealt with. Dr Reid then increases the diamorphine and Dr Wilcock could not ascertain why.

Mr Leper pointed out that the family had four concerns that there had been no assessment on the 26th August, there was a failure to act on the blood results, he was not transferred to the acute hospital and the diamorphine and medazalam seemed to be excessive. He confirmed that his condition was improving on transfer to Gosport but the signs of an internal bleed started on the 11th August 1999 and continue. Dr Barton did not feel that his transfer would have been in his interests and considered that his bleed may have been a one of and that the continuing tarry stools were a sign of the blood passing through the system.

Dr Wilcock was concerned that the significant blood test results were not received or acted upon despite the pathology laboratory trying to get the results through. Those results showed a haemoglobin level of 7.7 when it should have been 11+.

There seems to have been some problem with the diagnosis whether this was a GI Bleed or a myocardial infarction. He did query why Dr Barton did not put GI Bleed at the top of her working diagnosis but the fact of the matter is she took the view that this was a myocardial infarction.

Again he was concerned that a full assessment was not taken on 26th August because Mr Packman suffered an acute change of condition.

He considered a GI Bleed to be an emergency that on paper it was a treatable condition which could not have been treated at Driad Ward. He would therefore have transferred to QA. You may remember that Dr Barton took the view that she could not justify that transfer that Mr Packman was not well enough that she could not guarantee that he would not spend hours on a trolley she did not consider fit for surgery and her decision was therefore to make him comfortable.

Dr Wilcock felt that there should have been a discussion with a senior member of the medical team and that Dr Barton's decision should have been documented.

After her decision on 26th August Mr Packman was not going to recover.

The bleed continued and by 1st September 1999 he was certainly beyond the point of no return.

On 26th August 1999 he is given oramorph but then he is put on a driver with diamorphine going from 40 to 60 to 90mgs and medazalam from 20 to 80mgs. Again he was concerned that there was not justification for that in the notes.

If the medication was being given for pain that was not documented in the records.

In response to Mr Jenkins Dr Wilcock said that he was concerned that the decision not to transfer was not documented.

In response to a question from you Mr Wilcock did confirm that Mr Packman was very obese.