Version 4 of complete report June 04 2008 – Geoffrey Packman

SUMMARY OF CONCLUSIONS

Geoffrey PACKMAN
DOB: Code A
DOD: 03/09/1999

Mr Geoffrey Packman was a 67 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

However there were failings in the medical care provided to Geoffrey Packman and also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1 Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day.

2.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence).

3.1 Geoffrey Packman a sixty seven year old gentleman in 1999 was admitted as an emergency on the 6th August 1999 to Portsmouth Hospitals NHS Trust following an attendance at A&E (40,42).

3.2 Mr Packman had suffered from gross (morbid) obesity for many years, he had also had venous leg ulceration for at least five years (44), he was hypertensive and had a raised prostatic specific antigen, suggesting prostatic pathology. (8)

3.3 Following a fall at home he was completely immobile on the floor and two ambulance crews were needed to bring him to accident and emergency (42). He was currently receiving District Nursing three times a week for leg ulcer management (255). He had become increasingly immobile

complicated by the fact that his wife who lived with him and provided care was being investigated for breast cancer. The admission clerking showed that he not only had leg ulcers but he had marked cellulitis, was pyrexial and in atrial fibrillation. Cellulitis was both in his groin and the left lower limb (45). He was totally dependent needing all help (143) with a Barthel of 0 (163). His white cell count was significantly raised at 25.7 (48), his liver function tests were abnormal with an AST of 196 and his renal function was impaired with a urea of 14.9 and a creatinine of 173 (47). These had all been normal earlier in the year. He was treated with intravenous antibiotics (45) in a special bed (187).

3.4 He appeared to make some progress and on 9th August his cellulitis was settling (48). A Haemolytic Streptococcus sensitive to the penicillin he had been prescribed was identified (225). On 11th August the nursing cardex (134) stated that there appeared to have been a deterioration of his heel ulcers with a "large necrotic blister on the left heel". His haemoglobin on 12th August (211) was 13.5.

3.5 On 13th August white count was improved at 12.4 (50,52), his U's and E's were normal and the notes recorded a planned transfer to the Gosport War Memorial Hospital on 16th August.

3.6 Later on the 13th black bowel motion is noted but the doctor who examines him records a brown stool only. It is not clear whether he has had a gastro intestinal bleed (52). On 16th August no comment is made on the possible gastrointestinal (G.I) bleed, but on 20th August his haemoglobin is noted to be 12.9 (53) no further black stools have been reported so he is planned for transfer on 23rd August. Albumin at this stage is now reduced at 29 (190).

3.7 On 17th August sacral sores are now noted in the nursing cardex (118) which by the 20th are now recorded as "deep and malodorous" (125).

3.8 He is transferred to the Gosport War Memorial Hospital on 23rd August (54). A brief history and examination is undertaken which notes that there was a history of possible melaena, the clinical examination recorded suggests that he is stable. Blood tests are requested for the next day. The drug chart (168) suggests that his weight is 148 kgs but it is not clear if this is an estimate or a measurement. He is very dependent with a Barthel of 6 and a Waterlow score of 18, putting him in high risk. His haemoglobin on 24th is 12 (207). The nursing cardex on the 24th notes the multiple complex pressure sores on both the buttocks and the sacrum (96-100).

3.9 On 25th August the nursing cardex reports that he is passing blood rectally and also vomiting (62, 82).

3.10 On 26th August Dr Barton is asked to see him and records that he is clammy and unwell. (55) The notes suggest that he might have had a myocardial infarction and suggests treating him with Diamorphine and Oramorphine overnight. It records that as an alternative there might be a G.I. bleed but this is recorded as unlikely because he has not had haematemesis. It also notes that he is not well enough to transfer to an acute unit and he should be kept comfortable, including "I am happy for the nursing staff to confirm death". His Clexane (an anticoagulant given to prevent pulmonary embolus) is now stopped. The nursing cardex (62) on the same day records further deterioration throughout the day with pain in his throat and records a verbal request for Diamorphine. A full blood count is taken (this fact is not recorded in the notes) but the result is filed in the notes recording a haemoglobin markedly reduced at 7.7 (205). It also states "many attempts were made to phone Gosport War Memorial Hospital but no response from switchboard". These significant results are not commented on at any stage in the nursing or clinical notes.

3.11 On 27th August (63) the nursing notes record some improvement in the morning but discomfort in the afternoon especially with dressings. On 28th August both the medical (55) and the nursing records (63) are noted to be very poorly with no appetite. Opiates are to continue over the weekend. 29th August he is sleeping for long periods (63) and on 30th he is still in a very poor clinical condition but eating very small amounts of diet. He is re-catheterised the same day (55).

3.12 On 31st he is recorded as passing a large amount of blood rectally (83) and on the 1st September (55 and 64) he is reviewed by a consultant Dr Reid who notes that he is continuing to pass melaena stool, there are pressure sores across the buttocks and posterior aspects of both thighs, he is now significantly confused. Dr Reid records that he should be for TLC only and that his wife is now aware of the poor prognosis. Nursing notes (64) note that the dose of drugs in the syringe driver should be increased; the previous doses were not controlling his symptoms. The nursing notes of the 2nd September (62) record the fact the Diamorphine is again increased on the 2nd to 90mgs and on 3rd September he dies at 13.50 in the afternoon (55, 64).

3.13 Drug Chart review: There are two drug charts. Chart 1 (174-178) confirms his original admission to Portsmouth Hospital Trust in particular the appropriate use of the antibiotics, Penicillin, Flucloxacillin and the prescription of the anticoagulant Clexane. This goes from 6th August – 23rd August. Paracetamol is the only analgesic given in Portsmouth.

3.14 The second drug chart (168-172) goes from his admission to the Gosport War Memorial Hospital on 23rd August to his death on the 3rd September. The once only part of this drug chart on 26th August states Diamorphine IM 10 mgs verbal message given 18.00 hours. Then apparently two days later on 28th August, Diamorphine IM 10 mgs signed Dr Barton. This is never given, this may be a retrospective attempt to legitimise the prescription given verbally 2 days before.

3.15 On the 'as required' part of the drug chart only Gaviscon and Temazepam are written up. On the regular side of the drug chart Doxazosin, Frusemide, Clexane (until 25th August) Paracetamol, Magnesium, Metoclopramide and Loperamide are all written up. Though some of these drugs like the Magnesium appear to have been given in a "as required" fashion. Oramorphine (171) though written up regularly is never given. Diamorphine 40 – 200 mgs subcut in 24 hours is prescribed on the 26th (171) and appears to have been given as 40mgs on 30th, 31st, 1st changed to 60 mgs on 1st September and 90mgs on 2nd September. The drug chart is extremely confusing (171) as these prescriptions have not been properly put in the day and date boxes required, and the nursing staff appear to be putting two days of prescribing into a single day box. Midazolam 20 – 80 mgs subcut in 24 hours is written up and Midazolam is probably given 20 mgs on the 30th and 31th August, 40mgs on 1st September, changed to 60mgs on 1st September and given 80mgs on 2nd September.

3.16 On the next regular page of the drug chart (172) Oramorphine 10-20mgs 4 hourly is written up and is signed up to have been given for 4 doses daily on 27th, 28th and 29th August, with two further doses in the morning of the 30th August. I cannot tell from the drug chart whether 10mgs or 20mgs is actually given. Oramorphine is written up 20mgs at night and given on 26th, 27th, 28th and 29th August. Hyoscine is written up but never given, although it is prescribed as a regular prescription.

Drug	Date prescribed	Prescribed as	Prescriber	Given
Diamorphine	'verbal message'	10 mgs I/M start Once only part of drug chart	Dr Barton	26/08 1800
Diamorphine	28/08 (?)	10 mgs I/M start Once only part of drug chart	Dr Barton	Never given
Oramorphine	26/08	10 mgs 4 hourly oral Regular	Dr Barton	Never given Never crossed off
Oramorphine	26/08	10 mgs in 5 mls 10 - 20 mgs oral Regular	Dr Barton	27/08 4 doses 28/08 4 doses 29/08 3 doses 30/08 2 doses to 10am (Actual dose given never recorded)

Oramorphine	26/08	10 mgs in 5 mls 20 mgs nocte Regular	Dr Barton	26/08 2200 27/08 2200 28/08 2200 29/08 2200 Never crossed off
Diamorphine	26/08	40 – 200 mgs S/C in 24 hours Regular	Dr Barton	Not given until 30/08 30/08 1445 40 mgs 31/08 1545 40 mgs 01/09 1545 40 mgs changed to: 01/09 1915 60 mgs 02/09 1540 90 mgs
Midazolam	26/08	20 - 80 mgs S/C in 24 hours Regular	Dr Barton	Not given until 30/08 30/08 1445 20 mgs 31/08 1545 20 mgs 01/09 1545 40 mgs changed to: 01/09 1915 60 mgs 02/09 1540 80 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Geoffrey Packman. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Geoffrey Packman, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2 Mr Packman had a number of chronic diseases prior to his terminal admission. The most serious was his gross (morbid) obesity which led to severe immobility and non-healing leg ulcers.

4.3 He then develops an infection (cellulitis) of his leg ulcers which has spread to his groin causing his high white count, his pyrexia, then his total immobility requiring appropriate admission to the Portsmouth Hospitals NHS Trust. On admission he is recognised to be at high risk of pressure sore development and appears to have been put on a special bed. He is put "not for resuscitation" on the 11th August. This would have reflected the medical futility of trying to undertake resuscitation, but would have had no implication for any other medical treatment or decision.

4.4 He appears to make reasonable progress from the point of view of his cellulitis and is treated with appropriate antibiotics, however is noted to have developed buttock and sacral pressure sores by 17th August which are in a serious condition by 20th August.

4.5 In the meantime, a black stool is noted on 13th August and the question of whether this is melaena (blood leaking from the upper gastro-intestinal tract which turns black when passing through the gastro-intestinal tract) and whether he has a gastric or duodenal ulcer. Normally this would be investigated with an endoscopy. However this would be quite a major procedure on such a dependent gentleman. Although in retrospect it is easy to say that this was the first bleed, it would not have been clear at the time, the lack of further melaena and the fact that haemoglobin does not significantly fall over the next week, suggests that conservative management was appropriate. However, he is not put on any prophylactic anti-ulcer medication and his anticoagulant is continued. In retrospect both of these decisions may have contributed to his subsequent problems.

4.6 He is transferred to the Gosport War Memorial Hospital on 23rd August. The prognosis for a patient with gross obesity, who is catheterised, and who has recent deep and complex pressure sores is terrible. In my experience such patients often deteriorate despite the best efforts of staff and die in hospital. He is clerked on admission and appropriate investigations carried out including haemoglobin which is now 12. Although by itself this is a normal haemoglobin his level of haemoglobin has very slowly drifted down and again in retrospect suggests that he was starting to bleed slowly.

4.7 On 25th August the nursing staff note that he is passing blood rectally and he is vomiting, although the medical staff do not appear to have been asked to seem him, or if they do, no notes are written and no examination is undertaken. However on the 26th August he is seen when he is unwell, very cold and clammy. Dr Barton suggests the likeliest diagnosis is a myocardial infarction, although appropriately she does think of a gastro-intestinal bleed. No examination is recorded in the notes, nor are some simple and appropriate investigations undertaken (for example an ECG), to try and differentiate these two problems. However a blood count is sent to the laboratory and haemoglobin has now fallen to 7.7. Mr Packman has had a massive gastro-intestinal bleed, this is now a re-bleed and in itself would be a marker of significant risk of death. Proven re-bleed needing more than 4 units of blood would in a previously fit patient over 65 be an indication for an emergency operation. However as the laboratory cannot inform the hospital of this result, no-one would appear to have brought it to medical or nursing attention.

4.8 Despite this there is an important decision to be made on the 26th August. Whatever the cause, Dr Barton identifies that the patient is seriously ill and the acute problems whether a G.I. bleed or a myocardial infarction would not be appropriately managed in a community hospital.

Dr Barton makes the decision that the patient is too ill for transfer and should be managed symptomatically only at Gosport. In my view this is a complex and serious decision that should be discussed with the consultant in charge of the case as well as with the patient and their family if possible. I can find no evidence of such a discussion in the notes. It is my view however, that in view of his other problems it is within boundaries of a reasonable clinical decision to provide symptomatic care only at this stage. The chances of surviving any level of treatment, including intensive care unit and surgery were very small indeed.

4.9 Mr Packman deteriorates further in the evening and is prescribed a single dose of Diamorphine as a result of a verbal request. In paragraphs 5.13 – 5.16 I have identified significant failings in the way the drug chart has been used and written up. Controlled drugs are given on at least one occasion based on a verbal request and the prescription apparently written 2 days later. Regular drugs are written up and never given. The drug chart is used in a most irregular fashion and I do not believe that the standards of medical prescribing or nursing delivery meet the expectations of regulations on the prescription in the use of controlled drugs.

4.10 From the 26th August Mr Packman is slowly deteriorating and after a single dose of Diamorphine, then from the evening of 26th August, receives regular Oramorphine, then Diamorphine, and Midazolam until his death. Both Oramorphine and Diamorphine while specifically prescribed for pain are commonly used to manage the stress and restlessness of terminal illness. Diamorphine is compatible with Midazolam and in itself is particularly used to terminal restlessness, and can be mixed in the same syringe driver. It is very difficult to assess the actual starting dose of Oramorphine from the notes and he appears to receive either 60mg or 100mg in total on the 27th. Calculating the dose would be complicated in this case due to his the massive obesity which might well effect the oral dose required, together with his serious pressure sores which might have been extremely painful on being dressed. However, there is no documentation in the notes to justify the decision as to why opioid drugs are actually started, or the choice of starting dose, nor is any pain problem or assessment mentioned. Indeed it is not clear if the decision to start the syringe driver is a medical or nursing decision. This lack of documentation is poor medical practice.

He appears subsequently to have been started on 40mgs of Diamorphine in 24 hours together with 20mgs of Midazolam. The dose of s/c Diamorphine is usually given in a ratio of 1:2, so 30mg might have been the equivalent of the dose of 60mg of Oramorphine. However I can find no evidence in the notes that there were any significant side effects from

the Oramorphine or the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes.

4.11 He is reviewed by a consultant (Dr Reid) on 1st September where it has now become absolutely clear that it is a gastro-intestinal haemorrhage which is causing his death on top of his other problems. Dr Reid is happy with the management and later in the day the Diamorphine is increased as the previous dose is aparently no longer controlling his symptoms. However, the dose of Midazolam is increased from 20 mgs to 60 mgs over 28 hours between 30th August and the 1st September. It is not clear if this is a medical or nursing decision and no record is made in the notes. This is poor medical practice. Further increase of 50% in dosage occurs on 2nd September and he dies the following day.

4.12 In my view a death certificate should read:
1a Gastro-intestinal haemorrhage
2 Pressure sores and morbid obesity

The police report states that the cause of death on the death certificate was 'myocardial infarction'. If so this was inaccurate and misleading.

5. OPINION

5.1 Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

5.2 However there were failings in medical care provided to Geoffrey Packman, in particular:

- Gastro-intestinal haemorrhage is suspected in Portsmouth but although never disproven he is continued on an anticoagulant.
- The failure to have a medical assessment, or to record one if it happened, after a gastro-intestinal bleed is recorded by the nursing staff on 25th August.
- The failure of Dr Barton on the 26th August to undertake investigation to exclude the first diagnosis made (myocardial infarction) and the failure to review the investigation that was undertaken, the full blood count.
- The apparent failure of the Gosport War Memorial Hospital switchboard to answer calls.

- The failure to ask for senior medical opinion at the time of a complex and serious medical decision on the 26th August.
- The failure to document any reason for both starting regular opioid medication and possible high starting dose of Oramorphine on the 27th August.
- The failure to document any reason to start the syringe driver on the 30th August and whether that was a medical or nursing decision.
- The failure to record any need for the 300% increase in Midazolam dosages between 31st August and the evening of 1st September.
- Writing myocardial infarction not gastro-intestinal haemorrhage as the cause of death on the death certificate.

5.3 There are also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, in particular:

- The prescription of Diamorphine by verbal message.
- The regular prescription given for regular Oramorphine, which is never crossed out.
- The failure on 29th August to give a regular dose of Oramorphine, without explanation.
- The failure to give Diamorphine and Midazolam for the 26th, when written up as a regular prescription.
- The failure to cross off the regular dose of Oramorphine on the 30th August.
- The failure to record any of the actual doses of Oramorphine given between 27th and 30th August.
- The use of the regular side of the drug chart for variable doses of drugs given in the syringe driver, and the failure to rewrite prescriptions when changing doses.
- The failure to write dosages of controlled drugs in words and figures as well as the total to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.

3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____