https://www.gosportpanel.independent.gov.uk/panel-report/appendices/appendix-2/page-6/

Case Study – Elsie Devine

Summary of hospital admission

- In 1999, Elsie Devine was aged 88 and lived with her daughter and her family.
- On 9 October, she was admitted to Queen Alexandra Hospital. In the days before admission she had become confused and aggressive and had been found wandering.
- On 20 October, she was deemed to be *"suitable for a rehabilitation programme"* and fit for discharge.
- On 21 October, she was admitted to Gosport War Memorial Hospital for rehabilitation.
- On 15 November, she became restless and aggressive and on 18 November a locum staff psychiatrist from the Department of Elderly Mental Health assessed her and noted: *"This lady has deteriorated and has become much more restless and aggressive again. She's refusing medication and not eating well."*
- On 21 November 1999, Mrs Devine died on Dryad Ward at Gosport War Memorial Hospital at 20:30.

Background, care and treatment

In 1999, Mrs Devine was aged 88. She had one daughter and one son and lived with her daughter and her family. Mrs Devine had lost her husband 21 years earlier but had remained independent and self-caring, able to do her own cooking and cleaning. In January 1999, she started to experience some decline in her memory. Mrs Devine had a history of moderate chronic renal failure and in April the possibility of her having myeloma was considered.

Records confirm that Mrs Devine had an IgA lambda paraprotein, but no Bence-Jones proteins, and nephrotic syndrome. (Paraproteins and Bence-Jones proteins are found in multiple myeloma.) On 15 April, Dr Bob Logan, a consultant geriatrician, referred her to a haematologist to investigate whether she had myeloma. The referral letter stated: *"I would be very grateful for your help in managing this charming 87-year-old lady who is moderately frail, but is very bright mentally."*

A skeletal survey was carried out. Myeloma was not diagnosed but an IgA paraprotein was present.

On 20 July 1999, Mrs Devine was seen by Dr Lennon in Dr Stevens' outpatient clinic. Dr Stevens was a consultant renal physician. Dr Lennon recorded:

"She remains well on her current treatment with no new problems … her blood test show that her creatinine is slowly worsening and was 192 on the test sample taken. Her albumin is also low at 22. On examination she had oedema to above the knee plus a small sacral pad which may have been from waiting in the waiting room. JVP not raised, heart sounds normal, chest was clear. My impression is that she is stable and weight loss is probably secondary to increased fluid loss with her Frumil … there is no therapeutic intervention which we may undertake at this point."

On 7 September, Dr Stevens saw Mrs Devine in outpatients. She recorded:

"Problems: Chronic renal failure with small kidneys; nephrotic (syndrome); IgA lambda paraprotein. Mrs Devine's oedema is marked up to her knees. Unfortunately, she has no

record of her drugs with her so I was unable to change the dose of diuretics. I think her oedema would benefit from an increase. Blood pressure today was well controlled at 130/70 … Her creatinine is showing gradual rise and in July it was up to 192."

Mrs Devine's creatinine value was 203.

On 9 October, Mrs Devine was admitted to Queen Alexandra Hospital. In the days before admission she had become confused and aggressive and had been found wandering. The referral letter states: *"Confused for 2 days, aggressive and wandering. No history of SDAT [senile dementia of Alzheimer type]."* Mrs Devine was treated with antibiotics for a urinary tract infection (UTI) and was referred to the Mental Health Team.

On 15 October, Dr Taylor, a clinical assistant in old age psychiatry, saw Mrs Devine on the ward at Queen Alexandra Hospital and recorded:

"I understand that she was admitted on 9.10.99 with an episode of acute confusion. Her daughter says that she did not know who she was, did not know where she was, wandering and aggressive. On the ward apparently she remained acutely confused, trying to get out of windows and possibly hallucinating, although I understand that her behaviour has settled. She remains confused and disorientated but is no longer aggressive or difficult in her behaviour, and is now sleeping better … Up until January of this year [Mrs Devine] was able to look after herself, doing all her cooking and cleaning, but since January the family have noticed a decline in her memory. She has stopped being able to cook and has required somebody to look after her. This seems to have come on since her diagnosis with multiple myeloma back in January."

The letter noted that Mrs Devine's daughter was unable to continue to care for her mother at this time and continued:

"Past medical history:… Multiple myeloma and hyperthyroidism … There is no known psychiatric history. Current medication: Thyroxine 100mcg daily, Frusemide 80mgs daily, Amiloride 5mgs daily and Cefaclor 37.5mgs bd for presumed UTI, which was thought to be the reason for her coming in to hospital. The staff tell me that she is mobile, she is able to wash with prompting, she takes herself to the toilet and is independent in her self-care, but does tend to get lost around the ward and needs prompting. She is now sleeping well and settled during the day, but apparently is quite aggressive towards her daughter, and feels that her daughter has put her away. On examination of her mental state: She was in her nightie. She was very calm and co-operative and quite friendly. Her speech was normal in rate and form and [Mrs Devine] denied feeling unhappy. At the time of seeing her there was no evidence of delusions or hallucinations, but she did think her daughter was on holiday, and she had no idea where she was. She herself feels that she has no problems with her memory, but unfortunately she only scored 9/30 on an MMSE [mini mental state examination]. She is very deaf and may not have heard or understood a lot of what I was saying because of this. I am sure this lady has a diagnosis of dementia, how much this is related to her underlying myeloma I do not know, but the situation seems to be that she cannot return home, and would therefore recommend referring her to Social Services for Residential Care, and recommend that she needs 24-hour care with a Home that has experience in dealing with memory problems, but currently she does not need an EMI [elderly mentally infirm] Home, as her behaviour is settled. However, if her behaviour deteriorates whilst in hospital, let us know and we will consider transferring her to Mulberry for further assessment."

On the same day, Dr Taylor wrote to social services and expressed the view that Mrs Devine was *"suitable for experienced residential care"*.

On 18 October, a CT scan of Mrs Devine's brain was carried out. The scan report noted: *"Involutional and Ischaemic changes present."*

On 20 October, Mrs Devine was assessed by Dr Jayawardena, a consultant geriatrician on the ward at Queen Alexandra Hospital. He reported:

"I visited Mrs Devine, an 88 year old Lady, who suffers from moderate chronic renal failure and was admitted with a history of a urinary tract infection. She has recovered from the above problems. She is quite alert, can stand and rather unsteady on walking. I found her chest clear, no evidence of cardiac failure and I find her suitable for a rehabilitation programme. The patient requests to be transferred to Gosport War Memorial Hospital and I will make arrangements for this."

The transfer letter stated:

"… [patient] admitted with [inconclusive] confusion ?UTI. Originally was at times aggressive but this has resolved now she knows us better. Due to her CRF [chronic renal failure] we treated her for a UTI and apart from needing guidance and reassurance is self-caring. Her social circumstances have changed drastically and she needs temporary placement with you until a permanent place is [found]."

By this time, Mrs Devine had been diagnosed with dementia. However, her condition had improved, her behaviour was settled and she was ready for discharge from Queen Alexandra Hospital. At this stage she was described as alert and able to stand, although she was unsteady on her feet. Her chest was clear, there was no evidence of cardiac failure and she was deemed suitable for a rehabilitation programme. Although she was fit for discharge, Mrs Devine could not return home at this time because of an illness in the family. The hospital had arranged for her to be transferred to a care home but her daughter was very concerned about this placement and insisted that she be transferred to Gosport War Memorial Hospital.

On 21 October, Mrs Devine was transferred to Dryad Ward at Gosport War Memorial Hospital under the care of Dr Richard Ian Reid, pending her return home or discharge to an appropriate residential home. The admission record confirms her diagnosis to be chronic renal failure.

On admission, Mrs Devine was assessed by Dr Jane Barton, who noted:

"… transfer to Dryad Ward continuing care HPC [history of present condition] acute confusion admitted to Mulberry-QA-Dryad (Mulberry details not reviewed). PMH [past medical history] Dementia, Myeloma, Hypothyroidism. Bartel,- transfers with one, so far continent, needs some help with ADL. MMSE 9/30. Bartel - (8/30) Plan: - get to know, assess rehab. potential, probably for rest home in due course."

https://www.gosportpanel.independent.gov.uk/panel-report/appendices/appendix-2/page-7/

Panel comments – 1

- The Panel has not seen any document to confirm that Mrs Devine went to Mulberry Ward before being transferred to Dryad Ward.

The nursing notes record:

"… admitted this PM from F3 QAH. Was admitted due to increasing confusion and aggression. The aggression has now resolved. Still seems confused at times. Has [chronic renal failure] needs minimal assistance with ADLs. A very pleasant lady. Her appetite on the whole is not good and can be a little unsteady on her feet."

Dr Barton then prescribed morphine oral solution 2.5–5 ml (5–10 mg morphine) four hourly.

Panel comments – 2

- There are no medical records to confirm on what basis Dr Barton prescribed morphine oral solution.
- The Panel has not seen any record to confirm that this drug was clinically indicated at any time.

In relation to the morphine oral solution prescription, Dr Barton stated in a police interview in April 2006: *"I was concerned that a low dose of pain relieving medication should be available for [Mrs Devine] in case she experienced distress and discomfort and a Doctor was not available to write up a prescription for her."*

During the 2009 GMC Fitness to Practise (FtP) hearing, Dr Barton stated:

"At some time in the future, during her admission I imagine that she might suffer from pain from her chronic renal problem or pain and distress at the end stages of her dementia, and I wanted to have it there on the drug chart should we need it in the future. I was not anticipating using the drug at that time … We did use it in the confusion that we saw in end-stage dementia, because it was very difficult to find something to make somebody comfortable at that end of their life, even in terminal dementia … Confusion, mental distress, agitation, fear: all a spectrum of emotions with or without an element of psychological pain behind them, very difficult to distinguish, very difficult to treat, very difficult to look after. Sometimes these people deserved a small dose of opiate."

Panel comments – 3

- The Panel notes that Dr Barton did not record her rationale in the clinical notes at the time this decision was made.
- The Panel notes that Dr Barton did not prescribe simple analgesia.
- Dr Barton did not record the explanation for prescribing morphine oral solution she provided to the police in Mrs Devine's clinical notes at the time of her assessment.
- The Panel has not seen any record of administration of morphine oral solution.

On 25 October 1999, Dr Reid assessed Mrs Devine and noted that she was *"Mobile unaided, washes with supervision, dresses self, continent, mildly confused".*

On 1 November, Dr Reid assessed Mrs Devine again and noted that she was *"physically independent but needs supervision with washing and dressing, help with bathing. Continent. Quite confused and disorientated e.g. undressing during the day is unlikely to get much social support at home."* Dr Reid prescribed amiloride.

On 10 November, Mrs Devine was noted to be confused and wandering. The following day Dr Barton prescribed temazepam, trimethroprim and thioridazine.

In relation to the thioridazine, during the 2009 FtP hearing Dr Barton stated:

"… because we thought clinically she had a urinary tract infection at that time. Thioridazine is a major tranquiliser. The wandering around the ward became quite difficult to manage on an open geriatric ward quite invasive for the other patients and difficult for the staff and that was an attempt to keep her behaviour more in keeping with the rest of the ward. Not a chemical cosh in any way, but just to make her a bit less restless and agitated."

By 11 November, the plan was to arrange for Mrs Devine to visit her home twice weekly to see her family and to assess if she would function better in her own home.

By 15 November, when Dr Reid assessed her, Mrs Devine had become restless and aggressive. Dr Reid noted:

"… very aggressive at times, has needed thioridazine. On treatment for UTI; MSU sent, blood and protein in urine. Examined by Dr Reid: Pulse 100, regular. Temperature 36.4, JVP not raised, hepato-jugular reflex +ve. Heart sounds- nil added. Oedema +++ to thighs. Chest clear. Bowels regular- PR empty 13.11.99. but good bowel action since. (MSU* -no growth). Ask Dr Lusznat to see."

The nursing care plan records confirm that: between 21 October and 13 November Mrs Devine regularly opened her bowels; between 21 October and 20 November she slept well, except for 10 November when she wandered during the night, and 15 November when she got up to use the toilet and was *"disruptive before settling"* ; and between 21 October and 18 November she bathed and washed daily with assistance.

https://www.gosportpanel.independent.gov.uk/panel-report/appendices/appendix-2/page-8/

Panel comments – 4

- There are no bowel movement notes after 13 November.
- There are no personal hygiene notes after 18 November.

On 18 November, a locum staff psychiatrist from the Department of Elderly Mental Health assessed Mrs Devine and noted:

“This lady has deteriorated and has become much more restless and aggressive again. She’s refusing medication and not eating well. She does not seem to be depressed and her physical condition is stable. I'll arrange for her to go to Mulberry.”

Mrs Devine’s physical condition was noted to be stable and plans were made to transfer her to Mulberry Ward. Dr Barton prescribed a 25 microgram fentanyl patch every three days.

On the same day the staff psychiatrist also wrote, in a separate part of the medical records, that she had reviewed Mrs Devine on the ward. She recorded that Mrs Devine was *"happy, no complaints - waiting for her daughter, not obviously paranoid says tablets make her mouth sore."* The plan to transfer her to Mulberry Ward was not altered.

Panel comments – 5

- The Panel has not seen any record to confirm that fentanyl was clinically indicated.

In relation to the fentanyl prescription, Dr Barton stated during an interview with Hampshire Constabulary in November 2004:

“Having received the blood test results, it became apparent that transfer would not be appropriate, even if a bed did become available, and that her medical condition was deteriorating significantly, accompanied by marked restlessness and agitation. After discussion amongst the team who were concerned about her obvious discomfort, and given the fact she was refusing to take medication, I decided to commence a Fentanyl 25 mcg patch on the skin. This was in an attempt to calm her, to make her more comfortable, and to enable nursing care. [Mrs Devine] was not eating or drinking well by this stage. I did not feel that a subcutaneous infusion would be helpful at that point as she was likely simply to remove it.”

During the 2009 FtP hearing, Dr Barton stated:

“She was aggressive, wandering, moving other people's clothes, refusing medication, so anything that I was going to give her to make her more comfortable and peaceful would not be an oral agent because she would refuse it or spit it out. I was looking at a parenteral preparation to ease these symptoms. In my mind at that point she was becoming end-stage dementia which are the most difficult patients to look after and make comfortable because of all those things you talked about: What is the pain? Where is the pain? superimposed on her deteriorating renal function. So she had two major comorbidities, she was becoming very unwell, and I thought that a transdermal patch at that point in time was a kinder way of controlling her symptoms. Subcutaneous infusion would have been very difficult to administer in somebody who was that restless and aggressive … I think I probably would have gone for the [morphine oral solution] and carried on with a higher dose of the

thioridazine, but that was becoming impossible to give because she did not want to take the tablets."

In relation to the presence of pain, Dr Barton stated:

"Not physical pain but not happy, not comfortable, not easy to look after. Restless, wandering, climbing into other people's beds: not a picture of a lady who was at peace with herself, although there were no physical signs of pain."

Panel comments – 6

- The Panel notes that Dr Barton did not record the rationale provided to the police and the FtP hearing in the clinical notes at the time this decision was made.
- The Panel has not seen any record of Mrs Devine experiencing pain.
- The Panel has not seen any fluid charts in the medical records. In the case of a patient with renal failure, fluid management is essential.
- The Panel has not seen any record to confirm that there were adequate attempts to rehydrate Mrs Devine.
- The Panel found no document in the medical records to confirm Dr Barton's rationale for prescribing fentanyl. It is clear from later records that the fentanyl patch was administered; however, this is not recorded on the drug chart. The Panel observes that the use of fentanyl might have compounded the deterioration in Mrs Devine's mental state.

On 19 November, Dr Barton assessed Mrs Devine and noted that there had been:

"… [a] marked deterioration overnight, confused, aggressive. Creatinine 360. Fentanyl patch commenced yesterday; today further deterioration in general condition needs subcutaneous analgesia with midazolam. Son seen and aware of condition and diagnosis. Please make comfortable; I'm happy for nursing staff to confirm death."

Dr Barton prescribed a subcutaneous infusion of diamorphine 40–80 mg and midazolam 20–80 mg over 24 hours.

The nursing notes record:

"… marked deterioration over the last 24 hours. Extremely aggressive this am refusing all help from all staff. chlorpromazine 50mg given [intra muscularly] at 08.30. Taken two staff to special. Syringe driver commenced at 09.25 Diamorphine 40mg and Midazolam 40mg. Fentanyl Patch removed."

https://www.gosportpanel.independent.gov.uk/panel-report/appendices/appendix-2/page-9/

Panel comments – 7

- The Panel has not seen any record to confirm that diamorphine and midazolam were clinically indicated at this time. In addition, the Panel has not seen any document in the medical records to confirm the rationale for the high starting doses.

In relation to the diamorphine and midazolam prescription, Dr Barton stated in her police interview:

"… on the morning of 19th November I found [Mrs Devine] in an extremely aggressive state, hanging onto the bars in the main corridor of the ward. She was clearly very agitated, anxious, and distressed. She would not allow anyone to approach her or administer any of her usual medication; In due course we were able to administer 50mg of Chlorpromazine intramuscularly. This took some time to be effective, but in due course we were able to get her back into her own bed. This major tranquilliser had made her quite drowsy and we made the decision to discontinue the transdermal Fentanyl which I knew would have taken about 22 hours to reach steady state drug levels, and to opt instead for subcutaneous analgesia. As [Mrs Devine] had already received opiates in the form of the Fentanyl, and had been resistant to this to a degree, I prescribed 40mgs of Diamorphine, to be administered via syringe driver over 24 hours, together with 40mgs of Midazolam. This medication was prescribed at 9.25 a.m. (9:25) and was administered with the sole intention of relieving [Mrs Devine's] significant distress, anxiety and agitation, which were clearly very upsetting for her. I also prescribed Hyoscine to be given when required, to dry any chest secretions, but in fact it did not prove necessary to administer this. At this point it was clear that [Mrs Devine's] renal function had deteriorated markedly, superimposed on her dementia, and she was now dying. The Fentanyl patch was removed a little later."

During the 2009 FtP hearing, Dr Barton stated:

"[Mrs Devine] was halfway down the main corridor of the ward, hanging on to the bars and it was impossible for any of them to move her … [chlorpromazine was a] major tranquiliser, sedative. She was not safe standing there in the corridor. She needed to be in her bed, and it was going to take a major tranquiliser to peel her off the wall and get her into her own room … I suspected, her renal function had deteriorated quite quickly and quite markedly, and was probably contributing to the end stage dementia state that she was in. I did not think that it was related to the fentanyl. I thought that the fentanyl was not doing anything to make it better … [Although no active sign of pain] I wanted the midazolam. I needed the sedation and the anxiolytic properties of the midazolam in order to calm her down once the chlorpromazine wore off, and I was minded to continue an equivalent amount of diamorphine to replace the fentanyl dose that she had been having … I understood that the equivalence of the fentanyl was 90 mg of morphine in 24 hours, so using my conversion factor which was to halve it, the equivalent in diamorphine in 24 hours would be 40. I also knew that when you took the fentanyl patch off the level of fentanyl in the blood stream slowly reduced."

On 19 November, the 'Contact Records' found in the hospital records note: *"social services informed to close the case. Mulberry also informed."*

Panel comments – 8

- The Panel notes that Dr Barton did not record the rationale provided to the police and the FtP hearing in the clinical notes at the time she made the decision to prescribe diamorphine and midazolam.
- The Panel notes that Mrs Devine was an opioid-naïve patient with renal failure; however, she was commenced on a high dose of diamorphine.
- The Panel also notes that when diamorphine was administered, fentanyl would still have been pharmacologically active in Mrs Devine's system despite the patch having been removed.
- There are no clinical records to confirm on what basis Dr Barton prescribed diamorphine.
- There are no clinical records to confirm the rationale for the dose of diamorphine. There are no records to confirm that diamorphine was clinically indicated.

On 20 and 21 November, the syringe driver was recharged at 07:35 and 07:15 respectively. On 21 November, Mrs Devine died on Dryad Ward at Gosport War Memorial Hospital at 20:30.

https://www.gosportpanel.independent.gov.uk/panel-report/appendices/appendix-2/page-10/

Panel comments – 9

- The records confirm that Dr Logan referred Mrs Devine to a haematologist because he suspected that she might have myeloma. Although myeloma was not detected in the skeletal survey and was not diagnosed, this appears not to have been picked up by a number of clinicians, including the Mental Health Team who variously and wrongly referred to myeloma as part of Mrs Devine's medical history. During the FtP hearing in 2009, Dr Barton confirmed that *"the diagnosis was not, as it turned out, correct … I had taken it from the transfer letter … so it was not myeloma, it was a form of paraproteinemia".*
- The acute confusion which led to Mrs Devine's admission on 9 October, and its subsequent improvement, would be compatible with a diagnosis of delirium. The records indicate that Mrs Devine also had mild dementia.
- The Panel notes from the records that Mrs Devine was tested for a UTI and the result was reported as negative.
- The Panel notes that there are no records to indicate that at any stage when prescribing or administering morphine oral solution, fentanyl or diamorphine, Mrs Devine's severe renal impairment was considered.
- The Panel notes that Mrs Devine's renal function had deteriorated but had not been managed. The records do not contain any recent fluid balance chart or any urine output records.
- At the time of Mrs Devine's admission, guidance from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Royal College of Nursing (RCN) (see Bibliography) emphasised the requirement for nurses to work in an open and cooperative manner with patients and their families. In this regard, the Panel has seen no documents in the clinical records to confirm that nurses engaged in any adequate end of life care discussion with Mrs Devine's family.
- At the time of Mrs Devine's admission, accountability was an integral part of nursing practice. Nurses were accountable for their actions, and inactions, at all times. The relevant nursing professional codes of conduct and standards required nurses to scrutinise a prescription; question any ambiguity in the prescription; where they believed it necessary, refuse to administer a prescription; and report to an appropriate person or authority any circumstances which could jeopardise the standards of practice or any concern about health services within their employing Health Authority or Trust. The codes and guidance made it clear that to silently tolerate poor standards is to act in a manner contrary to the interests of patients or clients, and contrary to personal professional accountability. The Panel has not seen any document to confirm that nurses treating Mrs Devine challenged the proactive prescription of morphine oral solution, the prescription of fentanyl or the wide dose range in the prescription of diamorphine and midazolam. The Panel has not seen any document to show that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines to scrutinise the doses; nor did they question any of the consultants, doctors or the pharmacist at Gosport War Memorial Hospital in respect of the prescription and doses.
- The Panel notes that the relevant nursing codes of conduct and standards provided that, when administering or overseeing the administration of drugs, nurses should be able to justify and be accountable for any actions taken.
- The Panel has not seen any nursing document in the clinical records to show the reason or rationale for the decision to commence and continue the use of fentanyl, diamorphine and midazolam.

- The Panel has not seen any nursing document in the clinical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of fentanyl, diamorphine and midazolam.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on when to commence the administration of fentanyl, diamorphine and midazolam.
- At the time of Mrs Devine's admission, the UKCC guidance required nurses to carry out a comprehensive assessment of the patient's nursing requirements, and devise, implement and keep under review care plans. The UKCC guidance also required nurses to create and maintain medical records in order to provide accurate, current, comprehensive and concise information concerning the condition and care of the patient. Such records would include: details of observations, problems, evidence of care required, action taken, intervention by practitioners, patient responses, factors that appeared to affect the patient, the chronology of events, and reasons for any decision. These records would provide a baseline against which improvement or deterioration could be judged. Among other elements of care, *"Through their role in drug administration nurses are in an ideal position to monitor the drugs progress, reporting responses and side effects".* In this regard, the Panel found a lack of detail in Mrs Devine's daily nursing notes. The care plans seen by the Panel were scanty, were not personalised to the patient's needs and contained missing entries for entire days. For example, between 21 October and 20 November, the 'Sleep' care plan contained entries on ten days only. Between 21 October and 13 November, the 'Bowel Movement' care plan contained seven entries only. There was nothing that took account of Mrs Devine's cognitive impairment, capabilities, likes, dislikes and preferences. The Panel found no pain charts or pain management plans in Mrs Devine's clinical records. It is not clear to the Panel how Mrs Devine's anticipated pain and the effectiveness of any analgesia was to be adequately monitored. The Panel has found no document which confirms that any assessment of Mrs Devine's cognitive impairment was carried out or was the subject of a care plan.
- The Panel has not seen any fluid charts or nutrition plan among Mrs Devine's clinical records. Fluid and nutritional intake was an important part of the clinical picture. Fentanyl, diamorphine and midazolam could impair the ability to eat and drink.
- In addition to its intended effects, morphine might also have a number of side effects on a patient, including agitation and respiratory depression. The Panel has not seen any document in the clinical records to show that the nurses treating Mrs Devine understood or took into account these possible side effects of morphine when noting Mrs Devine's condition. In this regard, the relevant nursing codes of conduct and standards required nurses to take every reasonable opportunity to maintain and improve knowledge and competence, including understanding the substances used when treating a patient.

In a police statement dated November 2004, Dr Barton said:

"As you should be aware, following [Mrs Devine's] death, her care was considered carefully by an Independent Review Panel [IRP]. The [IRP] was assisted in its consideration by specialist clinical assessors, including an assessor who specialised in elderly medicine. The Panel's report contained the following observations 'The drugs given to Mrs Devine were not contradicted either by using in combinations stated or with her medical condition. On the morning of Friday 19th November 1999, [Mrs Devine] was wandering, agitated, acutely confused, disorientated and frightened. In a frail elderly person this is a very serious medical condition and may be as dangerous as a heart attack but it does not form part of the public perception of a serious or life threatening illness. For this reason she clearly required a large

dose of strong medication, as she was a danger to both herself and people around her. The fact that she was still responding to her daughter … by squeezing her hand at the sound of her voice, that day and the next day, suggested that the medications she was given was reasonable and was in the best interest of the patient to keep her comfortable. In conclusion the [IRP] found that the drugs, doses and devices used to make [Mrs Devine] comfortable on the 19 November were an appropriate and necessary response to an urgent medical situation' Given these findings I am at a loss to understand why you should consider there are any reasonable grounds whatsoever for suspecting that I might have committed any criminal offence."

In fact, after Mrs Devine's daughter had received the conclusions of the Independent Panel Review and remained dissatisfied, a member of the Independent Panel produced a further report, which contained the above conclusion. This was not the report of the entire Independent Panel.

Panel comments – 10

- This is an extraordinary conclusion, explicitly condoning the use of large doses of diamorphine simply to control symptoms of confusion and agitation, contrary to all relevant guidance.