STATEMENT OF DR JANE BARTON - RE: RUBY LAKE

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mrs Ruby Lake. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mrs Lake.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. I confirm that these comments are indeed a fair and accurate summary of the position in 1998 when I was involved in the care of Mrs Lake.

4. Ruby Lake was admitted to the Gosport War Memorial Hospital on 18th August 1998. She had previously been admitted to the Royal Hospital Haslar on the 5th August 1998 via Accident and Emergency after falling at home. She had fractured left neck of femur and had undergone left semi hemiarthroplasty.

5. Mrs Lake had been diagnosed as suffering with mild hypertension as early as 1980 and had gone on to develop arthritis and gout. In 1988 a chest x-ray had revealed cardiomegaly, an enlarged heart. She had also suffered with leg ulceration and liposclerosis with soft tissue calcification.

6. In September 1993 she was then admitted to the Queen Alexandra Hospital as an emergency suffering with chest pain, and it appears that those caring for her considered that she had left ventricular failure of the heart and that she had previously had a myocardial infarction.

7. Mrs Lake was then discharged from Hospital towards the end of September 1993, and after discharge was seen on 30th September by Consultant Geriatrician Dr Althea Lord. Dr Lord wrote to Mrs Lake's GP on the 30th September noting the diagnosis as left ventricular failure, controlled atrial fibrillation, aortic sclerosis, improving renal failure, and osteoarthrosis. She said that Mrs Lake had done well since discharge.

8. Mrs Lake returned to Dr Lord's clinic on the 4th November 1993. Dr Lord's senior registrar felt that on examination she was reasonably well but noted elevated blood pressure and that she remained in atrial fibrillation which was said to be controlled.

9. In August 1997 Mrs Lake was then referred by her General Practitioner to Dr Barrett, Consultant Dermatologist at the GWMH. The GP noted that Mrs Lake had had terrible ulcers on her legs in the past. She now had a recurrent lesion on her lower leg which the Practice Nurse had been trying to heal but without success. This had been getting bigger and her GP Dr North was concerned to see Dr Barrett's assessment and advice.

10. It seems that in due course Mrs Lake's condition improved. She was reviewed by Dr Barrett at his Dermatology Clinic on the 3rd January 1998, and he wrote to Mrs Lake's GP several days later indicating that her right leg was looking very much better, but said there was so much soft tissue calcification on the leg that there was likely to be further ulceration in the future.

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11. In March 1998 Mrs Lake was referred by her GP once more, to Consultant Rheumatologist Dr McCrae with further difficulties associated with her osteoarthritis. Dr McCrae's senior registrar reported to the GP that Mrs Lake had had joint pains affecting her shoulder and her knees intermittently for 20 years. These apparently continued to trouble her with difficulty standing and walking. Her main complaint at that point was apparently of lower left lumbar pain which had been worse since a fall at Christmas.

12. Following x-rays, Dr McCrae then saw Mrs Lake again on the 27th April 1998 on noting that there were quite marked degenerative changes in the lower lumbar facet joints. She planned to arrange physiotherapy.

13. In June 1988 Mrs Lake was then admitted to Sultan Ward at the GWMH with infected leg ulcers. It is not immediately clear to me when

she was then discharged, but her records show that on the 5th August she was then admitted to the Royal Hospital Haslar having fallen. A fractured left neck of femur was diagnosed, and as I have indicated an operation - a cemented hemiarthroplasty was then performed the same day. It appears that at some stage shortly after admission to hospital, Mrs Lake was given 2.5mgs of Diamorphine intravenously for pain relief.

14. Mrs Lake had something of a stormy post-operative course, in developing chest pain and pulmonary oedema, shortness of breath, diarrhoea and vomiting. By the 10th August she was suspected to have a chest infection and it was thought she might have suffered a myocardial infarction. She was also dehydrated.

15. On the 12th August the Registrar seems to have thought that Mrs Lake was much improved but she was developing sacral bed sores. The following day Dr Lord was asked to review her by Surgeon Captain Farquharson-Robert. His House Officer recorded in a note to Dr Lord in Mrs Lake's records that post-operative recovery had been slow with periods of confusion and pulmonary oedema, though she had been alert and well over the last two days. Dr Lord duly saw Mrs Lake the same day, noting in her records that she had a left bundle branch block and left ventricular failure, which was improving. The left bundle branch block would have resulted in the electrical pulses to the left side of the heart being interrupted. In addition, Dr Lord noted that Mrs Lake had sick sinus syndrome with atrial fibrillation. This meant that the heart was not transmitting electrical impulses properly and so was not beating efficiently - hence the reference to atrial fibrillation. Mrs Lake was said to be dehydrated but improving. She had bilateral buttock and leg ulcers and hypokalaemia - a low potassium level, together with

normochromic anaemia. Mrs Lake had been suffering with vomiting and diarrhoea.

16. Dr Lord suggested that Mrs Lake should have a potassium supplement in the form of slow K, given that she was on Digoxin, a cardiac glycoside which was being administered to reduce oedema in view of the left ventricular failure. Dr Lord also noted that Mrs Lake should be hydrated orally, and that stools should be sent for culture and sensitivity. She concluded her note by stating that it was difficult to know how much Mrs Lake would improve but that she would take her to an NHS continuing care bed at the GWMH the following week.

17. It was apparent from Dr Lord's note that she recognised that Mrs Lake might very well not recover, and I anticipate from those circumstances given her underlying condition, including heart failure, Mrs Lake might die.

18. Dr Lord then wrote to Surgeon Captain Farquharson-Roberts the following day recording her history and that the ECG showed atrial fibrillation and a variable interval indicating the sick sinus syndrome, with ischaemic heart disease and left ventricular failure also having been problems. She noted that Mrs Lake's appetite was poor and that she was eating and drinking small amounts. Dr Lord confirmed to Surgeon Captain Farquharson-Roberts that she was happy to arrange the transfer to the GWMH, uncertain as to whether there would be a significant improvement. She said that overall Mrs Lake was frail and quite unwell at present.

19. A Barthel assessment was conducted on the 15th August, giving a score of 9.

20. Following on from Dr Lord's assessment, Mrs Lake was then duly admitted to the GWMH on the 18th August 1998. It is apparent from her records that I admitted her, though I am unable now at this remove of time to recall anything about her. In any event, my note in her records on this occasion reads as follows:-

> "18-8-98 Transfer to Dryad Ward continuing care
> HPC # n o femur L 5-8-98
> PMH Angina
> CCF
> Catheterised
> transfers with 2
> needs some help c ADL
> Barthel 6
> Get to know
> gentle rehabilitation
> I am happy for nursing staff to confirm death"

21. As is apparent from my note the history of present complaint was the fracture of the neck of femur which had occurred on the 5th August. I also recorded the past medical history of angina and congestive cardiac failure, noting at this stage that Mrs Lake was catheterised, that she transferred with the assistance of two people, and needed help with activities of daily living. I noted a Barthel assessment of 6, though I anticipate that would have been related by others rather than being a reflection of my own assessment at that stage. Clearly Mrs Lake had a significant degree of dependence.

22. My note also indicates I hoped that gentle rehabilitation could take place, but I would have been aware that Mrs Lake was in a frail condition and quite unwell, as of course previously noted by Dr Lord. I was conscious that Mrs Lake might not recover hence my note that I was happy for nursing staff to confirm death. Mrs Lake had had the

trauma of a fractured neck of femur with a significant operation in consequence, she had heart failure, and had possibly experienced another myocardial infarction. She had also just undergone the stress of a hospital transfer at the advanced age of 84. My note was designed to ensure that the nursing staff were aware that it was not necessary to call a doctor to attend to certify if death occurred out of hours, as I indicated previously.

23. Having assessed Mrs Lake, I then prescribed various medications for her, specifically Digoxin administered to improve her cardiac output in view of the left ventricular failure, Slow K to maintain Potassium in view of her previous dehydration, Butemetamide a diuretic, again for her congestive cardiac failure, and Allopurinol for her gout. I also prescribed Temazepam as required to assist sleeping. All of these medications previously had been prescribed at the Royal Hospital Haslar.

24. In addition, I prescribed Oramorph for pain relief. I was concerned that Mrs Lake might very well require pain relief in view of the recent fracture and operation, and in consequence of the sacral and leg ulcers. The Oramorph was in a 10mg in 5 mls solution, and at a dose range of 2.5 to 5mls four hourly.

25. The records show that 5mgs of Oramorph was given at 2.15pm, and the nursing entry for that afternoon indicates that Mrs Lake seemed to have settled quite well and was fairly cheerful.

26. Mrs Lake was then noted to have settled and slept well from 10pm through to midnight, but she apparently awoke very distressed and anxious, saying that she needed someone with her. A further 10mgs of

Oramorph was given at 12.15am, but apparently with little effect, and Mrs Lake remained very anxious during the night and was confused at times. Temazepam was available for the nursing staff to administer, but they probably did not consider that appropriate, and preferred the Oramorph in view of the fact that she was suffering from anxiety and distress, for which the Oramorph would be appropriate.

27. Oramorph was also appropriate in view of Mrs Lake's history of congestive cardiac failure. Temazepam might have made Mrs Lake's heart failure worse, and it is conceivable at this stage Mrs Lake was experiencing further heart failure.

28. I would have reviewed Mrs Lake again the following morning, 19th August. I believe that I was chairing a Primary Care Group Steering group meeting at the GWMH starting at about 12.30pm, so I would have seen Mrs Lake, and all the other patients on the Dryad and Daedalus wards in advance of that.

29. I have not made a specific entry of this in Mrs Lake's medical records, and anticipate that I simply did not have an opportunity through excessive pressure of work, for the reasons previously stated. I anticipate I was concerned that Mrs Lake's condition had deteriorated from her already frail and poorly state in view of the transfer and the difficulty she had overnight. I believe I would have been concerned she might now be likely to die shortly, and was anxious that she should have appropriate relief from the pain of her fractured hip and sacral ulcers, and from her anxiety and distress which had been apparent overnight. Opiates provided for that purpose would also assist in relieving the pulmonary oedema from congestive cardiac failure.

30. Accordingly, I prescribed Diamorphine, 20 to 200mgs, Hyoscine 200 to 800mcgs and Midazolam 20 to 80mgs, all to be administered subcutaneously. It was of course my intention that these medications, if necessary, should be started at the bottom end of the dose range, but increase was available within this prescription if that proved necessary.

31. The nursing record shows that at 11.50am on 19th August Mrs Lake complained of chest pains. The nurse specifically noted that this was not radiating down the arm and was no worse on exertion. Mrs Lake's pulse was measured at 96 and she was noted to be grey around the mouth. Quite properly a further 10mgs of Oramorph were given. The nursing record also indicates that the doctor was notified, and my expectation is that I would have been informed of Mrs Lake's condition at about this time, and I would have been quite content that Oramorph should be given for the pain, though I have no recollection of events at this remove of time. There is no ECG available at the hospital, and it would have been difficult to say if Mrs Lake had experienced another myocardial infarction but I anticipate there was increasing cardiac failure.

32. Unfortunately, it seems that the Oramorph was not successful in relieving the pain over any prolonged period. A further nursing entry indicates that the pain was only relieved for a short period and Mrs Lake was said to be very anxious. Accordingly, the syringe driver was commenced with 20mgs of Diamorphine and 20mgs of Midazolam at 4pm that afternoon.

33. I do not know if I was informed of this at the time, but given the fact that Mrs Lake was still suffering with pain and was very anxious,

institution of the Diamorphine and Midazolam at these levels was in my view entirely appropriate. By this stage of course Mrs Lake had received quantities of Oramorph which sadly had not been sufficient.

34. It appears that in consequence, Mrs Lake had a comfortable night and did not suffer with distress and anxiety as she had the previous evening. The nursing entry records that she settled well, had a comfortable night and was drowsy but rousable the following morning.

35. Unfortunately it seems that Mrs Lake's condition was perceived to be deteriorating. The syringe driver was re-charged at 10.10am, on 20th August - and in addition to the 20mgs of Diamorphine and Midazolam, 400mcgs of Hyoscine was added. The Hyoscine would have assisted in reducing the pulmonary oedema and secretions consequent on Mrs Lake's heart failure. The nursing record also indicates that Mrs Lake's family were informed of her condition, with her daughter being present. Again, I anticipate I would have reviewed Mrs Lake that morning, but did not have an opportunity to note this in her records.

36. Over the course of the next night, Mrs Lake's condition apparently continued to deteriorate. The nurses recorded that she remained very bubbly, with suction being attempted, and it is likely that the Hyoscine had previously been administered in consequence of those secretions. Mrs Lake was apparently distressed when turned, and clearly in spite of the fact that Diamorphine and Midazolam were administered, they were not entirely successful in relieving Mrs Lake's distress.

37. In view of the continuing distress, it appears that the driver was re-charged at 7.35 - the following morning, this time with 60mgs of Diamorphine, 60mgs of Midazolam and 800mcgs of Hyoscine.

38. I believe I would have reviewed Mrs Lake's condition again that morning, though whether this was before or after the re-charging of the syringe driver I cannot say. It is possible that I was not informed of the increase at that point, but would have arrived very shortly afterwards and reviewed Mrs Lake, and would have been content that it was appropriate. Again I was probably unable to make an entry in her records for the reasons previously stated.

39. Unfortunately, as evidence by the nursing notes, Mrs Lake's condition continued to deteriorate. It is recorded that all care continued, and that her family were present all afternoon. Sadly she passed away at 6.25pm.

40. The Diamorphine, Midazolam and Hyoscine were prescribed, and in my view administered solely with the intention of relieving the pain, anxiety and stress which Mrs Lake was suffering, in conjunction with her congestive cardiac failure. At no time was any medication provided with the intention of hastening Mrs Lake's demise.

Signed in the presence of Dr Yates

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