Operation ROCHESTER .
Summary of expert evidence.
Ten cases of alleged negligence.
6th June 2006.

Overview.

Operation ROCHESTER is an investigation into 92 deaths of elderly Gosport War Memorial Hospital patients between 1988 and 2000.

It follows allegations initially made in 1998 that the death of patients was being hastened through the inappropriate and excessive administration of Diamorphine in many cases delivered by way of syringe driver.

Recent expert evidence raises further significant concerns in a small number of cases that the care afforded to patients was 'negligent' to a point that it contributed 'more than minimally' towards the death of the patient. These matters continue to be investigated as potential homicides.

Following police investigation in 2001/2 files of evidence were placed before the Crown Prosecution Service in respect of the death of five patients, Cunningham, Richards, Wilkie, Wilson and Page, the common denominator being that prior to death Diamorphine was prescribed by Dr Jane BARTON. CPS determined on 28th November 2002 that there was 'no reliable evidence that the named patients were unlawfully killed'.

The police investigation was resurrected in September 2002 following concerns raised by nursing staff around similar issues (the alleged excessive use of Diamorphine)

Subsequent enquiries revealed concerns raised by family members and healthcare professionals in respect of the standard of care afforded to 92 patients.

The patients medical case notes were recovered and reviewed by a team of medical experts (known as the key clinical team) in the fields of toxicology, general medicine, palliative care, geriatrics and nursing.

The cases were effectively 'categorised' as follows.

Category 1. (19 cases) No concerns. Optimal care delivered. The family members in respect of these cases have been informed that no further police action will be taken.

Category 2. (59 cases) 'Concerns' exist in that the medical team of experts assessed the care of these patients as 'sub optimal'. However, these cases have not been raised to the status of 'negligent', and as such it is highly unlikely that there will be any further police investigation into the particular circumstances. The family members have been informed of the category of the deceased and a summary of the care provided and attendant circumstances of death, by a legal/medico lawyer quality assuring the findings of the clinical team. Additionally the relevant category 2 case-file papers and medical notes have been forwarded to the GMC and Nursing and Midwifery counsel for their attention. Family members have been informed that these cases have been released from police investigation upon the basis that the criminal standard of proof could not be met.

Category 3. (14 cases) The medical team have assessed the care delivered in these cases as 'negligent.'

In four of the cat/3 cases however the death of the patients has been confirmed to be through 'natural causes'. These cases are shortly (June 2006) to be released from criminal investigation and forwarded to the GMC and NMC who no doubt will look to explore the potential 'negligence' issues.

There remain ten category 3 cases that have been assessed as 'negligent care' with the cause of death being 'unclear'. It is in these cases that a full police investigation has been conducted including the statementing of all relevant healthcare staff involved in the care of the patient prior to death, expert witness review of medical notes and geriatric and palliative care assessment, family group member statements, and interviews with healthcare staff under criminal caution.

It is anticipated that case-files in respect of all of these cases will have been passed to the CPS for their final consideration by 9th June 2006 or thereabouts (files have been submitted incrementally since December 2004).

This document provides an overview of these cases by summarising the initial findings of the multi-disciplinary team and the expert 'evidential' witnesses.

1. Arthur CUNNINGHAM.
    - Clinical team assessment - Negligent, medication possibly contributing towards cause of death bronchopneumonia.
    - Palliative expert - Appropriate levels of medication under the circumstances.
    - Geriatric expert - Appropriate management for terminal illness.

2. Elsie DEVINE.
    - Clinical team assessment - Negligent, cause of death unclear and use of opioids questionable.
    - Palliative expert - Doubt that patient had entered terminal phase, drugs excessive in any event. Recommends renal expert to assess whether terminal.

- Geriatric expert - Suggests irreversible kidney pathology. Drugs administered at a level higher than conventional guidance however terminally ill and appeared to receive good palliation for symptoms.
- Consultant Nephrologist - Worsening severe renal failure, possible to stabilise but prognosis death inevitable.

3. Sheila GREGORY.
   - Clinical team assessment - Negligent care, admitted for rehab for fractured neck of femur, no antibiotics given for chest infection.
   - Palliative expert - Natural decline into terminal phase dose of diamorphine unlikely to be excessive.
   - Geriatric expert - Admitted with a number of serious chronic diseases, satisfied death of natural causes.

4. Elsie LAVENDER.
   - Clinical team assessment - Suffered head injury or brain stem stroke, forms of analgesia other than diamorphine may have helped. A worrying five fold escalation when converting from morphine to diamorphine might have contributed towards death.
   - Palliative expert - Excessive doses of diamorphine and midazolam administered ultimately could have contributed more than minimally towards death. Reasonable doubt that patient had reached terminal phase and decline may have been reversible with appropriate treatment.
   - Geriatric expert - Failure to make proper assessment of multiple medical problems but likely to be entering terminal phase of life. Excessive doses of diamorphine and midazolam likely to cause respiratory depression. Cannot say beyond all reasonable doubt that life shortened.

5. Enid SPURGIN.
   - Clinical team assessment - Admitted following fractured hip, very high starting dose of diamorphine probably contributing towards death. No evidence of specialist consultation.
   - Palliative expert - Mrs SPURGIN not anticipated to be dying, doctors failed to adequately assess condition, symptoms in keeping with potentially reversible septicaemia/toxaemia. Exposed to inappropriate doses of diamorphine and midazolam that would have contributed more than minimally towards death.
   - Geriatric expert - Prognosis generally poor for fractures in the elderly. A number of areas of poor clinical practice in this case including lack of medical assessment, poor documentation and considering alternative analgesic regimes. High starting dose of diamorphine however unable to satisfy that death hastened by anything other than a short time (hours).
   - Orthopaedic expert - Suffered relatively complex hip fracture, significant bleed into thigh post operatively, of grave concern

that no further action can be identified in relation to a potentially serious and reversible diagnosis.

6. Robert WILSON.
   - Clinical team assessment - Admitted fracture left humerus, Code A Code A. Death presumably from an overdose of opiates in a man with poor opiate metabolism and reduced tolerance.
   - Palliative expert - Multiple Code A related problems, increases in diamorphine difficult to justify and likely to be excessive for needs, however difficult to state with certainty whether doses contributed more than minimally towards death.
   - Geriatric expert - Oramorphine dose not an appropriate clinical response to pain. Formed a major contribution toward clinical deterioration, the treatment negligent and more than minimally contributed towards the death of Mr WILSON.
   - Clinical governance expert - Mr WILSON suffered liver dysfunction and probably heart failure but the initiation of opiate medication an important factor leading to death. Might have left hospital alive had he not been commenced on opiate medication.
   - Gastroenterology expert - An unwell man whose life expectancy short but no attempt appears to have been made to justify the use of opiates in this 'at risk' patient group. Died of acute chronic (but reversible) liver failure precipitated by opiate medication.

7. Code A
   - Clinical team assessment - deteriorating physical and mental health, probably opiate toxic; cause of death unclear, opiates could have contributed.
   - Palliative expert - medical notes inadequate, pain not appropriately assessed, Opioids not appropriate to alleviate anxiety and agitation. Diamorphine excessive to need may have contributed more than minimally to death
   - Geriatric expert - Code A frail and dependent, at the end of chronic disease process of depression drug related side effects lasting 20 years. Starting dose of diamorphine 3 times greater than dose conventionally applied. Combination of drugs likely to have caused excessive sedation and may have shortened life by hours/days, but not beyond all reasonable doubt. Care sub-optimal but could not be proved negligent or criminally culpable.

8. Helena SERVICE.
   - Clinical team assessment – Old lady with many medical problems, diabetes, heart failure, confusion. Upon transfer was placed on sedation via syringe driver became less well and

diamorphine added, the need unclear and could have contributed towards her death.

- Palliative expert – Mrs SERVICE did not appear to be experiencing significant pain although opioids are used for breathlessness in end stage heart failure. Seek view of cardiologist. Not obviously in terminal stage, diamorphine dose excessive.
- Geriatric expert – Patient recorded as having long standing congestive heart failure. Cause of death multi-factorial. Drug doses higher than necessary and may have shortened life by hours, but not beyond all reasonable doubt.

9. Geoffrey PACKMAN.
    - Clinical team assessment – died of gastrointestinal bleed, not taken seriously and treated with opioids. Cause of death natural but potentially treatable and medical care terrible.
    - Gastroenterology expert – Limited medical assessment to bleed, managed by escalating doses of opiate analgesia. Transfer for endoscopic therapy should have been considered. Apparently no attempt to ascertain why patient had become so unwell.
    - Palliative expert – Transferred to dryad ward for rehabilitation. Inappropriate management of gastrointestinal haemorrhage together with exposure to unjustified and inappropriate doses of diamorphine and midazolam contributed more than minimally to death.
    - Geriatric expert – High risk patient, further bleed does not lead to medical attention, difficult clinical decision made without involvement of senior medical opinion, higher than conventional starting dose of diamorphine used without justification in notes. Despite the above deficiencies probably made little difference to outcome and died of natural causes.

10. Ruby LAKE
    - Palliative expert - Mrs Ruby Lake was a frail 84 year old who was admitted to hospital having fallen and fractured her left hip on 5th August 1998. This was surgically repaired and she had a difficult post-operative course due to events associated with her pre-existing heart and kidney problems, leading to heart failure, atrial fibrillation and renal impairment, along with a chest infection and episodic confusion/agitation at night. Apart from these episodes of pain, Mrs Lake appeared to be progressing rather than deteriorating whilst awaiting transfer to Gosport War Memorial Hospital and had begun to mobilise. Mrs LAKE not provided a good standard of care, poor notes make it difficult to understand her rapid deterioration. It is possible that her physical state had deteriorated in a temporary or reversible way and that with appropriate medical care she would have recovered. Reasonable doubt exists that she had entered her terminal

phase, and she was exposed to doses of midazolam and diamorphine that could have contributed more than minimally towards her death.

- Geriatric expert - Ruby Lake was an 84-year-old lady with a number of chronic diseases, she suffered a fall and a fractured neck of femur in August 1998. She was admitted to hospital and had operative treatment but developed post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorated and died in the Gosport War Memorial Hospital. The combination of a lack of a documented clinical examination, the lack of prescription of appropriate oral analgesia on admission to Gosport, the decision to start a syringe driver without documentation of a clinical diagnosis or the reason for it in the medical notes, together represent a negligent standard of medical care. It is impossible from the notes to determine the cause of death and a Coroner's Post Mortem should have been held. Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Mrs Lake's death. However the expert is unable to satisfy himself to the standard of beyond reasonable doubt that it made more than a minimal contribution.

Wider expert case summaries.

Clinical Team assessment.

1. Arthur CUNNINGHAM. 79. Died 26th September 1998 five days after admission to Gosport War Memorial Hospital, suffering Parkinson's disease, dementia, myelodysplasia, admitted from a nursing home with 'difficult behaviour'.

Admitted from day hospital with a large necrotic sacral sore which would have been painful but the reasons quoted for starting the diamorphine/midazolam infusion were related to behaviour.

No mention of pain on the 25th and 26th September but the dose of Diamorphine was increased on both days.

Cause of death was 'Bronchopneumonia' although the medication might have contributed to it. Several doctors involved in care and a rapid escalation of Diamorphine and high doses of Midazolam were administered.

Palliative expert - There appears little doubt that Mr Cunningham was 'naturally' coming to the end of his life. His death was in keeping with a progressive irreversible physical decline, documented over at least 10 days by different clinical teams, accompanied in his terminal phase by a bronchopneumonia. Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mr Cunningham a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge, illustrated, for example, by the reliance on large dose range of diamorphine by syringe driver

rather than a fixed dose along with the provision of smaller 'as required' doses that would allow Mr Cunningham's needs to guide the dose titration.

Dr Barton could also be seen as a doctor who breached the duty of care she owed to Mr Cunningham by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Cunningham by unnecessarily exposing him to potentially receiving excessive doses of diamorphine.

In the event, however, such large doses were not administered, and in the experts opinion, the use of diamorphine, midazolam and hyoscine in these doses could be seen as appropriate given Mr Cunningham's circumstances.

Geriatric expert - Mr Arthur Cunningham a 79 year-old gentleman, suffered from long-standing Parkinson's disease with multiple complications followed by a fairly rapid decline in health leading to his first admission to the Gosport War Memorial Hospital on 21st July, 1998 and a final admission 21st September, 1998.

He received terminal care including subcutaneous Diamorphine and Midazolam through a syringe driver and died on 26th September 1998. The expert opinion is:

Arthur Cunningham is an example of complex and challenging problems in geriatric medicine. He suffered from multiple chronic diseases and gradually deteriorated with increasing medical and physical dependency. It is always a challenge to clinicians to identify the point at which to stop trying to deal with each individual problem or crisis, to an acceptance that the patient is dying and that symptom control is appropriate.

Mr Cunningham was managed appropriately, including the decision to start a syringe driver for managing his symptoms and agitation as part of his terminal illness in September 1998.

The experts one concern is the increased dose of Diamorphine in the syringe driver on 25th and 26th September 1998. The expert was unable to find any justification for this increase in dosage in either the nursing or the medical notes. This increase in medication may have slightly shortened life for at most no more than a few hours to days. However the expert was not able to find evidence to satisfy that this is to the standard of 'beyond reasonable doubt'.

Clinical team assessment.

2. Elsie DEVINE. 88 died 21st November 1999 32 days after admission to Gosport War Memorial Hospital. She had suffered multi-infarct dementia, moderate/chronic renal failure and paraproteinaemia. She had been occasionally aggressive and restless being prescribed thioridazine for this.

When she became more agitated, she was started on fentanyl, and then converted to large doses of diamorphine and midazolam via a syringe driver. Pain was not raised as an issue. Cause of death (chronic renal failure) is not clear and the use of opiods questionable, especially when considering doses. An issue over whether or not she was dying before given Fentanyl which was inappropriately prescribed for sedation.

Palliative expert-

Mrs Devine was a frail 88yr old with significant medical problems.

A fentanyl transdermal patch was commenced for an unspecified reason. The following day Mrs DEVINE became more confused and agitated. An injection of chlorpromazine was given and a syringe driver started one hour later containing diamorphine and midazolam. She died 2 days later.

The medical care provided by Dr BARTON was sub optimal, there was a failure to keep clear accurate and contemporaneous patient records, there was an inadequate assessment of Mrs DEVINES condition, treatment's were prescribed that appeared excessive for her needs.

In particular the prescription of fentanyl and diamorphine appear unjustified and/or excessive for Mrs DEVINES needs.

The use of chlorpromazine and midazolam appears justifiable on the grounds of Mrs DEVINES confusion, but the doses used were excessive for her needs.

There is a reasonable doubt that she had definitely entered her terminal stage.

If it were that Mrs DEVINE had naturally entered the terminal phase of her life at best Dr BARTON could be seen as a doctor who whilst failing to keep clear accurate and contemporaneous patient records had in good faith been attempting to allow a peaceful death, albeit with what appears to be inappropriate and excessive use of medication due to a sufficient lack of knowledge.

At worst DR BARTON could be seen as a doctor who breached the duty of care she owed to Mrs DEVINE, by failing to provide treatment with a reasonable amount of skill and care.

This was to a degree that disregarded the safety of Mrs DEVINE by unnecessarily exposing her to inappropriate and excessive doses of medications as with the fentanyl which could have resulted in a worsening of her agitation and confusion.

Dr BARTON'S response to this was to further expose Mrs DEVINE to inappropriate and/or excessive doses of midazolam and diamorphine that could have contributed more than minimally negligibly or trivially to her death.

As a result Dr BARTON lays herself open to the accusation of gross negligence.

Mrs DEVINES death was not typical of patients dying from chronic renal failure.

Mrs DEVINE was incorrectly labelled as having 'myeloma' in the admission notes, this mistake is important if it influenced how the patient was managed eg deterioration could be incorrectly considered an 'expected' irreversible terminal event due to her cancer like condition.

It is difficult to endorse prescribing action morphine on the day of transfer that results in the use of an above average dose of a strong opioid as a first line analgesic in a frail elderly patient(against company prescribing advice). Medication was excessive even if it were considered she was dying of natural causes.

Increasing doses of opioids excessive to a patients needs are also associated with an increasing risk of delirium, nausea and vomiting and respiratory depression. Once unresponsive and not drinking Mrs DEVINES renal function would decline further.

In the absence of pain shortness of breath or cough in my view there is no justification for the use off diamorphine by syringe driver.

A starting dose of 5-10mg a day would have been more appropriate.

Geriatric expert-

This case presents as an example of the most complex and challenging problems in geriatric medicine.

Physicians including a renal physician and a haematologist all conclude that she suffered from a progressive problem with no easily treatable or remedial cause, the small kidneys shown on ultrasound usually suggest irreversible kidney pathology.

The mental health team describe increasing confusion and mental deterioration over the course of the year.

The major problem in deciding whether care is sub –optimal is the lack of documentation.

The drug management was sub-optimal, there was no apparent justification for the Diamorphine to be written up prn on admission to Gosport.

The logic for the prescription of Fentanyl is not explained.

There was a three hour overlap, between the prescription of the subcutaneous Diamorphine and Midazolam and the removal of the Fentanyl patch.

The starting doses of both Midazolam and Diamorphine were higher than conventional guidance, which may have shortened her life by a short period of time, this would have no more than hours to days (but she was also out of distress for the last 58hrs)

However she was terminally ill and appeared to receive good palliation of her symptoms.

It is not clear whether any advice was sought (by DR BARTON) from the consultant legally responsible for the care of this patient (DR REID) in respect of the administration of Fentanyl on 18th November 1999.

In my opinion on 19th November patient was terminally ill, on balance many clinicians would come to the same conclusion after a month in hospital.

In my view the death certificate would appropriately say acute renal failure, chronic glonerulonephritis, paraproteinemia and dementia.

The prediction of how long a terminally ill patient will live is virtually impossible, and even palliative experts show an enormous variation.

Whilst her care was sub-optimal I cannot prove it to be negligent or criminally culpable.

I am not able to say that the use of Fentanyl, Diamorphine and Midazolam were prescribed with the intention of deliberately shortening her life or had the definite effect of shortening her life in more than a minor fashion.

Expert Consultant Nephrologist-

Mrs DEVINE was admitted as an emergency to hospital with an acute confusional state for which no other cause other than multi-infarct dementia and severe renal impairment could be found.

After a period of stabilisation, her clinical condition worsened with severe renal failure and worsening agitation and restlessness.

Although it may have been possible to stabilise her condition with relatively simple measures, this would not have materially changed her prognosis as death was inevitable.

Clinical team assessment.

3. Sheila GREGORY. 91 died 22nd November 1999 81 days after admission to Gosport War Memorial Hospital, she had suffered a fractured neck of the femur and other medical problems. The original aim was rehabilitation, but there was an early entry about keeping her comfortable. There was a suggestion of a stroke early in her stay, at GWMH and she deteriorated. The decision was made to refer her to Nursing Home for care because she was unlikely to improve further. She then deteriorated with distress and breathlessness. The staff wondered about a chest infection but did not start antibiotics. Oromorph helped the distress and breathlessness, so she was started on a reasonably low dose of diamorphine through a syringe driver. Frusemide as a diuretic was given in case the breathlessness was due to fluid on the lungs. In the end the cause of death was not entirely clear (recorded as Bronchopneumonia) Should they have tried antibiotics or explained why they were not used? She probably would have died whatever was done from 15.11.1999.

Palliative expert - Mrs Gregory's decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of diamorphine the physical findings on the day of Mrs Gregory's death would suggest that the dose she was receiving was unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.

Geriatric expert - Sheila Gregory a 91 year old lady with a number of serious chronic diseases suffers a fall and fractured neck of femur in August 1999. She is admitted to the Haslar Hospital and making little rehabilitation progress, with a very poor prognosis she is transferred to the Gosport War Memorial Hospital.

There is some weakness in the documentation of her condition in particular on her admission to the Gosport War Memorial Hospital and on the 18th November when her definitive final clinical deterioration is documented. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patient's and any drugs or other treatment prescribed". The lack of clinical examination both on admission and more important Mrs Gregory care, deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above the expert is satisfied that Mrs Gregory's death was of natural causes and that her overall clinical management in Gosport was just adequate.

Clinical team assessment.

4. Elsie LAVENDER. 83. Died 6th March 1996, 14 days after admission to Gosport War Memorial Hospital, she had been suffering head injury or brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. It was possibly musculoskeletal pain from a fall downstairs. Other forms of analgesia such as anti-inflammatory drugs or hot/cold packs might have worked. The most worrying aspect is the large dose escalation when converting morphine to diamorphine via syringe driver (Five fold increase). The cause of death is unclear (cerebovascular accident) and the dose escalation might have contributed.

Palliative expert-

The medical notes were inadequate and the cause and treatment of Mrs LAVENDER'S urinary tract infection was not properly assessed/ treated.

The Morphine may have been inappropriate or excessive to the type of pain experienced and the possible role this played in her deterioration was not considered. Treatments were continued that may have aggravated her condition ie the diuretic.

Excessive doses of diamorphine/ midazolam were administered from 26th February 1996.

Blood tests of 27th February 1996 revealed low platelet count and deteriorating kidney function, not reflected in the notes and no action taken, not discussed with a consultant or specialist advice.

On 29th February 1996 no mention made of high blood sugar requiring high doses of insulin. No mention of pain in medical notes therefore inconsistent with nursing notes.

No pain assessment recorded against increase in morphine of 4th March 1996.

The reported deterioration mentioned in the notes of 5th March is not explained.

There is reasonable doubt that Mrs LAVENDER had reached her terminal phase. Causes of her decline may have been reversible with appropriate treatment.

Ultimately excessive doses of diamorphine and midazolam could have contributed more than minimally trivially or negligibly towards her death, Dr BARTON leaves herself open to the accusation of gross negligence.

Cause of death registered as cerebrovascular accident, validity difficult to comment upon but final deterioration does not seem typical of cerebrovascular accident, more likely immobility from fall leading to infection.

Geriatric expert-

Patient suffered long standing multiple medical problems, after admission found to be doubly incontinent, totally dependent, suffering constant pain to shoulders and arms and found to have serious abnormalities in various blood tests.

Increasing physical dependency and increased patient distress.

Doctors and consultants failed to make adequate medical assessment and diagnosis of her condition.

A belief that Mrs LAVENDER was misdiagnosed and had suffered a quadriplegia from a high cervical spinal cord injury secondary to her fall.

Abnormal blood tests could have represented systemic illness such as cancer of the bone marrow, the test should have been commented upon by the doctor in charge of the case as to their relevance.

The lack of examination and comment on abnormal blood tests make it impossible to assess the care as sub optimal, negligent or criminally culpable.

It was likely that Mrs LAVENDER had several serious illnesses and was entering the terminal phase of her life.

Mrs LAVENDER received a 'negligent' medical assessment both at Haslar and Gosport War Memorial Hospital, in particular she was not examined on admission to Gosport. No medical diagnosis made for pain, which would fit with spinal cord fracture. Without appropriate assessment impossible to plan appropriate management.

The two options were to either get further specialist opinion or provide palliative care it would have been wise to obtain specialist opinion, probably from the consultant in charge of the case. There is no evidence that this was done.

Unusually large dose of diamorphine written up on 26th February 1996, and subsequent excessive dose reported on 5th March 1996, together with high dose of Midazolam likely to cause excessive sedation and respiratory depression.

However this expert cannot say beyond all reasonable doubt that Mrs LAVENDERS life was shortened.

Clinical team assessment.

5. Enid SPURGIN.92. Died 12th April 1999 eighteen days after admission to Gosport War memorial hospital. She had suffered a fractured hip which had

been repaired with a dynamic hip screw. She could get from a bed to a chair with the help of 2 nurses before the transfer, and had paracetomal as required for pain relief.

Pain became an issue as soon as she arrived at Dryad. Analgesia was started with Oramorph regularly and then regular codydramol and then MST at low dose. The dose was increased after continued pain was noted. She had deteriorated on the day a syringe driver was started, but she is reported as denying pain. Diamorphine was started at 80mg per 24hrs via a syringe driver. This is a very high dose 5-6 fold increase. It is not clear who chose this dose but the way the drug was prescribed the nurses could have used a dose anywhere between 20 to 200 mg a day. It had to be reduced, because she was too drowsy and it probably contributed to her death. No evidence of consultation with appropriate specialist over the management of her operation wound infection. Rapid escalation of opiate dose. Poor drug prescription when diamorphine infusion was commenced, nurse could have set up anything from a dose of 20-200 mg per day and still been in compliance.

Palliative expert.

Mrs Spurgin was a relatively fit and independent 92 year old widow who lived alone. Whilst walking her dog, she fell and fractured her right hip which was surgically repaired using a dynamic hip screw on the 20th March 1999. Within hours of the surgery there was leakage from the wound and swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. Pain in Mrs Spurgin's hip/thigh on movement continued to be a problem noted by Dr Reid when he reviewed Mrs Spurgin on the 24th March 1999. Surgeon Commander Scott reviewed Mrs Spurgin but no specific comment was recorded in the medical notes regarding Mrs Spurgin's pain, no changes were made to her analgesia and on the 26th March 1999 she was transferred to Dryad Ward, Gosport War Memorial Hospital. With regards to the standard of care proffered to Mrs Spurgin in Haslar Hospital, the report of expert orthopaedic surgeon raises several concerns.

During her admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal: there was a lack of clear, accurate, and contemporaneous patient records; inadequate assessment of Mrs Spurgin's condition; a lack of consultation with colleagues to seek appropriate advice and support; the use of diamorphine and midazolam was in doses excessive to Mrs Spurgin's needs.

When Mrs Spurgin became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare there was no medical assessment or even simple observations documented.

Mrs Spurgin was not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/ toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites

due to dehydration. Potentially beneficial treatments (e.g. intravenous hydration, reduction in the dose of morphine, different antibiotics) were not proffered nor advice obtained from the orthopaedic team or a microbiologist.

Instead a syringe driver containing diamorphine (equivalent to a 4–6 fold increase in her morphine dose) and midazolam was commenced. On a subsequent review by Dr Reid, as a result of finding Mrs Spurgin unresponsive, the diamorphine dose was halved, however the midazolam dose was doubled.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to the use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Geriatric expert-

Mrs Enid Spurgin presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture.

The prognosis after such a fracture, particularly in those with impairments of daily living before their fracture is generally poor both in terms of mortality or morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and complications.

A significant problem in Mrs Spurgins case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, '(GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include – taking suitable and prompt action when necessary"..... "referring the patient to another practitioner, when indicated"..... "in providing care you must recognise and work within the limits of your professional competence"..... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

The expert comments that there are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport, the failure to address the cause of this lady's pain or to consider any other actions from 26th March until 7th April, the use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes.

Subsequent management of Mrs Spurgin's pain was within current practice with the exception of the starting dose of Diamorphine (80mg in the syringe drive is at best poor clinical judgement). However, the expert was unable to satisfy beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

Consultant Orthopaedic Surgeon-

Mrs Spurgin suffered a relatively complex hip fracture as a result of her fall on March 19th 1999. The decision to operate and the implants and operative technique employed were appropriate. The expert was unable to comment on the quality of the fixation of the fracture in the absence of radiographic record or post mortem findings.

The patient had a significant bleed into her thigh in the early stages post-operatively, and the possibility of compartment syndrome was raised. It is of grave concern that no further action can be identified in relation to this potentially serious and reversible diagnosis. Consequently, it is not possible to confirm that she had a compartment syndrome from the medical record.

Due consideration of the significance of her symptoms of pain and her inability to mobilise was not given consistently at either Haslar or at Gosport War Memorial Hospital. Specifically she did not undergo a further x-ray examination at either hospital, and she was not referred back to Haslar from Gosport War Memorial Hospital. The differential diagnosis should have included implant failure and uncontrolled infection. These complications would have been reversible.

Clinical team assessment.

6. Robert WILSON. 74. Died 18th October 1998 four days after admission to Gosport War memorial Hospital, he is recorded as having a high alcohol intake and poor nutritional status. He was admitted with a fracture of the left humerus.

During his last days on Dickens ward, he was on regular paracetomal and codeine as required needing one dose of codeine most days. On transfer to

dryad, he received 2 doses of oramorph and was then put on a moderate dose of oramorph every 4 hours with paracetomal as required. Liver and kidney problems make the body more sensitive to the effects of oramorph. He had both of these problems. He deteriorated, and was converted to a syringe driver at a dose, which was a close conversion from the oramorph dose.

Over the next 2 days the dose was increased without obvious indication. Death was presumably from overdose of opiates, in a man with a poor opiate metabolism, and reduced tolerance.

Unless the decision had been taken to treat pain 'regardless' then this was negligent. The initial dose of Morphine was inappropriate in a person with known alcoholic liver disease. A rapid increase in body weight was documented in notes, with no apparent clinical response.

Palliative expert –

Mr Wilson was a 74 year old man who was admitted to hospital after falling over and fracturing the greater tuberosity of his left humerus. He had multiple serious medical problems; alcohol-related cirrhosis leading to liver failure and encephalopathy, heart failure and kidney failure. Other problems included early dementia, depression and a high level of dependency.

Although the care he received at Queen Alexander Hospital led to Mr Wilson being mentally more alert and returned his kidney function to normal, he continued to become increasingly oedematous despite the re-introduction of his diuretic therapy which was considered due to heart failure. The pain he experienced from his fracture progressively improved as anticipated and during his time at Queen Alexander Hospital, his daily analgesic requirements reduced from the equivalent of 20mg to 3mg of oral morphine. Nevertheless, given the time it takes for a fracture to heal, it was not surprising that pain on movement was still present at the time of his transfer.

There are no concerns regarding the care proffered to Mr Wilson at the Queen Alexander Hospital.

On transfer to Dryad Ward, the care proffered to Mr Wilson by Dr Barton and Dr Knapman fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient (Dr Barton and Dr Knapman) and providing treatment that could be excessive to the patients needs (Dr Barton).

No pain assessment was carried out on Mr Wilson, but his only regular analgesic, paracetamol, was discontinued and prescribed p.r.n. (as required). Instead of his usual codeine 15–30mg p.r.n., approximately equivalent to morphine 1.5–3mg, he was prescribed morphine 5–10mg p.r.n. for pain relief. He received two doses of 10mg (a total of 20mg/24h) and the next day commenced on regular morphine 10mg every 4h and 20mg at night. In total he received 50mg of morphine in this 24h period, representing a larger dose

than that he received in the initial 24h after his fracture. This is against the general expectation that pain from a fracture would have been improving over time and, without a clearly documented pain assessment, it is difficult to justify. However, the impact of this dose of morphine on Mr Wilson is impossible to judge because he deteriorated rapidly in the early hours of the 16th October 1998.

The nature of his rapid decline and subsequent death were in keeping with worsening heart failure with or without a sudden event such as a heart attack. This, combined with his liver failure, could easily have precipitated his terminal decline. His reduced level of consciousness could have been due to a hepatic coma precipitated by the morphine or by a reduced level of blood oxygen secondary to the excess fluid on the lungs (pulmonary oedema) due to the heart failure. Later that day a syringe driver was commenced containing diamorphine 20mg/24h and increased over the next 48h to 60mg/24h, equivalent to oral morphine 120–180mg/24h. This increase in dose appears difficult to justify, as Mr Wilson was not reported to be distressed by pain, breathlessness or the secretions and was likely to be excessive for his needs. However, because heart and liver failure could also have led to a reduced level of consciousness, in my opinion, it is difficult to state with any certainty that the doses of morphine or diamorphine he received would have contributed more than minimally, negligibly or trivially to his death.

Geriatric expert-

Mr Robert Wilson a 74 year old gentleman with known severe alcoholic liver disease who was admitted with a complex and painful fracture of the left upper humerus. His physical condition deteriorates at first in hospital, with alteration in mental state, renal impairment and subsequent gross fluid retention. He then starts to improve and is transferred to the Gosport War Memorial Hospital for further assessment and possible rehabilitation or continuing care. He is started on regular oral strong opiate analgesia for pain in his left arm and rapidly deteriorates and dies within 5 days of admission.

There is weakness in the documentation of his condition, in particular on the admission to the Gosport War Memorial Hospital on 14th October, and on the15th October when the regular oral strong opiate analgesia is commenced. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must provide clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatments provided". The lack of clinical examination on admission and on the day of 15th October when the decision was made to start regular strong oral opiate analgesia represents poor clinical practice to the standards set by the General Medical Council.

It is the expert's belief that the prescription of a total of 50 mgs of Oramorphine on the 15th October following the 20 mgs that were given on the 14th October was not an appropriate clinical response to the pain in Mr Wilson's left arm.

This dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th-16th October, in particular, his rapid mental state deterioration. In the experts view this treatment was negligent, and more than minimally contributed to the death of Mr Robert Wilson on 19th October.

Clinical governance expert.

Studied the records provided by Hampshire Constabulary in order to consider three issues – the certified cause of death, the prescription of opiates and sedatives, and whether Mr Wilson fell into the category of patients who might have left hospital alive.

With respect to death certification the expert concluded that the certificate was inaccurate in that Mr Wilson did not have renal failure, and had liver dysfunction but not failure. He probably did have heart failure, although the expert believed the initiation of opiate medication was an important factor in leading to death.

With respect to the prescription of opiate drugs the expert concluded that on evidence available, that the initiation of opiate medication on transfer to Dryad ward was inappropriate. The expert also concluded that the starting dose was too high. The prescription of hyoscine and midazolam was justified by the use of opiates.

With respect to leaving hospital alive, it was concluded that Mr Wilson was in the category of patients who might have left hospital alive if he had not been commenced on opiate medicate on transfer to Dryad ward.

In the experts opinion, Mr Wilson had liver dysfunction but not full blown failure. His liver dysfunction did not cause death. In the presence of other life-threatening conditions, the liver dysfunction may impair the ability to recover, and it would have been reasonable to mention on the death certificate that Mr Wilson had chronic liver disease. The cause of his liver disease – alcohol – was not mentioned on the certificate.

Mr Wilson did not have renal failure. He did have abnormal blood test results after his admission to hospital, but these improved with re-hydration. Mr Wilson probably did have cardiac failure. There may have been other conditions as well. Haemoglobin estimations during his admission to Queen Alexandra Hospital had indicated mild anaemia. If this condition had deteriorated, the heart failure would also have become worse. However this was rather unlikely since he was being closely observed in Queen Alexandra Hospital and signs of increasing anaemia would almost certainly have been recognised. Evidence of bleeding would have been noted if it had occurred. There is no convincing evidence in the

records to confirm a diagnosis of myocardial infarction such as history of chest pain, raised cardiac enzymes or ECG evidence. One could also speculate about possible occurrence of some unsuspected condition.

However, despite all these speculations, it has to be acknowledged that his decline was associated with the regular administration of morphine, and was responded to by administration of diamorphine by syringe driver.

The reason for commencing Oramorph is not recorded in the medical notes [179]; in particular, the reasons for not using a non-opiate drug for pain relief are not given. Even if Mr Wilson did have pain from the fracture that was not controlled by paracetamol, regular does of 10mg of oral morphine would not have been the appropriate treatment. Other non-opiate or weak opiate medication should have been used first. If these medications had failed to adequately reduce the pain, a low dose of morphine (2.5-5mg) as had been used in the early days of his admission might have been reasonable. Although Mr Wilson did have congestive cardiac failure, therefore his death would have been hastened by opiate administration and the path to death may well have been initiated by the commencement of Oramorph on 14/10/98.

It is important to note that the general standard of completion of death certificates is unsatisfactory. For example, in a review of 1000 counterfoils of certificates in one teaching hospital in 1999-2000, only 55% of certificates had been completed to a minimally accepted standard (Swift and West, 2002). Of the remaining certificates, 25% had incomplete data, in 11% the part II section had been used inappropriately, and 9% were illogical or inappropriate. In her third report from the Shipman Inquiry, Dame Janet Smith observed: *A further problem with the current system is that the quality of certification is poor. Doctors receive little training in death certification.* (paragraph 17, page 4, Shipman Inquiry). The standard of completion of the death certificate in Mr Wilson's case should therefore be regarded as fairly typical. Although Mr Wilson did not have renal failure, the history of recent abnormal renal function tests prompted use of this diagnosis; the mention of liver failure was probably a convenient way of describing the impaired liver function.

Consultant Gastroenterologist.

The management of Mr Wilson's liver condition following the time of initial admission was not perfect but reasonable. He should have received Pabrenex to prevent *Wernickes'* encephalopathy in addition to lactulose to treat *hepatic* encephalopathy.

Mr Wilson was assessed by a psychogeriatrician who did not detect any of the classical signs of Wernickes' encephalopathy. During most of his admission as well Mr Wilson was generally alert and so the omission of lactulose or other anti-encephalopathy treatment cannot be cited as a major omission. In real-life I suspect Mr Wilson would have refused to take lactulose for presumed encephalopathy because of its taste and laxative effects.

Mr Wilson was clearly an un-well man whose life expectancy was short. His previous record demonstrates that he would have been likely to return to drinking on discharge from hospital. The administration of high doses of morphine whilst an in-patient on Dryad however must be considered reckless. Warnings about morphine usage in the context of liver disease are readily available in standard prescribing guides such as those cited from the BNF. No attempt appears to have been made to justify the use of opiates in this at risk patient group. There also does not appear to have been any attention paid to appropriate dose reduction and/or monitoring in Mr Wilson's case. The outcome was predictable in the clinical context of cirrhosis and escalating opiate dosage that Mr Wilson could not have survived.

Mr Wilsons cause of death is given as (1) Congestive Cardiac Failure (2) Renal failure and (3) Liver failure. The experts understanding was that this was a clinical diagnosis as opposed to a post-mortem finding.

Congestive cardiac failure was unlikely to be the primary cause of death in Mr Wilsons case. Mr Wilson had oedema and the *commonest* cause for oedema is as a consequence of heart failure. However oedema also occurs in cirrhotic liver disease and in the experts view this was far more likely cause of oedema and ultimate demise than heart failure.

Mr Wilson had Code A nd therefore cause of death (3) Code A was reasonable. Mr Wilson had signs of Code A throughout his hospital stay including oedema and probable hepatic encephalopathy. The experts view is that he died of *acute* Code A precipitated by opiate medication.

Code A

While there is limited evidence to support a diagnosis of Code A it is a common complication of Code A. Mr Wilson is likely to have had the 'hepatorenal syndrome.' This means reversible renal failure as a direct consequence of the liver failure. If the liver injury can in some way be reversed then the renal failure will correct.

Clinical Team assessment.

7 Code A 82. Died 24th January 1996, 15 days after admission to Gosport War Memorial Hospital. He was physically and mentally frail deteriorating on a mental health ward. Medical notes state pain in flexed right hand. Nursing notes state generalised pain. Arthrotec tried plus oramorph. A syringe driver started five days later with a large dose increase when converting from oramorph to diamorphine. Notes on the 21st January 1996 record a respiratory rate of 6 per minute, likely as a reflection of the dose of opiates ie he was probably opiate toxic but the dose was not reduced. Cause

of death unclear, although he was very frail, but opiates could have contributed.

Palliative expert.

Medical case-notes inadequate and pain not appropriately assessed. Opioids were not appropriate as administered to alleviate anxiety and agitation.

It was not necessary to use a syringe driver (unless the patient unwilling or unable to take medicines orally)

Doses of diamorphine 40-120mgs were excessive to needs of the patient (far exceeding appropriate starting dose of 10-15mgs.

There was little doubt that Code A was naturally coming to the end of his life.

At best DR BARTON had attempted to allow a peaceful death, albeit with excessive use of diamorphine.

Experts opinion was that Dr BARTON breached her duty of care, by failing to provide treatment with skill and care, it was difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs and may have contributed more than minimally negligibly or trivially to his death. Dr BARTON leaves herself open to the accusation of gross negligence.

Given the nature of Code A decline, Bronchopneumonia appears to be the most likely cause of death.

Geriatric expert.

Reports that Code A was extremely frail and dependent, and at the end of a chronic disease process of depression and drug related side effects spanning 20 or more years.

There was a problem in the expert assessing care due to lack of documentation.

The lack of notes represented poor clinical practice, no written justification for high doses of Diamorphine and Midazolam.

Drug management afforded to the patient was sub-optimal.

The starting dose of 80mgs of diamorphine was approximately 3 times the dose that would conventionally be applied.

A combination of higher than standard doses of drugs, Diamorphine, and Midazolam combined with Nozinan is likely to have caused excessive sedation and may have shortened life by a short period of time, hours to days. Whilst care was sub-optimal it could not be proved to be negligent or criminally culpable.

Predictions of how long terminally ill patients live are impossible, even palliative care experts show enormous variation.

Medication is likely to have shortened life but not beyond all reasonable doubt.

Clinical Team assessment.

8. Helena SERVICE. 99. Died 5th June 1997, two days after admission to Gosport War Memorial Hospital. This lady was very old, and had many medical problems including diabetes, heart failure, confusion and sore skin.

She was 'agitated' in the Queen Alexandra hospital but they accepted it and used thioridazine orally. Upon transfer to Gosport War Memorial Hospital, she was placed on sedation via a syringe driver at night. She became less well the next day and diamorphine was added to the driver (she had not required analgesia other than paracetomal at the Q.A.H). Mrs SERVICE died the following day.

Medication could have contributed towards her death, the need for such medication was not clear.

Palliative expert.

Mrs SERVICE did not appear to be experiencing significant pain although opioids are use for breathlessness in end stage heart failure.

The opinion of a cardiologist should be sought on Mrs Service's likely prognosis, scope for optimising her heart failure therapy and the role of opioids in chronic heart failure in 1997.

On Mrs Service's first night on Dryad ward she was commenced on a syringe driver containing midazolam in a dose sufficient to sedate an elderly patient. This in the experts opinion appeared to be an excessive reaction to what is a well recognised understandable response of a confused patient to new surroundings. Mrs Service was not obviously at her terminal stage but was elderly, hard of hearing, confused/prone to confusion, spending her first night in a new environment with new staff and her usual night sedation was not given.

Subsequently the increase in midazolam to 40mg and the addition of diamorphine 20mg over 24hrs are without justification in the medical and nursing notes.

Blood tests on 4th June 1997 show Mrs Service was dehydrated a reversible problem treated previously on F.1 ward (Queen Alexandra Hospital)

There is no comment in the notes about these results and why it was not felt appropriate to act on them. If it were considered that Mrs Service was actively dying then it would have been reasonable not to have re-hydrated her and the use of diamorphine and midazolam could be justified, albeit that the dose of diamorphine was excessive for her needs.

If it were that Mrs Service were not actively dying as the notes on her transfer to Dryad ward suggest then the failure to re-hydrate her together with the use of midazolam and diamorphine would have contributed more than minimally, negligibly or trivially to her death.

However, given that elderly frail patients with significant medical morbidity can deteriorate with little or sometimes no warning it could be argued that it would be difficult to ultimately distinguish which of the above was most likely without any doubt.

Geriatric expert.

Admitted to Queen Alexandra Hospital on 17th May 1997 at the age of 99 at the request of her GP to hospital with confusion, disorientation and progressive failure for the rest home to be able to cope with.

Diagnosed to have a combination of dehydration and left ventricular failure.

Recorded as having long standing congestive cardiac failure.

Transferred to Gosport War Memorial Hospital on 3rd June, confused, diabetes and heart failure.

The cause of death in the view of the expert was 'multi-factorial'. The dose of 20mg of diamorphine combined with the 40mg dose of midazolam was higher than necessary in this very elderly and frail lady's terminal care and the medication may have slightly shortened life although this opinion was not reach the standard of proof of beyond all reasonable doubt. The expert would have expected a difference (of survival) of at most no more than a few hours or days had a lower dose been used.

Clinical team member assessment (Geriatrician.)

9. Geoffrey PACKMAN. 67 years died 3rd September 1999 thirteen days after transfer to Gosport War Memorial hospital.

'I have more concerns with this case than the other members of the team. This man was treated for a myocardial infarction but died of a gastrointestinal bleed. I have been told that this was considered as the diagnosis in Queen Alexandra Hospital and the decision was made not to treat it. I have not found this and I believe they did not take this seriously in GWMH and treated him with opiates. I consider the cause of death to be natural (although potentially treatable) and the medical care terrible.

Quality assurance comment.

Mr PACKMAN was admitted to Gosport War Memorial Hospital in July 1999 with an irritating rash on his side and groin. It appears from the medical notes that he had an episode of black stools prior to being discharged from Portsmouth Hospitals NHS trust.

Following admission to Gosport War memorial Hospital on 23rd August 1999 Mr PACKMAN was noted as remaining very poorly with no appetite. It was noted in Mr PACKMANS nursing records that he was passing fresh blood per rectum on 25th August 1999.

On 26th August 1999 he complained of feeling unwell with indigestion pain in his throat together with nausea and vomiting.

At this point he was commenced on opiate medication. No active measures were taken to resuscitate Mr PACKMAN and following rapidly increasing doses of Diamorphine he died on 3rd September 1999.

There is a variation in the view taken of this case by the experts reviewing the notes. Concern is expressed by the geriatrician that although the death was natural the gastrointestinal bleed was potentially treatable.

An expert report from a gastrointestinal surgeon/physician is to be sought.

Expert Gastroentorologist.

Mr PACKMAN did not experience a significant life threatening gastrointestinal bleed while an in patient at Portsmouth Hospital. He developed a mild anemia of chronic disease secondary to his underlying medical problems during that part of his admission. His medical state was stable and there was no medical reasons to delay transfer to a 'step down' care facility from an acute hospital.

Mr PACKMAN is likely to have suffered a significant gastrointestinal bleed while an out patient at Gosport War Memorial Hospital (approx 3 days after transfer) Medical assessment at that time was limited and was managed with escalating doses of opiate analgesia before he died on 3rd September 1999.

His main problems recorded throughout his stay were obesity, leg oedema, cellulites, poor mobility, arthritis and pressure sores. His mental state was very good and he had no pain. Overall he doesn't look ill and it was mainly a nursing problem.

During the admission period at the previous hospital the only analgesia he received was paracetamol.

Following the passing of rectal blood a non urgent sigmoidoscopy examination would have been desirable to confirm haemorrhoids and exclude bowel cancer. Transfer for endoscopic therapy should have been considered.

There is no attempt apparently made to ascertain why Mr PACKMAN had become so acutely unwell.

Mr PACKMAN was obese. He would represent a high risk for surgery. It would be difficult to justify the potential mortality of elective surgery in a morbidly obese patient.

Palliative expert.

Mr Packman was a 67 year old man with obesity impairing his mobility, swelling of his legs and leg ulcers admitted to the Queen Alexander Hospital because of cellulitis (infection of the skin) affecting his left leg and groin. He also had pressure sores over his buttocks and thighs. He improved with treatment with antibiotics. He passed loose black stools, suggestive of melaena (blood in the stool) on a couple of occasions, but his haemoglobin was stable, excluding a significant gastrointestinal bleed. He was transferred to Dryad Ward for rehabilitation.

During his admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal; there was a lack of clear, accurate and contemporaneous patient records, inadequate assessment of Mr Packman's condition; a lack of consultation with colleagues and the use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs.

Mr Packman became acutely unwell on the 26th August 1999. A blood test revealed a large drop in his haemoglobin which made a significant gastrointestinal bleed likely. This is a serious and life-threatening medical emergency which requires urgent and appropriate medical care. The commonest underlying cause, a peptic ulcer, can however, be cured. Mr Packman should have been transferred without delay to the acute hospital. However, Mr Packman was not transferred; the blood test result was not obtained or acted upon and he went on to receive doses of diamorphine and midazolam which were not obviously justified and likely to have been excessive to his needs.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mr Packman by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Packman by failing to adequately assess his condition and taking suitable and prompt action when he became unwell with a gastrointestinal bleed. He was not appropriately assessed, resuscitated with

fluids, transferred or discussed with the on-call medical team. The use of regular morphine and subsequent use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs were inappropriate.

It is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Geriatric expert.

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 a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

There are a number of weaknesses in the clinical care provided to Mr Packman.

Gastro-intestinal haemorrhage is suspected in Portsmouth, but although never disproven he is continued on his anticoagulant.

Despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.

On assessment on 25th August 1999 a further bleed does not lead to medical attention.

On 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.

A difficult clinical decision is made without appropriate involvement of senior medical opinion.

Prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor. A higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is the experts opinion that Mr Packman died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

10. Ruby LAKE.

Palliative expert.

Mrs Ruby Lake was a frail 84 year old who was admitted to hospital having fallen and fractured her left hip on 5th August 1998. This was surgically repaired and she had a difficult post-operative course due to events associated with her pre-existing heart and kidney problems, leading to heart failure, atrial fibrillation and renal impairment, along with a chest infection and episodic confusion/agitation at night.

A combination of fluids, diuretics and antibiotics were required to support her through this period. At the time of Dr Lord's review, she summarised Mrs Lake as frail and quite unwell and was uncertain as to whether there would be significant improvement. Subsequent to Dr Lord's review, Mrs Lake experienced chest pains that appeared either related to her ischaemic heart disease or were musculoskeletal in origin, for which GTN (an anti-anginal treatment) or codeine/paracetamol were effective respectively.

Apart from these episodes of pain, Mrs Lake appeared to be progressing rather than deteriorating whilst awaiting transfer to Gosport War Memorial Hospital and had begun to mobilise. On the day prior to transfer, for a period of time, she was noted to appear confused and had a temperature. However, on the day of the transfer she was reported to be well, comfortable and happy with a normal temperature.

Infrequent entries in the medical notes during her stay on Dryad Ward make it difficult to closely follow Mrs Lake's progress over the last three days of her life. She apparently settled in well, but the next day complained of chest pain.

A syringe driver containing diamorphine and midazolam was commenced later that day. Mrs Lake became drowsy, her chest bubbly and the doses of drugs in the syringe driver were modified over the next two days to diamorphine 60mg, midazolam 60mg and hyoscine hydrobromide 800microgram/24h.

Mrs Lake was confirmed dead at 18.25h on the 21st August, the cause of death stated as bronchopneumonmia.

Dr Barton does not appear to have provided Mrs Lake a good standard of clinical care as defined by the GMC; Mrs Lake was not adequately medically assessed by Dr Barton at the time of her transfer or after her complaints of chest pain; there was no justification given for the prescription of morphine or the drugs administered in the syringe driver.
A lack of documentation makes it difficult to understand why Mrs Lake may have deteriorated in the rapid way that she did. A rapid deterioration often suggests an acute underlying medical cause. In this regard, a thorough medical assessment when she complained of chest pain (or indeed at the time of her transfer) may have identified possible contributing factors, such as a chest infection, that could have been appropriately treated. It is therefore

possible that her physical state had deteriorated in a temporary or reversible way and that with appropriate medical care she would have recovered.

If it were that Mrs Lake had naturally entered the terminal phase of her life, at best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mrs Lake a peaceful death, albeit with what appears to be an inappropriate use of medication due to a lack of sufficient knowledge. However, given the lack of medical and nursing records to the contrary, reasonable doubt exists that Mrs Lake had definitely entered her terminal stage.

Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lake by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lake by failing to adequately assess her physical state at the time of her transfer and when she complained of chest pain, failing to take suitable and prompt action when necessary and if her physical state had deteriorated in a temporary or reversible way exposing her to the inappropriate use of diamorphine and midazolam in doses that could have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton leaves herself open to the accusation of gross negligence.

Geriatric expert.

Ruby Lake was an 84-year-old lady with a number of chronic diseases, she suffered a fall and a fractured neck of femur in August 1998. She was admitted to hospital and had operative treatment but developed post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorated and died in the Gosport War Memorial Hospital.

Mrs Lake had a number of chronic diseases prior to her terminal admission following a fractured neck of femur. She had cardiac disease with known atrial fibrillation, aortic sclerosis and heart failure, documented in 1993. She also had not just osteoarthritis but an auto-immune arthritis that was thought variously to be either rheumatoid arthritis or variant auto-immune arthritis (the CREST syndrome). She also had problems as a result of her long-standing varicose swelling of her lower limbs, with many years of unresolved and very painful leg ulcers. Finally she had impaired renal function, developed mild acute renal failure when she was given on occasion, non-steroidal anti-inflammatory drugs.

When she is transferred to the Gosport War Memorial Hospital she is seen by Dr Barton who fails to record a clinical examination, apart from a statement regarding her functional status.

The continuation notes of Dr Barton then mention rehabilitation with a statement about being happy for the nursing staff to confirm death. There are no further medical notes at all and in view of the subsequent changing

clinical condition documented in the nursing cardex on 19th August and that the nurses contacted the doctor this is a poor standard of care. It also makes it very difficult to asses whether appropriate medical management was given to Mrs. Lake.

On admission the regular drugs being prescribed at Haslar were continued but the Paracetamol and Tramadol she had received in the Gosport War Memorial Hospital only a month before were not prescribed, nor was any other milder analgesia such as Paracetamol. The only analgesia written up was Oramorphine on the 'as required' part of the drug prescription. While it is probably appropriate for somebody who might have been having episodes of angina and left ventricular failure while in Gosport to have a Morphine drug available for nurses to give, it is very poor prescribing to write up no other form of analgesia, particularly if a doctor is not on site. The nursing staff could have no alternative but to go straight to a strong opioid analgesia.

On her first night she is documented as anxious and confused. This is then treated by giving a dose of Oramorphine despite there being no record in the medical or nursing cardex that it was pain causing this confusion. It should be noted this was probably no different from her evenings in Haslar which did not need any specific medication management. It is the experts view that this is poor nursing and medical care in the management of confusion in the evening.

On 19th August an event happened at 11.50 in the morning with the nursing notes recording that she had marked chest pain and was grey around her mouth. This could have been a heart attack, it could have been a pulmonary embolus, it could have been another episode of angina, it could simply have been some non-specific chest pain. No investigations are put in train to make a diagnosis, she does not appear to have been medically assessed, or if she was it was not recorded in the notes and would be poor medical practice. However, if the patient was seriously distressed, it would have been appropriate to have given the Oramorphine 10 mgs that was written up on the 'as required' side of the drug chart. The first aim would be to relieve distress while a diagnosis was made.

Later on 19th August a syringe driver is started containing Diamorphine 20 mgs and 20 mgs of Midazolam. The only justification for this is recorded in the nursing notes where it says pain is relieved for a short period. I am unable to find any records of observations, for example, pulse or blood pressure while the patient continues to have pain.

The syringe driver is continued the next day and Hyoscine is add and the dose of Diamorphine, Midazolam and Hyoscine all increase during the afternoon of the 20th and again when the syringe driver is replaced on 21st. Mrs Lake dies peacefully on 21st August.

Diamorphine is specifically prescribed for pain, is commonly used for pain in cardiac disease as well as in terminal care. Diamorphine is compatible

with Midazolam and can be mixed in the same syringe driver and is widely used subcutaneously as doses from 5 – 80 mgs per 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 20 mgs for the first 24 hours, which is within current guidance.

The original dose of Diamorphine appeared to be for continued chest pain. It is unusual to use continuous Diamorphine for chest pain without making a specific diagnosis. It is possible the patient had had a myocardial infarction and was now in cardiogenic shock. In that case it would be very reasonable to use a syringe driver and indeed to add Midazolam and Hyoscine over the subsequent 48 hours. This can only be supposition without adequate documentation.

It is impossible from the notes to determine the cause of death and a Coroner's Post Mortem should have been held.

The combination of a lack of a documented clinical examination, the lack of prescription of appropriate oral analgesia on admission to Gosport, the decision to start a syringe driver without documentation of a clinical diagnosis or the reason for it in the medical notes, together represent a negligent standard of medical care.

Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Mrs Lake's death. However the expert unable to satisfy himself to the standard of beyond reasonable doubt that it made more than a minimal contribution.

Summary prepared from medical evidence received to date.

Code A

D.M.Williams Det Supt
Senior Investigating Officer.
6th June 2006.