**OPERATION ROCHESTER**

**Re Geoffrey Packman**

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**Note**

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**Summary of the Facts**

*Overview*

1. On 3 September 1999, Geoffrey Packman, who was aged 67, died.

2. At the time of his death, Mr Packman was a patient on Dryad Ward at the Gosport War Memorial Hospital ('GWMH').

3. During his time on Dryad Ward he was under the care of Dr Reid, a consultant, but was treated on a day to day basis by Dr Barton.

4. Mr Packman had for a number of years suffered from various significant medical problems. He was obese, and had a five year history of swelling to his lower legs. This had recently got worse. Since 1985, he had suffered from high blood pressure. Recently, he had experienced difficulty mobilising.

5. On 6 August 1999, Mr Packman was admitted to the Queen Alexander Hospital ('QAH') following a fall at home. On examination he was found to have an irregular heart beat, swollen legs and swelling in the groin area. He was treated with intravenous antibiotics. His renal function was later found to be impaired. It

was clear that he was extremely poorly, and it was deemed appropriate that in the event of a cardiorespiratory arrest, he should not be resuscitated.

6. During his time at QAH Mr Packman's condition improved to some degree. On 23 August he was moved to GWMH for rehabilitation.

*GWMH*

7. On 26 August, Mr Packman was examined by Dr Barton. She suspected that he may have experienced myocardial infarction, or alternatively gastrointestinal bleeding. She prescribed diamorphine 10mg, and noted that nursing staff could confirm death. Diamorphine 10mg was administered at 6 p.m. At 7 p.m. Dr Barton prescribed oramorph 10-20mg every four hours, with 20mg at night. Mr Packman continued to receive this medication until 10 a.m. on 30 August.

8. At 2.45 p.m. on 30 August, a syringe driver was commenced, containing diamorphine 40mg and midazolam 20mg.

9. On 1 September, Dr Reid reviewed Mr Packman, and appeared content with the treatment being provided. At 3.45 p.m. the dose of midazolam was increased to 40mg. At 7.15 p.m. the doses were increased to diamorphine 60mg and midazolam 60mg.

10. On 2 September, the dose of diamorphine was increased to 90mg.

11. Mr Packman died at 1.50 p.m. on 3 September. The cause of death was recorded as 1a myocardial infarction, with and approximate interval between onset and death of five days.

**Summary of Expert Evidence**

*Dr Wilcock*

12. Dr Wilcock's opinion is that the treatment given to Mr Packman by Dr Barton and Dr Reid was sub-optimal. His conclusions may be summarised as follows:

    (1) Mr Packman's death was more in keeping with gastrointestinal haemorrhage than myocardial infarction;

    (2) A gastrointestinal haemorrhage is a medical emergency which can be treated. Mr Packman may have had a potentially and reversible medical condition, and he should have been transferred to an acute hospital setting;

    (3) Dr Barton should have ensured such a transfer, instead of forming the conclusion that Mr Packman was too poorly to be transferred;

    (4) The use of oramorph to treat either a gastrointestinal haemorrhage or myocardial infarction was inappropriate;

    (5) Furthermore, the doses of diamorphine administered via the syringe driver were excessive, and contributed more than minimally, negligibly or trivially to death;

    (6) In the circumstances, Dr Barton and Dr Reid leave themselves open to accusations of gross negligence.

*Dr Black*

13. Dr Black conclusions may be summarised as follows:

    (1) On 26 August, Dr Barton correctly identified that Mr Packman was seriously ill. There is no doubt that he suffered a massive gastrointestinal bleed;

    (2) In the case of a fit patient aged over 65, a gastrointestinal bleed could be treated by way of an emergency operation. In Mr Packman's case, the

chances of surviving an operation, or any level of treatment, were very small indeed. In fact, from this time, he was dying;

(3) Having identified that Mr Packman was seriously ill, and recognising that his condition (whether a gastrointestinal bleed or a myocardial infarction) could not be appropriately managed at GWMH, Dr Barton ought to have discussed matters with a more senior colleague before deciding he should be given palliative care on Dryad Ward;

(4) However, in view of Mr Packman's other problems, it is within the boundaries of a reasonable clinical decision to decide to provide only symptomatic care at this stage;

(5) It is difficult to assess the levels of oramorph or diamorphine. Although higher than might have been conventional at the start, they were required to control Mr Packman's symptoms and did not contribute in any significant fashion to his death;

(6) Mr Packman died of natural causes, and the deficiencies which have been identified probably made very little difference to the eventual outcome.

*Dr Marshall*

14. Dr Marshall's conclusions may be summarised as follows:

(1) Mr Packman was likely to have experienced a significant gastrointestinal bleed on 26 August;

(2) Mr Packman would have represented a high risk for surgery. If he had been transferred to an appropriate unit, the risks and limits of any treatment would have been explained to him and his family.

**Summary of Analysis**

15. The two areas of potential negligence on the part of Dr Barton are her decision not to transfer Mr Packman to an appropriate unit on 26 August, and thereafter her prescription of oramorph, diamorphine and midazolam thereafter.

    (1) In respect of her decision not to transfer Mr Packman, Dr Wilcock's view is that this was negligent. On the other hand, Dr Black's view was that it was within the range of reasonable clinical decisions. In my view, negligence could not be established;

    (2) In respect of the prescription of the above medication, Dr Wilcock's view is that it was unnecessary and excessive. On the other hand, Dr Black's view is that it was appropriate to provide palliative case, and the doses administered were appropriate in that regard. In my view, negligence could not be established.

16. In respect of causation, Dr Wilcock's view is that Mr Packman may have had a treatable condition, and that the medication administered contributed to death. On the other hand, Dr Black's view is that Mr Packman was dying prior to Dr Barton's decision not to transfer him, and that the medication administered did not contribute to death. In my view, causation could not be established.

LM

1 August 2006