From: Code A
Sent: 14 April 2008 12:52
To: Code A
Cc: Code A 'Tamsin Hall ffw (formerly Tomlinson)
Subject: RE: Meeting

Importance: High

Dear Mark,

As Sarah and Tamsin will be travelling from Manchester for this meeting, I would be grateful if you would acknowledge receipt of the email below.

With thanks
Code A

From: Code A
Sent: 03 Apr 2008 15:28
To: Code A
Cc:
Subject: Meeting

Dear Mark,

Further to our telephone conversation today thank you for confirming that Claire is able to attend the meeting to discuss the Gosport War Memorial Case on the 16th.

The details of the meeting are:

Date: 16 May 2008
Time; 9.30 to 11.30
Venue: GMC, Room 2.18, Second Floor, 350 Euston Road, Regents Place, London NW1 3JN

Please ask Claire to report to our ground floor reception when she arrives.

I will be attending the meeting as well as our Solicitors, Sarah Ellson and Tasmin Hall.

I would be grateful if you would let me know if anyone else from the NMC will accompany Claire.

Please acknowledge receipt of this email.

With kind regards
Code A

From: Hall, Tamsin Code A
Sent: 02 April 2008 17:37
To: Code A
Cc: Watson, Adele
Subject: Meeting with counsel next week / Black latest reports
Attachments: DOCS_7226650_1.DOC; DOCS_7209340_1.DOC

Hi Code A

Please find attached the draft reports on Stevens and Purnell I have received from Black.

I have arranged to meet with Ben and Tom next week to discuss these on a preliminary basis and sort out some more administrative details regarding witnesses. I was not anticipating that you attend as it is not a con as such - we think we will probably need to sit down later in the month with Professor Black and it would be useful for you to attend that. I want to meet with Ben face to face and pore over the witness evidence we have gathered to see if we can come up with a more definitive list of who we need to call. This should enable us to plan more effectively for the telecon later in April and be able to provide the defence with a more realistic time estimate.

I have now visited the Healthcare Commission - and they have sent me copies of their documents. It is currently being copied and will be sent out shortly.

I am now away on holiday until 9 April so please call Adele if you have any queries.

Regards

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
dd Code A

Mobile Code A

Consider the environment, think before you print!

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qualifications is available at its registered office, 35 Vine Street, London, EC3N 2AA.
We use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with equivalent standing and qualifications.

Jean STEVENS
DOB: Code A
Died: 22/05/1999

SUMMARY OF CONCLUSIONS

Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with severe left hemiplegia , probable myocardial infarction and continued myocardial ischemia.

She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

There is some evidence of poor medical practice in Haslar.

Documentation and management of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital.

The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient.

1. INSTRUCTIONS

To examine the medical records, and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

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

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

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence. For the three volumes: number / 1, number / 2 and number / 3)

3.1. Jean Stevens was a 72 year old lady at the time of her death in the Gosport War Memorial Hospital on 22 May 1999. She had a long past medical history including diverticular disease diagnosed in 1982 (24/1), appendisectomy in 1967, various arthritic pains, atrial fibrilation from 1994 (854/2), asthma needing inhalers and a gastric ulcer in 1994 (753/2).

3.2. However as a result of abdominal pain she undergoes a Sigmoid colectomy in 1995. This is complicated by what is eventually found to be an colo-vaginal fistula and she undergoes a further laparotomy (135-36/1) after which she is very ill and needs a period of time in the intensive care unit. However, she does eventually return home although continues to get chronic abdominal pain with normal investigations (113/1) including a normal CT (121/1) and is finally referred to the pain clinic for her chronic abdominal pain although she does not receive the appointment before her final admission to Hasler.

3.3. 26th April 1999 she is admitted acutely to Hasler Hospital through the A&E department for both the onset of a left hemiplegia together with constant chest pain (114-117/1). The medical notes document her stormy admission (174-205/1). On 28th April she has chest pain with both EGC and cardiac enzyme abnormalities (179/1) suggesting an acute myocardial infarction and is admitted to the coronary care unit. Subsequently she has probable aspiration pneumonia on 30th April (183/1) and possibly a further MI, certainly with more chest pain on 5th May (192/1).

3.4. Nursing notes confirm her serious condition. On 5th and 6th May she is agitated and distressed needing doses of Diamorphine. On 6th May she is seen by Dr Lord (194/1) who finds her extremely unwell and certainly not fit for rehabilitation or transfer to the Gosport War Memorial Hospital. She has more chest pain on 10th May (197/1) and the family are seen on 12th May and the poor prognosis is explained (200/1). On 12th May she is reviewed by Dr Tandy (67/1) who notes she has a dense flaccid hemiplegia and very dysarthric speech although she can obey simple commands. She is tolerating naso-gastric feeding but because of her recent chest pain was certainly not stable for transfer yet.

3.5. The nursing notes said that she was stressed and agitated on 15th May (95/1) and required subcutaneous Diamorphine, however, on 16th May (98/1) she slept well without it. On 17th May she is very demanding and continually disturbing other patients with calling out. On 18th May she has general aches and pains despite regular Co-codamol, although on 19th May (91/1) she is settled and slept all night. Her blood tests confirm her poor health with a very low albumin of 23 and a raised white cell count of 16 (201/1) on 13th May. She remains pyrexial on 17th May with crepitations at her left base and an albumin of 22 and a white cell count of 14 (203/1).

3.6. She is transferred after discussion with the Gosport War Memorial Hospital (GWMH). But the transfer letter written on the 19th (69/1)

fails to mention that she is receiving regular Co-dydramol, although it does state she is on Diamorphine 5 mgs subcutaneous PRN for pain.

3.7. The drug chart from Haslar appears on pages (71-72/1) and (550-560/2). She is written up for Diamorphine 2.5mg IV 4hourly PRN on the 1st May, changed to 5mg SC PRN from the 13th May and receives 12 doses in total between the 5th of May and the 16th May. She is also written up for Co-codamol 2 tablets QDS on the 26th April and receives regular doses until the 29th April. Co-dydramol is started on the 17th May and continues until the 19th. According to the drug chart no drugs of any sort are given on the morning of the 20th May, the day she is transferred.

3.8. The medical receiving notes on 20th May (20/3) comprise a brief summary starting with "transfer to Daedalus Ward 555K". It documents that she had a left dense hemiplegia, her past medical history and her current Barthel. Her examination is recorded. So there is no other medical note and the next note is a nursing note on 22nd May verifying death by a nurse. I do not understand the 555K note.

3.9. The nursing cardex records her transfer at 1340 on 20th May. It records her NG feeding and slurred speech but Mrs Stevens appeared quite alert and aware of her surroundings (26/3). A Barthel is recorded at 1 (32/3), a Waterlow of 25 (30/3) and an abbreviated mental test score of 4 out of 10 (33/3). The nursing contact sheet starts on 21st May (34/3) at 1130. It is possible that the contacts sheet for the 20th May is missing. This sheet records that "now on regular (4 hourly Oramorphine 10 mgs in 5 mls)". At 1800 she has been "uncomfortable despite 4 hourly Diamorphine. Husband seen and care discussed, very upset, agreed to commence syringe driver at an equivalent dose to Oramorphine with Midazolam, aware of poor outlook but anxious that medication given should not shorten her life. At 1945 commenced syringe driver". On 22nd May condition deteriorating, very bubbly, on Hyoscine 800 mgs added to 20 mgs of Diamorphine and 20 mgs Midazolam. With Hyoscine increased to 1600 is very bubbly at 1020 (35/3).

3.10. The handling profile (42/3) under the client risk factor 'pain' states "abdominal pain". The nursing care plan of 20th May (58/3) documents problems with the nasal gastric tube and the night care plan (60/3) states that on 20th May, Oramorphine 2.5 mls given as per cardex, complaining of pain in stomach and arm.

3.11. The drug chart has Oramorphine in 10 mgs in 5 mls, oral 5 mgs 4 hourly enough to start on 21st May, however, only two doses are given at 1000 and 1400 and the other doses are omitted. It also has

Oramorphine 10 mgs in 5 mls for 10 mls nocte to start on 21st May also written as a regular prescription but again this is never given. Oramorphine 10 mgs in 5 mls orally 2.5 – 5 mls 4 hourly as required is written up on 20th May, 5 mgs are given on 4 doses as documented in Table 1. Diamorphine 20 – 200 mgs S/C in 24 hours is written up on 20th May on the as required part of the drug chart and started at 1920 on 21st May, 0830 on 22nd May and restarted again with the increase of dose of Hyoscine at 1030 on 22nd May. Midazolam 20 – 80 mgs subcut in 24 hours in written up on 20th May as required and 20 mgs is started at 1920 on 21st May at 0800 on 22nd May and again restarted at 20 mgs at 1030 on 22nd May.

TABLE 1

Drug	Prescribed as	Prescriber	Given Doses
Diamorphine 2.5 mg IV PRN 01/05 changed to: 5mg SC PRN 13/05	As required	?	05/05 x1 06/05 x2 08/05 x2 09/05 x1 10/05 x1 12/05 x1 13/05 x1 15/05 x2 16/05 x1
Oramorphine 10 mgs in 5 mls For 10mls nocte to start 21/05	Regular	BARTON	Never given
Oramorphine 10 mgs in 5 mls Oral 5 mls 4 hourly to start 21/05	Regular	BARTON	21/05 1000 10mgs 21/5 1400 10mgs (other doses not given)
Oramorphine	As required	BARTON	20/05 1430 5 mgs

10 mgs in 5 mls Oral 2.5 – 5 mls 20/05 4 hourly	(PRN)		20/05 1830 5 mgs 20/05 2245 5 mgs 21/05 0735 5 mgs
Diamorphine 20 – 200 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 1920 20 mgs 22/05 0830 20 mgs 22/05 1030 20 mgs
Midazolam 20 – 80 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 1900 20 mgs 22/05 0800 20 mgs 22/05 1030 20 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Jean Stevens, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Stevens was 72 at the time of her final admission to the Gosport War Memorial Hospital although she had long standing cardiac and gastrointestinal problems and had been very seriously ill needing intensive care during 1995. She also had chronic unexplained abdominal pain and with recent negative investigations she had been referred to a chronic pain clinic for management.

4.3. However, her acute admission was with a severe and dense left sided stroke on 26th April. She had also had constant chest pain that day and when she had further chest pain on 28th April, it seems likely that she had a definite myocardial infarction simultaneously with her stroke. She then suffered from probable

aspiration pneumonia and was extremely ill for several days including having further chest pain.

4.4. Nursing and medical notes document that the family is seen and indeed the medical staff think that it is likely that she is going to die. Certainly she is restless and distressed and in my view probably clinically unstable certainly until 17th May as she still had abnormal signs in her chest, pyrexial and had a raised white count with a very low albumin. There is to be no doubt that her prognosis was extremely poor both from the likelihood of surviving or even getting significant improvement from her stroke.

4.5. During her admission to Hasler she is written up on the PRN side of the drug chart for 2.5 ms IV then 5 mgs SC PRN of Diamorphine. This would be a standard regime for people suffering myocardial infarction with recurrent cardiac pain. The drug is given on a number of occasions in Haslar sometimes for pain and sometimes for non-specific distress, judging from the nursing cardex. It would be perfectly appropriate to use this dose of Diamorphine if she was getting recurrent pain as it would not be possible to intervene in other ways because of her stroke. It seems likely that a clinical management decision (not recorded) was made on the 17th May to stop using Diamorphine and restart a regular oral analgesic, Co-dydramol, given via the NG tube. No further doses of Diamorphine are given in Haslar after 00.10 early on the morning of the 16th May.

4.6. She is seen on two occasions by Geriatricians, who both think she was unstable at that time and not yet suitable for transfer. I would strongly agree. Indeed there is then a further a discussion before it is agreed that she will go to the GWMH. In my view she was likely to be still unstable and it will have been clinically prudent to keep her for another week in Haslar. There can be no doubt that she is getting continued pain. She is written up for 6 hourly Co-dydramol which she received 4 times a day for the 2 days before her transfer to GWMH.

4.7. The drug chart appears to show poor prescribing practice at Haslar as the dose of Diamorphine is not written in words as well as figures nor is the total dose to be given written on the drug chart. There is no evidence she was given her regular medication, including oral analgesia, on the morning of her transfer and the Co-dydramol is not mentioned on the transfer letter.

4.8. There is a summary of the clinical problems functional status upon arrival at GWMH but it is not clear from the notes whether the

patient was examined, and if she was, the examination was not recorded. There is no medical assessment on whether or not she is pain, and if she is in pain why she is pain, nor of her clinical status upon arrival in particularly as she had been so ill recently. In my view this is poor clinical practice.

4.9. She is not written up for the Co-dydramol that she was on regularly at Haslar although it was not mentioned in the transfer letter. On the PRN part of the drug chart doses of Oramorphine are written up orally and a large range of Diamorphine and Midazolam is written up as required There is no documentation in the medical notes at Gosport War Memorial Hospital as to why these drugs were written up upon admission without apparently a clinical assessment of her pain or clinical status. Nor is there any explanation of why no other analgesics apart from strong opiates were prescribed. One note in the nursing cardex refers to abdominal pain which of course may have been the same pain that she had for many years prior to her admission. In general the Diamorphine she had received at Hasler had been for chest pain and further angina. There is no evidence in the medical or nursing cardex that she has any acute cardiac problems or angina in GWMH. In my view this management was poor clinical practice

4.10. She receives her first dose of Oramorphine at 1430, only 45 minutes after the nursing cardex records her arrival and then receives a further 3 doses until the morning of 21st. It is not clear whether it was a nursing or medical decision to actually give the Oramorphine.

4.11. On 21st May a decision is made that she is dying and she should be for symptom control with a syringe driver. Including the two doses given on the morning of 21st May she had received in total 40 mgs of Oramorphine in a 24 hour period. In these circumstances and assuming the patient was still distressed then it would be reasonable to start with 20 mgs of Diamorphine in a syringe driver over 24 hours. However, in my view it is unacceptable clinical practice to give the doses of Oramorphine in the first 24 hours after her arrival and start the syringe driver without making and recording a clinical assessment in the medical notes.

4.12. There are significant irregularities with the drug charts. Oramorphine has been written up on the regular side of the drug chart but not actually prescribed with no note to say why. A large range of Diamorphine is written up on the PRN part of the drug

chart before it is required and it is not written in words or figures nor is the total dose written.

4.13. Midazolam is a sedative which can be suitable for very restless patients and is usually given initially in a dose of 20 mgs in 24 hours although some people believe the dose should be much lower (5 – 20 mgs in older people, in particular the most frail). There is nothing in the notes to explain why it was thought that both Midazolam and Diamorphine were required in this patient. In my view the regular doses of Oramorphine and then the syringe driver together with the 20 mgs of Midazolam would have given a risk of over sedation for example causing respiratory depression in this lady who already had severe heart, lung and neurological disease.

5. OPINION

5.1. Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with a severe left hemiplegia, probable myocardial infarction and continued myocardial ischemia.

5.2. She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

5.3. There is some evidence of poor medical practice in Haslar. In particular:

- Use of the drug chart in Hasler with the failure to write controlled doses of drugs in word and figures as well as the total dosages to be given.
- The apparent failure to give her regular medication, including oral analgesia, on the morning of her transfer to the GWMH.
- The failure to document the regular Co-dydramol in the transfer letter.
- The early transfer of a patient who had been seriously ill and clinically unstable to the short period before transfer.

5.4. Documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital. In particular:

- Lack of a documented medical assessment on admission.
- Lack of any recorded assessment of her clinical condition and in particular her source of pain.

- Starting regular opioid analgesia within an hour of admission and a syringe driver within 24 hours of admission ,without any medical records of justification for either regular strong opioid analgesia or a syringe driver .
- The failure to prescribe any analgesia other than the strong opiate analgesia on admission to the GWMH.
- The lack of a written justification requiring both Diamorphine and Midazolam in the syringe driver.

5.5. The use of the drug chart in the Gosport War Memorial Hospital is also significantly in deficient. In particular:

- The failure to give regularly the drugs prescribed on the regular side of the drug chart without explanation in medical or nursing notes.
- Prescription of a large range of a controlled drug in the "as required" side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I

subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

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

Signature: ____ Date: ________________

Edna PURNELL
DOB: Code A
Died: 03/12/1998

SUMMARY OF CONCLUSIONS

Edna Purnell, a 91 year old lady with moderately severe dementing illness who suffered a fracture neck of femur which she never properly recovered medically or functionally and subsequently deteriorated and died in the Gosport War Memorial Hospital. The post mortem showed bronco pneumonia which is the common end point pathological process found at post mortem after prolonged debilitating illness.

It was appropriate to transfer her to the Gosport War Memorial Hospital where many aspects of her care and the approach to symptom management of someone who was terminally ill were appropriate.

There is some evidence of poor medical practice in the Gosport War Memorial Hospital

The use of the drug chart in the Gosport War Memorial Hospital is significantly deficient

1. INSTRUCTIONS

To examine the medical records, the statement of Code A and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

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

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

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

3.1. Edna Purnell was a 91 year old lady at the time of her death in the Gosport War Memorial Hospital on 3rd December 1998.

3.2. Her long standing problems included palpitations, anxiety, vaginal prolapse, herpes zoster, previous right Colles fracture, transient ischaemic episodes and cervical spondylosis (70). She was also noted to have aortic valve disease (118).

3.3. However, her main problem was a dementing illness. Possible early evidence in October 1995 (47) definite evidence by November 1995 (45). Subsequently seen by the psycho-geriatric team on a domiciliary visit in January 1996, a formal diagnosis of dementia of moderate severity is made (37) which is followed up by the psycho-geriatric team and it is clear by October 1997 that she is failing at home (31). Following a probable stroke in October 1997 (21) she moves to Addenbrookes Residential Home and the community psychiatric nurse notes her to be settled in May 1998 (14).

3.4. She is admitted to the Haslar Hospital on 25 October having had a fall and suffered a fractured right neck of femur (58). Unfortunately none of the Hasler notes were available in the medical records provided to me. The only information is her nursing discharge letter (58, 60) and part of her drug chart in the statement of Code A Code A The nursing letter states post operatively her condition was very poor and that she remained not for active resuscitation. It also states that she had suffered with senile dementia and required full assistance with washing, feeding although her oral intake had been reasonable with encouragement. Despite the best efforts she had sustained pressure sores on her heels. The letter states that "Mrs Purnell is a challenging patient and wish you every success in her care".

3.5. The drug charts in Haslar notes note that 10 mgs of Morphine were given intramuscularly on 26th October. They also note that Diclofenac was given orally on 30th and 31st October and that soluble Co-codamol (a weak oral opioid) was given up until 5th November. However, as I only have the as required prescription part of that drug chart I cannot comment on whether other oral analgesia was being given on a regular basis.

3.6. Dr Lord visits Mrs Purnell at Haslar on 5th November. The letter documents recent fracture, post operative oedema, poor mobility, faecal and urinary incontinence (with a catheter)and bilateral pressure sores. As a result of her assessment she states that the son and daughter-in-law were present and that she explained to them rehabilitation was going to be very difficult given the mental state and pressure sores, but she would be given a "gentle rehabilitation" in an NHS continuing care bed for a month initially. She might well need a nursing home subsequently.

3.7. On the 11th November she is transferred to Gosport War Memorial Hospital. A problem list is recorded in the medical notes (125) although it is not clear if she is medically examined. She is extremely dependent as documented in the nursing notes (161) and a Barthel of 2 out of 20 (185).

3.8. On the 12th November in the medical notes she " is in pain despite Co-codamol (unreadable word) Oramorphine". The nursing cardex confirms the pain (161) stating "has been complaining of great deal of pain". On 15th November there is an unreadable medical record stating that she is for Diazepam.

3.9. The nursing records document that Code A has concerns about possible opiate sedation on 14th and there was a discussion about her prognosis and the needs to control her pain. She continues to complain of pain on 15th November (160).

3.10. The nursing and medical notes are extremely detailed on 17th November following a visit to the ward by Code A who raises concerns about his mother's medical care which leads to a confrontational situation. Mrs Purnell is examined in detail by a Dr Brodie, who finds her semi-conscious with arms and legs flexed and appears in distress when moved. The doctor finds her in distress which need analgesia although her son is not happy for her to receive analgesia. The doctor appropriately discusses her with the consultant, Dr Lord who agrees the plan and for subcutaneous fluids. Another consultant is covering so comes in to assess the patient (Dr Reid) (126 – 127). Dr Reid is also quite clear having assessed her that she is in pain and distress and this must be relieved. He also reports some recent swallowing difficulties, however she continues to receive oral medication until the 22nd November.

3.11. On 18th November (127) she is less well and there is evidence of Cheyne-Stoking respiration and subcutaneous fluids needs to be continued. The assessment is that her prognosis is extremely poor. There appears to be considerable difficulty contacting the son. On 19th she remains poorly but on 20th she is recorded as being comfortable with Oramorphine.

3.12. On 23rd November she is groaning and in pain and frowns when lightly handled. She was taking liquids, Oramorphine and Diazepam the day before. The management plan is to continue sub-cut fluids where appropriate, to use Oramorphine/Diamorphine, Diazepam or Midazolam to keep comfortable and if more than one injection of Diamorphine is required for a syringe driver. The consultant's view is that she is now obviously dying and the management should continue to be to keep her free of pain and distress (140).

3.13. Further medical records confirm further deterioration on 28th November and the 1st December. The record on 28th stating that Mrs Purnell was now on sub-cut analgesia. Death is recorded on 3rd December by a RGN and the final note written subsequently on 18th December states the cause of death was bronchopneumonia and

senile dementia (139). This chronology is also confirmed in the nursing notes. The nursing notes states that on 24th November she was seen by Dr Barton (154) because her condition was deteriorating, she was distressed and reluctant with oral medication that the syringe driver should start. On 25th she continued to deteriorate and it occurred until 27th when her subcutaneous fluids were discontinued. The nursing notes continued to record her deterioration each day with the syringe driver being re-charged. The nursing notes say that Diamorphine was increased to 30 mgs on 1st December (165) although the drug chart says 40 mgs. On the 2nd December she is bubbly and 40 mgs a day of Diamorphine is recorded in the syringe driver. Death is verified at 1130 on 3rd December (166).

3.14. The Gosport War Memorial drug charts are slightly confusing in that there appear to be 3 front sheets (147, 148 and 149). It is possible that an extra front sheet was simply added to a previous drug chart as the space for the "as required" prescription drug box becomes full.

3.15. In summary, two tablets of Co-codamol are prescribed at 0830 on 12th November (which had been written up on admission) thereafter Oramorphine at 10 mgs and 5 mls at a dose of 2.5 – 5 mls is given starting on 12th November when three doses are given and then one or two doses most days until 24th November. There is no particular pattern for the timing of this although on 8 days there is a dose given late at night.

3.16. Diclofenac suppositories are written up on 17th November on a PRN basis but do not appear to be prescribed. Diamorphine is written up on a PRN basis SC/IM by Dr Lord on 23rd November but does not appear to have been prescribed. Diamorphine 20 – 200 mgs sub-cut in 24 hours, Hyoscine 200 – 800 micrograms sub-cut in 24 hours and Midazolam 20 – 80 mgs sub-cut in 24 hours are all written up on the PRN side of the drug chart on 19th November but do not appear to have been given. On the regular side of the drug chart Diamorphine 20 – 200 mgs sub-cut in 24 hours, Midazolam 20 – 80 mgs sub-cut in 24 hours and Hyoscine 200 – 800 micrograms sub-cut in 24 hours are all written up on 24th November. 20 mgs of Diamorphine is prescribed each day until 1st December when 40 mgs is prescribed until she dies. Midazolam 20 mgs is prescribed on 24th November and then 40 mgs each day until the day she dies. Hyoscine 200 micro grams is given on 2nd December and 400 on 3rd December.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Co-codamol 1 – 2	11/11	As required (PRN)	?	12/11 0830
Oramorphine 10 mgs in 5 mls Oral 2.5 – 5 mls	12/11	As required (PRN)	AK	*12/11 1405 5 mgs 1830 5 mgs 2234 10 mgs *13/11 1025 10 mgs 2225 10 mgs 14/11 1030 10 mgs *15/11 0050 10 mgs *16/11 2215 10 mgs *18/11 0105 10 mgs 2015 10 mgs *19/11 2316 10 mgs 20/11 1155 10 mgs 1800 5 mgs *21/11 2315 10 mgs *22/11 0630 10 mgs 2240 10 mgs 24/11 0920 10 mgs ** = Late evening dose on that date*
Diamorphine SC/IM 2.5 mgs – 5 mgs	23/11	As required (PRN)	LORD	-----
Diamorphine	19/11	As required	BARTON	-----

20 – 200 mgs SC in 24 hours		(PRN)		
Midazolam 20 – 80 mgs SC in 24 hours	19/11	As required (PRN)	BARTON	-----
Diamorphine 20 – 200 mgs SC in 24 hours	24/11	Regular	BARTON	24 – 30 Nov 20 mgs daily 1 – 3 Dec 40 mgs daily
Midazolam	24/11	Regular	BARTON	24 Nov 20 mgs daily 25 Nov – 3 Dec 40 mgs daily

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Edna Purnell, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Edna Purnell was a very elderly lady with multiple medical problems although moderately severe dementia was the main functional problem leading to residential care. There is debate in the notes whether this was Alzheimer's or vascular dementia, indeed it is not uncommon for elderly people to have both.

4.3. She was admitted to the Haslar Hospital having had a fall and a fractured neck of femur on 25th October. She was already known to have osteoporosis having previously had a Colles fracture. Unfortunately the prognosis of patients with dementia and a fractured neck of femur is extremely poor, very few return to their previous functional state and an in-hospital mortality rate at 25% is not uncommon. Those that remain immobile and incontinent immediately after the operation have by far the highest mobility

and mortality. Although the notes from Haslar are missing, the nursing summary documents that she remains totally dependent, develops bed sores and is seen as “a very challenging problem”. Her dependency is also confirmed by the Barthel of 2 recorded upon admission to the Gosport War Memorial Hospital (GWMH).

4.4. She is thoroughly assessed by Dr Lord in Haslar who also sees the relatives at that time. The letter makes it clear that rehabilitation was going to be very difficult and Dr Lord expects her to remain severely dependent. She has already indicated at this early stage the likelihood of a nursing home placement. Dr Lord does not expect the patient to improve but is giving the family time to come terms with her changed status.

4.5. On admission to GWMH her problems are assessed but it is not clear whether she is medically examined. If she is not I would regard this as poor practice as it fails to give an accurate base line in the notes for future management of her medical problems.

4.6. It is then clearly document in both the medical and nursing notes that she is in considerable pain on 12th November despite the appropriate use of oral co-codamol. There is no medical examination recorded in the notes or any explanation as to where this pain is coming from. If the (incomplete) medical cardex from Haslar is correct she has not received analgesia for 6 days so what has changed? Is the pain coming from her pressure sores, which is very likely, has some other medical condition occurred, for example dislocating her hip during the transfer or some other post-operative complication? Failure to adequately examine the patient to explain her symptoms is poor medical practice. The use of oral strong opioid analgesia after weak opioid analgesia has failed is perfectly appropriate and the doses used are well within recognised standard dosages. However there is no explanation in the notes of why oral weak opioid analgesia is not continued on a regular basis using the stronger opioid analgesia for breakthrough pain. Without explanation I would consider this poor medical practice.

4.7. Mrs Purnell makes no improvement during her time at GWMH and indeed appears to enter a period of slow decline. In Table 1 demonstrates she requires a dose of analgesia most nights to manage her symptoms and allows her to sleep. The causes of decline are often multi-factorial. Her failure to get over the anaesthesia, a possible further vascular event causing swallowing difficulties, poor nutrition, pressure sores from dependency and hypostatic pneumonia. In the presence of multiple other

pathology and old age, a relentless downhill course is not uncommon and it often becomes appropriate to manage symptoms and any distress.

4.8. A crisis occurs on 17th when there is a conflict on the ward between the son and the nursing staff although there had been previous discussions on the 14th. As a result of this there is a very detailed clinical examination undertaken by a Dr Brodie which documents she is semi-conscious, has got arms and legs flexed and appears to be in distress when moved. He appropriately discusses her with Dr Lord and starts subcutaneous fluids. She is then reviewed by another consultant, Dr Reid, in detail who assesses the situation and makes it quite clear that the prognosis is very poor (a statement often put in notes to indicate the consultant believes the patient will die shortly) and that symptom control and support is paramount. I would agree with the assessment and management at this stage.

4.9. Medical and nursing notes then document slow further decline in Mrs Purnell's clinical condition up until 23rd November and she is reviewed by a consultant, Dr Lord. There are detailed notes that she is groaning and in pain and frowns when lightly handled. A clear plan of management is set out in particular if she cannot take medication orally then she should have a syringe driver. I would agree with this management.

4.10. The medication for the syringe driver is written up by Dr Barton on 24th November and starts the same day although there is no record in the medical notes of who actually decided the starting dose in the syringe driver. However in my view a syringe driver was appropriate management at this stage in Mrs Purnell's care. She is started on 20 mgs of Diamorphine in 24 hours together with 20 mgs of Midazolam. As Mrs Purnell had received between 10 and 20 mgs of Oramorphine most days for the previous 12 days I believe this was within the appropriate range of doses to use. Midazolam was also started at 20 mgs in 24 hours. Midazolam is a sedative which can be suitable for very restless patients and is usually initially given in a dose of 20 mgs in 24 hours although some believe the dose should be much lower (5 – 20 mgs) in older people in particular the most frail. She was also on regular oral diazepam at this stage. There is nothing specific in the notes to explain why it was thought that both Midazolam and Diamorphine were required or why a dose of 40 mgs of Midazolam after the first 24 hours was needed. There is a potential risk of over sedation in the last few days although I am certain this lady was terminally ill.

4.11. The use of drug chart is poor. Diamorphine and Midazolam are written up on the PRN part of the drug chart on 19th November but although they are not prescribed there is no documentation in the notes as to why this occurred. A very large dose range is written up on the regular side of the drug chart when a new prescription should have been written for each change in dosage. The dosages of the controlled drugs were not written in words and figures nor was the total dosage to be given made clear in the prescription.

5. OPINION

5.1. Edna Purnell, a 91 year old lady with moderately severe dementing illness who suffered a fracture neck of femur which she never properly recovered medically or functionally and subsequently deteriorated and died in the Gosport War Memorial Hospital. The post mortem showed bronco pneumonia which is the common end point pathological process found at post mortem after prolonged debilitating illness.

5.2. It was appropriate to transfer her to the Gosport War Memorial Hospital where many aspects of her care and the approach to symptom management of someone who was terminally ill were appropriate.

5.3. There is some evidence of poor medical practice in the Gosport War Memorial Hospital. In particular:

- The lack of a documented medical examination on admission.
- The poor assessment of pain and the reason for it on the 12th November.
- The failure to use, or document why not, regular weaker oral analgesia was not used after the 12th November
- The absence of documentation of who made the final decision to choose the dose of diamorphine and midazolam on 24th November and why the dose of midazolam was increased to 40 mgs on 25th November.

5.4. The use of the drug chart in the Gosport War Memorial Hospital is significantly deficient. In particular:

- The prescription of a large range of a controlled drug and both the "daily review prescriptions" and the regular sides of the drug chart.
- The failure to re-write the dose of drugs when changed on the regular side of the drug chart

- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. EXPERTS' DECLARATION

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

7. STATEMENT OF TRUTH

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

Signature: ______________________________ Date: ____________

From: Code A
Sent: 21 April 2008 12:22
To: Valerie Barr Code A
Subject: FW: Meeting

Val,

You have already booked a room and refreshments for this meeting on 16 May but you will note that two additional people from the NMWC are now attending, in light of this please see whether you can obtain a bigger room and increase the catering.

Please also update the visitors list.

Attendees:

Me
Sarah Ellson (FFW)
Tamsin Hall (FFW)

Claire Strickland (Nursing and Midwifery and Council)
Code A (Nursing and Midwifery and Council)

Mark Mallinson (Nursing and Midwifery and Council)

Peter Swain may also attend.

Please let me know the outcome.

Thanks
Code A

From: Mark Mallinson Code A
Sent: 21 Apr 2008 10:37
To: Code A
Subject: RE: Meeting

Code A

Thanks for arranging this. Please note that I and Code A will also be attending with Clare. Several recent enquiries concerning the nurses have meant that Code A, who is head of case management, should attend any discussions.

Mark

From: Code A
Sent: 14 April 2008 12:52
To: Code A
Cc:

Subject: RE: Meeting
Importance: High

Dear Mark,

As Sarah and Tamsin will be travelling from Manchester for this meeting, I would be grateful if you would acknowledge receipt of the email below.

With thanks
Code A

From: Code A
Sent: 03 Apr 2008 15:28
To:
Cc: Code A
Subject: Meeting

Dear Mark,

Further to our telephone conversation today thank you for confirming that Claire is able to attend the meeting to discuss the Gosport War Memorial Case on the 16th.

The details of the meeting are:

Date: 16 May 2008
Time; 9.30 to 11.30
Venue: GMC, Room 2.18, Second Floor, 350 Euston Road, Regents Place, London NW1 3JN

Please ask Claire to report to our ground floor reception when she arrives.

I will be attending the meeting as well as our Solicitors, Sarah Ellson and Tasmin Hall.

I would be grateful if you would let me know if anyone else from the NMC will accompany Claire.

Please acknowledge receipt of this email.

With kind regards
Code A

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W1B 1PZ and registered charity number 1091434.

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charity number SC038362

www.nmc-uk.org

****

From: Code A
Sent: 21 April 2008 12:37
To: 'Mark Mallinson'
Cc: Code A Tamsin Hall ffw (formerly Tomlinson)
Subject: RE: Meeting

Mark,

Thank you for confirming who is attending.

We look forward to meeting to you all.

Code A

From: Mark Mallinson Code A
Sent: 21 Apr 2008 10:37
To: Code A
Subject: RE: Meeting

Code A

Thanks for arranging this. Please note that I and Code A will also be attending with Clare. Several recent enquiries concerning the nurses have meant that Code A, who is head of case management, should attend any discussions.

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charity number SC038362

www.nmc-uk.org

****

From: Code A
Sent: 21 April 2008 16:30
To: 'Hall, Tamsin'
Cc: Code A
Subject: RE: Ltr to Ian Barker MDU 21.04.08.DOC

Tamsin,

Thank you for the draft letter and comments.

In respect of Jean Stevens and Edna Purnell the final decision rests with Peter as to how to proceed and he may decide that despite Professor Black's criticms in the Stevens case we do not need to add further allegations in order to prove our case or he may decide that it should be added, in light of this I have made an amendment to your paragraph below.

'Please find enclosed with this letter the expert reports of Professor Black regarding patients Jean Stevens and Edna Purnell. We also enclose the generic report of Professor Black.

We have disclosed Professor Black's report concerning Jean Stevens and Edna Purnell to the GMC and await their instructions, which we hope to receive later this week.

~~*We have advised the GMC to include Jean Stevens within the charges.*~~
~~*The Draft Notice of Hearing is currently with the GMC for amendment to include these charges.*~~
Please find enclosed with this letter, by way of disclosure, the witness statement of Mr Ernest Stevens. We do not currently have any other witness statements regarding Mrs Stevens.

I will discuss with Peter on Wednesday:

1. How to proceed with the Stevens and Purnell cases

2. Whether we want to risk the hearing going part heard

3. Who should sign off letters to the families.

I suspect that the defence will require a further telecon due to outstanding matters such as finalised witness statements and our pharmacist's report.

Code A

From: Hall, Tamsin Code A
Sent: 21 Apr 2008 15:54
To: Code A
Subject: Ltr to Ian Barker MDU 21.04.08.DOC

As promised, here is my draft letter to the defence.

I particularly wanted to check you are happy with the section I have left in italics regarding

Jean Stevens.

Also, please note that we do have a lot of witnesses to get through. We are hoping that the defence will agree much of the evidence and some of the witnesses will not take too long on the stand. However, we do have some concerns about the 8 week listing potentially which I wanted to flag up now.

We don't think that we need to alter the listing at this stage but will need to keep an eye on this. As we have 'booked' Counsel and the expert it would perhaps be preferable to take the risk of going part-heard so as not to lose the September start. I would be grateful for your thoughts.

Also, I need to discuss with you notifying the families of the patients as to whether their cases will be proceeding. I wondered if you would like the letters to go out from Field Fisher Waterhouse or from the GMC? (Either way I am, of course, happy to draft the letters)

Thanks for looking at this letter, I would like to send it over to the defence this evening.

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
dd Code A

Mobile Code A

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From: Hall, Tamsin Code A
Sent: 21 April 2008 15:54
To: Code A
Subject: Ltr to Ian Barker MDU 21.04.08.DOC
Attachments: DOCS_7343749_1.DOC

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I particularly wanted to check you are happy with the section I have left in italics regarding Jean Stevens.

Also, please note that we do have a lot of witnesses to get through. We are hoping that the defence will agree much of the evidence and some of the witnesses will not take too long on the stand. However, we do have some concerns about the 8 week listing potentially which I wanted to flag up now.

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Also, I need to discuss with you notifying the families of the patients as to whether their cases will be proceeding. I wondered if you would like the letters to go out from Field Fisher Waterhouse or from the GMC? (Either way I am, of course, happy to draft the letters)

Thanks for looking at this letter, I would like to send it over to the defence this evening.

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Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
dd Code A

Mobile Code A

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FAO Ian Barker
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

Our ref: TET/GML/00492-15579/7343749 v1
Your ref:

21 April 2008

Dear Sirs

General Medical Council - Dr Jane Barton

Yours faithfully

Field Fisher Waterhouse LLP

Encs

From: Thomas Wood Code A
Sent: 21 April 2008 15:03
To: Code A
Attachments: Scan001.PDF

Code A

This letter came by fax today, I've put a copy on Siebel.

Tom

Thomas Wood
Investigation Officer
Fitness to Practise Directorate
Direct Dial: Code A
Fax No: Code A
Email: Code A

-----Original Message-----
From: SCANNER@GMC-UK.ORG [mailto:SCANNER@GMC-UK.ORG]
Sent: 21 April 2008 17:21
To: Thomas Wood Code A
Subject: Scan from a Xerox WorkCentre Pro

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Number of Images: 2
Attachment File Type: PDF

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Dr Bryony Hooper Medicolegal Adviser
LLM BM MRCGP MFPHM DRCOG

By post and fax 0161 923 6401

Ms Jacqui Thomas
Assistant Registrar
Fitness to Practise Directorate
General Medical Council
5th Floor, St James's Buildings
79 Oxford Street
Manchester M1 6FQ

Your Reference: TW/C1-5325180
Our Reference: BH/ba/167386/8
Please quote our reference when contacting MPS

21 April 2008

Dear Ms Thomas

MPS Member: Dr Michael Davies

I write on behalf of Dr Michael Davies, in relation to your letter to Dr Davies dated 27 November 2007. In that letter, you have stated that the panel has asked that when it reviews Dr Davies' case, the panel would wish to have information from professional colleagues and persons of standing regarding Dr Davies' conduct since the last hearing. You therefore asked for names and addresses to be provided so that the GMC may write to them to request this information.

I apologise for the tardy reply on this point. This was due to a delay in passing on information from Dr Davies to the GMC.

I include below the names of three colleagues of Dr Davies, who would be happy to be contacted by the General Medical Council to provide information regarding Dr Davies' conduct since his last fitness to practise hearing. As time is very short before the forthcoming hearing on 25 April 2008, it may be helpful to point out that Dr Elizabeth Ashley intends to attend the hearing and will be available to give evidence. I have taken the liberty of contacting the other two persons named, and asked them to provide any information of relevance to the GMC at their earliest convenience.

Yours sincerely

Code A

Dr Bryony Hooper
Medicolegal Adviser

Secretary
Direct Telephone
Direct Facsimile
Email
Encs.
cc:

Code A

Medical.London@mps.org.uk

Mr Ian Sadler, RadcliffesLeBrasseur

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33 Cavendish Square, London W1G 0PS, UK

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LIST OF NAME

1. Dr Elizabeth Ashley
   Consultant Anaesthetist
   University College Hospitals and the Heart Hospital

   Dr Ashley is also a college tutor.

   Email: **Code A**
   Tel:

2. Dr Andrew Smith
   Consultant Anaesthetist and Department Chair
   University College Hospitals

   Email: **Code A**
   Tel:

3. Dr Ernie Grundy
   Consultant Anaesthetist and Head of School
   UCL Hospital Trust

   Email: **Code A**
   Tel:

From: Hall, Tamsin Code A
Sent: 16 April 2008 18:08
To: Code A
Cc: Ellson, Sarah; Watson, Adele
Subject: Barton - update - Jean Stevens and Edna Purnell
Attachments: DOCS_7320801_1.DOC; DOCS_7320808_1.DOC; DOCS_7226650_1.DOC; DOCS_7209340_1.DOC; DOCS_7275186_1 (2).DOC

Hi Code A

Regards

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
dd Code A

Mobile Code A

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GMC

V

Dr Barton

Tom Kark

QEB Hollis Whiteman Chambers

Temple, London EC4Y 9BS

11th April 2008

Jean STEVENS
DOB: Code A
Died: 22/05/1999

SUMMARY OF CONCLUSIONS

Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with severe left hemiplegia , probable myocardial infarction and continued myocardial ischemia.

She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

There is some evidence of poor medical practice in Haslar.

Documentation and management of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital.

The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient.

1. INSTRUCTIONS

To examine the medical records, and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

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

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

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence. For the three volumes: number / 1, number / 2 and number / 3)

3.1. Jean Stevens was a 72 year old lady at the time of her death in the Gosport War Memorial Hospital on 22 May 1999. She had a long past medical history including diverticular disease diagnosed in 1982 (24/1), appendisectomy in 1967, various arthritic pains, atrial fibrilation from 1994 (854/2), asthma needing inhalers and a gastric ulcer in 1994 (753/2).

3.2. However as a result of abdominal pain she undergoes a Sigmoid colectomy in 1995. This is complicated by what is eventually found to be an colo-vaginal fistula and she undergoes a further laparotomy (135-36/1) after which she is very ill and needs a period of time in the intensive care unit. However, she does eventually return home although continues to get chronic abdominal pain with normal investigations (113/1) including a normal CT (121/1) and is finally referred to the pain clinic for her chronic abdominal pain although she does not receive the appointment before her final admission to Hasler.

3.3. 26th April 1999 she is admitted acutely to Hasler Hospital through the A&E department for both the onset of a left hemiplegia together with constant chest pain (114-117/1). The medical notes document her stormy admission (174-205/1). On 28th April she has chest pain with both EGC and cardiac enzyme abnormalities (179/1) suggesting an acute myocardial infarction and is admitted to the coronary care unit. Subsequently she has probable aspiration pneumonia on 30th April (183/1) and possibly a further MI, certainly with more chest pain on 5th May (192/1).

3.4. Nursing notes confirm her serious condition. On 5th and 6th May she is agitated and distressed needing doses of Diamorphine. On 6th May she is seen by Dr Lord (194/1) who finds her extremely unwell and certainly not fit for rehabilitation or transfer to the Gosport War Memorial Hospital. She has more chest pain on 10th May (197/1) and the family are seen on 12th May and the poor prognosis is explained (200/1). On 12th May she is reviewed by Dr Tandy (67/1) who notes she has a dense flaccid hemiplegia and very dysarthric speech although she can obey simple commands. She is tolerating naso-gastric feeding but because of her recent chest pain was certainly not stable for transfer yet.

3.5. The nursing notes said that she was stressed and agitated on 15th May (95/1) and required subcutaneous Diamorphine, however, on 16th May (98/1) she slept well without it. On 17th May she is very demanding and continually disturbing other patients with calling out. On 18th May she has general aches and pains despite regular Co-codamol, although on 19th May (91/1) she is settled and slept all night. Her blood tests confirm her poor health with a very low albumin of 23 and a raised white cell count of 16 (201/1) on 13th May. She remains pyrexial on 17th May with crepitations at her left base and an albumin of 22 and a white cell count of 14 (203/1).

3.6. She is transferred after discussion with the Gosport War Memorial Hospital (GWMH). But the transfer letter written on the 19th (69/1)

fails to mention that she is receiving regular Co-dydramol, although it does state she is on Diamorphine 5 mgs subcutaneous PRN for pain.

3.7. The drug chart from Haslar appears on pages (71-72/1) and (550-560/2). She is written up for Diamorphine 2.5mg IV 4hourly PRN on the 1st May, changed to 5mg SC PRN from the 13th May and receives 12 doses in total between the 5th of May and the 16th May. She is also written up for Co-codamol 2 tablets QDS on the 26th April and receives regular doses until the 29th April. Co-dydramol is started on the 17th May and continues until the 19th. According to the drug chart no drugs of any sort are given on the morning of the 20th May, the day she is transferred.

3.8. The medical receiving notes on 20th May (20/3) comprise a brief summary starting with "transfer to Daedalus Ward 555K". It documents that she had a left dense hemiplegia, her past medical history and her current Barthel. Her examination is recorded. So there is no other medical note and the next note is a nursing note on 22nd May verifying death by a nurse. I do not understand the 555K note.

3.9. The nursing cardex records her transfer at 1340 on 20th May. It records her NG feeding and slurred speech but Mrs Stevens appeared quite alert and aware of her surroundings (26/3). A Barthel is recorded at 1 (32/3), a Waterlow of 25 (30/3) and an abbreviated mental test score of 4 out of 10 (33/3). The nursing contact sheet starts on 21st May (34/3) at 1130. It is possible that the contacts sheet for the 20th May is missing. This sheet records that "now on regular (4 hourly Oramorphine 10 mgs in 5 mls)". At 1800 she has been "uncomfortable despite 4 hourly Diamorphine. Husband seen and care discussed, very upset, agreed to commence syringe driver at an equivalent dose to Oramorphine with Midazolam, aware of poor outlook but anxious that medication given should not shorten her life. At 1945 commenced syringe driver". On 22nd May condition deteriorating, very bubbly, on Hyoscine 800 mgs added to 20 mgs of Diamorphine and 20 mgs Midazolam. With Hyoscine increased to 1600 is very bubbly at 1020 (35/3).

3.10. The handling profile (42/3) under the client risk factor 'pain' states "abdominal pain". The nursing care plan of 20th May (58/3) documents problems with the nasal gastric tube and the night care plan (60/3) states that on 20th May, Oramorphine 2.5 mls given as per cardex, complaining of pain in stomach and arm.

3.11. The drug chart has Oramorphine in 10 mgs in 5 mls, oral 5 mgs 4 hourly enough to start on 21st May, however, only two doses are given at 1000 and 1400 and the other doses are omitted. It also has

Oramorphine 10 mgs in 5 mls for 10 mls nocte to start on 21st May also written as a regular prescription but again this is never given. Oramorphine 10 mgs in 5 mls orally 2.5 – 5 mls 4 hourly as required is written up on 20th May, 5 mgs are given on 4 doses as documented in Table 1. Diamorphine 20 – 200 mgs S/C in 24 hours is written up on 20th May on the as required part of the drug chart and started at 1920 on 21st May, 0830 on 22nd May and restarted again with the increase of dose of Hyoscine at 1030 on 22nd May. Midazolam 20 – 80 mgs subcut in 24 hours in written up on 20th May as required and 20 mgs is started at 1920 on 21st May at 0800 on 22nd May and again restarted at 20 mgs at 1030 on 22nd May.

TABLE 1

Drug	Prescribed as	Prescriber	Given Doses
Diamorphine 2.5 mg IV PRN 01/05 changed to: 5mg SC PRN 13/05	As required	?	05/05 x1 06/05 x2 08/05 x2 09/05 x1 10/05 x1 12/05 x1 13/05 x1 15/05 x2 16/05 x1
Oramorphine 10 mgs in 5 mls For 10mls nocte to start 21/05	Regular	BARTON	Never given
Oramorphine 10 mgs in 5 mls Oral 5 mls 4 hourly to start 21/05	Regular	BARTON	21/05 1000 10mgs 21/5 1400 10mgs (other doses not given)
Oramorphine	As required	BARTON	20/05 1430 5 mgs

10 mgs in 5 mls Oral 2.5 – 5 mls 20/05 4 hourly	(PRN)		20/05 1830 5 mgs 20/05 2245 5 mgs 21/05 0735 5 mgs
Diamorphine 20 – 200 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 1920 20 mgs 22/05 0830 20 mgs 22/05 1030 20 mgs
Midazolam 20 – 80 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 1900 20 mgs 22/05 0800 20 mgs 22/05 1030 20 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Jean Stevens, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Stevens was 72 at the time of her final admission to the Gosport War Memorial Hospital although she had long standing cardiac and gastrointestinal problems and had been very seriously ill needing intensive care during 1995. She also had chronic unexplained abdominal pain and with recent negative investigations she had been referred to a chronic pain clinic for management.

4.3. However, her acute admission was with a severe and dense left sided stroke on 26th April. She had also had constant chest pain that day and when she had further chest pain on 28th April, it seems likely that she had a definite myocardial infarction simultaneously with her stroke. She then suffered from probable

aspiration pneumonia and was extremely ill for several days including having further chest pain.

4.4. Nursing and medical notes document that the family is seen and indeed the medical staff think that it is likely that she is going to die. Certainly she is restless and distressed and in my view probably clinically unstable certainly until 17th May as she still had abnormal signs in her chest, pyrexial and had a raised white count with a very low albumin. There is to be no doubt that her prognosis was extremely poor both from the likelihood of surviving or even getting significant improvement from her stroke.

4.5. During her admission to Hasler she is written up on the PRN side of the drug chart for 2.5 ms IV then 5 mgs SC PRN of Diamorphine. This would be a standard regime for people suffering myocardial infarction with recurrent cardiac pain. The drug is given on a number of occasions in Haslar sometimes for pain and sometimes for non-specific distress, judging from the nursing cardex. It would be perfectly appropriate to use this dose of Diamorphine if she was getting recurrent pain as it would not be possible to intervene in other ways because of her stroke. It seems likely that a clinical management decision (not recorded) was made on the 17th May to stop using Diamorphine and restart a regular oral analgesic, Co-dydramol, given via the NG tube. No further doses of Diamorphine are given in Haslar after 00.10 early on the morning of the 16th May.

4.6. She is seen on two occasions by Geriatricians, who both think she was unstable at that time and not yet suitable for transfer. I would strongly agree. Indeed there is then a further a discussion before it is agreed that she will go to the GWMH. In my view she was likely to be still unstable and it will have been clinically prudent to keep her for another week in Haslar. There can be no doubt that she is getting continued pain. She is written up for 6 hourly Co-dydramol which she received 4 times a day for the 2 days before her transfer to GWMH.

4.7. The drug chart appears to show poor prescribing practice at Haslar as the dose of Diamorphine is not written in words as well as figures nor is the total dose to be given written on the drug chart. There is no evidence she was given her regular medication, including oral analgesia, on the morning of her transfer and the Co-dydramol is not mentioned on the transfer letter.

4.8. There is a summary of the clinical problems functional status upon arrival at GWMH but it is not clear from the notes whether the

patient was examined, and if she was, the examination was not recorded. There is no medical assessment on whether or not she is pain, and if she is in pain why she is pain, nor of her clinical status upon arrival in particularly as she had been so ill recently. In my view this is poor clinical practice.

4.9. She is not written up for the Co-dydramol that she was on regularly at Haslar although it was not mentioned in the transfer letter. On the PRN part of the drug chart doses of Oramorphine are written up orally and a large range of Diamorphine and Midazolam is written up as required There is no documentation in the medical notes at Gosport War Memorial Hospital as to why these drugs were written up upon admission without apparently a clinical assessment of her pain or clinical status. Nor is there any explanation of why no other analgesics apart from strong opiates were prescribed. One note in the nursing cardex refers to abdominal pain which of course may have been the same pain that she had for many years prior to her admission. In general the Diamorphine she had received at Hasler had been for chest pain and further angina. There is no evidence in the medical or nursing cardex that she has any acute cardiac problems or angina in GWMH. In my view this management was poor clinical practice

4.10. She receives her first dose of Oramorphine at 1430, only 45 minutes after the nursing cardex records her arrival and then receives a further 3 doses until the morning of 21st. It is not clear whether it was a nursing or medical decision to actually give the Oramorphine.

4.11. On 21st May a decision is made that she is dying and she should be for symptom control with a syringe driver. Including the two doses given on the morning of 21st May she had received in total 40 mgs of Oramorphine in a 24 hour period. In these circumstances and assuming the patient was still distressed then it would be reasonable to start with 20 mgs of Diamorphine in a syringe driver over 24 hours. However, in my view it is unacceptable clinical practice to give the doses of Oramorphine in the first 24 hours after her arrival and start the syringe driver without making and recording a clinical assessment in the medical notes.

4.12. There are significant irregularities with the drug charts. Oramorphine has been written up on the regular side of the drug chart but not actually prescribed with no note to say why. A large range of Diamorphine is written up on the PRN part of the drug

chart before it is required and it is not written in words or figures nor is the total dose written.

4.13. Midazolam is a sedative which can be suitable for very restless patients and is usually given initially in a dose of 20 mgs in 24 hours although some people believe the dose should be much lower (5 – 20 mgs in older people, in particular the most frail). There is nothing in the notes to explain why it was thought that both Midazolam and Diamorphine were required in this patient. In my view the regular doses of Oramorphine and then the syringe driver together with the 20 mgs of Midazolam would have given a risk of over sedation for example causing respiratory depression in this lady who already had severe heart, lung and neurological disease.

5. OPINION

5.1. Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with a severe left hemiplegia, probable myocardial infarction and continued myocardial ischemia.

5.2. She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

5.3. There is some evidence of poor medical practice in Haslar. In particular:

- Use of the drug chart in Hasler with the failure to write controlled doses of drugs in word and figures as well as the total dosages to be given.
- The apparent failure to give her regular medication, including oral analgesia, on the morning of her transfer to the GWMH.
- The failure to document the regular Co-dydramol in the transfer letter.
- The early transfer of a patient who had been seriously ill and clinically unstable to the short period before transfer.

5.4. Documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital. In particular:

- Lack of a documented medical assessment on admission.
- Lack of any recorded assessment of her clinical condition and in particular her source of pain.

- Starting regular opioid analgesia within an hour of admission and a syringe driver within 24 hours of admission ,without any medical records of justification for either regular strong opioid analgesia or a syringe driver .
- The failure to prescribe any analgesia other than the strong opiate analgesia on admission to the GWMH.
- The lack of a written justification requiring both Diamorphine and Midazolam in the syringe driver.

5.5. The use of the drug chart in the Gosport War Memorial Hospital is also significantly in deficient. In particular:

- The failure to give regularly the drugs prescribed on the regular side of the drug chart without explanation in medical or nursing notes.
- Prescription of a large range of a controlled drug in the “as required” side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I

subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

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

Signature: ________________________________ Date: ______________

Edna PURNELL
DOB: Code A
Died: 03/12/1998

SUMMARY OF CONCLUSIONS

Edna Purnell, a 91 year old lady with moderately severe dementing illness who suffered a fracture neck of femur which she never properly recovered medically or functionally and subsequently deteriorated and died in the Gosport War Memorial Hospital. The post mortem showed bronco pneumonia which is the common end point pathological process found at post mortem after prolonged debilitating illness.

It was appropriate to transfer her to the Gosport War Memorial Hospital where many aspects of her care and the approach to symptom management of someone who was terminally ill were appropriate.

There is some evidence of poor medical practice in the Gosport War Memorial Hospital

The use of the drug chart in the Gosport War Memorial Hospital is significantly deficient

1. INSTRUCTIONS

To examine the medical records, the statement of Code A and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

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

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

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

3.1. Edna Purnell was a 91 year old lady at the time of her death in the Gosport War Memorial Hospital on 3rd December 1998.

3.2. Her long standing problems included palpitations, anxiety, vaginal prolapse, herpes zoster, previous right Colles fracture, transient ischaemic episodes and cervical spondylosis (70). She was also noted to have aortic valve disease (118).

3.3. However, her main problem was a dementing illness. Possible early evidence in October 1995 (47) definite evidence by November 1995 (45). Subsequently seen by the psycho-geriatric team on a domiciliary visit in January 1996, a formal diagnosis of dementia of moderate severity is made (37) which is followed up by the psycho-geriatric team and it is clear by October 1997 that she is failing at home (31). Following a probable stroke in October 1997 (21) she moves to Addenbrookes Residential Home and the community psychiatric nurse notes her to be settled in May 1998 (14).

3.4. She is admitted to the Haslar Hospital on 25 October having had a fall and suffered a fractured right neck of femur (58). Unfortunately none of the Hasler notes were available in the medical records provided to me. The only information is her nursing discharge letter (58, 60) and part of her drug chart in the statement of Code A Code A The nursing letter states post operatively her condition was very poor and that she remained not for active resuscitation. It also states that she had suffered with senile dementia and required full assistance with washing, feeding although her oral intake had been reasonable with encouragement. Despite the best efforts she had sustained pressure sores on her heels. The letter states that "Mrs Purnell is a challenging patient and wish you every success in her care".

3.5. The drug charts in Haslar notes note that 10 mgs of Morphine were given intramuscularly on 26th October. They also note that Diclofenac was given orally on 30th and 31st October and that soluble Co-codamol (a weak oral opioid) was given up until 5th November. However, as I only have the as required prescription part of that drug chart I cannot comment on whether other oral analgesia was being given on a regular basis.

3.6. Dr Lord visits Mrs Purnell at Haslar on 5th November. The letter documents recent fracture, post operative oedema, poor mobility, faecal and urinary incontinence (with a catheter)and bilateral pressure sores. As a result of her assessment she states that the son and daughter-in-law were present and that she explained to them rehabilitation was going to be very difficult given the mental state and pressure sores, but she would be given a "gentle rehabilitation" in an NHS continuing care bed for a month initially. She might well need a nursing home subsequently.

3.7. On the 11th November she is transferred to Gosport War Memorial Hospital. A problem list is recorded in the medical notes (125) although it is not clear if she is medically examined. She is extremely dependent as documented in the nursing notes (161) and a Barthel of 2 out of 20 (185).

3.8. On the 12th November in the medical notes she " is in pain despite Co-codamol (unreadable word) Oramorphine". The nursing cardex confirms the pain (161) stating "has been complaining of great deal of pain". On 15th November there is an unreadable medical record stating that she is for Diazepam.

3.9. The nursing records document that Code A has concerns about possible opiate sedation on 14th and there was a discussion about her prognosis and the needs to control her pain. She continues to complain of pain on 15th November (160).

3.10. The nursing and medical notes are extremely detailed on 17th November following a visit to the ward by Code A who raises concerns about his mother's medical care which leads to a confrontational situation. Mrs Purnell is examined in detail by a Dr Brodie, who finds her semi-conscious with arms and legs flexed and appears in distress when moved. The doctor finds her in distress which need analgesia although her son is not happy for her to receive analgesia. The doctor appropriately discusses her with the consultant, Dr Lord who agrees the plan and for subcutaneous fluids. Another consultant is covering so comes in to assess the patient (Dr Reid) (126 – 127). Dr Reid is also quite clear having assessed her that she is in pain and distress and this must be relieved. He also reports some recent swallowing difficulties, however she continues to receive oral medication until the 22nd November.

3.11. On 18th November (127) she is less well and there is evidence of Cheyne-Stoking respiration and subcutaneous fluids needs to be continued. The assessment is that her prognosis is extremely poor. There appears to be considerable difficulty contacting the son. On 19th she remains poorly but on 20th she is recorded as being comfortable with Oramorphine.

3.12. On 23rd November she is groaning and in pain and frowns when lightly handled. She was taking liquids, Oramorphine and Diazepam the day before. The management plan is to continue sub-cut fluids where appropriate, to use Oramorphine/Diamorphine, Diazepam or Midazolam to keep comfortable and if more than one injection of Diamorphine is required for a syringe driver. The consultant's view is that she is now obviously dying and the management should continue to be to keep her free of pain and distress (140).

3.13. Further medical records confirm further deterioration on 28th November and the 1st December. The record on 28th stating that Code A Code A was now on sub-cut analgesia. Death is recorded on Code A Code A by a RGN and the final note written subsequently on 18th December states the cause of death was bronchopneumonia and

senile dementia (139). This chronology is also confirmed in the nursing notes. The nursing notes states that on 24th November she was seen by Dr Barton (154) because her condition was deteriorating, she was distressed and reluctant with oral medication that the syringe driver should start. On 25th she continued to deteriorate and it occurred until 27th when her subcutaneous fluids were discontinued. The nursing notes continued to record her deterioration each day with the syringe driver being re-charged. The nursing notes say that Diamorphine was increased to 30 mgs on 1st December (165) although the drug chart says 40 mgs. On the 2nd December she is bubbly and 40 mgs a day of Diamorphine is recorded in the syringe driver. Death is verified at 1130 on 3rd December (166).

3.14. The Gosport War Memorial drug charts are slightly confusing in that there appear to be 3 front sheets (147, 148 and 149). It is possible that an extra front sheet was simply added to a previous drug chart as the space for the "as required" prescription drug box becomes full.

3.15. In summary, two tablets of Co-codamol are prescribed at 0830 on 12th November (which had been written up on admission) thereafter Oramorphine at 10 mgs and 5 mls at a dose of 2.5 – 5 mls is given starting on 12th November when three doses are given and then one or two doses most days until 24th November. There is no particular pattern for the timing of this although on 8 days there is a dose given late at night.

3.16. Diclofenac suppositories are written up on 17th November on a PRN basis but do not appear to be prescribed. Diamorphine is written up on a PRN basis SC/IM by Dr Lord on 23rd November but does not appear to have been prescribed. Diamorphine 20 – 200 mgs sub-cut in 24 hours, Hyoscine 200 – 800 micrograms sub-cut in 24 hours and Midazolam 20 – 80 mgs sub-cut in 24 hours are all written up on the PRN side of the drug chart on 19th November but do not appear to have been given. On the regular side of the drug chart Diamorphine 20 – 200 mgs sub-cut in 24 hours, Midazolam 20 – 80 mgs sub-cut in 24 hours and Hyoscine 200 – 800 micrograms sub-cut in 24 hours are all written up on 24th November. 20 mgs of Diamorphine is prescribed each day until 1st December when 40 mgs is prescribed until she dies. Midazolam 20 mgs is prescribed on 24th November and then 40 mgs each day until the day she dies. Hyoscine 200 micro grams is given on 2nd December and 400 on 3rd December.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Co-codamol 1 – 2	11/11	As required (PRN)	?	12/11 0830
Oramorphine 10 mgs in 5 mls Oral 2.5 – 5 mls	12/11	As required (PRN)	AK	*12/11 1405 5 mgs 1830 5 mgs 2234 10 mgs *13/11 1025 10 mgs 2225 10 mgs 14/11 1030 10 mgs *15/11 0050 10 mgs *16/11 2215 10 mgs *18/11 0105 10 mgs 2015 10 mgs *19/11 2316 10 mgs 20/11 1155 10 mgs 1800 5 mgs *21/11 2315 10 mgs *22/11 0630 10 mgs 2240 10 mgs 24/11 0920 10 mgs ** = Late evening dose on that date*
Diamorphine SC/IM 2.5 mgs – 5 mgs	23/11	As required (PRN)	LORD	-----
Diamorphine	19/11	As required	BARTON	-----

20 – 200 mgs SC in 24 hours		(PRN)		
Midazolam 20 – 80 mgs SC in 24 hours	19/11	As required (PRN)	BARTON	-----
Diamorphine 20 – 200 mgs SC in 24 hours	24/11	Regular	BARTON	24 – 30 Nov 20 mgs daily 1 – 3 Dec 40 mgs daily
Midazolam	24/11	Regular	BARTON	24 Nov 20 mgs daily 25 Nov – 3 Dec 40 mgs daily

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Edna Purnell, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Edna Purnell was a very elderly lady with multiple medical problems although moderately severe dementia was the main functional problem leading to residential care. There is debate in the notes whether this was Alzheimer's or vascular dementia, indeed it is not uncommon for elderly people to have both.

4.3. She was admitted to the Haslar Hospital having had a fall and a fractured neck of femur on 25th October. She was already known to have osteoporosis having previously had a Colles fracture. Unfortunately the prognosis of patients with dementia and a fractured neck of femur is extremely poor, very few return to their previous functional state and an in-hospital mortality rate at 25% is not uncommon. Those that remain immobile and incontinent immediately after the operation have by far the highest mobility

and mortality. Although the notes from Haslar are missing, the nursing summary documents that she remains totally dependent, develops bed sores and is seen as "a very challenging problem". Her dependency is also confirmed by the Barthel of 2 recorded upon admission to the Gosport War Memorial Hospital (GWMH).

4.4. She is thoroughly assessed by Dr Lord in Haslar who also sees the relatives at that time. The letter makes it clear that rehabilitation was going to be very difficult and Dr Lord expects her to remain severely dependent. She has already indicated at this early stage the likelihood of a nursing home placement. Dr Lord does not expect the patient to improve but is giving the family time to come terms with her changed status.

4.5. On admission to GWMH her problems are assessed but it is not clear whether she is medically examined. If she is not I would regard this as poor practice as it fails to give an accurate base line in the notes for future management of her medical problems.

4.6. It is then clearly document in both the medical and nursing notes that she is in considerable pain on 12th November despite the appropriate use of oral co-codamol. There is no medical examination recorded in the notes or any explanation as to where this pain is coming from. If the (incomplete) medical cardex from Haslar is correct she has not received analgesia for 6 days so what has changed? Is the pain coming from her pressure sores, which is very likely, has some other medical condition occurred, for example dislocating her hip during the transfer or some other post-operative complication? Failure to adequately examine the patient to explain her symptoms is poor medical practice. The use of oral strong opioid analgesia after weak opioid analgesia has failed is perfectly appropriate and the doses used are well within recognised standard dosages. However there is no explanation in the notes of why oral weak opioid analgesia is not continued on a regular basis using the stronger opioid analgesia for breakthrough pain. Without explanation I would consider this poor medical practice.

4.7. Mrs Purnell makes no improvement during her time at GWMH and indeed appears to enter a period of slow decline. In Table 1 demonstrates she requires a dose of analgesia most nights to manage her symptoms and allows her to sleep. The causes of decline are often multi-factorial. Her failure to get over the anaesthesia, a possible further vascular event causing swallowing difficulties, poor nutrition, pressure sores from dependency and hypostatic pneumonia. In the presence of multiple other

pathology and old age, a relentless downhill course is not uncommon and it often becomes appropriate to manage symptoms and any distress.

4.8. A crisis occurs on 17th when there is a conflict on the ward between the son and the nursing staff although there had been previous discussions on the 14th. As a result of this there is a very detailed clinical examination undertaken by a Dr Brodie which documents she is semi-conscious, has got arms and legs flexed and appears to be in distress when moved. He appropriately discusses her with Dr Lord and starts subcutaneous fluids. She is then reviewed by another consultant, Dr Reid, in detail who assesses the situation and makes it quite clear that the prognosis is very poor (a statement often put in notes to indicate the consultant believes the patient will die shortly) and that symptom control and support is paramount. I would agree with the assessment and management at this stage.

4.9. Medical and nursing notes then document slow further decline in Mrs Purnell's clinical condition up until 23rd November and she is reviewed by a consultant, Dr Lord. There are detailed notes that she is groaning and in pain and frowns when lightly handled. A clear plan of management is set out in particular if she cannot take medication orally then she should have a syringe driver. I would agree with this management.

4.10. The medication for the syringe driver is written up by Dr Barton on 24th November and starts the same day although there is no record in the medical notes of who actually decided the starting dose in the syringe driver. However in my view a syringe driver was appropriate management at this stage in Mrs Purnell's care. She is started on 20 mgs of Diamorphine in 24 hours together with 20 mgs of Midazolam. As Mrs Purnell had received between 10 and 20 mgs of Oramorphine most days for the previous 12 days I believe this was within the appropriate range of doses to use. Midazolam was also started at 20 mgs in 24 hours. Midazolam is a sedative which can be suitable for very restless patients and is usually initially given in a dose of 20 mgs in 24 hours although some believe the dose should be much lower (5 – 20 mgs) in older people in particular the most frail. She was also on regular oral diazepam at this stage. There is nothing specific in the notes to explain why it was thought that both Midazolam and Diamorphine were required or why a dose of 40 mgs of Midazolam after the first 24 hours was needed. There is a potential risk of over sedation in the last few days although I am certain this lady was terminally ill.

4.11. The use of drug chart is poor. Diamorphine and Midazolam are written up on the PRN part of the drug chart on 19th November but although they are not prescribed there is no documentation in the notes as to why this occurred. A very large dose range is written up on the regular side of the drug chart when a new prescription should have been written for each change in dosage. The dosages of the controlled drugs were not written in words and figures nor was the total dosage to be given made clear in the prescription.

5. OPINION

5.1. Edna Purnell, a 91 year old lady with moderately severe dementing illness who suffered a fracture neck of femur which she never properly recovered medically or functionally and subsequently deteriorated and died in the Gosport War Memorial Hospital. The post mortem showed bronco pneumonia which is the common end point pathological process found at post mortem after prolonged debilitating illness.

5.2. It was appropriate to transfer her to the Gosport War Memorial Hospital where many aspects of her care and the approach to symptom management of someone who was terminally ill were appropriate.

5.3. There is some evidence of poor medical practice in the Gosport War Memorial Hospital. In particular:

- The lack of a documented medical examination on admission.
- The poor assessment of pain and the reason for it on the 12th November.
- The failure to use, or document why not, regular weaker oral analgesia was not used after the 12th November
- The absence of documentation of who made the final decision to choose the dose of diamorphine and midazolam on 24th November and why the dose of midazolam was increased to 40 mgs on 25th November.

5.4. The use of the drug chart in the Gosport War Memorial Hospital is significantly deficient. In particular:

- The prescription of a large range of a controlled drug and both the “daily review prescriptions” and the regular sides of the drug chart.
- The failure to re-write the dose of drugs when changed on the regular side of the drug chart

- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. EXPERTS' DECLARATION

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

7. STATEMENT OF TRUTH

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

Signature: ______________________________ Date: ______________

REPORT FOR THE GENERAL MEDICAL COUNCIL ON ASPECTS OF CARE AT GOSPORT WAR MEMORIAL HOSPITAL

Instructions

To prepare a generic report for the General Medical Council covering principles of medical care and matters specific to the Gosport War Memorial Hospital in relation to the individual cases and separate individual reports that have been provided to the GMC.

1. Principles of Medical Care

1.1 Pain Relief

Pain is a complex phenomena that is a subjective, personal experience, only known to the person who suffers. Experience of pain may occur at several levels:

- Sensory dimension, the intensity, location and character.
- The affective dimension; the emotional component of pain and how it is perceived.
- Impact; disabling effect of the pain on the person's ability to function and participate in society.

1.1.1 Analgesic Ladder for pain

The relief of pain is therefore part of a comprehensive pattern of care. However, whatever the cause or the effect on the patient the Analgesic Ladder has for many years been the main stay of the approach to analgesia [1, 2]. It is a very simple concept that the choice of drug should be based on the severity of the pain not the stage of the disease. Drugs should be given at standard doses, at regular intervals in a step wise fashion. Thus for mild pain, non-opioid analgesics such as Paracetamol or a non-steroidal anti-inflammatory agent (e.g. Diclofenac) is used. If this non-opioid is not effective or the patient is in moderate pain, a moderate opioid (e.g. Codeine or Dihydrocodeine, often in combination with a non-opioid drug, such as Paracetamol with Codeine in Co-Codamol) is used. If the patient is in severe pain or the pain has not settled or the pain management for moderate pain has not worked, strong opioid analgesia (e.g. morphine) should be used ideally on an oral basis in the first instance.

1.1.2 Assessment of pain

Comprehensive assessment of pain involves:

a) Direct enquiry or observation for signs of pain. It is important to use alternative descriptions such as sore, hurting or aching. Patients with severe cognitive impairment, communication difficulties or language or cultural barriers present further complexities. There may be other observational signs associated with pain including crying, distress, aggression, moaning, calling out, pacing, rocking, various facial expressions and autonomic changes such as sweating, altered breathing patterns and tachycardia.

b) A description of the pain in terms of its sensory and affective and impact should be obtained and high quality services will often use a standardised scale to assist in assessment.

c) A full physical examination should then be undertaken to identify the cause of the pain.

d) Where a cause can be identified the cause should be treated and if it is not identifiable then it is appropriate to treat the symptoms.

e) The patient should then be reassessed to evaluate the effects of treatment.

1.1.3 Principles of administration of pain relief

This involves the Analgesic Ladder. As well as:

- Using the oral route if possible.
- Providing therapeutic doses of an analgesia regularly.
- Titrating the dose of the drug to the individual's analgesic requirement.
- Providing effective analgesia for breakthrough pain.
- Assessing pain control regularly.
- Assessing and treating the psychosocial dimensions of chronic pain.
- Paying attention to bowel function in particular use of laxatives with opioids.
- Providing appropriate adjuvant therapy (e.g. Bisphosphonates for bone pain, Tricyclic Antidepressants for neuropathic pain, non-steroidals for inflammatory pain).
- Keeping the patient and family fully informed.

1.1.4 Use of opioids

In a patient starting at level 3 of the analgesic ladder for the first time a dose of 5 – 10 mgs, four hourly, of Morphine is usual, given orally. Also prescribe Morphine at one sixth of the 24 hour dose for breakthrough or incidental pain.

- Titrate the dose against the individual's level of pain and side effect profile.
- When indicated, increase the dose by 20 - 50%, or by the amount of breakthrough Morphine used in the previous 24 hours.
- When pain is controlled convert to a sustained release formulation in an equivalent dose.
- Prescribe a regular laxative unless contraindicated.
- For injection Diamorphine is preferred as it is more soluble and can be given in smaller volume. In converting an oral dose of Morphine to a subcutaneous dose of Diamorphine, the BNF states that the equivalent intramuscular or subcutaneous dose of Diamorphine is approximately a third of the oral dose [3]. However, the Wessex Protocol states "conversion from oral Morphine to subcutaneous Diamorphine (total daily dose) varies between 2:1 and 3:1 allowing some flexibility depending on the requirement for increased or decreased opioid effect".

1.1.5 Syringe Drivers

Syringe drivers allow a continuous subcutaneous infusion which can provide good control of symptoms with little discomfort or inconvenience to the patient. Indications include:

- Patient unable to take medicines by mouth for example due to vomiting or coma.
- There is malignant bowel obstruction where further surgery is not possible.
- Where the patient does not wish to take a regular medication by mouth.
- The Wessex Protocol also states “the last 24 / 48 hours of life”.

The most common causes of problems with syringe drivers are putting the wrong dosage in the driver, problems with the driver either going too fast or too slow and poor training of staff.

1.1.6 Opioid toxicity and side effects

a) Drowsiness and sedation. Most commonly within the first few days of opioid usage. Severe overdosage may lead to coma and slowing of respiration to the point of respiratory failure.

b) Nausea and vomiting. Nausea is particularly common in those taking oral Morphine. It can be helped with the co-prescription of either Metoclopramide or Haloperidol.

c) Constipation. Develops in almost all patients who should be treated routinely with laxatives.

d) A dry mouth is often troublesome.

Individuals can vary enormously in their tolerability of Opioids. Opioid toxicity may also present as agitation, hallucinations, increased confusion leading to interpretation as uncontrolled pain, and when further opioids are given leading to sedation, lack of fluid intake and further toxicity. This syndrome is sometimes misdiagnosed as terminal agitation.[4]

Patients with both renal impairment and hepatic impairment are both extremely sensitive to opioids.

1.1.7 The use of Midazolam with Diamorphine

Research has shown that a high proportion of patients are distressed in the last week of life. Agitation and restlessness is particularly common. In a terminally restless patient there should be a proper attempt to determine the etiology of the distress. Where this is pain, appropriate analgesia is the first approach. However, if this does not relieve the agitation and distress it is appropriate to add further drugs to manage the symptoms of terminal restlessness. Haloperidol is particularly helpful in cases of agitation, and Midazolam for restlessness. Both can be put subcutaneously in a syringe

driver and can be mixed with Diamorphine where required. Midazolam also has the advantage that it raises the seizure threshold. The BNF[3] states that it should be given in a dose of 20 – 100 mgs per 24 hours, the Wessex Protocol state 10 – 100 mgs per 24 hours[2] although others believe that in older people a lower dose of 5 – 20 mgs per 24 hours is normally sufficient[5]. Thus pain by itself is not a reason to add Midazolam. If excessive doses of Midazolam are used with excessive doses of opioid analgesia it would significantly increase the risk of over sedation, respiratory failure, coma and potentially hasten death.

1.1.8 Principles of prescribing in old age

The British National Formulary[3] sets out important issues around old people particularly the very old and frail.

a) Appropriate prescribing to people receiving multiple drugs - this greatly increases the risks of drug interactions, adverse interactions and poor compliance.
b) Forms of medication in the frail - an older patient may have difficulty swallowing and there may be problems with fluid intake.
c) Manifestations of disease – problems of normal age may be mistaken to disease such as age related muscle weakness being confused with neurological disease.
d) Sensitivity – the nervous system of older people is particularly sensitive to many commonly used drugs and the BNF mentions opioid analgesics and Benzodiazepines (such as Midazolam).
e) Pharmacokinetics – the most important affects of age is the reduction in renal clearance and therefore atoxic drug metabolites may accumulate with greater preponderancy with adverse effects. Liver metabolism of some drugs is also reduced in old age.

The key principles are:

- Use as few drugs as possible, use dosages substantially lower than for younger patients, often 50% of adult dose, review regularly, simplify regimes, explain clearly. Doctors should use the BNF to check dosages and drug interactions.

2. Medical Assessment and Records

2.1 Assessment and Records

Doctors have a responsibility to make the care of the patient their first concern. The attributes of good clinical care are set out in the GMC's document Good Medical Practice[6]. This states that good clinical care must include:

- Adequate assessment of the patient's condition based on the history and clinical signs including, where necessary, an appropriate examination.
- Providing or arranging investigations or treatments where necessary.
- Referring the patient to another practitioner, when indicated.

It also states that in providing care you must:

- Recognise the limits of your professional competence.
- Be willing to consult colleagues.
- Be competent when making diagnoses and when giving or arranging treatment.
- Keep clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed.
- Keep colleagues well informed sharing the care of patients.

A failure to meet these standards puts the patient at risk:

- Without assessment there can be no proper treatment and would be a clear failing in duty of care to the patient.
- Without recording assessments there are risks to the patient of:
  - Missing and forgetting important matters.
  - No base line on which to document, understand and assess changes in condition.
  - No information for other members of staff whether medical or other members of the health care team to understand the problems and base their own management upon it.
  - No audit trail when decisions are questioned or challenged.

2.2. Use of Drug Charts

On hospital drug charts there are broadly speaking 4 ways to prescribe a drug each with its own section.

- Drugs may be given as a single dose. This is usually on the front of the chart which should state the dose, the route of administration and the time and date of that administration. It would be normal for the nursing (or medical) staff to give the medication at the time and date specified and if not to make a record of why that failed to happen.

- Drugs may be prescribed on a regular basis at the same time and dosages each day. There is often a column where the timing of dosages should be included. The drugs should always be given by the nursing (or medical) staff at the time and at the dose indicated. If it is not given at the time or dose indicated there should be a record made on the drug chart or in the notes as to why this happened. If the dose and/or the timings of the drugs are to be changed the whole prescription should have a line put through it, it should be dated and initialled and a new regular prescription written up on a different line.

- Many medications are prescribed on an "as required" basis (PRN which abbreviates *pro re nata: 'as the occasion arises; when necessary'*). The nursing staff or sometimes the patient may then use their judgement when these drugs are given. It would be normal to specify the dose and the minimum dose interval. It is common practice to give a small dose range. For example, Paracetamol one or two tablets at 6 hourly PRN. This part of the drug chart is most commonly used for sleeping tablets, mild analgesia, laxatives and anti-emetics, but may be condition specific. For example a small dose range of Diamorphine 2.5-5mg is often written up in patients admitted with acute myocardial infarction or unstable angina. This

reflects the need for rapid analgesia but allows some judgement as to the actual dose required particularly if a previous dose has not worked while further medical attention is obtained. As indicated earlier breakthrough doses of analgesics PRN may also be written up when a regular opioid has been started on the regular side of the drug chart.

- The final part of the drug chart is for infusions and fluid management.

Prescribing requires:

- The drug, the dose, the strength, the route of administration and the frequency to be written up for all prescriptions.
- Avoid multiple route prescribing for a single prescription (e.g. IV and oral).
- When changing the dosage you should draw a line through the prescription, date and initial, and then re-write a new prescription.
- The law for controlled drugs states that a prescription must be signed and dated and must always state:
    - the name and address of the patient
    - the form and strength of the preparation
    - either the total quantity (in both word and figures) of the preparation, or the number (in both words and figures) of dosage units, as appropriate, to be supplied in any other case the total quantity (in both words and figures) of the controlled drug to be supplied.
    - the dose

- In a guideline for responsibility on prescribing [7] the Department of Health has advised that the legal responsibility for prescribing lies with the doctor who signs the prescription.
- It is good practice to review the drug chart of every patient as part of a normal ward round. This would also be the case when new drugs are to be prescribed or there is a change in the patient's condition.

Comment

Where these guidelines and instructions are not followed patient care and safety may be compromised due to:

- Confusion as to whether the drugs are to be given regularly or irregularly.
- Important doses of required drug medication being missed.
- Confusion and misunderstanding over the appropriate dose of drug to use and when it should be used.
- A risk of treating patients symptomatically when medical reassessment of a patient's condition would be more appropriate.

In particular I can find no justification for writing up drugs for a possible syringe driver on a PRN part of a drug chart with a very large dosage range in many cases (20 – 200 mgs of Diamorphine). The reasons for this are:

- A decision to start a syringe driver is an important clinical decision that should always require the patient to be seen and reassessed.
- Syringe driver medication should always be written up on the regular side of the drug chart and the prescription should be re-written each time the dosage is changed.

- It might be appropriate for single PRN doses of an oral or parental opioid to be made available on the PRN side of the drug chart with a very small dosage range in those cases where the medical assessment had already noted pain or other symptoms that might not be managed in a short period of time while awaiting further medical attention. 24 hour medical attention was available for all patients at GWMH.
- There is a theoretical risk that a high and clinically inappropriate dose of drugs could be mistakenly started at any time without further medical review or assessment.

2.3 Limits of clinical competence

The GMC Guidelines above state that in providing care the clinician must:

- Recognise the limits of their professional competence.
- Be willing to consult colleagues.

All patients on Dryad and Daedalus Ward had a named consultant Geriatrician responsible for their care. However, the day to day responsibility was devolved to the clinical assistant, a General Practitioner. There is no doubt that many of the patients had complex multiple pathology and were challenging clinical and management problems. The type of complexity faced in managing older people at GWMH included:

- Being prepared to look for a medical reason for change in status or symptomatology. For example a recent onset of confusion may indicate an undiagnosed and untreated urinary tract infection.
- High technology interventions and diagnostics were not available on the Gosport War Memorial Hospital site. Yet such interventions are often crucial in the modern management of patients. It would have been a significant decision to have to arrange for a patient to return to a DGH for an investigation or in-patient care. Such decisions should normally be subject to discussion between the clinical assistant and the consultant in charge of the patient or the consultant on call.
- In patients with multiple pathology where there has been active treatment so far but a further significant clinical events happens. Whether to continue to actively treat, investigate or to make a decision regarding palliative and terminal care can often be complex and emotional. A multi-disciplinary approach involvement of a senior clinician, usually the consultant in charge of the patient's care, would be normal good practice.

3. Matters specific to the Gosport War Memorial Hospital

3.1. The position of a Clinical Assistant

Clinical assistant posts are part-time hospital posts that were initially intended for GPs who wished to work in hospital and were appointed under paragraph 94 of Terms and Conditions of Service[8]. GP clinical assistants can do no more than 9 notional half days. There are no clearly defined terms and condition of service. The role is a career grade role, not a training role and may be permanent. They are usually responsible to a named consultant. Clinical assistants may have had variable experience before being appointed to a post but there is no minimal standard set. It is the employing

organisation that would be responsible for ensuring any clinical assessment had the appropriate skills and training to undertake the task set out in the job description.

3.2 The Job Description

The job description[9] is undated but confirms that the clinical assistant is responsible for a maximum of 46 patients. The job description makes clear there is:

- There is 24 hour medical cover and to be available on call as necessary.
- To ensure that all new patients are seen promptly after admission.
- To be responsible for writing up the case notes and ensuring that follow up notes are kept up to date and reviewed regularly.
- To take part in the weekly consultant ward round.

However there is no comment on the medical cover to be provided if the post holder is unavailable out of hours or for longer periods of leave such as holiday.

There is some confusion in the job summary as it states that it is to provide 24 hour cover to the long stay patients but then goes on to state that patients are "slow stream" or "slow stream rehabilitation".

References

1. World Health Organisation: Cancer Pain Relief and Palliative Care. WHO, Geneva, 1990.
2. Palliative Care Handbook: Guidelines on Clinical Management. 3rd Edition, Salisbury Palliative Care Services (also known as "Wessex Protocols"), May 1995.
3. British National Formulary.
4. ABC of Palliative Care: Principles of Control of Cancer Pain. BMJ: 332; 1022-1024, 2006.
5. Welsh J, Fallon M, Keeley P W. Chapter 23, Brocklehurst Text Book of Medicine 6th Ed. 2002
6. Good Medical Practice. The GMC, October 1995.
7. DoH Circular EL (91) 127.
8. Terms and Conditions of Service, paragraph 94.
9. Job Description for the post of Clinical Assistant to the Geriatric Division in Gosport War Memorial Hospital.

From: Code A
Sent: 23 April 2008 16:12
To: Tamsin Hall ffw (formerly Tomlinson) Code A
Cc: Code A
Subject: Dr Barton

Hello,

Code A

From: Rebecca Faulkner Code A
Sent: 22 April 2008 10:44
To: Code A
Cc:
Subject: Dr Barton Further Stage 5 (22 April 08)
Attachments: Barton Further Stage 5 22 April 08.doc; GMC Case Protocol stage 5 form.doc; Annex F - BT Meet Me Guide.doc

Hello,

Please find attached the minutes of this morning's conference

<<Barton Further Stage 5 22 April 08.doc>>

As noted, we will speak again on 5 June 08 at 10:00. Blank agenda and dial in details attached for your reference.

<<GMC Case Protocol stage 5 form.doc>> <<Annex F - BT Meet Me Guide.doc>>

Kind regards,

Rebecca

Rebecca Faulkner
Adjudication Co-ordinator
General Medical Council
Manchester DDI : Code A

GMC Case Protocol - Stage 5 Telephone Conference

Attendees:
Sarah Ellson Field Fisher Waterhouse
Ian Barker, Medical Defence Union
Code A GMC Investigation Officer
Rebecca Faulkner, GMC Adjudication Team

Apologies: Tamsin Hall, Field Fisher Waterhouse, unable to attend owing to ill health

Case: Dr Barton

Conference date: 22 April 2008 @ 10:00

	Action	Outcome
1.	Stage 3 actions complete? Details have been sent to Defence of 2 extra patients and the reports have been completed. GMC anticipate confirming to Defence by the end of the week if either or both of the additional cases will be included, along with finalised charges. The majority of other evidence is up to date, awaiting finalisation are production statements, and 2 statements (Tandy and Reed) and that of a family member. The interviews have been carried out. Defence position remains largely the same as at the last telecon of 4 March 08. The large volume of material and extended preparation period for the GMC – noted without prejudice – has compressed Defence preparation time. Defence note that they will move forward as best they can, and suggested a further conference to keep matters closely under review. All parties agreed, and a further conference is scheduled for **5 June 08 at 10:00.** An earlier conference can be scheduled should Defence require it.	No
2.	Any outstanding procedural or legal issues? Defence sought clarification on the calling of a Pharmacy expert – GMC noted that this was more in the spirit of a 'text book of drugs available at the time' rather than a whole new case. Defence also questioned when he could expect 3 further particular statements – GMC will be in contact via email with 48 hours on this point.	Yes
3.	Are you aware of any health issues regarding the doctor, which may affect the planned hearing date for this case	TBC
4.	Confirm hearing date A non sit day occurs at panellist request on 8 Oct. GMC stated that any more than 1 non sit day would be prejudicial to the completion of the case. Parties will keep this under review, and if necessary can look at listing for	8 Sep – 31 Oct 08

	additional time.	
5.	Confirm time estimate	39 Days
6.	Confirm location of hearing	London
7.	Check whether there will witnesses giving evidence via video link up. If so check where they will be giving evidence from i.e Country or location in UK	TBC
8.	Check whether facilities are required i.e: Video player / tape player etc	TBC

GMC Case Protocol - Stage 5 Telephone Conference

Case: **PPC referral:**

Conference date:

Areas to be covered

	Action	Outcome
1.	Stage 3 actions complete? If no, please record below actions and timescale for completion	Yes / No (please circle)
2.	Any outstanding procedural or legal issues? If so, please record below	Yes / No (please circle)
3.	Are you aware of any health issues regarding the doctor, which may affect the planned hearing date for this case	
4.	Confirm hearing date	Date:
5.	Confirm time estimate	Days:
6.	Confirm location of hearing	Location:
7.	Check whether there will witnesses giving evidence via video link up. If so check where they will be giving evidence from i.e Country or location in UK **Any details here**	Yes / No
8.	Check whether facilities are required i.e: Video player / tape player etc	Yes / No

Annex F

GMC Pre-adjudication case management procedure

BT MeetMe telephone conferencing – A step-by-step guide

Participant passcode: Code A

MeetMe telephone no: Code A

1. Date and time of telephone conference must be agreed in advance.

2. At the agreed time, ring the MeetMe telephone number - Code A Code A

3. You will be prompted to enter the participant passcode.

4. Enter Code A and then a #.

5. You may be prompted to give your name. Please do so, if asked, and accept the subsequent recording.

6. Wait for the telephone conference to start.

Points to note

- The telephone conference cannot begin until the GMC Adjudication Management Section listings officer (as Chair) has joined it.

- The cost to participants (doctor and/or legal representatives and GMC solicitors) will be that of a normal telephone call. All call costs will be borne by the GMC.

- It is important to call in at the agreed time so that we are efficient with time and money.

- Participants can use additional features during the telephone conference:

  *0 Signals BT co-ordinator for assistance;

  *4 Automatic volume equalisation (adjusts the volume of your line);

  *6 Mutes/unmutes your telephone line (useful for noisy connections).