Version 2 of complete report 19th November 2005 – Robert Wilson

SUMMARY OF CONCLUSIONS

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

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

It is my belief that the prescription of a total of 50 mgs of Oramorphine on the 15th October following the 20 mgs that were given on the 14th October was not an appropriate clinical response to the pain in Mr Wilson's left arm. In my view this dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th-16th October, in particular, his rapid mental state deterioration. In my view this treatment was negligent, and more than minimally contributed to the death of Mr Robert Wilson on 19th October.

1.INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to his 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.

2.3. If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups.

3. CURRICULUM VITAE

Name	Professor David Andrew Black
Address	Code A
Telephone	Code A E-mail: Code A

DOB	23rd March 1956
Place	Windsor, England.
GMC	Full registration. No: Code A
Defence Union	Medical Defence Union. No: Code A

EDUCATION	Leighton Park School, Reading, Berks.	1969-1973
	St John's College, Cambridge University.	1974-1977
	St Thomas' Hospital, London SE1	1977-1980

DEGREES AND QUALIFICATIONS

BA, Cambridge University	1977
(Upper Second in Medical Sciences)	
MB BChir, Cambridge University	1980
MA, Cambridge University	1981
MRCP (UK)	1983
Accreditation in General (internal) Medicine	
and Geriatric Medicine	1989
FRCP	1994
MBA (Distinction) University of Hull.	1997

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Certificate in Teaching	2001
NHS/INSEAD Clinical strategists program	2003

SPECIALIST SOCIETIES

British Geriatrics Society

British Society of Gastroenterology

British Association of Medical Managers

PRESENT POST

Dean Director of Postgraduate Medical and Dental Education	
Kent, Surrey and Sussex Deanery.	2004-present
Honorary Chair in Medical Education. Brighton & Sussex	
Medical School.	2005
Consultant Physician (Geriatric Medicine)	1987-present
Queen Mary's Hospital, Sidcup, Kent.	
Associate member General Medical Council	2002-present

PREVIOUS POSTS

Associate Dean.	
London Deanery.	2004
Medical Director (part time)	1997-2003
Queen Mary's Hospital	
Operations Manager (part time)	1996-1997
Queen Mary's Hospital, Sidcup, Kent	
Senior Registrar in General and Geriatric Medicine	
Guy's Hospital London and St Helen's Hospital	
Hastings.	1985-1987
Registrar in General Medicine and Gastroenterology	
St Thomas' Hospital, London.	1984-1985
Registrar in General Medicine	
Medway Hospital, Gillingham, Kent	1983-1984
SHO rotation in General Medicine	

Kent & Canterbury Hospital, Canterbury	1982-1983
SHO in General Medicine	
Kent & Sussex Hospital, Tunbridge Wells	1981-1982
House Physician, St Thomas' Hospital	1981
House Surgeon, St Mary's Portsmouth	1980

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The Geriatricians view of the NSF. BGS Autumn Meeting 2001

The Organisation of Stroke Care. Physicians and managers working together to develop services. Professional training and clinical governance in geriatric medicine. All at Argentinean Gerontological Society 50th Anniversary meeting. Nov 2001

The future of Geriatric Medicine in the UK. Workshop: American Geriatrics Society May 2002

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4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Robert Wilson (BJC/55)

[2] Operation Rochester Briefing Document Criminal Investigation Summary.

[3] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[4] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).

[5] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

5. **CHRONOLOGY/CASE ABSTRACT.** (The numbers in brackets refer to the page of evidence).

5.1. Robert Wilson a 74 year old gentleman in 1998 attended Queen Alexandra Hospital, Portsmouth A&E Department on the 21st September 1998 (125-127) with a fracture of the left femoral head and tuberosity (169).

5.2. Mr Wilson had suffered many years before with Malaria and Diphtheria (143) but was first noticed to be abusing alcohol at the time of an endoscopy in 1994 (313). In 1997 he was admitted to

hospital with a fall, epigastric pain and was found to have evidence of severe alcoholic liver disease (129). During the 1997 admission, an ultra sound showed a small bright liver compatible with cirrhosis and moderate ascites (129). His Albumin was very low at 19 (150) and a bilirubin was 48 (129). All these are markers of serious alcoholic liver disease with a poor long term prognosis. His weight was 100 kgs (152). There is no record of follow up attendance.

5.3. When he attends A&E it is originally intended to offer him an operation on his arm, which he refuses. However, he is kept in A&E overnight for observation (161-2). It becomes apparent by the next day that he is not well, is vomiting (163) and he is needing Morphine for pain (11). His wife is on holiday (11) and it is not thought possible for him to go home so he is transferred on 22nd September to the Care of the Elderly team at the Queen Alexandra Hospital (163).

5.4. The day after admission he is no longer thought fit enough to have an operation on his arm, although he would now be prepared to. He is recognised to have been an extremely heavy drinker with considerable oedema and abdominal distension on admission (167). He has abnormal blood tests on admission including a mild anaemia of 10.5 with a very raised mean cell volume of 113 and his platelet count is reduced at 133 (239). Five days later his haemoglobin has fallen to 9.7 and the platelet count has fallen to 123 (237). There are no further full blood counts in the notes, although his haemoglobin was normal with haemoglobin of 13 in 1997 (241).

5.5. He is noted to have impaired renal function with a Urea of 6.7 and a Creatinine of 185 on admission (209) and on 25th September Urea of 17.8 and a Creatinine of 246 (203). He is started on intravenous fluids on 27th September (12) and his renal function then continues to improve so that by the 7th October both his Urea and Creatinine are normal at 6.1 and 101 (199).

5.6. His liver function is significantly abnormal on admission and on 29th his albumin is 22, his bilirubin 82 (he would have been clinically jaundice) there is then little change over his admission. On the 7th October is albumin is 23 and his bilirubin also 82 (199). His AST is 66 (171).

5.7. His vomiting within 24 hours of admission may have been due to alcohol withdrawal but he had also been given Morphine for pain (11). He is started on a Chlordiazepoxide regime (11) as standard

management plan to try and prevent significant symptoms of alcohol withdrawal. This has some sedative effects as well.

5.8. His physical condition in hospital deteriorates at first. He is noted to have considerable pain for the first 2 – 3 days, he is found to have extremely poor nutritional intake and has eaten little at home (12). His renal function deteriorates as documented above. He is communicating poorly with the nursing staff (28) and is restless at night on 30th September (30). His Barthel deteriorates from 13 on 23rd September to 3 on the 2nd October (69), his continued nutritional problems are documented by the dietician on 2nd October (16). In the nursing cardex he is vomiting, he has variable communication problems, he is irritable and cross on 1st October (30). On 4th October (16) his arm is noted to be markedly swollen and very painful and it is suggested he needs Morphine for pain (31). The following day he knocks his arm and gets a laceration (16).

5.9. There is ongoing communication with his family which is complicated by inter-family relationships between his first wife's family and his current wife. The plan by 6th October is that he will need nursing home care when he leaves hospital and his Barthel at this stage is 5 (16) (69). However on the 5th the nursing cardex note that he is starting to improve (32) although, he remains catheterised and has been faecally incontinent on occasion.

5.10. On 7th October is now more alert and is now telling the staff that he wishes to return home (17). The nursing staff notes that he is now much more adamant in his opinions (33). However on 8th he had refused to wash for 2 days (18). He is then reviewed at the request of the medical staff by a psycho-geriatrician. The opinion is that he has early dementia, which may be alcohol related and depression. He is noted to be difficult to understand with a dysarthria (117-118). He is started on Trazodone as an antidepressant and as a night sedative, he is still asking for stronger analgesics on 8th October (35). The letter also mentions (429) rather sleepy and withdrawn..... his nights had been disturbed.

5.11. On the 9th October an occupational therapy assessment is difficult because he is reluctant to comply and a debate occurs about whether he is capable of going home (19). By the 12th October (21) his Barthel has improved to 7 (69) so Social Services say that he no longer fits their criteria for a nursing homeand he should now be considered for further rehabilitation (21). The nursing cardex notes that his catheter is out (35) he is eating better but he

still gets bad pain in his left arm (36). His arms, hands and feet are noted to be significantly more swollen on 12th October (36). His weight has now increased from 103 kgs on 27th September to 114 kgs by 14th October (61,63). However his Waterlow score remains at "high risk" for all his admission (71). A decision is made to transfer him for possible further rehabilitation, although the medical review on 13th October states in view of the medical staff and because of his oedematous limbs, he is at high risk of tissue breakdown. He is also noted to be in cardiac failure with low protein and at very high risk of self neglect and injury if he starts to take alcohol again. He currently needs 24 hour hospital care (21).

5.12. On 14th October he is transferred to Draed Ward and the notes (179) say "for continuing care". The notes document the history of fractured humerus, his alcohol problem, current oedema and heart failure. No examination is documented. The notes state that he needs help with ADL, he is incontinent, Barthel 7, he lives with his wife and is for gentle rehabilitation. I am unable to read four words. The single word on the line above incontinence, two words after lives with wife (this may be a street address) and the word in front of gentle mobilisation.

5.13. The next medical notes (179) are on 16th October and state that he had declined overnight with shortness of breath. On examination he is reported to have a weak pulse, unresponsive to spoken orders, oedema plus plus in arms and legs. The diagnosis is "? silent MI, ? liver function" and the treatment is to increase the Frusemide. The nursing cardex for 14th October confirms he was seen by Dr Barton, that Oramorphine 10 mgs was given and he was continent of urine. On 15th October the nursing notes 9265) state commenced Oramorphine 10 mgs 4 hourly for pain in left arm, poor condition is explained to wife. On 16th on the nursing cardex he is "seen by Dr Knapman am as deteriorated overnight, increased Frusemide". However I find some possible confusion with the nursing care plan (278), this states for 15th October, settled and slept well, Oramorphine 20 mgs given 12 midnight with good effect, Oramorphine 10 mgs given 06.00 hours. Condition deteriorated overnight, very chesty and difficulty in swallowing medications. Then on 16th it states has been on syringe driver since 16.30 hours. As will be seen from the analysis of the drug chart, Mr Wilson received the Oramorph at midnight on 15th and then 06.00 hours Oramorph on 16th. The first clinical deterioration is on the night of 15th – 16th October not the night of the 14th – 15th October.

5.14. The next medical note is on 19th October which notes that he had been comfortable at night with rapid deterioration (179) and death is later recorded at 23.40 hours and certified by Staff Nurse Code A The nursing cardex mentions a bubbly chest late pm on 16th October (265). On the 17th Hyoscine is increased because of the increasing oropharyngeal secretions (265). Copious amounts of fluid are being suctioned on 17th. He further deteriorates on 18th and he continues to require regular suction (266). The higher dose of Diamorphine on the 18th and Midazolam is recorded in the nursing cardex (266).

5.15. Two Drug Charts: The first is the Queen Alexandra drug chart (106-116). This records the regular laxatives, vitamins and diuretics given for his liver disease. The reducing dose of Chlordiazepoxide stops on 30th September for his alcohol withdrawal and the Trazodone started for his mild depression and night sedation. In terms of pain management Morphine, slow IV or subcutaneous 2.5 – 5 mgs written up on the prn side and 5 mgs given on 23rd September and 2.5 mgs twice on 24th September. Morphine is also written up IM 2 – 5 mgs on 3rd October and he receives 2.5 mgs on 3rd and 2.5 mgs on 5th. He is also written up for prn Codeine Phosphate and receives single doses often at night up until 13th October but never needing more than 1 dose a day after 25th September. Regular Co-dydramol starts on 25th September until 30th September when it is replaced by 4 times a day regular Paracetamol which continues until his transfer.

In summary, his pain relief for the last week in the Queen Alexandra is 4 times a day Paracetamol and occasional night time dose of Codeine Phosphate.

5.16. The second drug chart is the drug chart of the Gosport War Memorial Hospital (258-263). His diuretics, anti-depressant, vitamins and laxatives are all prescribed regularily. The regular Paracetamol is not prescribed but is written up on the as required (prn) after the drug chart. This is never given. Regular prescriptions also contains Oramorphine 10 mgs in 5 mls to be given 10 mgs 4 hourly, starting on 15th October (261). 10 mgs is given at 10 am, 2pm and 6 pm on 15th, 6am, 10 am and 2 pm on 16th. A further dose of 20 mgs at night given at 10 pm is given at 10 pm on 15th October. Although these prescriptions are dated 15th October it is not clear if they were written up on the 14th or 15th.

5.17. On a further sheet of this drug chart (262) regular prescription has been crossed out and prn written instead. Oramorphine, 10 mgs in

5 mls, 2.5 – 5 mls 4 hourly is then prescribed on this sheet. It is not dated but it would appear 10 mgs is given at 2.45 on 14th October and 10 mgs at midnight on 14th October. Further down this page Diamorphine 20 – 200 mgs subcut in 24 hours from Hyoscine 200 – 800 micrograms subcut in 24 hours, Midazolam 20 – 80 mgs subcut in 24 hours are all prescribed. It is not clear what date these were written up. The first prescription is 16th October and the 20mls of Diamorphine with 400 micrograms of Hyoscine are started at 16.10. On 17th October, 20 mgs of Diamorphine, 600 micrograms of Hyoscine are started at 5.15 and the notes suggest that what was left in the syringe driver at that stage was destroyed (262). At 15.50 hours on 17th October, 40 mgs, 800 mgs of Hyoscine and 20 mgs of Midazolam are started and on 18th 60 mgs of Diamorphine, 1200 micrograms of Hyoscine (a new prescription has been written for the Hyoscine) and 40 mgs of Midazolam are started in the syringe driver at 14.50 and again the notes suggest the remainder that was previously in the syringe driver is destroyed.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1. This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Robert Wilson. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Robert Wilson, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2. The principle underlying medical problem in Mr Wilson is his alcoholic liver disease. There is no doubt that he had hepatocellular failure based on long-standing alcohol abuse, with evidence at least back to his admission in 1997 where he has evidence of portal hypertension giving him a significant ascites. He also at that stage had a low albumin and a persistently raised bilirubin, hall-markers of a poor medium to long-term prognosis.

6.3. The presenting problem on admission was his complex fracture of his left upper arm, which ideally would have had an operative repair. First he refuses this, and then by the time he agrees it his physical status has significantly deteriorated to a point that he was not fit for an anaesthetic. He gets continual pain from this arm throughout his admission. His admission treatment is strong opiate analgesia; this is then replaced by regular oral mild opiate analgesia and finally by regular Paracetamol supplemented by

mild oral opiate analgesia (Codeine Phosphate) at night. There is no doubt though that he does have continuing pain from this arm.

6.4. His health deteriorates for at least the first 7 – 8 days after his admission. He develops impaired renal function; there is evidence of change in mental state with comments on poor communication, sleepiness, irritability and restlessness, and "dysarthria". There are a number of possibilities for this. The first possibility is that he is having alcohol withdrawal, combined with the sedative effect of Chlordiazepoxide to prevent marked symptoms of alcohol withdrawal delirium. The psycho-geriatrician wonders if he has alcohol related dementia plus some depression. I believe it is very likely that he has early hepatic encephalopathy, a change in mental state that goes with hepatic failure. This includes disturbed consciousness with sleep disorder, personality change and intellectual deterioration. It is often precipitated by acute events including gastro-intestinal blood loss and drugs, in particular opiates. There is evidence of other deterioration in his liver function including a reduced platelet count suggesting an enlarged spleen due to portal hypertension, his bilirubin which is significantly higher than his previous admission and his persistent very low albumin. His haemoglobin does fall during admission. It is possible that he has had a small gastro-intestinal bleed at some stage but this is not pursued.

6.5. Despite all of this, there is a an improvement in his condition recorded in both his better functioning on the ward with the nursing staff, his greater alertness and communication improvement. The fact that his catheter can be removed and he becomes continent and that his overall measured functional status through the Barthel score improves to a point that Social Services will no longer place him in a nursing home, although he clearly needs nursing care. However, his weight dramatically increases by 11 kgs during his admission and this will be almost entirely fluid retention going to his abdomen, legs and potentially his chest. This is not adequately managed medically.

6.6. He is transferred on 14th October for ongoing assessment, possible rehabilitation and decisions about long-term care arrangements. No examination has been recorded on admission by the medical staff. Not even a basic clinical examination has been undertaken which appears to me to be poor clinical practice to the standards set by the General Medical Council.

6.7. The only management that is really needed at this stage is to continue the management that was ongoing from the Queen

Alexandra Hospital while gently addressing the fluid balance problems. However the regular oral analgesics that he was on are not written up regularly, no explanation is given for this. Strong opioid analgesia is written up and two doses of 10 mgs Oramorphine are given on the day of transfer, the 14th October. At the Queen Alexandra Hospital the single doses on the 3rd and 5th October has been at 2.5 mgs. Regular Oramorphine to a total dose of 50 mgs is then given on the 15th October. It is now being given regularly and it is not clear whether the original intention to give it regularly was from the admission on the 14th, though the prescription is clearly written and starts at 10 am on 15th. There is no documentation in the nursing or medical notes to suggest the patient was seen by a doctor on 15th where the decision to start the regular dose of Morphine appears to be made.

6.8. The decision to give regular Morphine at this dose on 15th October is crucial to the future understanding of this case. *".....the effects of hepatitis or cirrhosis on drug deposition range from impaired to increased drug clearance in an unpredictable fashion..... the oral availability for high first class drugs such as Morphine.....is almost double in patients with cirrhosis compared to those with normal liver function. Therefore the size of the oral dose of such drugs should be reduced in this setting" (Harrison).* In my view the decision to give regular oral doses of high oral doses of strong opiates on 15th was negligent. The appropriate use of weaker analgesics had not been used, though these had controlled his symptoms the previous week in the Queen Alexandra Hospital. The dose of Morphine used, particularly in the presence of severe liver disease, was very likely to have serious implications.

6.9. By the 16th October there has been a very significant clinical deterioration overnight and Mr Wilson is examined by a doctor. He is noted to be unwell and unresponsive to spoken orders. While it is possible that Mr Wilson has gone into heart failure to frank left ventricular failure due to his salt and water retention documented previously, the unresponsiveness makes it almost certain in my view that he is either now unresponsive because of a direct cerebral effect of the Morphine or he is being precipitated again into Hepatic Encephalopathy. The situation may or may not have been reversible but he is probably now entering a period of irreversible terminal decline. However, it would have been appropriate to have obtained senior medical opinion as to whether other management should be considered. In my view, the failure to obtain senior medical opinion was poor clinical practice.

6.10. He is no longer able to take oral medication and as the clinical decision has been made that he is now in terminal decline he is started on a syringe driver containing Diamorphine and Hyoscine. Diamorphine, Hyoscine (and Midazolam) are all compatible in the same syringe driver. Hyoscine is particularly useful for patients with a large amount of secretion as is documented in this case. When starting Diamorphine in a syringe driver it is conventional to do it at a dose of 2 to 1 i.e. half the dose of Diamorphine in the syringe driver than was being given orally. On 15th October 50 mgs in total of Oramorphine was prescribed, it was reasonable to start 20 mgs in the syringe driver on 16th October. The dose of Diamorphine is increased on both 17th and 18th and Midazolam is started on 17th. Apart from comments about secretions in the nursing cardex, there is no rationale for the increase in dose of Diamorphine or the addition of Midazolam provided in either the medical or nursing notes. It is not clear whether the decision to increase the dose is a medical or nursing decision. I have indicated in section 5 that there are significant problems with the use of the drug chart in Gosport which seems to have been used in an irregular fashion.

6.11. It is my view the regular prescription and dosage of Oramorphine was unnecessary and inappropriate on 15th October and in a patient with serious hepatocellular dysfunction was the major cause of the deterioration, in particular in mental state, on the night of 15th and the 16th. In my view it is beyond reasonable doubt that these actions more than minimally contributed to the death of Mr Wilson.

7. OPINION

7.1. Mr Robert Wilson is a 71 year old gentleman with known severe alcoholic liver disease who was admitted with a complex and painful fracture of the left upper humerus. His physical condition deteriorates at first in hospital, with alteration in mental state, renal impairment and subsequent gross fluid retention. He then starts to improve and is transferred to the Gosport War Memorial Hospital for further assessment and possible rehabilitation or continuing care. He is started on regular oral strong opiate analgesia for pain in his left arm and rapidly deteriorates and dies within 5 days of admission.

7.2. There is weakness in the documentation of his condition, in particular on the admission to the Gosport War Memorial Hospital on 14th October, and on the15th October when the regular oral strong opiate analgesia is commenced. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of

the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must provide clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatments provided". The lack of clinical examination on admission and on the day of 15th October when the decision was made to start regular strong oral opiate analgesia represents poor clinical practice to the standards set by the General Medical Council.

7.3. It is my belief that the prescription of a total of 50 mgs of Oramorphine on the 15th October following the 20 mgs that were given on the 14th October was not an appropriate clinical response to the pain in Mr Wilson's left arm. In my view this dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th-16th October, in particular, his rapid mental state deterioration. In my view this treatment was negligent, and more than minimally contributed to the death of Mr Robert Wilson on 19th October.

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129
6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.
7. Diseases of the Liver and Biliary System. Sheila Sherlock and James Dooley. 9th Edition Oxford 1993.
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9. 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.

10. 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: _____