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Preliminary Proceedings Committee
12 and 13 April 2010

Agenda Item - Part 2 (joint case)

Name:	Code A
Case Reference Number:	**12053.1/11978**
PIN:	**81F0106E**
Date of Birth:	Code A
Part(s) of the register and fields of practice:	**Registered nurse (sub part 1) Adult – September 1984**
Council's lawyers	**None**
Complainant:	**1. Mrs M Jackson** **2. Mrs M Bulbeck** **3. Mrs RE Carby**
Date of incident(s):	**August 1998; April 1999; May 2001**
Date complaint received:	**2002**

Summary of allegations: failure to maintain accurate patient records; failed to ascertain the level of care a patient was in; failed to monitor a patient and keep her family informed; failed to ensure that meals were within reach of a patient; failed to ensure that the alarm bell was within her reach; failed to ensure that a patient was kept warm; failed to ensure that a patient received basic nursing care or treated with dignity; was negligent in the care of a patient.

Name:	Code A
Case Reference Number:	**12053.2/12010**
PIN:	**70G0632E**
Date of Birth:	Code A
Part(s) of the register and fields of practice:	**Registered nurse (sub part 1) Adult – July 1970**
Council's lawyers	**None**
Complainant:	**1.** Code A **2. Mr B Page**
Date of incident(s):	**February – March 1998; November 1999**
Date complaint received:	**2002**

Summary of Allegations: failed to act in the interests of a patient; failed to act in the interests of a patient by failing to remove a fentanyl patch from her until three hours after the morphine syringe driver has started; failed to provide accurate information to a patient's family; returned patient's clothes to her family saying they were "too good" for a hospital stay; failed to ensure accurate notes were maintained for a patient; made a false assertion about a patient; made an unprofessional comment about tension between family members of a patient..

Name:	Code A
Case Reference Number:	**12053.3/12011**
PIN:	**72A0602S**
Date of Birth:	Code A
Part(s) of the register and fields of practice:	**Registered nurse (sub part 1) Adult – November 1977** **Registered nurse (sub part 1) Learning Disabilities – March 1975**
Council's lawyers	**None**
Complainant:	**1. Mr B Page** Code A
Date of incident(s):	**February/March 1998; November 1999**
Date complaint received:	**2002**

Summary of Allegations: failed to act in the interests of a patient; failed to provide adequate information to a patient's family about her medication or deterioration.

Name:	Code A
Case Reference Number:	**12053.5**
PIN:	**91C1104E**
Date of Birth:	**02.02.1971**
Part(s) of the register and fields of practice:	**Registered nurse (sub part 1) Adult – March 1994**
Council's lawyers	**None**
Complainant:	**Mrs RE Carby**
Date of incident(s):	**April 1999**
Date complaint received:	**2002**

Summary of Allegations: negligent in the care provided to a patient.

Name:	Code A
Case Reference Number:	**12053.6/12012**
PIN:	**82G0508E**
Date of Birth:	Code A
Part(s) of the register and fields of practice:	**Registered nurse (sub part 1) Adult – November 1985** **Registered midwife – March 1991 (lapsed)**
Council's lawyers:	**None**
Complainant:	Code A
Date of incident(s):	**November 1999.**
Date complaint received:	**2002**

Summary of allegations: while no specific allegation is made against Mrs Barker, she is named within a complaint about the standard of care provided to a patient.

Name:	Code A
Case Reference Number:	**12053.3/12013**
PIN:	**78E2469E**
Date of Birth:	Code A
Part(s) of the register and fields of practice:	**Registered nurse (sub part 2) Adult –** **September 1980**
Council's lawyers	**None**
Complainant:	Code A
Date of incident(s):	**November 1999**
Date complaint received:	**2002**

Summary of allegations: while no specific allegation is made against Mrs Bell, she is named within a complaint about the standard of care provided to a patient.

Previously considered: 24 September 2002.

Decision: to adjourn the proceedings to await the outcome of the police investigation into this matter.

Papers attached:

Allegations	**Section A, pages 1 - 4**
Report prepared by the Fitness to Practise directorate's in-house legal team	**Section B, pages 1 - 22**
Index of documents	**Section C, pages 1 - 3**
Documentation submitted to the NMC and listed in the index	**1 - 360**
Reference submitted in respect of Code A 12 March 2010, Rose Butcher, Clinical Manager Multi Disciplinary Response Team, Hampshire Community Health Care NHS Trust	**361 - 362**
Report by Code A general practitioner, Dr Stuart RE Morgan, 3 March 2010*	**363**
Reference submitted in respect of Code A by Portsmouth Hospitals NHS Trust, undated.	**364**
Reference submitted in respect of Code A by Colleen Lloyd, Ward Sister, Division of Medicine for Older People, Portsmouth Hospitals NHS Trust, 4 February 2010	**365**
Email exchange between NMC and Portsmouth Hospitals NHS Trust, 2 March 2010	**366 - 368**

Reference submitted in respect of Code A by Alison Grant, Ward Manager, Dolphin Day Hospital, Gosport War Memorial Hospital, undated.	**369**
Reference submitted in respect of Code A by Dr Carmel Sheppard, Consultant Nurse – Breast Services, undated.	**370**
Reference submitted in respect of Code A by Hampshire Community Heath Care, 8 March 2010.	**371**
Practitioners' responses	**none at this time**

* **Note:** while Hampshire Community Health Care NHS Trust was prepared to confirm to the NMC that Mrs Hamblin had retired on health grounds, it was not prepared to disclose the reasons for this without her written consent. Ultimately, it was decided not to pursue the Trust for any further information.

Case officer: Code A

Allegations

Code A

Case ref.: 12053.1/11978

That you, while employed as Clinical Manager, Daedalus Ward, Gosport War Memorial Hospital

In respect of Patient A (Alice Wilkie)

1. failed to maintain accurate patient records

    1. on 17 August 1998, by writing a note suggesting that her daughter, Mrs Jackson, had agreed to a syringe driver for Patient A and that active treatment was not appropriate;

    2. on 21 August 1998, wrote in Patient A's clinical notes that her family had been present when she had died when they had not been;

2. on 20 August 1998, failed to ascertain the level of pain Patient A was in;

3. on 21 August 1998, failed to monitor Patient A appropriately and keep her family informed of her condition;

In respect of Patient B (Dulcie Middleton)

On dates between 29 May 2001 – 16 May 2001,

4. failed to ensure that meals were provided within her reach and on an occasion on an unknown date, without cutlery;

5. failed to ensure that her alarm bell was within her reach so that she could call for assistance;

6. failure to ensure that Patient B was kept warm;

7. failure to ensure that Patient B received basic nursing care or was treated with dignity;

In respect of Patient C (Stanley Carby)

8. Between 26 – 27 April 1999, were negligent in the care provided to Patient C

Code A

Case ref.: 12053.2/12010

That you, while employed as Clinical Manager at Gosport War Memorial Hospital NHS Trust

1. On dates from 27 February to 3 March 1998, failed to act in the interests of Patient D (Eva Page);

In respect of Patient E (Elsie Devine)

2. On 19 November 1999, failed to act in the interests of Patient E by failing to remove a fentanyl patch from her until three hours after the morphine syringe driver has started;

3. On or around 19 November 1999, failed to provide accurate information to Patient E's family when you telephoned that morning, in that you said that while she was confused you denied there was any urgency in family members attending;

4. In November 1999, returned clothes provided by Patient E's family by saying that they were "too good" for a hospital stay (as they were dry clean only);

5. In November 1999, failed to ensure accurate patient notes were maintained for Patient E in that

   there was an incorrect statement in the notes on 3 November 1999 that she could not climb stairs.

   a kidney infection was diagnosed and antibiotics started, but this was not written up in the notes.

At a subsequent independent review meeting relating to the care provided to Patient E:

6. suggested that she was agitated on the morning of 19 November 1999, but none of the family had ever seen her agitated.

7. made an unprofessional comment about Code A
   Code A

Code A

Case ref. 12053.3/12011

That you, while employed as a staff nurse at Redcliffe Annex and Dryad Ward, Gosport War Memorial Hospital,

1. On dates from 27 February to 3 March 1998, failed to act in the interests of Patient D (Eva Page).

2. On an unknown date in November 1999, failed to provide the family of Patient E (Elsie Devine) with any explanation about her medication;

3. On or around 19 November 1999, failed to adequately account to Patient E's family for her sudden deterioration.

Code A

Case ref.: 12053.4/12012

That you, while employed as a staff nurse on Daedalus Ward, Gosport War Memorial Hospital,

1. On 27 April 1999, failed to maintain accurate patient records in respect of Patient C (Stanley Carby), in that you failed to record the time in entries on the contact record;

2. Between 26 – 27 April 1999, were negligent in the care provided to Patient C.

Code A

Case ref.: 12053.5/12013

1. That you, while employed as a staff nurse on Daedalus Ward, Gosport War Memorial Hospital, between 26 – 27 April 1999, were negligent in the care provided to Patient C (Stanley Carby).

Code A

Case ref.: 12053.6 and 12053.7

Both practitioners have been advised that the NMC has received a complaint from Mrs Ann Reeves regarding the care her mother received while a patient at Gosport War Memorial Hospital.

The practitioners have been advised that while Mrs Reeves makes no specific allegation against them, they are named as part of her complaint as Patient E's named nurse (see page 295).

The practitioners have been advised that the complaint is to be considered by the Preliminary Proceedings Committee on 12 and 13 April 2010 and that, as their names appear in the attached bundle of documentation, we are offering them the opportunity to provide any comment they would like the committee to consider when it reaches its decision.

Report to the Preliminary Proceedings Committee

Gosport War Memorial Hospital Nurses

Report from the in-house legal team 12 March 2010

Introduction

1. This report summarises the background to this case, the material received by the NMC, and the current situation.

2. The NMC has received a number of complaints about named nurses at the Gosport War Memorial Hospital ("GWMH"), and a number of agencies have investigated concerns about clinical practice there in the late 1990s. Three wards are involved: Daedalus, Dryad, and (to a lesser extent) Sultan.

3. Those investigations began in September 1998. A patient named Mrs Richards had died on Daedalus Ward earlier that year, and her relatives made a complaint to the police. The police investigated the complaint, but in March 1999 the CPS advised that there was insufficient evidence to prosecute any member of staff for any offence.

4. The investigation was reopened in 2001. The police obtained an expert report into Mrs Richards' death from Professor Livesley. Three nurses were named in this report – Code A Code A In September 2001, the UKCC's PPC considered the matters raised in the Livesley report about Mrs Richards, and decided to close the case.

5. At about the same time, the CPS again advised the police that there was insufficient evidence to prosecute any member of staff.

6. As a result of local media coverage, other families contacted the police with concerns about the deaths of their relatives. The police referred five cases – Richards, Cunningham, Wilkie, Wilson and Page - to another expert, Professor Ford. Professor Ford reported in December 2001 (bundle pp 1 – 40)

7. The police made the expert reports available to a number of bodies, including the Commission for Health Improvement ("CHI"), General Medical Council ("GMC") and NMC.

8. The CHI conducted an investigation into the trust's systems since 1998, and reported in July 2002. The CHI report is at pp 43 - 135 of the bundle. The CHI's key findings were as follows:

    - There were insufficient local prescribing guidelines in place covering the prescription of powerful pain relieving and sedative medicines;
    - A lack of rigorous routine review of pharmacy data led to high levels of prescribing on wards caring for older people going unquestioned;
    - The absence of adequate trust-wide supervision and appraisal systems meant that poor prescribing practice went unidentified;
    - There was a lack of thorough multi-disciplinary patient assessment to determine care needs on admission;

9. By the time of the report in 2002, the Trust had resolved the problems by ensuring that adequate policies and guidelines were in place to govern the prescription and administration of pain relieving medicines.

10. In response to the Ford report, the NMC asked the Trust for comments. The Trust replied on 15 May 2002 with details of its response to the concerns raised (bundle pp 345 - 349). No disciplinary action was taken against any nurse.

11. Also in May 2002, Mr Page, son of Mrs Page, made a direct complaint to the NMC. He named nurses Code A (bundle p 334).

12. In June 2002, the NMC received three further complaints:

    - Mrs Jackson complained about nurse Code A in respect of her deceased mother Mrs Wilkie (bundle pp 281 - 283);
    - Code A complained about nurses Code A and Code A in respect of her deceased mother, Mrs Devine (bundle pp 295 - 298)
    - Mrs Bulbeck complained about the general care given to her deceased mother Mrs Middleton (she subsequently named Phillip Beed as being the manager with overall responsibility) (bundle pp 303 - 305; 310)

13. In August 2002, the NMC received a further complaint from Mrs Carby against nurses Code A in respect of her deceased husband Mr Carby (bundle p 321).

14. In September 2002, the police reopened the case and began a large-scale investigation into 90 deaths at the hospital. Further details of this investigation are given below, and in the attached police summary of the investigation (bundle pp 144 - 156)

15. On 24 September 2002, the PPC considered the following cases:

    - Code A – allegation from Jackson re: Wilkie
    - Code A – allegations from Code A re: Devine and Page re: Page
    - Code A – allegations from Code A re: Devine and Page re: Page
    - Code A – allegation from Code A re: Devine
    - Code A – allegations from Code A re: Devine

16. The Committee was assisted by a detailed summary of the evidence from Code A Code A (bundle pp 138 - 141). These cases were adjourned pending the outcome of the police investigation.

17. There is no evidence to suggest that the PPC has considered the Carby complaint against nurses Code A or the Bulbeck complaint against Code A.

Police investigation

18. In October 2004, Hampshire police provided the NMC with an update on the police investigation. The police had considered 90 patient deaths. They interviewed relatives of patients. They also commissioned a team of clinical experts: Irene Waters, a nursing expert (and at the time, an NMC panel member), Robin Ferner, a pharmacologist, Peter Lawson, a geriatrician, and Anne Naysmith, an expert in palliative care. Matthew Lohn of Field Fisher Waterhouse solicitors prepared a summary of evidence in most cases for the police.

19. The experts were instructed to review the medical records and provide an analysis of treatment. The doctors rated care given on a scale from 1 to 4, where 1 is optimal, 2 sub-optimal, 3 is negligent and 4 is intended to cause harm. They then assessed the cause of death, with A meaning natural causes, B meaning cause of death is unclear, and C meaning the cause of death is unexplained by illness. Cases were put into one of 3 categories. Cases were put into Category 1 where the experts concluded that treatment was acceptable. Category 2 cases were those where the treatment was considered to be sub-optimal, but did not present evidence of criminal activity. Category 3 cases were considered to warrant further investigation with a view to determining whether criminal activity took place.

20. By October 2004, the police had contacted all of the families of patients whose cases fell into Category 1 to notify them of their findings. The NMC was told that investigations in Category 3 cases were ongoing, and was not given the names of the patients whose cases fall into these categories.

21. It was agreed that the police would provide the NMC with all of evidence gathered in Category 2 cases. They had reached a similar agreement with the GMC. The police informed the relatives, who all consented to this course of action.

22. Throughout 2004, 2005 and 2006, the NMC received files relating to the 80 cases in Category 2. Typically, these contained the following information in respect of each case:

    - Police reports of interviews with family members (not in formal witness statement format);
    - Expert summaries;
    - Summary comments by Matthew Lohn;
    - Medical records;

23. We have logged each file and reviewed the police reports, expert comments, and summaries of the evidence. Except where these documents draw attention to particular points, we have not reviewed the medical records for each of the Category 2 patients.

24. Of the cases where relatives have made complaints to the NMC, all but one (Devine) fell into the police's Category 2, i.e. Wilkie, Page, Middleton and Carby.

25. In December 2006, the police announced the outcome of their investigation into the ten Category 3 cases. The Crown Prosecution Service had concluded that no further action should be taken on each of the cases (the police report is at pp 144 - 156 of the bundle; see p 155).

26. In March 2007, the police delivered further files to the NMC. These included a large number of generic further statements, full records of police interviews with Dr Barton and Dr Reid (a consultant at the hospital), expert reports, and witness statements and medical records relating to each of the ten Category 3 patients. The police had obtained statements from family members and all members of staff involved in the patients' care. They had instructed two further experts: Dr Wilcock, a palliative care expert, and Dr Black, a geriatrician. Further experts had been instructed to advise on individual cases as required. Mrs Devine's case was in this group.

27. Among this material was evidence that in 1991, at least one of the nurses (Anita Tubritt) had raised concerns about the use of syringe drivers. There was correspondence between management, the unions, and the staff, and meetings took place. The outcome of this process is not clear.

28. The police reported that the coroner might decide to hold inquests into the deaths of three patients (Mrs Devine, Mrs Lavender, and Mrs Gregory), as they had been buried rather than cremated.

Coroner's inquest

29. In fact, in March and April 2009, a coroner's inquest was held into the deaths of ten patients, one of whose death is the subject of a complaint to the NMC (Mrs Devine). A transcript of the jury's narrative verdict is attached (bundle pp 172 - 178).

30. In respect of Mrs Devine, the jury concluded that:

    - Her cause of death was 1(a) chronic renal failure 1(b) ameloidosis 1(c) IgA paraproteinaemia
    - Medication contributed to her death
    - The medication was given for therapeutic purposes
    - The medication was not appropriate for her condition and symptoms.

31. Also attached is an extract from the coroner's summing up, in which he summarises the evidence heard about Mrs Devine (bundle pp 157 - 171).

GMC proceedings against Dr Barton

32. In 2009 and 2010, the GMC hearing into Dr Barton's conduct took place. The proceedings were under the GMC's old rules. She was charged with serious professional misconduct arising out of her care for 10 patients:

    - Code A
    - Elsie Lavender
    - Eva Page (also an NMC case)
    - Alice Wilkie (also an NMC case)
    - Gladys Richards (was an NMC case, closed by the PPC in 2001)
    - Ruby Lake
    - Arthur Cunningham

- Robert Wilson
- Enid Spurgeon
- Geoffrey Packman
- Elsie Devine (also an NMC case)
- Jean Stevens

33. In respect of Mrs Page, the charges against Dr Barton, and the panel's findings, were as follows:

    4.(a)(i) On 27 February 1998 Patient C *(Mrs Page)* was transferred to Dryad Ward at GWMH for palliative care,

    Admitted and found proved

    (ii) On 3 March 1998 you prescribed diamorphine with a dose range of 20mg - 200mg and midazolam with a dose range of 20 - 80mg to be administered SC over a twenty four hour period on a continuing daily basis,

    Admitted and found proved

    (b)In relation to your prescription for drugs described in paragraph 4(a)(ii),

    (i) the dose range of diamorphine and midazolam was too wide,

    Admitted and found proved

    (ii) the prescription created a situation whereby drugs could be administered to the patient which were excessive to the Patient C's needs,

    Admitted and found proved

    (c)Your actions in prescribing the drugs described in paragraph 4(a)(ii) were,

    (i) inappropriate,

    Not admitted - proved

    (ii) potentially hazardous,

    Admitted and found proved

    (iii) not in the best interests of your patient;

    Not admitted - proved

34. The charges and findings in respect of Mrs Wilkie were as follows:

    5(a)(i) On 6 August 1998 Patient D (Mrs Wilkie) was transferred to Daedalus Ward at GWMH for continuing care observation,

    Admitted and proved

(ii)On or before 20 August 1998 you prescribed diamorphine with a dose range of 20mg - 200mg and midazolam with a dose range of 20mg - 80mg to be administered SC over a twenty four hour period on a continuing daily basis,

Admitted and proved

(b) In relation to your prescription for drugs as described in paragraph 5(a)(ii),

(i) the dose range was too wide,

Admitted and proved

(ii) the prescription created a situation whereby drugs could be administered to Patient D which were excessive to the patient's needs,

Not admitted - proved

(c) Your actions in prescribing the drugs as described in paragraph 5(a)(ii) were,

(i) inappropriate,

Not admitted - proved

(ii) potentially hazardous,

Admitted and found proved

(iii) not in the best interests of Patient D;

Not admitted - proved

35. The charges and findings relating to Mrs Devine were:

12(a)(i) Patient K was admitted to Dryad Ward at GWMH for continuing care on 21 October 1999 from Queen Alexandra Hospital She was reported to be suffering from chronic renal failure and multi infarct dementia,

Admitted and found proved

(ii) on admission you prescribed morphine solution 10mg in 5 ml as required,

Admitted and found proved

(iii) on 18 and 19 November 1999 there was a deterioration in the Patient K's condition and on 18 November 1999 you prescribed Fentanyl 25 µg by patch,

Admitted and found proved

(iv) on 19 November 1999 you prescribed diamorphine with a dose range of 40 - 80 mg midazolam with a dose range of 20 to 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

Admitted and found proved

(b) The prescription on admission described in paragraph 12(a)(ii) was not justified by the patient's presenting symptoms,

Not admitted - proved

(c) In relation to your prescription for drugs described in paragraph 12(a)(iv),

(i) the lowest doses of diamorphine and midazolam prescribed were too high,

Not admitted - proved

(ii) the dose range was too wide,

Not admitted – not proved re: diamorphine, proved re: midazolam

(iii) the prescription created a situation whereby drugs could be administered to Patient K which were excessive to the patient's needs,

Not admitted – proved

(d) Your actions in prescribing the drugs described in paragraphs 12(a)(ii), (iii) and/or (iv) were,

(i) inappropriate,

Not admitted - proved

(ii) potentially hazardous,

Not admitted – proved

(iii) not in the best interests of Patient K,

Not admitted - proved

(e) You did not obtain the advice of a colleague when Patient K's condition deteriorated;

Admitted and found proved

36. In relation to all patients, there were two general charges:

14(a) You did not keep clear, accurate and contemporaneous notes in relation to Patients A, B, C, D, E, F, G, H, I, J K and/or L 's care and in particular you did not sufficiently record,

(i) the findings upon each examination,

Admitted and proved re: Mrs Page, Mrs Wilkie and Mrs Devine

(ii) an assessment of the patient's condition,

Admitted and proved re: Mrs Page, Mrs Wilkie and Mrs Devine

(iii) the decisions made as a result of examination,

Admitted and proved re: Mrs Page, Mrs Wikie and Mrs Devine

(iv) the drug regime,

Not admitted - proved re: Mrs Page, Mrs Wilkie and Mrs Devine

(v) the reason for the drug regime prescribed by you,

Admitted and proved re: Mrs Page, Mrs Wilkie and Mrs Devine

(vi) the reason for the changes in the drug regime prescribed and/or directed by you,

Admitted and proved re: Mrs Page, Mrs Wilkie and Mrs Devine

(b) Your actions and omissions in relation to keeping notes for Patients A, B, C, D, E, F, G, H, I, J, K and/or L were,

(i) inappropriate,

Admitted and found proved re: Mrs Page, Mrs Wilkie and Mrs Devine

(ii) not in the best interests of your patients;

Admitted and found proved re: Mrs Page, Mrs Wilkie and Mrs Devine

15(a) In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K, L,

Not proved re: Mrs Page and Mrs Devine

Not admitted – proved re: Mrs Wilkie and Mrs Devine

(b) Your failure to assess the patients in paragraph (a) appropriately before prescribing opiates was not in their best interests.

Not proved re: Mrs Page

Not admitted – proved re: Mrs Wilkie

37. Extracts from the transcript of the GMC proceedings are attached (charges, bundle pp 179 – 198; determination, bundle pp 199 – 264; sanction, bundle pp 265 - 280).

NMC complaint cases

38. Having conducted preliminary reviews of the material available, I am able to summarise the cases as follows.

Evidence in the case of Page

39. On 17 May 2002, Mr Page wrote to the NMC to complain about nurses Gillian Hamblin, Freda Shaw and others unnamed. His mother died at GWMH in 1998. He did not express specific concerns about nursing care, but referred to the Ford report. It appears that at the time he wrote to complain, Mr Page had not seen a copy of the Ford report.

40. On 12 June 2002, the NMC wrote to ask Mr Page to provide details of his specific concerns about the nursing care his mother received (bundle pp 335 - 336). There is no evidence that he replied to this request. The NMC then wrote to him on 12 August 2002 to tell him that the PPC would consider the case and then on 27 September 2002 to inform him of the PPC's decision to adjourn the case (bundle p 337).

41. Professor Ford's only significant concern about Mrs Page's treatment was with the decision to commence subcutaneous diamorphine and midazolam on the day of her death. He considers that there was no indication in the notes that she was in pain or distress. In his view, the prescription was poor practice and potentially very hazardous. He would have expected very clear reasons for this prescription to have been recorded in the medical notes. He considers that, apart from this, the medical and nursing records were of adequate quality. He concludes:

    In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death.

42. Professor Ford does not name any individual nurses. From the medical records, we have been unable to identify whether nurses Gillian Hamblin and Freda Shaw were on duty on the day of Mrs Page's death.

43. From the prescription chart (bundle pp 341), we see that Mrs Page was started on 20mg diamorphine and 20mg midazolam at 10.50am on 3 March 1998. This was the lowest dose possible within the range of the prescription. It should be noted that the GMC did not allege against Dr Barton that the starting doses of diamorphine and midazolam were too high.

44. The police experts' agreed that the case fell into category A2. Robin Ferner notes that diamorphine was used for confusion rather than pain, and queries the rapid increase in dose. Peter Lawson concluded:

    Care being graded as sub-optimal is perhaps a little picky but relates to the changes in opioid and method of administration rather than the doses used.

45. Anne Naysmith considers that it was not ideal palliative care, and particularly criticises the dose of Fentanyl.

46. The police record of interview with Mr Page contains no other significant evidence.

Page – conclusion

47. Although Mr Page named nurses Code A he does not make any particular complaint about them. Professor Ford does not refer to either of them. It is not apparent from the medical records whether nurses Hamblin or Shaw were involved in Mrs Page's care on the day of her death, or were in a position to challenge the prescription on the day of Mrs Page's death. The police experts concluded that, on balance, treatment was sub-optimal, but they do not all agree as to what was wrong with it. The GMC did not allege that the starting dose, which was the dose administered, was too high.

48. Taking all of this together, the PPC may conclude that there is insufficient material to proceed with any allegation of misconduct against nurses Hamblin and Shaw in connection with Mrs Page's death.

Evidence in the case of Carby

49. On 22 August 2002, Mrs Carby wrote to the NMC alleging that her husband' s sudden death in 1999 was caused by the negligence of nurses [Code A], and Code A (bundle p 321). She did not particularise her complaint, but stated that Mr Carby's medical records contained ample evidence of nursing misconduct.

50. On 5 September 2002, the NMC passed the complaint to the Trust for its internal investigation.

51. The Trust instructed an expert, Professor Jean Hooper, to review Mr Carby's medical records. Professor Hooper's report was sent to the NMC on 15 November 2002 (bundle pp 323 - 326). She expressed concern about discrepancies as to dates and times in the nursing records, but could find no evidence in the records to indicate that the nurses were negligent in their treatment of Mr Carby.

52. In addition to Professor Hooper's report, the Trust provided the NMC with excerpts from the ward controlled drugs record book (bundle pp 327 - 330), which showed that a syringe driver was set up with 40mgs of diamorphine and 40mgs of midazolam at 12.15pm. One of the signatures appears to be that of nurse Joice, the other may be that of nurse Neville but it is not possible to identify with certainty. The syringe driver was discontinued at 1.20pm on the same day, and 9.5 of the original 10mls of fluid discarded.

53. The drug chart (bundle p 333) shows that Mr Carby was prescribed 40 – 200mg diamorphine and 40 – 80mg midazolam. Accordingly, the nurses started the syringe driver on the lowest dose prescribed.

54. The police experts agreed that this was an A2 case. All criticised the high dose of diamorphine and midazolam, but noted that Mr Carby died within 45 minutes of the syringe driver being set up, before the drugs had time to take effect.

55. In interview with the police, Mr Carby's family criticised Nurse Joice, saying that they did not like her manner. They also suggest that after Mr Carby's death, when one of his daughters became extremely upset, an unnamed nurse suggested giving her an injection to calm her down. This has not been raised with the NMC

Carby – conclusion

56. It is possible to prove that Code A failed to record the time of her nursing notes entries on 27 April 2004. However, the PPC may conclude that this alone would not amount to misconduct.

57. From the records, it is not possible to identify with certainty who started the syringe driver, although it would appear that Christine Joice was involved. She and her colleague gave the lowest prescribed dose. This case was not pursued against Dr Barton by the GMC. Taking this, the PPC may conclude that there is no real likelihood of a finding of misconduct likely to lead to removal.

Evidence in the case of Middleton

58. In June 2002, Mrs Bulbeck wrote to the NMC to complain about the general level of care her mother Mrs Middleton received at the Gosport War Memorial Hospital from initial admission on 29 May 2001 to August 2001, when she was transferred to another hospital shortly before her death (bundle pp 303 - 305).

59. Mrs Bulbeck gave a number of examples of her concerns:

- On one visit, she found her mother sitting up with her meal and call bell too far away for her to reach and no cutlery;
- Her mother had a "fluid overload" despite being on a drip and having a catheter, and as a result of this, suffered congestive cardiac failure on 4 July 2001;
- On another visit, she arrived to find her mother sitting in chair with a bowl in front of her and another bowl full of vomit by her. Her mother was being sick and choking. She was covered in sweat, and was unable to call for help because bell out of reach. Mrs Bulbeck called a nurse, who in turn called doctor. The doctor carried out an x-ray, which showed that Mrs Middleton had a blocked bowel;
- Mrs Middleton had to wait 45 minutes for a bedpan;
- When Mrs Middleton told a nurse that she was worried about smelling because of catheter, the nurse said "don't worry all old ladies smell";
- Mrs Bulbeck often found her mother sitting up in a chair, with bare feet/legs and no blankets;
- Mrs Bulbeck was worried about the drugs her mother was given because she "behaved very strangely some days";
- Some of the nurses were uncaring and had an unprofessional attitude to the patients;
- Some of the nurses failed to carry out doctors' orders.

60. Mrs Bulbeck was asked if she could provide further detail, but confirmed that she was unable to name individual nurses. She could only name Code A the clinical manager, as having responsibility for her mother's care.

61. The NMC forwarded a copy of Mrs Bulbeck's letter of complaint to the trust. The trust commissioned an investigation and provided the NMC with a copy of the investigation report, and its letter to Mrs Bulbeck (bundle pp 313 - 317). Some generic issues were identified, but none of these were attributed to named nurses.

62. The police experts reached the following conclusions in this case:

- Irene Waters (Nurse) - no opinion expressed about the quality of nursing care (although her notes are incomplete).
- Robin Ferner (pharmacologist) - Mrs Middleton received optimal care and died from natural causes.
- Peter Lawson (geriatrician) - Mrs Middleton was given appropriate doses of analgesia and died from natural causes.
- Anne Naysmith (palliative care expert) - Mrs Middleton had abdominal pain and aspiration pneumonia, and was very frail (on continuous oxygen). She was started on oral diamorphine PRN, then moved to continuous administration via a syringe driver when the pain became more severe. This was very reasonable treatment. Mrs Middleton had breakthrough pain, so the dose of diamorphine was increased. She was also prescribed midazolam because she became agitated and distressed.

Middleton – conclusions

63. Given the expert conclusions, it is clear that there is no prospect of establishing a case based on failure to challenge inappropriate prescribing, even if one could identify the nurses on duty at the time.

64. Mrs Bulbeck has made allegations about specific incidents, but is unable to name the nurses involved and has not provided any dates. Accordingly, there is no prospect of proving allegations relating to any particular incident against any named nurse.

65. The only nurse she has named is Code A on the basis that he was responsible for poor care because he was the clinical manager. To establish this, we would have to prove poor care, in addition to proving that Code A as manager, was culpable. Given the material we have received to date, and the passage of time, the PPC may conclude that there is no realistic prospect of establishing misconduct.

Evidence in the case of Wilkie

66. On 1 June 2002, Mrs Wilkie's daughter, Mrs Jackson, wrote to the NMC to complain about the care given to her mother prior to her mother's death in August 1998 (bundle pp 281 - 283). She made a number of general points, but I have summarised below those could perhaps be attributed to individual named nurses.

67. She noted that her mother was transferred from Queen Alexandra Hospital to GWMH for rehabilitation – on admission, she could walk and feed herself with assistance. After transfer, her mother appeared increasingly sleepy, weak and unwell, and could not stand unaided. After a few days, she received a call telling her to go to the hospital and spoke to Code A d in the office. He told her that her mother was dying and nothing could be done for her. Mrs Jackson told Code A that she did not want her mother to suffer.

68. On 20 August 1998, Mrs Jackson considered that her mother was in pain, and told nursing staff, who were dismissive. She had to ask for help twice, and wait one hour, until Code A attended and said that he would arrange pain relief which would make Mrs Wilkie sleepy. When Mrs Jackson left the hospital at 13.55, nothing had been done to alleviate her mother's discomfort. When Mrs Jackson returned to visit at 20.00, her mother was unconscious.

69. On 21 August 1998, Mrs Wilkie's catheter bag contained blood. Late in the afternoon of 21 August 1998, the nursing staff persuaded Mrs Jackson to go and take some rest. She only agreed when they assured her that they would call her if anything happened. When she returned to the ward at 18.30, Code A said that Mrs Wilkie has just died, and had heard their voices before she went. From her mother's appearance, Mrs Jackson believes that her mother had not only just died.

70. Having reviewed her mother's records, Mrs Wilkie has the following complaints:

- On 17 August 1998, Code A made an entry in the nursing notes "Condition has generally deteriorated over the weekend Daughter seen – aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain". Mrs Jackson denies that her conversation with Code A was as recorded. She states that she did not agree that active treatment was not appropriate, and that there was no discussion about a syringe driver. She maintains that she was never told about the syringe driver.

- Nobody carried out a pain assessment a) when Mrs Jackson complained about her mother' s pain on 17 August 1998 or b) before starting the s/c diamorpine on 20 August 1998.

- The drug administration record states that the syringe driver was started at 13.50. Mrs Jackson maintains that she did not leave the hospital until 13.55, and the syringe driver had not been started when she left.

- The nursing records falsely state that Mrs Wilkie's family were with her when she died.

- There are errors in the nursing records. On a nursing care plan there are two incorrect entries:

    - 13 August 1998, entry scored through, reads "oramorph 10mgs given at 21.00 as distressed. Settled and slept. Written in error as outside Gladys Richards room!"

    - 21 August 1998 "condition remained poorly pronounced dead @ 21.20 hrs by S/N Sylvia Roberts ?? ?? relatives (2 daughters) present". Elsewhere in the nursing notes, it is recorded that Mrs Wilkie died at 18.30, which is around the time when Mrs Jackson returned to the ward.

  These entries are initialled/signed, but we cannot identify the authors.

- There is no mention in the notes about the blood in the catheter bag on 21 August 1998.

- Why was her mother given diamorphine, and why was she started on such a high dose? The prescription chart, written by Dr Barton, was undated. She prescribed as a regular daily dose (not PRN) of diamorphine 20-200mg/24hr, hyoscine 200-800mg/24hr and midazolam 20-80mg/24hr, all to be administered subcutaneously.

71. This case has been reviewed by a number of experts instructed by the police. The first of these was Professor Ford, who reported in December 2001. His conclusions were:

    - The initial assessment and plan as noted by Dr Lord on 10 August 1998 was reasonable.
    - No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15 August 1998, and there was no recorded medical assessment.
    - There is no clear evidence of pain or explanation of why Mrs Wilkie was started on the syringe driver.
    - Oral analgesics could and should have been tried before starting the syringe driver.
    - The undated prescription was poor practice and potentially very hazardous, as Mrs Wilkie was a frail elderly underweight patient with dementia.
    - The medical and nursing records are inadequate.
    - The use of the syringe driver may have hastened death, but Mrs Wilkie was a frail dependant lady with dementia who was at high risk of developing pneumonia even if she had not been administered sedative and opiate drugs.

72. As part of the second police investigation, this case was reviewed by the panel of experts. Their conclusions were:

    - Irene Waters (nurse) - No opinion expressed about the quality of nursing care.
    - Robin Ferner (pharmacologist) - noted that there was a high dose of diamorphine from the outset. Concluded that treatment was sub-optimal or negligent, but unclear as to cause of death.
    - Peter Lawson (geriatrician) - unable to assess cause of death and standard of care as medical notes and a section of the drug chart were not available from the police.
    - Anne Naysmith (palliative care expert) - noted that medical notes and a second drug chart appeared to be missing from the material provided by the police, but concluded that the cause of death was unclear and treatment sub-optimal. This conclusion was based on the inadequacy of the medical notes. The patient was in late-stage dementia and had become very dependent following a UTI requiring IV antibiotics. She may have died of dementia in GWMH whatever management had taken place.

73. The clinical notes show that on 21 August 1998, Dr Barton wrote (bundle p 286): "Marked deterioration over last few days. SC analgesia commenced yesterday. Family aware and happy"

74. The drug chart we have (bundle p 293) shows that Dr Barton prescribed 20 – 200mg diamorphine and 20 – 80mg midazolam on an unknown date. On 20 August 1998, an unknown nurse started the syringe driver with a dose of 30mg diamorphine and 20mg midazolam.

Wilkie – conclusion

75. There is at least one potential allegation of misconduct that could be put to Code A and it relates to his disputed note on 17 August 1998. Mrs Jackson accepts that there was a conversation about her mother's pain, but denies that she agreed active treatment was inappropriate or that a syringe driver should be used. Accordingly, she alleges that Code A falsified the note of their conversation.

76. There are clear problems in establishing this allegation:

- It would appear that the only people present during the conversation were Mrs Jackson and Code A
- Mrs Jackson accepts that she was concerned that her mother should not suffer pain;
- The passage of time will make it difficult to prove to the required standard exactly what was said during a conversation over 12 years ago.

77. Of the other possible allegations:

- The failure to carry out a pain assessment on 17 August 1998 is impossible to attribute to a named nurse;
- The PPC may consider that Mrs Jackson's allegation about the start time of the syringe driver on 20 August 1998 is not capable of proof or that, if proved, would be likely to lead to the removal of the nurse responsible. The most that could be proved would be a 5-10 minutes discrepancy between the time Mrs Jackson says she left the ward and the time the syringe driver is recorded as starting;
- Whilst it may be possible to prove that the notes incorrectly record the time of death, and that the family was present at death, and the PPC may consider that this is unlikely to lead to removal;
- It would be possible to prove that the notes contain an incorrect entry dated 13 August 1998 that was then scored through and corrected, but the PPC may consider that this is unlikely to lead to removal;
- It could proved that there was no entry in the notes on 21 August 1998 that the patient's catheter bag contained blood. However, the Council would then have to prove that the catheter bag did contain blood, that an individual named nurse did or should have noticed this and recorded it, and that the individual named nurse failed to record this in the notes. The PPC may conclude that this is not possible.

78. Finally, there is the wider concern about the alleged poor prescribing, the administration of high starting doses, and the failure of the nurse(s) to challenge. Potential evidential issues relating to these concerns are as follows:

- The identity of the nurse who started the syringe driver is not clear, but his/her initials appear on the prescription records and so it is possible that he/she could be identified.

- The Council could seek an independent expert to review the material we have and give an opinion on the prescription and whether a nurse should have challenged it/administered medication on the strength of it as per the prescription record. However, it is noted that two of the experts instructed by the police comment on the apparent absence of a drug chart and the inadequacy of the records.

- The GMC did make findings of against Dr Barton in respect of the prescription, but it did not allege that the starting doses were too high, merely that the range was too wide.

- The Council is not in a position to make an allegation of inadequate record keeping against any named nurse(s), as we have no information about who was responsible for the records, who was on duty, etc.

Evidence in the case of Devine

79. In June 2002, Code A wrote to the NMC to lodge a formal complaint against Code A Code A in respect of the care received by Code A Elsie Devine at GWMH between admission in October 1999 and her mother's death on 21 November 1999 (bundle pp 295 - 298).

80. Code A referred to an independent review carried out by the hospital following her complaint to the hospital. Code A gave evidence at that review.

81. Code A complaints may be summarised as follows:

- Code A suggested that Mrs Devine was agitated on the morning of 19 November 1999, but none of the family had ever seen her agitated.

- Code A applied a fentanyl patch one day, and the next day, another nurse (LB) gave 50mg chlorpromazine without removing the fentanyl patch first.

- At 8.15am, Code A telephoned Code A Code A to say that Mrs Devine was confused. She did not suggest that there was any urgency, but by 1pm, when Code A Code A attended the hospital, Mrs Devine was unconscious and no one could speak to her again.

- Code A made an unprofessional comment about Code A Code A

- Staff bathed and washed Mrs Devine's hair excessively, apparently because she asked for it.

- There was an incorrect statement in the notes on 3 November 1999 that Mrs Devine could not climb stairs.

- Code A sent home clothes that had been provided by the family because they were considered "too good" for a hospital stay (they were dry clean only).

- A relative asked to take Mrs Devine to the hospital restaurant and was refused without explanation.

- A kidney infection was diagnosed and antibiotics started, but this was not written up in the notes.

- When Code A arrived at the hospital following Code A sudden deterioration, Code A did not explain the medication and said she could not explain what had happened because she had only just come on duty.

82. The letter contains no specific allegations about Code A

83. In July 2002, the NMC wrote to Code A requesting a copy of the independent review report, and consent to approach the GWMH for documents and evidence relating to Mrs Devine's care (p 299). The NMC wrote to Code A again in September to inform her that the PPC had adjourned the case pending the outcome of the criminal investigation (bundle p 300).

84. In October 2002, the Fareham and Gosport NHT PCT wrote to the NMC asking for details of the allegations against Code A and Code A, as the PCT had not previously been aware of this referral (bundle p 351). There is no indication on the file that the NMC responded to this letter.

85. The police have provided voluminous material relating to this case, as it was one of the 10 cases investigated in full. From this material, it is possible to establish the following:

86. Mrs Devine was born on Code A After the death of her husband in 1979, she lived Code A From January 1999, her health deteriorated. In February 1999, it was suspected that she was suffering from myeloma, but following tests, an expert advised in May 1999 that there was insufficient evidence to support a myeloma diagnosis.

87. Code A

88. On 9 October 1999, Mrs Devine saw her GP complaining of pain when urinating. A suspected kidney infection was diagnosed and she was admitted to Queen Alexandra Hospital for treatment. She was fit to leave by mid-October, but because of Code A Code A arrangements were made for her to be transferred to GWMH and she was admitted on 21 October 1999.

89. On the day of admission, she was seen by Dr Barton. The only analgesic prescribed was PRN oramorph (10mg/5ml). No reason for this was given in the notes. In fact, oramorph was never administered during Mrs Devine' s admission.

90. On 25 October and 1 November 1999, other doctors noted that Mrs Devine was physically independent and continent but needed supervision with washing and dressing. She was confused and disorientated and wandered during the day.

91. On 11 November 1999, she was prescribed PRN thioridazine, an anti-psychotic. There is no corresponding entry in the notes to explain why. She was also prescribed trimethoprim for a presumed urinary tract infection, but an entry in the notes on 15 November 1999 showed that the urine specimen had not yielded any growth.

92. The thioridazine was first administered on 15 November 1999, when Mrs Devine was reported as being very aggressive and restless at times. It was also administered on 16 November 1999. On that day, Dr Reid the consultant asked for a referral to be made to Dr Luznat, a psychiatrist, as a result of Mrs Devine's worsening confusion, and also noted that renal function was deteriorating. Also, Mrs Devine creatinine level had increased from 187 to 360micromol/L between 22 October and 16 November 1999.

93. She was seen on 18 November 1999 by Dr Taylor, who assessed her mental state and agreed that it had deteriorated. Mrs Devine was placed on the waiting list for Mulberry Ward as a result.

94. On 18 November 1999, a fentanyl patch was applied (25 micrograms per hour) but there is no explanation for this in the medical or nursing notes. A prescription chart continuation sheet shows that it was prescribed by Dr Barton and administered by Gillian Hamblin at 9.15am.

95. On 19 November 1999, there are records of a marked deterioration, and statements from nurses who came on duty that morning to the effect that Mrs Devine was agitated and physically aggressive towards them. Code A and Code A give largely consistent accounts. It is agreed that Lynne Barrett gave an injection of 50mg chlorpromazine at Dr Barton's direction, but it is not agreed whether Dr Barton was present or gave the instruction by telephone. The chlorpromazine was given at 8.30am. Mrs Devine was then "specialed" by two of the nurses.

96. There is an undated prescription by Dr Barton for 40-80mg diamorphine and 20 – 80mg midazolam, to be administered sub-cutaneously via syringe driver. On 19 November 1999, Gillian Hamblin started the syringe driver with 40mg diamorphine and 40mg midazolam. Dr Barton's note reads:

"Marked deterioration overnight
Confused aggressive
Creatinine 360
Fentanyl patch commenced yesterday
Today further deterioration in general condition
Needs SC analgesia with midazolam
Son seen and aware of condition and diagnosis
Please make comfortable
I am happy for nursing staff to certify death"

97. Code A nursing note for 19 November 1999 reads:

"Marked deterioration over past 24 hours. Extremely aggressive this am refusing all help from staff. Chlorpromazine 50mg given IM at 08.30 – taken 2 staff to special. Syringe driver commenced at 09.25 with diamorphine 40mg and midazolam 40mg. Fentanyl patch removed. Code A seen by Dr Barton at 13.00 and situation explained to Code A will contact Code A and inform Code A of Elsie's poor condition."

98. Dr Barton was interviewed by the police and made prepared statements, then answered "no comment" to all questions asked.

99. The material has been examined by a number of experts, whose conclusions are as follows:

- Dr Wilcock, palliative medicine expert - use of the fentanyl patch was not appropriate (too strong for the patient, less flexible than morphine solution in dose titration). There was an inadequate assessment and documentation of Mrs Devine's marked deterioration. If midazolam was deemed necessary, it would have been more appropriate to give small doses of by intermittent subcutaneous injection as required – to go straight to a syringe driver could only be justified if it was considered without reasonable doubt that Mrs Devine was experiencing agitated confusion as a terminal event and was actively dying. In the absence of pain, shortness of breath or cough, there is no justification for use of diamorphine in a syringe driver

- Dr Black, geriatrician - there was no apparent justification for prescription of PRN oramorph on admission and no explanation in the notes for the use of fentanyl patch. The fentanyl patch was only removed 3 hrs after s/c diamorphine started. The starting doses of diamorphone and midazolam were higher than conventional guidance. However, the patient was terminally ill and the drugs given provided good palliation of symptoms

- Dr Dudley, nephrologist - beyond all reasonable doubt, Mrs Devine was dying from amyloidosis, progressive renal failure and dementia. Simple measures may have improved or stabilised her condition for a few days, but further deterioration culminating in death was inevitable.

100. The police files also contain a copy of the independent review panel report dated 10 August 2001, which concluded that there was inadequate communication between the hospital staff and Code A gave evidence that Code A

Code A

this should have been documented, and that greater care should have been taken to ensure that Code A was kept informed. The panel concluded that Mrs Devine's medical management was appropriate.

101. Dr Reid, the consultant responsible for Mrs Devine's care, made a police statement. Generally, he is supportive of the medical notes and treatment given, but had some reservations:

- In his view, it was not appropriate to prescribe oramorph PRN on admission, as no pain had been noted at that stage. However, oramorph was never administered;

- Small doses of diamorphine injected over 24 hours may have been more appropriate than the fentanyl patch, but this would have involved multiple injections, which may have increased distress;

- 40mg diamorphine in the syringe driver was a high starting dose. 20-30mg would have been more prudent;

- 50mg chlorpromazine is at the upper limit of dosage range. He would expect to see the effect within 3 – 6 hours. Therefore it is of some concern that midazolam was started before the chlorpromazine may have reached maximum effect. However, the midazolam was being administered slowly over 24 hours.

- It is undesirable that there is no note explaining the reason for high start doses of diamorphine and midazolam

102. Dr Reid also stated that he established a good rapport with Code A while she was pursuing her complaints with the hospital, and reports that she told him that had she been able to deal him at the time of Code A illness and death, Code A would never have made a complaint.

103. It should be noted that there are no police statements from Code A

Code A

Devine – conclusions

104. The PPC may conclude that there is no realistic prospect of establishing that any of the nurses was guilty of misconduct in the way in which they communicated with Mrs Reeves about what was happening. Given Code A difficult personal circumstances, and the nurses' account that Code A had instructed that she should not be troubled, the PPC may conclude that it was not misconduct for them to communicate with Code A Code A Any attempt to pursue an allegation of this sort would be bound to fail because Code A never made any statement contradicting what the nurses say about his instruction.

105. The PPC may consider that Code A comment at the independent review Code A does not amount to misconduct. Code A comment was made when she was giving evidence (not in patient notes) and was accurate.

106. Further, the PPC may consider that Code A refusal to accept the clothes originally sent for Mrs Devine was not misconduct. They were dry clean only, and the PPC may conclude that it was reasonable for Code A to ask for clothing that was easier to keep clean.

107. There could be grounds for criticising the nurse Code A who gave the chlorpromazine without removing the fentanyl patch (it was not removed until 3 hours later). However, Code A s not the subject of a complaint from Code A Further, the PPC may conclude that there is no realistic prospect of this amounting to misconduct likely to lead to removal.

108. The PPC may consider that Code A account of Code A comments is not capable of supporting a charge of misconduct that is likely to lead to removal. Her account is disputed and there is little prospect of it being proved. Even if it was, a panel is unlikely to find misconduct in all the circumstances.

109. The other complaints made by Code A are non-specific and do not amount to allegations of misconduct against named nurses that are likely to lead to removal.

110. Therefore, the only potential allegation that could be pursued is the general allegation of failure to challenge inappropriate prescribing and/or starting the syringe driver at too high a dose. Among the experts (including Dr Reid, Mrs Devine's consultant), there seems to be general agreement that there were defects in Dr Barton's prescribing. Apparently, this is reflected by the decision of the jury at the inquest and the panel of the GMC.

The passage of time and delay

111. The events in question took place in 1998 (deaths of Mrs Wilkie and Mrs Page), 1999 (deaths of Mr Carby and Mrs Devine) and 2001 (death of Mrs Middleton).

112. All of the direct complaints to the NMC were made in 2002. Three of those complaints (arising from the deaths of Mrs Wilkie, Mrs Devine and Mrs Page) were considered by the PPC in August 2002 and adjourned. They were in part 1 of the agenda, and the allegations were not served on the nurses concerned [Code A] [Code A]

113. The other complaints (arising from the deaths of Mrs Middleton and Mr Carby) have never been before the PPC, and so the registrants involved ([Code A] and [Code A]) had never been notified these allegations either.

114. The trust was given the opportunity to comment on the complaints arising from the deaths of Middleton and Carby, and on the report of Professor Ford, which dealt with the death of Mrs Wilkie. There is nothing on file to suggest that the NMC served information on the trust about the complaints arising from the deaths of Mrs Devine and Mrs Page.

115. The police investigation did not conclude until 2007, as was followed thereafter by the coroner's inquest (which had been due to take place sooner than it did) and the GMC hearing into Dr Barton (which lasted longer than estimated).

116. We obtained an opinion from Johannah Cutts QC, which gives guidance to the PPC on the approach that should be taken when considering this issue at this stage (bundle pp 352 - 356).

117. We also attach a copy of the *UKCC Code of Professional Conduct* that was in force at the relevant time (bundle pp 357 - 360).

Further information

118. From the analysis above, it will be clear that a central part of any case against any nurse would be an assertion that the prescriptions were flawed. That issue has now been determined by a panel of the GMC, and it is apparent from the findings of fact that Dr Barton's practice was deficient in this regard.

119. The GMC's decision in respect of serious professional misconduct and the final decision in respect of sanction can be found at bundle pp 265 – 280. In summary:

- Dr Barton was guilty of serious professional misconduct;
- She will be allowed to continue to practise subject to conditions placed on her registration.

120. The NMC has attended meetings with the various NHS trusts in the case, and in particular, has requested employment references in respect of the nurses named in the complaints to the NMC. Some have been received and are attached. The outstanding references will be made available to the PPC as soon as we receive them.

121. The NMC has received medical evidence in respect of Sister Hamblin. Her statement was read at the inquest on the basis that she was very unwell and could not attend, and she did not give evidence before the GMC.

122. Each of the named registrants has been served with a copy of this report and the accompanying bundle, and invited to submit a response for the PPC's consideration. All responses will be provided to the PPC.

Clare Strickland
Senior Hearings Lawyer
In-house Legal Team

12 March 2010

GOSPORT WAR MEMORIAL HOSPITAL NURSES

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MEDICO-LEGAL REPORT

Re: **Gladys Mabel RICHARDS**
Arthur "Brian" CUNNINGHAM
Alice WILKE
Robert WILSON
Eva PAGE

Prepared by:

Professor G A Ford, MA, FRCP
Consultant Physician, Freeman Hospital
Newcastle upon Tyne
Professor of Pharmacology of Old Age, University of Newcastle upon Tyne

For: **Hampshire Constabulary**

Date: **12th December 2001**

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Introduction and Remit of the Report

8.1 I am Professor of Pharmacology of Old Age in the Wolfson Unit of Clinical Pharmacology at the University of Newcastle upon Tyne, and a Consultant Physician in Clinical Pharmacology at Freeman Hospital. I am a Doctor of Medicine and care for patients with acute medical problems, acute poisoning and stroke. I have trained and am accredited on the Specialist Register in Geriatric Medicine, Clinical Pharmacology and Therapeutics and General Internal Medicine. I provide medical advice and support to the Regional Drugs and Therapeutics Centre Regional National Poisons Information Service. I was previously clinical head of the Freeman Hospital Care of the Elderly Service and have headed the Freeman Hospital Stroke Service since 1993. I undertake research into the effects of drugs in older people. I am co-editor of the book 'Drugs and the Older Population' and in 2000 was awarded the William B Abrams award for outstanding contributions to Geriatric Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a Fellow of the Royal College of Physicians and have practised as a Consultant Physician for nine years.

8.2 I have been asked by Detective Superintendent John James of Hampshire Constabulary to examine the clinical notes of five patients (Gladys Mabel Richards, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson, Eva Page) treated at the Gosport War Memorial Hospital and to apply my professional judgement to the following:

- The gamut of patient management and clinical practices exercised at the hospital
- Articulation of the leadership, roles, responsibilities and communication in respect of the clinicians involved
- The accuracy of diagnosis and prognosis including risk assessments
- An evaluation of drugs prescribed and the administration regimes
- The quality and sufficiency of the medical records
- The appropriateness and justification of the decisions that were made
- Comment on the recorded causes of death
- Articulate the duty of care issues and highlight any failures

1.3 I have prepared individual reports on each case and an additional report commenting on general aspects of care at Gosport War Hospital from a consideration of all five cases.

1.4 I have been provided with the following documents by Hampshire Constabulary, which I have reviewed in preparing this report:

- Comment on the recorded causes of death
- Letter DS J James dated 15th August 2001
- Terms of Reference document
- Hospital Medical Records of Gladys Richards, Brian Cunningham, Alice Wilkie, Robert Wilson and Eva Page
- Witness statements by Leslie France Lack, and Gillian MacKenzie
- Report of Professor Brian Livesley
- Transcripts of police interviews with Gosport War Memorial staff Dr Barton, Mr Beed, Ms Couchman, Ms Joice

- Transcript of police interviews with Royal Hospital Haslar staff Dr Reid and Flt. Lt. Edmondson
- Transcript of interviews with patient transfer staff Mr Warren and Mr Tanner
- Transcript of police interviews with or statements from following medical and nursing staff: Dr Lord, LM Baldacchino, M Berry, JM Brewer, J Cook, E Dalton, W Edgar, A Fletcher, J Florio and A Funnell.

Gladys Mabel RICHARDS

Course of Events

2.1 Gladys Richards was 91 years old when admitted as an emergency via the Accident & Emergency Department to Haslar Hospital on 29Th July 1998. She had fallen onto her right hip and developed pain. At this time she lived in a nursing home and was diagnosed as having dementia. She had experienced a number of falls in the previous 6 months and the admission notes comments "*quality of life has ↓↓ markedly last 6/12*". She was found to have a fracture of the right neck of femur. An entry in the medical notes by Surgeon Commander Malcom Pott, Consultant orthopaedic surgeon dated 30 July 1998 states '*After discussion with the patient's daughters in the event of this patient having a cardiac arrest she is NOT for cardiopulmonary resuscitation. However she is to be kept pain free, hydrated and nourished.*' Surgery (right hemiarthroplasty) was performed on 30 July 1998.

2.2 On 3rd August she was referred for a geriatric opinion and seen by Dr Reid, Consultant Physician in Geriatrics on 3rd August 1998. In his letter dated 5th August 1998 he notes she had been on treatment with haloperidol and trazadone and that her daughters thought she had been 'knocked off' by this medication for months, and had not spoken to then for 6-7 months. Her mobility had deteriorated. Her daughters commented to Dr Reid that she had spoken to them and had been brighter mentally since the trazadone had been omitted following admission. Dr Reid found Mrs Richards to be confused but pleasant and cooperative, unable to actively lift her right leg from the bed but appeared to have little discomfort on passive movement of the right hip. He commented '*I understand she has been sitting out in a chair and I think that despite her dementia, she should be afforded the opportunity to try to re-mobilise her.* He arranged for her transfer to Gosport War Memorial Hospital.

2.3 Following Dr Reid's entry in the notes on 3rd August two further entries are made in the medical notes by the on call house officer (Dr Coales?) on 8th August 1998. Dr Coales was asked to see Mrs Richards who was agitated on the ward. She had been given 2mg haloperidol and was asleep when first seen at 0045h. At 02130 hr a further entry records Mrs Richards was '*noisy and disturbing other patients n ward. Unable to reason with patient. Prescribed 25mg thioridazine'*. A transfer letter for Sergeant Curran, staff nurse to the Sister in Charge dated 10th August 1998 describes Mrs Richards status immediately prior to transfer and notes *'Is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Gladys needs total care with washing and dressing eating and drinking. Gladys is continent, when she becomes fidgety and agitated it means she wants the toilet. Occasionally incontinent at night, but usually wakes.*

2.4 On 11th August 1998 Mrs Richards was transferred to Daedalus ward. Dr Barton writes in the medical notes *"Impression frail demented lady, not obviously in pain, please make comfortable. Transfers with hoist, usually continent, [illegible] with ADL Barthel? I am happy for nursing staff to confirm death"*. The summary admitting nursing notes record *"now fully weight bearing and walking with the aid of two nurses and a Zimmer frame"*. On 12th August the nursing notes record "*Haloperidol given at 2330 as woke from sleep. Very agitated, shaking and crying. Didn't settle for more than a few*

*minutes at a time. Did not seem to be in pain".*On 13th August nursing notes record "*found on floor at 1330h. Checked for injury none apparent at time. Hoisted into safer chair. 1930 pain Rt hip internally rotated, Dr Brigg contacted advised Xray am and analgesia during the night. Inappropriate to transfer for Xray this pm."*

2.5 On 14th August 1998 Dr Barton wrote '*sedation/pain relief has been a problem. Screaming not controlled by haloperidol 1g ? but very sensitive to Oramorph. Fell out of chair last night. R hip shorter and internally rotated, Daughter nurse and not happy. Plan Xray . Is this lady well enough for another surgical procedure?"* A further entry the same day states "*Dear Cdr Spalding, further to our telephone conversation thank you for seeing this unfortunate lady who slipped from her chair and appears to have dislocated her R hip. Hemiarthroplasty was done on 30-8-98. I am sending Xrays. She has had 2.5ml of 10mg/5ml oramoroph at midday. Many thanks".*

2.6 Following readmission to Haslar hospital Mrs Richards underwent manipulation of R hip under iv sedation (2 mg midazolam) at 1400h. At 2215h the same day she was not responding to verbal stimulation but observations of blood pressure, pulse, respiration and temperature were all in the normal range. A further entry on 17th August by Dr Hamlin (House Officer) states "*fit for discharge today (Gosport War Mem) To remain in straight knee splint for 4/52. For pillow between legs (abduction) at night.*" A transfer letter to the nurse in charge at Daedalus ward states "*Thank you for taking Mrs Richards back under your care... was decided to pass an indwelling catheter which still remains in situ. She has been given a canvas knee immobilising splint to discourage any further dislocation and this must stay in situ for 4 weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing".*

2.7 Nursing notes record on 17th August " 1148h *returned from R.N.Haslar patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew."* Later that day at 1305h "*in pain and distress, agreed with daughter to give her mother Oramorph 2.5mg in 5ml*". A further hip Xray was performed which demonstrated no fracture. Dr Barton writes on 17th August 1998 *"readmission to Daedalus ward. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See daughter again"* and on 18th August "*still in great pain, nursing a problem, I suggest sc diamorphine/ haloperidol/midazolam. I will see daughters today. Please make comfortable".* Nursing notes record "*reviewed by Dr Barton for pain control via syringe driver".* At 2000h "*patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs".* On 19th August the nursing notes record "*Mrs Richards comfortable*" and in a separate entry "*apparently pain free*". There are no nursing entries I can find on 20th August. I can find no entries in the nursing notes describing fluid or food intake following admission on 17th August.

2.8 The next entry in the medical notes is on 21st August by Dr Barton "*much more peaceful. Needs hyoscine for rattly chest*". The nursing notes record "*patient's overall condition deteriorating. Medication keeping her comfortable*". A staff

nurse records Mrs Richards's death in the notes at 2120h later that day. The cause of death was recorded as bronchopneumonia.

2.9 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards's first admission to Haslar Hospital.

29 July 2000h Trazadone 100mg (then discontinued)
29 July to 11th August. Haloperidol 1mg twice daily
30 July 0230h Morphine iv 2.5mg
31 July 0150h morphine iv 2.5mg
1905h morphine iv 2.5 mg
1 Aug 1920h morphine iv 2.5mg
2 Aug 0720h morphine iv 2.5mg
Cocodamol two tablets as required taken on 16 occasions at varying times between 1-9th August

2.10 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards second admission to Haslar Hospital

14 Aug 1410h midazolam 2mg iv
15 Aug 0325h cocodamol two tablets orally
16 Aug 0410h haloperidol 2mg orally
0800h haloperidol 1mg orally
1800h haloperidol 1mg orally
2310h haloperidol 2mg orally
!7 Aug 0800h haloperidol 1mg orally

2.11 Medication charts record the following administration of opiate and sedative drugs on Daedalus ward:

11 Aug	1115h	5mg/5ml Oramorph
	1145h	10 mg Oramorph
	1800h	1 mg haloperidol
12 Aug	0615h	10 mg Oramorph
		haloperidol
13 Aug	2050h	10mg Oramorph
14 Aug	1150h	10mg Oramorph
17 Aug	1300h	5mg Oramorph
	?	5 mg Oramorph
	1645h	5mg Oramorph
	2030h	10mg Oramorph
18 Aug	0230h	10mg Oramorph
	?	10mg Oramorph
	1145h	diamorphine 40mg/24hr, haloperidol 5mg/24hr
		midazolam 20mg/24hrby
19 Aug	1120h	diamorphine 40mg/24hr, haloperidol 5mg/24hr
		midazolam 20mg/24hr, hyoscine 400microg/24hr
20 Aug	1045h	diamorphine 40mg/24hr, haloperidol 5mg/24hr
		midazolam 20mg/24hr, hyoscine 400microg/24hr
21 Aug	1155h	diamorphine 40mg/24h, haloperidol 5mg/24hr
		midazolam 20mg/24hr hyoscine 400microg/24hr

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

2.12 Primary responsibility for the medical care of Mrs Richards during her two admissions to Gosport Hospital lay with Dr Lord, as the consultant responsible for his care. My understanding is that day-to-day medical care was delegated to the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital (statement of Dr Lord in interview with DC Colvin and DC McNally). Primary responsibility for the medical care of Mrs Richards during her two admissions to Queen Alexandra Hospital lay with Surgeon Commander Scott, Consultant Orthopaedic Surgeon. Junior medical staff were responsible for day-to-day medical care of Mrs Richards whilst at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Richards and informing medical staff of any significant deterioration.

2.13 Dr Reid, Consultant Geriatrician was responsible for assessing Mrs Richards and making recommendations concerning her future care following her orthopaedic surgery, and arranged transfer to Gosport Hospital for rehabilitation.

Accuracy of diagnosis and prognosis including risk assessments

2.14 The initial assessment by the orthopaedic team was in my opinion competent and the admitting medical team obtained a good history of her decline in the previous six months. Surgeon Commander Pott discussed management options with the family and a decision was made to proceed with surgery but for Mrs Richards to not undergo cardiopulmonary resuscitation if she sustained a cardiac arrest, with a clear decision to keep Mrs Richards pain free, hydrated and nourished. There are good reasons to offer surgery for a fractured neck of femur to very frail patients with dementia even when a high risk of peri-operative death or complications is present. This is because without surgery patients continue to be in pain, remain immobile and nearly invariably develop serious complications such as pneumonia and pressure sores, which are usually fatal. From the information I have seen I would, as a consultant physician/geriatrician recommended the initial management undertaken. I consider it good management that the trazadone as discontinued when the history from the daughters suggested this might have been responsible for decline in the recent past.

2.15 After Mrs Richards was stable a few days following surgery it was appropriate to refer her for a geriatric opinion, and Dr Reid rapidly provided this. Dr Reid's assessment was in my opinion thorough and competent. He identified the potential for her to benefit from rehabilitation. I would consider his decision to refer her for rehabilitation despite her dementia to be appropriate. An elderly care rehabilitation, rather than an acute orthopaedic ward is in general a preferable environment to undertake such rehabilitation. It is implicit in his decision to transfer her to Gosport War Memorial Hospital that she would receive rehabilitation there and not care on a continuing care ward without input from a rehabilitation team. Dr Lord in an interview with DC McNally and DC Colvin describes Daedalus ward as "*Back in '98 .. Daedalus was a continuing care ward with 24 beds of which 8 beds were for slow stream stroke*

rehabilitation". Although Mrs Richards had a fractured neck of femur and not stroke as her primary problem requiring rehabilitation I would assume, in the light of Dr Reid's letter that she was transferred to one of the 8 slow stream rehabilitation beds on Daedalus ward.

2.16 The transfer letter from Sergeant Curran provides a clear description of Mrs Richards's status at the time of transfer. The observation that she was walking with the aid of two nurses and a zimmer frame, and the usual cause of agitation was when she needed to use the toilet are relevant to subsequent events following transfer to Gosport Hospital. The use of a Barthel Index score as a measure of disability is good practice and demonstrates that Mrs Richards was severely dependent at the time of her transfer to Gosport Hospital.

2.17 The initial entry by Dr Barton following Mrs Richards' transfer to Daedalus ward does not mention that she has been transferred for rehabilitation, and focuses on keeping her 'comfortable' despite recording that she is "*not obviously in pain*". The statement '*I am happy for nursing staff to confirm death*" also suggests that Dr Barton's assessment was that Mrs Richards might die in the near future. Dr Barton in her statement to Code A and DC Colvin, confirms this when she states "*I appreciated that there was a possibility that she might die sooner rather than later*". Dr Barton refers to her admission as a "*holding manoeuvre*" and her statement suggests a much more negative view of the potential for rehabilitation. She does not describe any rehabilitation team or focus on the ward and suggests her transfer was necessary because she was not appropriate for an acute bed, rather than her being appropriate for rehabilitation- "*.her condition was not appropriate for an acute bed. ....seen whether she would recover and mobilise after surgery. If as was more likely she would deteriorate due to her age, her dementia, her frail condition and the shock of the fall followed by the major surgery, then she was to be nursed in a clam environment away from the stresses of an acute ward*". In my opinion this initial note entry and the statement by Dr Baron indicate a much less proactive view of rehabilitation, less appreciation than Dr Reid of the potential for Mrs Richards to recover to her previous level of functioning, and probably a failure to appreciate the potential benefits of appropriate multidisciplinary rehabilitation to Mrs Richards. This leads me to believe that Dr Barton's approach to Mrs Richards was in the context of considering her as a continuing care patient who was likely to die on the ward. It was not wrong or incorrect of Dr Barton to believe Mrs Richards might die on the ward, but I would consider her apparent failure to recognise Mrs Barton's rehabilitation needs may have led to subsequent sub-optimal care.

2.18 There are a number of explanations and contributory factors that may have led to Dr Barton possibly not recognising Mrs Richard's rehabilitation needs in addition to her nursing and analgesic needs. First she may have not clearly understood Dr Reid's assessment that she needed rehabilitation. In her statement Dr Barton states " *Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to remobilise*" which suggests Dr Barton may not have considered it possible for Mrs Richards to receive Physiotherapy as a necessary part of her opportunity to remobilise. Second the ward had both continuing care and rehabilitation beds and these patients may require very different care. It is not uncommon for "slow stream" rehabilitation beds to be in the same ward as continuing care beds, but it does

require much broader range of care to meet the medical and social needs of these patients. I would anticipate that some patients would move from the slow stream rehabilitation to continuing care category. Dr Lord describes the existence of fortnightly multidisciplinary ward case conference suggesting there was a structured team approach that would have made Dr Barton and nursing staff aware of rehabilitation needs of patients. In Mrs Richards's case no such case conference took place because she became too unwell in a short period. Third Dr Barton may not have received sufficient training or gained adequate experience of rehabilitation or geriatrics despite working under the supervision of Dr Lord. Dr Lord states that Dr Barton was "*an experienced GP*" who had rights of admission to a GP ward and that Dr Lord had admitted patients "*under her care say for palliative care*". Experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

2.19 The assessment of Mrs Richard's agitation the following day on 12th August was in my opinion sub-optimal. The nursing records state that she did not appear to be in pain. There is no entry from Dr Barton this day but in her statement she states which I have some difficulty in interpreting: "*When I assessed Mrs Richards on her arrival she was clearly confused and unable to give any history. She was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including Oramorph and Diamorphine. This allowed nursing staff to respond to their clinical assessment of her needs rather than wait until my next visit the following day. This is an integral part of team management. It was not in fact necessary to give diamorphine over the first few days following her admission but a limited number of small doses of Oramorph were given totalling 20mg over the first 24 hours and 10mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure*".

2.20 I am unable establish from the notes and Dr Barton's statement whether she saw Mrs Richards in pain after she wrote in the notes and then wrote up the oplate drugs later on the 11th August, or if she wrote up these drugs after seeing her when she was not in pain, because she considered she might develop pain and agitation. In either case there is no evidence that the previous information provided by Sergeant Curran that Mrs Richards usually required the toilet when she was agitated was considered by Dr Barton. Screaming is a well-described behavioural disturbance in dementia (Dr Barton was clearly aware of this), which can be due to pain but is often not. In some cases it is not possible to identify a clear precipitating cause although a move to a new ward could precipitate such a behavioural disturbance. I would consider the assumption by Dr Barton that Mrs Richards screaming was due to pain was not supported by her own recorded observations. There is no evidence from the notes that Dr Barton examined Mrs Richards in the first two days to find any evidence on clinical examination that pain from her hip was the cause of her screaming. If the screaming had been worse on weight bearing or movement of the hip this would have provided supportive evidence that her screaming was

due to hip pain. Staff Nurse Jennifer Brewer in her interview with DC Colvin and DC McNally states that the nursing staff had considered the need for toileting and other potential causes of Mrs Richards screaming.

2.21 Mrs Richards pain following surgery had been controlled at Haslar hospital by intermittent doses of intravenous morphine and then intermittent doses of cocodamol (paracetamol and codeine phosphate). Dr Barton did not prescribe cocodamol or another mild or moderate analgesic to Mrs Richards to take on a prn basis when she was transferred. This makes me consider it probable that Dr Barton prescribed prn Oramorph, diamorphine, hyoscine and midazolam when she first saw Mrs Richards and she was not in pain. If this is the case it is highly unusual practice in a patient who has been transferred for rehabilitation, was not taking any regular or intermittent analgesics for 36 hours prior to transfer, and had last taken two tablets of cocodamol. In a rehabilitation or continuing care ward without resident medical staff I would consider it reasonable and usual practice to prescribe a mild or moderate analgesic to take on an as required basis in case further pain developed. In Mrs Richards's case a reasonable choice would have been cocodamol since she had been taking this a few days earlier without problems. I do not consider it was appropriate to administer intermittent doses of oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. It is not appropriate to prescribe powerful opiate drugs as a first line treatment for pain not clearly due to a fracture or dislocation to a patient such as Mrs Richards 12 days following surgery. Dr Barton's statement that diamorphine and oramorph were appropriate analgesics at this stage following surgery when she had been pain free is incorrect and in my opinion would not be a view held by the vast majority of practising general practitioners and geriatricians.

2.22 The management of Mrs Richards when sustained a dislocation of her hip on 13th August was in my opinion sub-optimal. The hip dislocation most likely occurred following the fall from her chair at 1330h. The nursing notes suggest signs of a dislocation were noted at 1930h. If there was a delay in recognising the dislocation I would not consider this indicates poor care, as hip fractures and dislocations can be difficult to detect in patients who have dementia and communication difficulties. Mrs Richards suspected dislocation or fracture was discussed with the on-call doctor, Dr Briggs, who I would assume is a medical house officer. Given the concern about a fracture or dislocation I would judge it would have been preferable for her to b transferred to the orthopaedic ward that evening and be assessed by the orthopaedic team. I certainly consider the case should have been discussed with either the on call consultant geriatrician or the orthopaedic team. The benefits of transfer that evening in a patient where it was highly probable a fracture or dislocation were present would have been Mrs Richards could have received manipulation earlier the following morning and possibly that same evening, and that traction could have been applied even if reduction was not attempted.

2.23 Mrs Richards was found to have a dislocation of her right hip and this was manipulated under intravenous sedation the next day. Although she was initially unresponsive, most probably due to prolonged effects of the intravenous midazolam, 3 days later on 17th August she was mobilising and fully weight bearing and not requiring any analgesia. Although there are few medical note entries, the management at Haslar hospital during this period

appears to be appropriate and competent. Shortly after transfer back to Daedalus ward Mrs Richards again became very distressed. The nursing notes indicate there was an incorrect transfer by the ambulance staff of Mrs Richards onto her bed. Repeat dislocation of the right hip was reasonably suspected but not found on a repeat Xray. My impression is that this transfer may have precipitated hip or other musculoskeletal pain in Mrs Richards but that other causes of screaming were possible.

2.24 Intermittent doses of oral morphine were first administered to Mrs Richards, again without first determining whether less powerful analgesics would have been helpful. On 18th August Dr Barton suggested commencing subcutaneous diamorphine, haloperidol and midazolam. The diamorphine and midazolam had been prescribed 7 days earlier. An infusion of the three drugs was commenced later that morning and hyoscine was added on 19th August. Both Dr Barton's notes and the nursing notes indicate Mrs Richards was in pain, although it is not clear what they considered was the cause of the pain at this stage, having excluded a fracture or dislocation of the right hip. Dr Barton states in her prepared statement "... *it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated*".

2.25 Although there are no clear descriptions of Mrs Richard's conscious level in the last few days, her level of alertness appears to have deteriorated once the subcutaneous infusion of diamorphine, haloperidol and midazolam was commenced. It also seems that she was not offered fluids or food and intravenous or subcutaneous fluids were not considered as an alternative. My interpretation is that this was most probably because medical and nursing staff were of the opinion that Mrs Richards were dying and that provision of fluids or nutrition would not change this outcome. In her prepared statement Dr Barton states "*As their mother was not eating or drinking or able to swallow, subcutaneous infusion of pain killers was the best way to control her pain.*" and "*I was aware that Mrs Richards was not taking food or water by mouth*". She then goes on to say "*I believe I would have explained to the daughters that subcutaneous fluids were not appropriate*".

Evaluation of drugs prescribed and the administration regimens

2.26 The decision to prescribe oral opiates and subcutaneous diamorphine to Mrs Richards initial admission to Daedalus ward was in my opinion inappropriate and placed Mrs Richards at significant risk of developing adverse effects of excessive sedation and respiratory depression. The prescription of oral paracetamol, mild opiates such as codeine or non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen would have been appropriate oral and preferable with a better risk/benefit ratio. The prescription of subcutaneous diamorphine, haloperidol and midazolam infusions to be taken if required was inappropriate even if she was experiencing pain. Subcutaneous opiate infusions should be used only in patients whose pain is not controlled by oral analgesia and who cannot swallow oral opiates. The prescription by Dr Barton on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Mrs Richards at serious risk of developing coma and respiratory depression had these been administered by the nursing staff. It is exceptionally unusual to prescribe subcutaneous infusion of these three drugs with powerful effects on conscious level and respiration to

frail elderly patients with non-malignant conditions in a continuing care or slow stream rehabilitation ward and I have not personally used, seen or heard of this practice in other care of the elderly rehabilitation or continuing care wards. The prescription of three sedative drugs is potentially hazardous in any patient but particularly so in a frail older patient with dementia and would be expected to carry a high risk of producing respiratory depression or coma.

2.27 I consider the statement by Dr Barton "*my use of midazolam in the dose of 20mg over 24 hours was as a muscle relaxant, to assist movement of Mrs Richards for nursing procedures in the hope that she could be as comfortable as possible. I felt it appropriate to prescribe an equivalence of haloperidol to that which she had been having orally since her first admission.*" Indicates poor knowledge of the indications for and appropriate use of midazolam administered by subcutaneous infusion to older people. Midazolam is primarily used for sedation and is not licensed for use as a muscle relaxant. Doses of benzodiazepine that produce significant muscle relaxation in general produce unacceptable depression of conscious level, and it is not usual practice amongst continuing care and rehabilitation wards to administer subcutaneous midazolam to assist moving patients.

Quality and sufficiency of the medical records

2.28 The medical and nursing records relating to Mrs Richards admissions to Daedalus ward are in my opinion not of an adequate standard. The medical notes fail to adequately account for the reasons why oramorph and then infusions of diamorphine and haloperidol were used. The nursing records do not adequately document hydration and nutritional needs of Mrs Richards during her admissions to Daedalus ward.

Appropriateness and justification of the decisions that were made

2.29 There are a number of decisions made in the care of Mrs Richards that I consider to be inappropriate. The initial management of her dislocated hip prosthesis was sub-optimal. The decision to prescribe oral morphine without first observing the response to milder opiate or other analgesic drugs was inappropriate. The decision to prescribe diamorphine, haloperidol and midazolam by subcutaneous infusion was, in my opinion, highly inappropriate.

Recorded cause of death

2.30 The recorded cause of death was bronchopneumonia. I understand that the cause of death was discussed with the coroner. A post mortem was not obtained and the recorded cause was certainly a possible cause of Mrs Richards's death. I am surprised the death certificate makes no mention of Mrs Richards's fractured neck of femur or her dementia. It is possible that Mrs Richards died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mrs Richards was at high risk of developing pneumonia because of the immobility that resulted following her transfer back to Daedalus ward even if she had not received sedative and opiate drugs. Bronchopneumonia can also occur as a secondary complication of opiate and sedative-induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia was possible. However given the rapid decline in

conscious level that preceded the development of respiratory symptoms (rattly chest) I would consider it more likely that Mrs Richards became unconscious because of the sedative and opiate drugs she received by subcutaneous infusion, that these drugs caused respiratory depression and that Mrs Richards died from drug induced respiratory depression and/or without bronchopneumonia resulting from immobility or drug induced respiratory depression. There are no accurate records of Mrs Richards respiratory rate but with the doses used and her previous marked sedative response to intravenous midazolam it is highly probable that respiratory depression was present.

Duty of care issues

2.31 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care to attempt to monitor Mrs Richards and to document the effects of drugs prescribed. In my opinion this duty of care was not adequately met. The prescription of diamorphine, midazolam and haloperidol was extremely hazardous and Mrs Richards was inadequately monitored. The duty of care of the medical and nursing staff to meet Mrs Richard's hydration and nutritional needs was also in my opinion probably not met.

Summary

2.32 Gladys Richards was a frail older lady with dementia who sustained a fractured neck of femur, successfully surgically treated with a hemiarthroplasty, and then complicated by dislocation. During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Baron. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death. In my opinion it is likely the administration of the drugs hastened her death. There is some evidence that Mrs Richards was in pain during the three days prior to her heath and the administration of opiates can be justified on these grounds. However Mrs Richards was at high risk of developing pneumonia and it possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Arthur "Brian" CUNNINGHAM

Course of Events

3.1 Mr Cunningham was 79 years old when admitted to Dryad ward, Gosport Hospital under the care of Dr Lord. Dr Lord had assessed him on a number of occasions in the previous 4 years. A letter dated 2nd December 1994 from Dr Bell, Clinical Assistant, indicates Parkinson's disease had been diagnosed in the mid 1980s and that he was having difficulties walking at this time. In 1998 it was noted he had experienced visual hallucinations and had moved into Merlin Park Rest Home. His weight was 69Kg in August 1998. In July 1998 he was admitted under the care of Dr Banks, Consultant in Old Age Psychiatry to Mulberry Ward A and discharged after 6 weeks to Thalassa Nursing Home. He was assessed to have Parkinson's disease and dementia, depression and myelodysplasia. Dr Lord in a letter dated 1 September 1998 summarises her assessment of Mr Cunningham when she saw him on Mulberry Ward A on 27 August 1998 before he was discharged to Thalassa Nursing Home. At this time he required 1-2 people to transfer and was unable to wheel himself around in his wheelchair. She commented that more levodopa might be required but was concerned it would upset his mental state. She arranged to review him at the Dolphin Day Hospital.

3.2 On 21st September 1998 he was seen at the Dolphin Day Hospital by Dr Lord who recorded *'very frail, tablets found in mouth, offensive large necrotic sacral sore with thick black scar. PD - no worse. Diagnoses listed as sacral sore (in N/H), PD, old back injury, depression and element of dementia, diabetes mellitus –diet, catheterised for retention. Plan – stop codanthramer and metronidazole. looks fine. TCI Dyad today –aserbine for sacral ulcer – nurse on side – high protein diet – oramorph prn if pain. N/Home to keep bed open for next 3/52 at least. Pt informed of admission agrees. Inform N/Home Dr Banks and social worker. Analgesics prn.'* He was admitted to Dyad ward. An entry by Dr Baron on 21 September states *'make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death.'* On 24th September Dr Lord has written *'remains unwell. Son has ??? again today and is aware of how unwell he is. sc analgesia is controlling pain just. I am happy for nursing staff to confirm death.'* The next entry by Dr Brook is on 25th September *'remains very poorly. On syringe driver. For TLC'.*

3.3 Medication charts record the following administration of opiate and sedative drugs:

21 Sep 1415h Oramorph 5mg
1800h Coproxamol two tablets
(subsequent regular doses not administered)
2015h Oramorph 10mg
21 Sep 2310h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
22 Sep 2020h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
23 Sep 0925h Diamorphine 20mg/24hr, hyoscine 200microg/24hr
midazolam 20 mg/24hr infusion sc
2000h Diamorphine 20mg/24hr, hyoscine 200microg/24hr
midazolam 60mg/24hr infusion sc
24 Sep 1055h Diamorphine 20mg/24hr, hyoscine 800microg/24hr
midazolam 80mg/24hr infusion sc
25 Sep 1015h Diamorphine 60mg/24hr, hyoscine 1200mg/24hr

midazolam 80mg/24hr infusion
26 Sep 1150h Diamorphine 80mg/24hr, hyoscine 1200mg/24hr
midazolam 100mg/24hr infusion
Sinemet 110 5 times/day was discontinued on 23rd September

3.4 The nursing notes relating to the admission to Dyad ward record on 21st Sept *'remained agitated until approx 2030h. Syringe driver commenced as requested* (unclear who made this request) *diamorphine 20mg, midazolam 20mg at 2300. Peaceful following".* On 22nd Sep *'explained that a syringe driver contains diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode where Arthur tried to wipe sputum on a nurse saying he had HIV and going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself.'*

3.5 On 23rd Sep *'Has become chesty overnight to have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked is this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed.'* A later entry *'now fully aware that Brian is dying and needs to be made comfortable. Became a little agitated at 2300h, syringe driver adjusted with effect. Seems in some discomfort when moved, driver boosted prior to position change'.* On 24th Sept *'report from night staff that Brian was in pain when attended to, also in pain with day staff – especially his knees. Syringe driver renewed at 1055".* On 25th Sept *'All care given this am. Driver recharged at 1015 –diamorphine 60mg, midazolam 80mg and hyoscine 1200mcg at a rate of 50mmols/hr. Peaceful night - unchanged, still doesn't like being moved.'* On 26th September *'condition appears to be deteriorating slowly'.*

3.6 On 26th September staff nurse Tubbritt records death at 2315h. Cause of death was recorded on the death certificate as bronchopneumonia with contributory causes of Parkinson's disease and Sacral Ulcer.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

3.7 Primary responsibility for the medical care of Mr Cunningham during his last admission lay with Dr Lord, as the consultant responsible for his care. She saw Mr Cunningham 5 days before his death in the Dolphin Day Hospital, and 2 days before his death on Dyad ward. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Cunningham and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

3.8 Initial assessment by Dr Lord was comprehensive and appropriate with a clear management plan described. The nursing staff record Mr Cunningham was agitated following admission on 21st September. Dr Lord had prescribed prn (intermittent as required) oramorph for pain. Nursing staff made the decision to administer oramorph but there is no clear recording in the nursing notes that he

was in pain or the site of pain. The nursing entry on 22nd Sept indicates a syringe driver was commenced for 'pain relief and to allay anxiety. Again the site of pain is not states. My interpretation of the records is that the nursing staff considered his agitation was due to pain from his sacral ulcer. The medical and nursing teams view on the cause of Mr Cunningham's deterioration on 23rd September when he became 'chesty' are not explicitly stated, but would seem to have been thought to be due to bronchopneumonia since this was the cause of death later entered on the death certificate. The medical and nursing staff may not have considered the possibility that Mr Cunningham's respiratory symptoms and deterioration may have been due to opiate and benzodiazepine induced respiratory depression. The nursing staff filed to appreciate that the agitation Mr Cunningham experienced on 23rd Sept at 2300h may have been due to the midazolam and diamorphine. It was appropriate for nursing staff to discuss Mr Cunningham's condition with medical staff at this stage.

3.9 When Dr Lord reviewed Mr Cunningham on 24th September the notes imply that he was much worse that when she had seen him 3 days earlier. There is clear recording by Dr Lord that Mr Cunningham was in pain. The following day the diamorphine dose was increased three fold from 20mg/24hr to 60mg/24hr and the dose was further increased on 26th September to 80mg/24hr although the nursing and medical notes do not record the reason for this. The notes suggest that the nursing and medical staff may have failed to consider causes of agitation other than pain in Mr Cunningham or to recognise the adverse consequences of opiates and sedative drugs on respiratory function in frail older individuals.

Evaluation of drugs prescribed and the administration regimens

3.10 The prescription of oramorph to be taken 4 hourly as required by Mr Cunningham was reasonable if his pain was uncontrolled from cocodamol. I consider the decision by Dr Barton to prescribe and administer diamorphine and midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate, particularly when there was a clear instruction by Dr Lord that he should be prescribed intermittent (underlined instruction) doses of oramorph earlier in the day. I consider the undated prescription by Dr Baron of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. In my opinion it is poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mr Cunningham. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

3.11 In my opinion it is doubtful the nursing and medical staff understood that when a syringe infusion pump rate is increased it takes an often appreciable effect of time before the maximum effect of the increased dose rate becomes evident. Typically the time period would be 5 drug half-lives. In the case of diamorphine this would be between 15 and 25 hours in an older frail individual.

Quality and sufficiency of the medical records

3.12 In my opinion the medical and nursing records are inadequate following Mr Cunningham's admission to Dryad ward. The initial assessment by Dr Lord on 21st September is in my opinion competent and appropriate. The medical notes following this are inadequate and do not explain why he was commenced on subcutaneous infusions of diamorphine and midazolam. The nursing notes are variable and at times inadequate.

Appropriateness and justification of the decisions that were made

3.13 An inappropriately high dose of diamorphine and midazolam was first prescribed. There was a failure to recognise or respond to drug induced problems. Inappropriate dose escalation of diamorphine and midazolam and poor assessment by Dr Lord. The assessment by Dr Lord on 21st September 1998 was thorough and competent and a clear plan of management was outlined. There is a clear note by Dr Lord that oramorph was to be given intermittently (PRN) for pain and not regularly. It is not clear from the medical and nursing notes why Mr Cunningham was not administered the regular cocodamol he was prescribed following the initial dose he received at 1800h following admission. It is good practice to provide regular oral analgesia, with paracetamol and a mild opiate, particularly when a patient has been already taking this medication and to use prn morphine for breakthrough pain. I consider the prescription by Dr Barton on admission of prn subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be unjustified, poor practice and potentially very hazardous. It is particularly notable that only hours earlier Dr Lord had written that oramorph was to be given intermittently and this had been underlined in the medical notes. There is no clear justification in the notes for the commencement of subcutaneous diamorphine and midazolam on the evening following admission. If increased opiate analgesia was required increasing the oramorph dose and frequency could have provided this. I would judge it poor management to initially commence both diamorphine and midazolam. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam.

3.14 I am concerned by the initial note entry by Dr Barton on 21st September 1998 that she was happy for nursing staff to confirm death. There was no indication by Dr Lord that Mr Barton was expected to die, and Dr Barton does not list the reason she would have cause to consider Mr Cunningham would die within the next 24 hours before he was reviewed the following day by medical staff. In my opinion it is of concern that the nursing notes suggest the diamorphine and midazolam infusions were commenced because of Mr Cunningham's behaviour recorded in the nursing entry on 22nd September.

3.15 Hyoscine was commenced on 23rd September after Mr Cunningham had become 'chesty' overnight. I consider it very poor practice that there is no record of Mr Cunningham being examined by a doctor following admission on 21st September, and a decision to treat this symptomatically with hyoscine appears to have been made by the medical staff. At this stage Mr Cunningham's respiratory signs are likely to have been due to bronchopneumonia or respiratory depression resulting in depressed clearance of bronchial secretions. A medical assessment was very necessary at this

stage to diagnose the cause of symptoms and to consider treatment with antibiotics or reduction in the dose of diamorphine and midazolam.

3.16 Again I consider it very poor practice that the midazolam was increased from 20mg/24hr to 60mg/24 hr at 2000h on 23rd September. There is no entry in the medical notes to explain this dose increase. The decision to triple the midazolam dose appears to have been made by a member of nursing staff as the nursing notes record *"agitated at 2300h, syringe driver boosted with effect."*

3.17 A medical assessment should have been obtained before the decision to increase the midazolam dose was made. At the very least Mr Cunningham's problems should have been discussed with on call medical staff. Mr Cunningham's agitation may have been due to pain, where increasing analgesia would have been appropriate, or hypoxia (lack of oxygen). If Mr Cunningham's agitation was due to hypoxia a number of interventions may have been indicated. Reducing the diamorphine and midazolam dose would have been appropriate if hypoxia was due to respiratory depression. Commencement of oxygen therapy and possibly antibiotics would have been appropriate if hypoxia was due to pneumonia. Reducing the dose diamorphine or midazolam would have been indicated if hypoxia was due to drug-induced respiratory depression. The decision to increase the midazolam dose was not appropriately made by the ward nursing staff without discussion with medical staff.

3.18 When Mr Cunningham was reviewed by Dr Lord on 24th September he was very unwell but there is not a clear description of his respiratory status or whether he had signs of pneumonia. At this stage Dr Lord notes Mr Cunningham is in pain, but does not state the site of his pain. It is not clear to me whether the subsequent alteration in infusion rate of diamorphine, hyoscine and midazolam was discussed with and sanctioned by Dr Lord or Dr Barton. I consider the increase in midazolam from 60mg/24 hr to 80mg/24 hr was inappropriate as a response to the observation that Mr Cunningham was in pain. It would have been more appropriate to increase the diamorphine dose or even consider treatment with a non-steroidal anti-inflammatory drug. The increase in midazolam dose to 80mg/24 hr would simply make Mr Cunningham less conscious than he already appears to have been (there is not a clear description of his conscious level at this stage).

3.19 The increase in hyoscine dose to 800microg/24 hr is also difficult to justify when there is no record that the management of bronchial secretions was a problem. The subsequent threefold increase in diamorphine dose later that day to 60mg/24 hr is in my view very poor practice. Such an increase was highly likely to result in respiratory depression and marked depression of conscious level, both of which could lead to premature death. The description of Mr Cunningham, was that analgesia was 'just' controlling pain and a more cautious increase in diamorphine dose, certainly no more than two fold, was indicated with careful review of respiratory status and conscious level after steady state levels of diamorphine would have been obtained about 20 hours later. A more appropriate response to deal with any acute breakthrough pain is to administer a single prn (intermittent) dose of opiate by the oral or intramuscular route, depending on whether Mr Cunningham was unable to swallow at this time.

3.20 The increase in both diamorphine dose and midazolam dose on 26th September is difficult to justify when there is no record in the medical or nursing notes that Mr Cunningham's pain was uncontrolled. Although it is possible to accept the increase in diamorphine dose may have been appropriate if Mr Cunningham was observed to be in pain, I find the further increase in midazolam dose to 100mg/24hr of great concern. I would anticipate that this dose of midazolam administered with 80mg/24hr of diamorphine would be virtually certain to produce respiratory depression and severe depression of conscious level. This would be expected to result in death in a frail individual such as Mr Cunningham. I would expect to see very clear reasons for the use of such doses recorded in the medical notes.

3.21 I can find no record of Mr Cunningham receiving food or fluids following his admission on 21st September despite a note from Dr Lord that Mr Cunningham was to receive a 'high protein diet'. There is no indication in the medical or nursing notes as to whether this had been discussed, but given that Mr Cunningham was admitted with the intention of returning to his Nursing Home (it was to be held open for 3 weeks) I would expect the notes to record a clear discussion and decision making process involving senior medical staff accounting for the decision to not administer subcutaneous fluids and/or nasogastric nutrition once Mr Cunningham was commenced on drugs which may have made him unable to swallow fluids or food.

Recorded causes of death

3.22 The recorded cause of death was bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer. A post mortem was not obtained and the recorded causes were in my opinion reasonable. It is possible that Mr Cunningham died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mr Cunningham was at high risk of developing pneumonia even if he had not received sedative or opiate drugs, bronchopneumonia can occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia as reasonable. Even if the staff had considered Mr Cunningham had drug-induced respiratory depression as a contributory factor, it would not be usual medical practice to enter this as a contributory cause of death where the administration of such drugs was considered appropriate for symptom relief.

Duty of care issues

3.23 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care to attempt to heal Mr Cunningham's sacral ulcer and to document the effects of drugs prescribed. In my opinion this duty of are was not adequately met and the denial of fluid and diet and prescription of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Cunningham's death.

Summary

3.24 In summary although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer, Dr Barton and the ward staff appear to have considered Mr Cunningham was dying and had been admitted for terminal care. The medical and nursing records are inadequate in documenting his clinical state at this time. The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression.

ALICE WILKIE

Course of Events

4.1 Alice Wilkie was 81 years old when admitted under the care of Dr Lord, by her general practitioner on 31st July 1998 from Addenbrooke Rest Home to Phillip Ward, Department of Medicine for Elderly People, at the Queen Alexandra Hospital, Portsmouth. The general practitioner referral letter states "*This demented lady has been in this psychogeriatric care home for a year. She had a UTI early this week and has not responded to trimethoprim. Having fallen last night, she is not refusing fluids and is becoming a little dry*". The medical admitting notes record she was taking prozac (fluoxetine) syrup 20 mg once daily, codanthramer 5-10ml nocte, lactulose 10ml once daily zopiclone 1.875 or 3.75mg nocte and promazine syrup 25mg as required. On examination she had a fever and bilateral conjunctivitis but no other significant findings. The admitting doctor diagnosed a urinary tract infection and commenced intravenous antibiotics to be administered after a blood culture and catheter specimen of urine had been obtained. The following day DNR (do not resuscitate) is recorded in the notes. On 3rd August 1998 the medical notes record the fever had settled, that she was taking some fluids orally, was taking the antibiotic Augmentin elixir orally and receiving subcutaneous fluids. The notes then record (date not clear) that her Mental Test Score was 0/10 and Barthel 1/20 (indicating severe dependency). Mrs Wilkie was to be transferred to Daedalus NHS continuing care ward on 6th August 1998 with a note that her bed was to be kept at Addenbrooke Rest Home.

4.2 Following transfer on 6th August an entry in the medical notes states "*Transferred from Phillips Ward. For 4-6/52 only. On Augmentin for UTI*". Dr Lord writes on 10th August 1998 '*Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrooke's. R/V* (review) *in 1/12* (one month) *–if no specialist medical or nursing problems D* (discharge) *to a N/Home. Stop fluoxetine'*. The next entry is by Dr Barton on 21st August "*Marked deterioration over last few days. sc analgesia commenced yesterday. Family aware and happy*". The final entry is on the same day at 1830h where death is confirmed. The most recent record of the patient's weight I can find is 56Kg in April 1994.

4.3 The nursing notes, which have daily entries during her one week stay on Phillip ward note she was catheterised, was confused at times and was sleeping well prior to transfer. The nursing notes on Daedalus ward record "6/8/98 *Transferred from Philip ward QAH for 4-6 weeks assessment and observation and then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration*" and that she was seen by Dr Peters. The nursing assessment sheet notes *"does have pain at times unable to ascertain where"*. The nutrition care plan states on 6th August 1998 *"Due to dementia patient has a poor dietary intake"*. And dietary intake is recorded between 12th August and 18th August but not before or following these dates. Nursing entries in the contact record state on 17th August 1998 *"Condition has generally deteriorated over the weekend. Daughter Shen aware that mums condition worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain"*. There is no entry in the notes on 20th August or preceding few days indicating Mrs Wilkie was in pain.

4.4 A nursing entry on 21st August 1998 at 1255h states "*Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free*". There are a number of routine entries in the period 6th August 1998 to death on 21st August 1998 in nutrition, pressure area care, constipation, catheter care, and personal hygiene. The nursing care plan records no significant deterioration until 21st August where it is noted death was pronounced at 2120h by staff nurse Sylvia Roberts. Cause of death was recorded as bronchopneumonia.

4.5 The drug charts records that Dr Barton prescribed as a regular daily review (not intermittent as required) prescription diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr all to be administered subcutaneously. The prescription is not dated. Drugs were first administered on 20th August, diamorphine at 30mg/24hr and midazolam 20mg/24hr from 1350h and then again on 21st August. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her admission to Daedalus ward prior to administration of the diamorphine and midazolam infusions. During the period 16th-18th August she was prescribed and received zopiclone (a sedative hypnotic) 3.75mg nocte and co-danthramer 5-10ml (a laxative) orally.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

4.6 Primary responsibility for the medical care of Mrs Wilkie during her admission to Daedalus ward lay with Dr Lord, as the consultant responsible for her care. She saw Mrs Wilkie on 10th August 1998, 11 days prior to her death. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Wilkie and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

4.7 The initial diagnosis of a urinary tract infection and dehydration was reasonable and appears correct. Mrs Wilkie had a diagnosis of dementia, which there was clear evidence for. The entry by Dr Lord on 10th August 1998 provides a reasonable assessment of her functional level at this time, and a plan to review appropriate placement in one month's time. No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15th August. There is no medical assessment in the notes following 10th August except documentation on 21st August 1998 of a marked deterioration. There is no clear evidence that Mrs Wilkie was in pain although she was commenced on opiate analgesics.

Evaluation of drugs prescribed and the administration regimens

4.8 No information is recorded in the medical or nursing notes to explain why Mrs Wilkie was commenced on diamorphine and hyoscine infusions. In my opinion there was no indication for the use of diamorphine and hyoscine in Mrs Wilkie. Other oral analgesics, such as paracetamol and mild opiate drugs could and should first have been tried, if Mrs Wilkie was in pain, although there is no evidence that she was. If these were inadequate oral morphine would have

been the next appropriate choice. From the information I have seen in the notes it appears the diamorphine and midazolam may have been commenced for non-specific reasons, perhaps as a non-defined palliative reasons as it was judged she was likely to die in the near future.

4.9 I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. I consider it poor and hazardous management to initially commence both diamorphine and midazolam in a frail elderly underweight patient with dementia such as Mrs Wilkie. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

Quality and sufficiency of the medical records

4.10 The medical and nursing records during her stay on Daedalus ward are inadequate not sufficiently detailed, and do not provide a clear picture of Mrs Wilkie's condition. In my opinion the standard of the notes falls below the expected level of documentation on a continuing care or rehabilitation ward. The assessment by Dr Lord on 10th August 1998 is the only satisfactory medical note entry during her 15 day stay on Daedalus ward.

Appropriateness and justification of the decisions that were made

4.11 As discussed above I do not consider the decision to commence diamorphine and hyoscine was appropriate on the basis of the information recorded in the clinical notes.

Recorded causes of death

4.12 There was no specific evidence that bronchopneumonia was present, although this is a common pre-terminal event in frail older people, and is often entered as the final cause of death in frail older patients. I am surprised the death certificate did not apparently refer to Mrs Wilkie's dementia as a contributory cause. It is possible Mrs Wilkie's death was due at least in part to respiratory depression from the diamorphine she received, or that the diamorphine led to the development of bronchopneumonia. However since there are no clear observations of Mrs Wilkie's respiratory observations it is difficult to know whether respiratory depression was present Mrs Wilkie deteriorated prior to administration of diamorphine and midazolam infusion, and in view of this, my opinion would be that although the opiate and sedative drugs administered may have hastened death, and these drugs were not indicated, Mrs Wilkie may well have died at the time she did even if she had not received the diamorphine and midazolam infusions.

Duty of care issues

4.13 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care, to monitor, and to document the effects of drugs prescribed to Mrs Wilkie. In my opinion this duty of care was not adequately met, the prescription of diamorphine and midazolam was poor practice and this may have contributed to Mrs Wilkie's death.

Summary

4.14 In my opinion the prescription of subcutaneous diamorphine and midazolam was inappropriate, and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death. However Mrs Wilkie was a frail very dependent lady with dementia who was at high risk of developing pneumonia. It is possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Robert WILSON

5.1 Mr Wilson was 75 years old man when he was admitted to Queen Alexandra Hospital on 22nd September 1998 after he sustained a proximal fracture of the left humerus. He was treated with morphine, initially administered intravenously and then subcutaneously. He developed vomiting. On 24th September he was given 5mg diamorphine and lost sensation in the left hand. On 29th September an entry in the medical notes states *"ref to social worker, review resus status. Not for resuscitation in view of quality of life and poor prognosis".*

5.2 On 7th October the notes record he was *"not keen on residential home and wished to return to his own home".* Dr Lusznat, Consultant in Old Age Psychiatry on 8th October 1998, saw him. Dr Lusznat's letter on 8th October notes that Mr Wilson had been sleepy and withdrawn and low in mood but was now eating and drinking well and appeared brighter in mood. His Barthel score was 5/20. Dr Lusznat noted he had a heavy alcohol intake during the last 5 years. At the time he was seen by Dr Lusznat her was prescribed thiamine 100 mg daily, multivitamins two tablets daily, senna two tablets daily, magnesium hydroxide 10 mls twice daily and paracetamol 1g four time daily. On examination he had mildly impaired cognitive function (Mini Mental State Examination 24/30). Dr Lusznat considered Mr Wilson might have developed an early dementia, which could have been alcohol related, Alzheimer's disease or vascular dementia. An antidepressant trazadone 50mg nocte was commenced. Dr Lusznat states at the end of her letter *"On the practical side he may well require nursing home care though at the moment he is strongly opposed to that idea I shall be happy to arrange follow up by our team once we know when and where he is going to be discharged".* On 13th October the medical notes record a ward round took place, that he required both nursing and medical care, was at risk of falling and that a short spell in long-term NHS care would be appropriate. Reviewing the drug charts Mr Wilson was taking regular soluble paracetamol (1g four times daily) and codeine phosphate 30mg as required for pain. Between 8th and 13th October Mr Wilson was administered four doses of 30mg codeine. Mr Wilson's weight in March 1997 was 93Kg

5.3 On the 14th October Mr Wilson was transferred to Dryad Ward. An entry in the medical notes by Dr Barton reads *"Transfer to Dryad ward continuing care. HPC fracture humerus. needs help with ADL (*activities of Daily Living*), hoisting, continent, Barthel 7. Lives with wife. Plan further mobilisation".* On 16th November the notes record; *'Decline overnight with S.O.B. o/e ? weak pulse. Unresponsive to spoken work. Oedema ++ in arms and legs. Diagnosis ?silent MI, ? decreased ___function. ↑frusemide to 2 x 40mg om '.* On 17th October the notes record *'comfortable but rapid deterioration'.* On 18th October staff nurse Collins records death at 2340h. Cause of death is recorded as congestive cardiac failure.

5.4 Nursing notes state in the summary section on 14th October *"History of left humerus fracture, arm in collar and cuff. Long history of heavy drinking. I.V.F. cannula to right hand & legs. S/B Dr Barton. Oramorph 10mg/5ml given. Continent of urine. uses bottles".* On 15th October *"Commenced oramorph 10mg/5ml 4 hrly for pain in L arm. Wife seen by sis. Hamblin who explained Robert's condition is poor".* An earlier note states *"settled and slept well".* On 16th October *"seen by Dr Knapman an as deteriorated over night. Increase*

*frusemide to 80mgdaily. For A.N.C (*active nursing care)". Later that day a further entry states "*Patient very bubbly chest this pm. Syringe driver commenced 20mg diamorphine, 400mcgs hyoscine. Explained to family reason for driver*". A separate note on 16th October in the nursing care plan states "*More secretions – pharyngeal – during the night, but Robert hasn't been distressed. Appears comfortable*". On 17th October 0515h "*Hyoscine increased to 600mcgs as oro-pharyngeal secretions increasing. Diamorphine 20mg.*" Later that day a further entry states "*Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver reviewed at 15.50 s/c diamorphine 40mg, midazolam 20mcgs, hyoscine 800 mcgs*". A later note states "*night: noisy secretions but not distressing Robert. Suction given as required during night. Appears comfortable*". On 18th October "*further deterioration in already poor condition. Syringe driver reviewed at 14:40 s/c diamorphine 60mg, midazolam 40mg, hyoscine 1200mcg. Continues to require regular suction*".

5.5 The medication charts record administration of the following drugs:

14 Sep 1445h oramorph 10mg
2345h oramorph 10mg
16 Sep 1610h diamorphine 20mg/24 hr, hyoscine 400 microg/24hr subcutaneous infusion
17 Sep 0515h diamorphine 20mg/24hr, hyoscine 600 microg/24hr
1550h diamorphine 40mg/24hr, hyoscine 800 microg/24hr midazolam 20mg/24hr
18 Sep 1450h diamorphine 60mg/24hr, hyoscine 1200 microg/24hr midazolam 40mg/24hr

Frusemide was administered at a dose of 80mg daily at 0900h on 15th and 16th October. An additional 80 mg oral dose was administered at an unstated time on 16th October.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

5.6 Responsibility for the care of Mr Wilson during his admission to Dryad ward lay with Dr Lord as the consultant responsible for his care. My understanding is that day to day medical care was delegated to the clinical assistant Dr Barton and during the out of hours responsibility was with the on call doctor based at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Wilson and informing medical staff of any significant deterioration.

5.7 Dr Lusznat was responsible for assessing Mr Wilson and making further recommendations concerning his future care when he was seen at Queen Alexandra Hospital.

Accuracy of diagnosis and prognosis including risk assessments

5.8 Dr Barton assessed Mr Wilson on 14th October the day he was transferred to Dyad ward. There was a plan to attempt to improve his mobilisation through rehabilitation. There is no record of any significant symptomatic medical problems, in particular any record that Mr Wilson was in pain in the medical

notes. The nursing notes suggest Mr Wilson was prescribed oramorph for pain in his arm following his admission to Dryad Ward. He was prescribed paracetamol to take as required but did not receive any paracetamol whilst on Dryad Ward.

5.9 Mr Wilson deteriorated on 15th September when he became short of breath. The working diagnosis was of heart failure due to a myocardial infarct. I do not consider the assessment by the on call doctor of Mr Wilson was adequate or competent. There is no record of his blood pressure, clinical examination findings in the chest (which might have indicated whether he had signs of pulmonary oedema or pneumonia). In my opinion an ECG should have been obtained that night, and a Chest Xray obtained the following morning to provide supporting evidence for the diagnosis. Mr Wilson was admitted for rehabilitation not terminal care and it was necessary and appropriate to perform reasonable clinical assessments and investigations to make a correct diagnosis.

5.10 Following treatment Mr Wilson was noted to have had a rapid deterioration. The medical and nursing teams appear to have failed to consider that Mr Wilson's deterioration may have been due to the diamorphine infusion. In my opinion when Mr Wilson was unconscious the diamorphine infusion should have been reduced or discontinued. The nursing and medical staff failed to record Mr Wilson's respiratory rate, which was likely to have been reduced, because of respiratory depressant effects of the diamorphine. The diamorphine and hyoscine infusion should have been discontinued to determine whether this was contributing to his deteriorating state. There is no record of the reason for the prescribing of the midazolam infusion commenced the day before his death. At this time the nursing notes record he was comfortable. Mr Wilson did not improve. The medical and nursing teams did not appear to consider that the diamorphine, hyoscine and midazolam infusion could be a major contributory factor in Mr Wilson's subsequent decline. The infusion should have been discontinued and the need for this treatment, in my opinion unnecessary at the time of commencement, reviewed.

Evaluation of drugs prescribed and the administration regimens

5.11 The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate. His pain had been controlled with regular paracetamol and as required codeine phosphate (a mild opiate) prior to his transfer, and in the first instance these should have been discontinued.

5.12 I am unable to establish when Dr Barton wrote the prescription for subcutaneous diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr, and midazolam 20-80mg/24hr as these are undated. The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate. The prescription of a single dose of intravenous opiate is standard treatment for a patient with chest pain following a myocardial infarction is appropriate standard practice but was not indicated in Mr Wilson's case as he did not have pain. The prescription of an initial single dose of diamorphine is appropriate as a treatment for pulmonary oedema if a patient fails to respond to intravenous diuretics such as frusemide. Mr Wilson was not administered intravenous

frusemide or another loop diuretic. Instead only a single additional oral dose of frusemide was administered. In my opinion this was an inadequate response to Mr Wilson's deterioration. The prescription of continuous subcutaneous infusion of diamorphine and hyoscine is not appropriate treatment for a patient who is pain free with a diagnosis of a myocardial infarction and heart failure. When opiates are used to treat heart failure, close monitoring of blood pressure and respiratory rate, preferably with monitoring of oxygen saturation is required. This was not undertaken.

5.13 The increase in diamorphine dose to 40mg/24hr and then 60mg/24 hr in the following 48 hours is not appropriate when the nursing and medical notes record no evidence that Mr Wilson was in pain or distressed at this time. This was poor practice and potentially very hazardous. Similarly the addition of midazolam and subsequent increase in dose to 40mg/24hr was in my opinion highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive.

Quality and sufficiency of the medical records

5.14 The initial entry in the medical records by Dr Barton on 14th October is reasonable and sufficient. The subsequent entries relating to Mr Wilson's deterioration are in my opinion inadequate, and greater detail and the results of examination findings should have been recorded. No justification for the increases in diamorphine, midazolam and hyoscine dose are written in the medical notes. The nursing notes are generally of adequate quality but I can find no record of fluid and food intake by Mr Wilson.

Appropriateness and justification of the decisions that were made

5.15 I consider the prescription of oramorph was inappropriate. The subsequent prescription and administration of diamorphine, hyoscine and midazolam was highly inappropriate, not justified by information presented in the notes and could be expected to result in profound depression of conscious level and respiratory depression in a frail elderly man such as Mr Wilson.

Recorded causes of death

5.16 The recorded cause of death was congestive cardiac failure. The limited clinical information recorded in the absence of a chest Xray result or post-mortem findings, suggest this may have been the cause of Mr Wilson's death. However in my opinion it is highly likely that the diamorphine, hyoscine and midazolam infusion led to respiratory depression and/or bronchopneumonia and it is possible that Mr Wilson died from drug induced respiratory depression.

Duty of care issues

5.17 Medical and nursing staff on Dryad ward had a duty of care to deliver appropriate medical and nursing care to Mr Wilson, and to monitor the effects of drugs prescribed. In my opinion this duty of care was not adequate. The administration of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Wilson's death.

Summary

5.18 Mr Wilson was a frail elderly man with early dementia who was physically dependent. Following his admission to Dryad ward he was, in my opinion, inappropriately treated with high doses of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and/or the development of bronchopneumonia and may have contributed to his death.

Eva PAGE

6.1 Eva Page was 87 years old when admitted as an emergency on 6th February 1998 to the Department of Medicine for Elderly People at Queen Alexandra Hospital. The medical notes record that she had experienced a general deterioration over the last 5 days was complaining of nausea and reduced appetite and was dehydrated. She had felt 'depressed' during the last few weeks. On admission she was taking ramipril 5mg once daily (a treatment for heart failure and hypertension), frusemide 40mg once daily (treatment for fluid retention), digoxin 125microg once daily (to control irregular heart rate), sotalol 40 mg twice daily (to control irregular heart rate), aspirin 75 mg once daily (to prevent stroke and myocardial infarction) and sertraline 50mg once daily (an antidepressant commenced by her general practitioner on 26th January 1998). A discharge summary and medical notes relating to an admission in May 1997 states that she was admitted with acute confusion, had reduced movement on the right side and was discharged back to her residential home on aspirin. No admitting diagnosis is recorded in the clerking notes written by Dr Harris on 6th February 1998 but they record that *"patient refuses iv fluids and is willing to accept increased oral fluids"*.

6.2 On 7th February 1998 the medical notes record an opacity seen on the chest Xray and sate *"mood low. Feels frightened – doesn't know why. Nausea and ??. Little else. Nil clinically."* An increased white cell count is noted (13.0) and antibiotics commenced. A subsequent chest Xray report (undated) states there is a 5cm mass superimposed on the left hilum highly suspicious of malignancy. The medical notes on 11 February 1998 record this at the Xray meeting. On 12th February 1998 the notes record (? Dr Shain) *'In view of advanced age aim in the management should be palliative care. Charles Ward is suitable. Not for CPR'.* On 13th February the notes record *'remains v low Appears to have 'given up' d/w son re probably diagnosis d/w RH (residential home) re ability to cope'.* The notes record *'son agrees not suitable for invasive Tx (*treatment*). Matron from RH visiting today will check on ability to cope.'*

6.3 On 19th February the notes record she fell on the ward and experienced minor cuts. On 16th February *'gradual deterioration, no pain, confused. For Charles Ward she could be discharged to community from Charles Ward'.* On 19th February the notes summarise her problems *'probable Carcinoma of the bronchus, previous left ventricular failure, atrial fibrillation, digoxin toxicity and a transient ischaemic attack, that she was sleepy but responsive, states that she is frightened but doesn't know why. Says she has forgotten things, not possible to elicit what she can't remember, low MTS (mental test score). Plan encourage oral fluids, s/c fluid over night if tolerated. Continue antidepressants'*. On 18th February the medical notes state *"No change. Awaiting Charles Ward bed"*.

6.4 The nursing notes record she was confused but mobilised independently. On 19th February she was transferred to Charles Ward instead of the preferred [illegible] bed at Gosport Hospital, which the ward informed was full (no beds). The Queen Alexandra Hospital medical notes record a summary of her problems on 19th February prior to transfer as follows *"Diagnosis CA bronchus probable [no histology] Diag based on CXR. PMH 95 LVF + AF 95 Digoxin toxicity 97 TIA. Admitted 6.2.98 general deterioration CXR ? Ca Bronchus.*

Well defined O lesion. Exam: sleepy but responsive answers appropriately. States that she is frightened but doesn't know why. Says she has forgotten things. Not possible to elicit what she can't remember. Low MTS" and *"Feels in general tired and very thirsty. Plan encourage oral fluids, s/c fluid overnight is tolerated continue antidepressants".*

6.5 The medical notes on 23rd February record diagnoses of depression, dementia, ? Ca bronchus, ischaemic heart disease and congestive heart failure. On 25th February Dr Lord records in the medical notes "*confused and some agitation towards afternoon – evening try tds* (three times daily) *thioridazine, son in Gosport, transfer to Gosport 27/2, heminevrin prn nocte'.* A further entry states *'All other drugs stopped by Dr Lord'.*

6.6 Mrs Page was transferred to Dryad ward at Gosport War Memorial Hospital on 27th February 1998. Dr Barton writes in the medical notes "*Transfer to Dryad ward continuing care, Diagnosis of Ca Bronchus on CXR on admission. Generally unwell off legs, not eating, bronchoscopy not done, catheterised, needs help with eating and drinking, needs hoisting, Barthel 0. Family seen and well aware of prognosis. Opiates commenced. I'm happy for nursing staff to confirm death".* The nursing notes state she was admitted for *'palliative care'*, that she had a urinary catheter (inserted on 22nd February 1998) was incontinent of faeces, and was dependent for washing and dressing but could hold a beaker and pick up small amounts of food. Barthel Index was 2/20. The nursing action plan states *'encourage adequate fluid intake'.* On 28th February an entry in the medical notes by Dr Laing (duty GP) record *'asked to see: confused. Feels 'lost' agitated esp. night/evening, not in pain, to give thioridazine 25mg tds regular, heminevrin noct.* The nursing notes record she was very distressed and that she was administered thioridazine and Oramorph 2.5ml.

6.7 On 2nd March Dr Barton records *'no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain; Son to be seen by Dr Lord today'.* A subsequent entry by Dr Lord on the same day states *' spitting out thioridazine, quieter on prn sc diamorphine. Fentanyl patch started today. Agitated and calling out even when staff present (diagnoses) 1) Ca Bronchus 2) ? Cerebral metastases. -ct* (continue) *fentanyl patches.'* A further entry by Dr Lord that day records *'son seen. Concerned about deterioration today. Explained about agitation and that drowsiness was probably due in part to diamorphine. He accepts that his mother is dying and agrees we continue present plan of Mx* (management)".

6.8 On 2nd March the nursing notes record "*commenced on Fentanyl 25mcg this am. Very distressed this morning seen by Dr Barton to have and diamorphine 5mg i/m (intramuscular) same given 0810h by a syringe driver.* A further entry the same day states "*S/B Dr Lord. Diamorphine 5mg i/m given for syringe driver with diamorphine loaded*". On 3rd March a rapid deterioration in Mrs Page's condition is recorded *'Neck and left side of body rigid – right side rigid. At 1000h diamorphine and midazolam were continued by syringe driver.* Death is recorded later that day at 2130h, 4 days following admission to Dyad ward.

6.9 The prescription charts (which are incompletely copied in notes made available to me) indicate she received the following drugs during this admission Two doses of intramuscular diamorphine 5 mg were administered at 0800 and 1500h (date not visible)

28 Feb 1998	1300h thioridazine 25mg
	1620h oramorph 5mg
	2200h heminevrin 250mg in 5ml
1 Mar 1998	0700h thioridazine 25 mg
	1300h thioridazine 25 mg
	2200h heminevrin 250mg
2 Mar 1998	0700h thioridazine 25mg
	0800h fentanyl 25microg
3 Mar 1998	1050h diamorphine 20mg/24hr, midazolam 20 mg/24hr by subcutaneous infusion

On 27th February Dr Barton prescribed thioridazine 25mg (prn tds) and Oramorph (10mg/5ml) 4hrly prn. On 2nd March Dr Barton prescribed fentanyl 25microg patch (x3 days) to take as required (prn). On 3rd March Dr Barton prescribed diamorphine 20-200mg/24hr, hyoscine 200-800ucg/24hr and midazolam 20-80mg/24hr by subcutaneous infusion.
The notes do not indicate that the fentanyl patch was removed and I would assume this was continued when the diamorphine and midazolam infusion was commenced.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

6.10 Primary responsibility for the medical care of Mrs Page during her admission to Dryad Ward lay with Dr Lord, as the consultant responsible for his care. She saw Mrs Page 2 days before her transfer to Dryad ward and two days following her admission, the day before she died. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Page and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

6.11 The assessment and management of Mrs Page at Alexandra Hospital was in my opinion competent and considered. From the information in the clinical notes I would agree with the diagnosis of probable carcinoma of bronchus. The decision to prescribe an antidepressant was in my opinion appropriate. Prior to transfer to Dryad ward she was not in pain but was transferred for palliative care. Although Mrs Page was clearly very dependent and unwell, it is not clear why Dr Barton prescribed opiates to Mrs Page on admission to Dryad ward when there is no evidence she was in pain. I suspect the reason was to provide relief for Mrs Page's anxiety and agitation. This is a reasonable indication for opiates in the palliative care of a patient with known inoperable carcinoma. Mrs Page was clearly to be severely dependent, Barthel Index 0, and in conjunction with a probable carcinoma of the bronchus the assessment that she required palliative care and was likely to die in the near future was appropriate.

Evaluation of drugs prescribed and the administration regimens

6.12 The prescription of the major tranquilliser thioridazine for anxiety was reasonable and appropriate. The prescribing of the sedative/hypnotic drug heminevrin was similarly reasonable although potential problems of sedation from the combination need to be considered. Mrs Page was not in pain but I consider the prescription of oramorph on 28th February to attempt to improve her distress was reasonable. By 2nd March Mrs Page remained very distressed despite prescription of Oramorph, thioridazine and heminevrin. Since the notes reported she was more settled following intramuscular diamorphine and she had been spitting out her oral medication, I would consider it appropriate to prescribe a transdermal fentanyl patch to provide continuing opioid drugs to Mrs Page. The lowest dose patch was administered but it would have been important to be aware of the potential for depression of respiration and/or conscious level that could occur.

6.13 I do not understand why subcutaneous diamorphine and midazolam infusions were commenced on 3rd March when Mrs Page had deteriorated whilst on the fentanyl patch. There is no indication in the notes that Mrs Page was in pain or distressed. The notes describe her as having undergone a rapid deterioration, which could have been due to a number of different causes, including a stroke or an adverse effect of the fentanyl patch. In my opinion the prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr was poor practice and potentially very hazardous. I would judge it poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mrs Page who was already receiving transdermal fentanyl. I would expect very clear reasons to support the use of the drugs to be recorded in the medical notes. The combination could result in profound respiratory depression and there are no symptoms recorded which suggest the administration of either drug was appropriate.

Quality and sufficiency of the medical records

6.14 The medical and nursing records relating to Mrs Page's admission to Dryad ward are in my view of adequate quality, although as stated above the reasons for the use of midazolam and diamorphine are not recorded in either the medical or nursing notes.

Appropriateness and justification of the decisions that were made

6.15 In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death. From the information I have seen in the notes it appears that Dr Barton may have commenced the diamorphine and midazolam infusion for non-specific reasons or for non-defined palliative reasons when it was judged she was likely to die in the near future.

Recorded causes of death

6.16 In the absence of a post-mortem the recorded cause of death is reasonable. Mrs Page had a probable carcinoma of the bronchus and experienced a slow deterioration in her general health and functional abilities. It is possible that Mrs Page died from drug induced respiratory depression. However Mrs Page was at high risk of dying from the effects of her probable carcinoma of the bronchus even if she had not received sedative and opiate drugs. Bronchopneumonia

can also occur as a complication of opiate and sedative induced respiratory depression but also in patients deteriorating from malignancy. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mrs Page's respiratory rate I would consider the recorded cause of death was possible. The deterioration on between the 2nd March and 3rd March could have been secondary to the fentanyl patch she received but again could have occurred in the absence of receiving this drug. There are no accurate records of Mrs Page's respiratory rate but significant potentially fatal respiratory depression was likely to have resulted could have resulted from the combination of diamorphine, midazolam and fentanyl.

Duty of care issues

6.17 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care, to monitor Mrs Page and to document the effects of drugs prescribed. In my opinion this duty of care was adequately met except during the last day of her life when the prescription of diamorphine and midazolam was poor practice and may have contributed to Mrs Wilkie's death.

Summary

6.18 Mrs Page was a frail elderly lady with probable carcinoma of the bronchus who had been deteriorating during the two weeks prior to admission to Dryad ward. In general I consider the medical and nursing care she received was appropriate and of adequate quality. However I cannot identify a reason for the prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton on the 3rd March. In my view this was an inappropriate, potentially hazardous prescription. I would consider it highly likely that Mrs Page experienced respiratory depression and profound depression of conscious level from the combination of these two drugs and fentanyl but I cannot exclude other causes for her deterioration and death at this time such as stroke or pneumonia.

Opinion on clinical management at Gosport War Memorial Hospital based on review of five cases presented by Hampshire Police

7.1 My opinion on the five cases I have been asked to review at Gosport War Memorial Hospital must be considered in context. My understanding is that the five cases have been selected by Hampshire Police because of concerns expressed relating to the management of these patients. Therefore my comments should not be interpreted as an opinion on the quality of care in general at Gosport War Memorial Hospital or of the general quality of care by the clinicians involved. My comments also relate to a period 2-4 years ago and the current clinical practice at the hospital may be very different today. An opinion on the quality of care in general at the hospital or of the clinicians would require a systematic review of cases, selected at random or with pre-defined patient characteristics. Examination of selected cases is not an appropriate mechanism to comment on the general quality of care of an institution or individual practitioners.

7.2 However having reviewed the five cases I would consider they raise a number of concerns that merit further examination by independent enquiry. Such enquiries could be made through further police interviews or perhaps more appropriately through mechanisms within the National Health Service, such as the Commission for Health Improvement, and professional medical and nursing bodies such as the General Medical Council or United Kingdom Central Council for Nursery, Midwifery and Health Visiting.

7.3 My principle concerns relate to the following three areas of practice: prescription and administration of subcutaneous infusions of opiate and sedative drugs in patients with non-malignant disease, lack of training and appropriate medical supervision of decisions made by nursing staff, and the level of nursing and non-consultant medical skills on the wards in relation to the management of older people with rehabilitation needs.

7.4 In all five cases subcutaneous infusions of diamorphine and in combination with sedative drugs were administered to older people who were mostly admitted for rehabilitation. One patient with carcinoma of the bronchus was admitted for palliative care. Although intravenous infusion of these drugs are used frequently in intensive care settings, very close monitoring of patients is undertaken to ensure respiratory depression does not occur. Subcutaneous infusion of these drugs is also used in palliative care, but the British National Formulary indicates this route should be used only when the patient is unable to take medicines by mouth, has malignant bowel obstruction or where the patient does not wish to take regular medication (Appendix 2). In only one case were these criteria clearly fulfilled i.e. in Mrs Page who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive doses and in combination with often no indication for dose escalation that took place. There was a failure by medical and nursing staff to recognise or respond to severe adverse effects of depressed respiratory function and conscious level that seemed to have occurred in many patients. Nursing and medical staff appeared to have little knowledge of the adverse effects of these drugs in older people.

7.5 Review of the cases suggested that the decision to commence and increase the dose of diamorphine and sedative drugs might have been made by nursing staff without appropriate consultation with medical staff. There is a possibility that prescriptions of subcutaneous infusions of diamorphine, midazolam and hyoscine may have been routinely written up for many older frail patients admitted to Daedalus and Dryad wards, which nurses then had the discretion to commence. This practice if present was highly inappropriate, hazardous to patients and suggests failure of the senior hospital medical and managerial staff to monitor and supervise care on the ward. Routine use of opiate and sedative drug infusions without clear indications for their use would raise concerns that a culture of "involuntary euthanasia" existed on the ward. Closer enquiry into the ward practice, philosophy and individual staff's understanding of these practices would be necessary to establish whether this was the case. Any problems may have been due to inadequate training in management of older patients. It would be important to examine levels of staffing in relation to patient need during this period, as the failure to keep adequate nursing records could have resulted from under-staffing of the ward. Similarly there may have been inadequate senior medical staff input into the wards, and it would be important to examine this in detail, both in terms of weekly patient contact and in time available to lead practice development on the wards. My review of Dr Lord's medical notes and her statement leads me to conclude she is a competent, thoughtful geriatrician who had a considerable clinical workload during the period the above cases took place.

7.6 I consider the five cases raise serious concerns about the general management of older people admitted for rehabilitation on Daedalus and Dryad wards and that the level of skills of nursing and non-consultant medical staff, particularly Dr Barton, were not adequate at the time these patients were admitted.

7.7 Having reviewed the five cases presented to me by Hampshire Police, I consider they raise serious concerns about nursing and medical practice on Daedalus and Dryad wards at Gosport War Memorial Hospital. In my opinion a review of practice at the institution is necessary, if this has not already taken place. I would recommend that if criminal proceedings do not take place, that these cases are brought to the attention of the General Medical Council and United Kingdom Central Council for Nursery, Midwifery and Health Visiting, in relation to the professional competence of the medical and nursing staff, and the Commission for Health Improvement, in relation to the quality of service provided to older people in the Trust.

APPENDIX 1

Pharmacology of Opiate and Sedative Drugs

Morphine

8.1 Morphine is a potent opiate analgesic considered by many to the 'drug of choice' for the control of acute pain (Therapeutic Drugs Dollery). Recommended starting dosage regimens for a fit adult of 70Kg are for intravenous bolus dosing 2.5mg every 5 min until analgesia achieved with monitoring of the duration of pain and dosing interval, or a loading dose of 5-15mg over 30min than 2,5mg – 5mg every hour. A standard reference text recommends 'morphine doses should be reduced in elderly patients and titrated to provide optimal pain relief with minimal side effects'. Morphine can be used for sedation where sedation and pain relief are indicated, Dollery comments *'it should be noted that morphine is not indicated as a sedative drug for long-term use. Rather the use of morphine is indicated where the requirement for pain relief and sedation coexist such as in patients admitted to intensive care units and other high dependency areas, the morphine dose should be titrated to provide pain relief and an appropriate level of sedation. Frequently other pharmacological agents (e.g.: benzodiazepines) are added to this regimen to increase the level of sedation".*

8.2 Diamorphine

8.3

8.4 **Fentanyl**

8.5 Fentanyl is a transdermal opioid analgesic available as a transdermal patch. The '25' patch releases 25microg/hr.

8.6 The British National Formulary (copy of prescribing in palliative care attached Appendix 2) comments on the use of syringe drivers in prescribing in palliative care that drugs can usually be administered by mouth to control symptoms, and that indications for the parenteral route are: patient unable to take medicines by mouth, where there is malignant bowel obstruction, and where the patient does not wish to take regular medication by mouth, It comments that staff using syringe drivers should be adequately trained and that incorrect use of syringe drivers is a common cause of drug errors.

Heminevrin

Midazolam

8.1 Midazolam is a benzodiazepine sedative drug. It is used as a hypnotic, preoperative medication, sedation for procedures such as dentistry and GO endoscopy, long-term sedation and induction of general anaesthesia. Iot is not licensed for subcutaneous use, but is described in the British National Formulary prescribing in palliative care section as 'suitable for a very restless patient: it is given in a subcutaneous infusion dose of 20-100mg/24 hrs.

8.2 DA standard text describes the use of sedation with midazolam in the intensive care unit setting, and states, *"sedation is most commonly met by a combination of a benzodiazepine and an opioid, and midazolam has generally replaced diazepam in this respect".* It goes on to state, "in critically ill patients, prolonged sedation may follow the use of midazolam infusions as a result of delayed administration". Potentially life threatening adverse effects are described, "Midazolam can cause dose-related CNS depression, respiratory and

cardiovascular depression. There is a wide variation in susceptibility to its effects, the elderly being particularly sensitive. Respiratory depression, respiratory arrest, hypotension and even death have been reported following its use usually during conscious sedation. The elderly are listed as a high-risk group; the elderly are particularly sensitive to midazolam. The dose should be reduced and the drug given slowly intravenously in a diluted form until the desired response is achieved. In drug interactions the following is stated. "*midazolam will also potentiate the central depressant effects of opioids, barbituates, and other sedatives and anaesthetics, and profound and prolonged respiratory depression might result.*

8.3

Hyoscine

8.4 The British National Formulary describes hyoscine hydrobromide as an antagonist (blocking drug) of acetylcholine. It reduces salivary and respiratory secretions and provides a degree of amnesia, sedation and antiemesis (antinausea). IN some patients, especially the elderly, hyoscine may cause the central anticholinergic syndrome (excitement, ataxia, hallucinations, behavioural abnormalities, and drowsiness). The palliative care section describes it as being given in a subcutaneous infusion dose of 0.6-2.4mg/24 hours.

8.5

Use of syringe drivers

8.1 The BNF states 'oral medication is usually satisfactory unless there is severe nausea and vomiting, dysphagia, weakness, or coma in which case parenteral medication may be necessary. In the pain section it comments the non-opioid analgesics aspirin or paracetamol given regularly will often make the use of opioids unnecessary. An opioid such as codeine or dextropropoxyphene alone or in combination with a non-opioid analgesic at adequate dosage may be helpful in the control of moderate pain id non-opioids are not sufficient. If these preparations are not controlling the pain, morphine is the most useful opioid analgesic. Alternatives to morphine are hydromoprhine, oxycodone and transdermal fentanyl. In prescribing morphine it states 'morphine is given as an oral solution or as standard tablets every 4 hour, the initial dose depending largely on the patient's previous treatment. A dose of 5-10mg is enough to replace a weaker analgesic. If the first dose of morphine is no more effective than the previous analgesic it should be increased by 50% the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and the use of adjuvant analgesics (such as NSAIDs) should also be considered. Although morphine in a dose of 5-10mg is usually adequate there should be no hesitation in increasing it stepwise according to response to 100mg or occasionally up to 500mg or higher if necessary. The BNF comments on the parenteral route '*diamorphine is preferred for injection. The equivalent intramuscular or subcutaneous dose of diamorphine is approximately a third of the oral dose of morphine.*'

8.2 In the chapter on pain relief in 'Drugs and the Older Person' Crome writes on the treatment of acute pain ' *treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patient and the presence of comorbidity will dictate whether to start with a mild analgesic or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of*

prescribing morphine for chronic pain is to start with standard oral morphine in a dose of 5-10mg every four hours. The dose should be halved in frail older people.

Prescribing for the Elderly

The British National Formulary states in Prescribing for the Elderly section "*The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and antiparkinsonian drugs, all of which must be used with caution*".

APPENDIX 2

BNF Prescribing in palliative care

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Portsmouth HealthCare NHS
NHS Trust

14 MAR 2002

Department of Medicine for Elderly People
Queen Alexandra Hospital
Cosham
Portsmouth
Hants
PO6 3LY

Code A

Detective Superintendent John James
Major Incident Room
Hampshire Constabulary
Kingston Crescent
Portsmouth

08 March 2002

RIR/cmp

Dear Superintendent James

Further to you letter of 5th February 2002, to Mr Millett regarding Police enquiries at Gosport War Memorial Hospital and our subsequent discussion, we are considering within the Trust what further appropriate action we need to take as the employer of the staff named in the three reports commissioned by the Police.

In the course of this we have identified several inaccuracies in the text of one of the reports (that from Professor Ford). I am quite sure that these are to do with a misreading of the draft when finally being typed up, but given that the GMC and UKCC, along with ourselves, are considering individual staff on the basis of these reports, I felt that I should write highlighting the points so that they can be corrected:

- **Page 17, paragraph 3.13, fourth sentence**

  This reads "poor assessment by Dr. Lord"

  However in view of the subsequent sentence (which reads that "the assessment by Dr Lord was thorough and competent") and of the context of the patient's medical notes (where there is a comprehensive note by Dr Lord but only four lines by Dr Barton), we assume that this should read "poor assessment by Dr Barton".

- **Page 21, paragraph 4.1, line seven**

  This reads "... she is not refusing fluids ..."

  The G.P. letter referred to states "... she is now refusing fluids".

- **Page 26, paragraph 5.5**

This lists the dates of prescriptions as in September, whereas the prescription chart for the patient shows them as in October.

❖ **Page 27, paragraph 5.9, line one**

This reads as ".. deteriorated on 15 September..."

This should read "October". The patient was admitted on 22 September and was not an in-patient on 15 September.

In paragraph 5.9 there is a reference to Mr Wilson having been seen by the "on-call Doctor". The on-call Doctor concerned was Dr A C Knapnan.

❖ **Page 34, paragraph 6.16, final sentence**

This reads "... was likely to have resulted could have resulted..."

We assume that only one of these statements is meant to be there.

Yours sincerely

Code A

Dr R I Reid
Medical Director

cc: GMC
[redacted]
CHI

Gosport War Memorial Hospital: CHI Investigation Report

July 2002

Executive summary

▼ Key conclusions
▼ Key findings

▶ Recommendations

CHI has undertaken this investigation as a result concerns expressed by the police and others around the care and treatment of frail older peopl provided by Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. This follows polic investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. As part of their investigations, the police commissioned expert medical opinion, which was made available to CHI, relating to a total of five patient deaths in 1998. In February 2002, the police decided not to proceed with further investigations.

Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at Gosport War Memorial Hospital to share their concerns with CHI in August 2001. CHI is grateful to the Hampshire Constabulary for sharing information with us which contributed towards th local and national recommendations CHI makes t improve the care of this vulnerable group of NHS patients.

CHI has conducted a detailed review of the systems in place to ensure good quality patient care. CHI does not have a statutory remit to investigate either the circumstances around any particular death or the conduct of any individual.

Top

Key conclusions

CHI concludes that a number of factors, detailed i the report, contributed to a failure of trust systen to ensure good quality patient care:

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- there were insufficient local prescribing

guidelines in place governing the prescriptic of powerful pain relieving and sedative medicines
- the lack of a rigorous, routine review of pharmacy data led to high levels of prescribing on wards caring for older people not being questioned
- the absence of adequate trust wide supervision and appraisal systems meant that poor prescribing practice was not identified
- there was a lack of thorough multidisciplina total patient assessment to determine care needs on admission

CHI also concludes that the trust now has adequate policies and guidelines in place which ar being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Top

Key findings

National and local context (Chapter 3)

- Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of valu at corporate and divisional level in Portsmouth Healthcare NHS Trust. The seni management team was well established and together with the trust board, functioned as a cohesive team.
- There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had be communicated to patients and relatives, which had led to expectations of rehabilitation which had not been fulfilled.

Arrangements for the prescription, administration review and recording of medicines (Chapter 4)

- CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing referred to as the "Wessex guidelines", this was inappropriately applied to patients admitted for rehabilitation.
- Though CHI is unable to determine whether these levels of prescribing contributed to th deaths of any patients, it is clear that had

adequate checking mechanisms existed in the trust, this level of prescribing may have been questioned.

- CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Although the palliative care Wessex guidelines refer to non physical symptoms of pain, the trust's policies do not include methods of non verbal pain assessment and rely on the patient articulating when they are in pain.

Quality of care and the patient experience (Chapter 5)

- Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.
- Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

Staffing arrangements and responsibility for patient care (Chapter 6)

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards.
- There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health profession staff.

Lessons learnt from complaints (Chapter 7)

- The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake a review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation, which it was aware of in late 1998.
- Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result

of patient complaints, including increased medical staffing levels and improved processes for communication with patients, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

Clinical governance (Chapter 8)

- The trust responded proactively to the clinical governance agenda and had a robus framework in place with strong corporate leadership.

Top

Recommendations

It is clear from a number of CHI recommendation to the Fareham and Gosport Primary Care Trust (PCT) and the East Hampshire PCT, that continued close and effective working relationships between both PCTs will be essential in order to implement the recommendations in this report.
CHI is aware of the high level of interdependence that already exists between thes two organisations and urges that this continues.
CHI is aware that many of these recommendation will be relevant to emerging PCTs and urges all PCTs to take action where appropriate.

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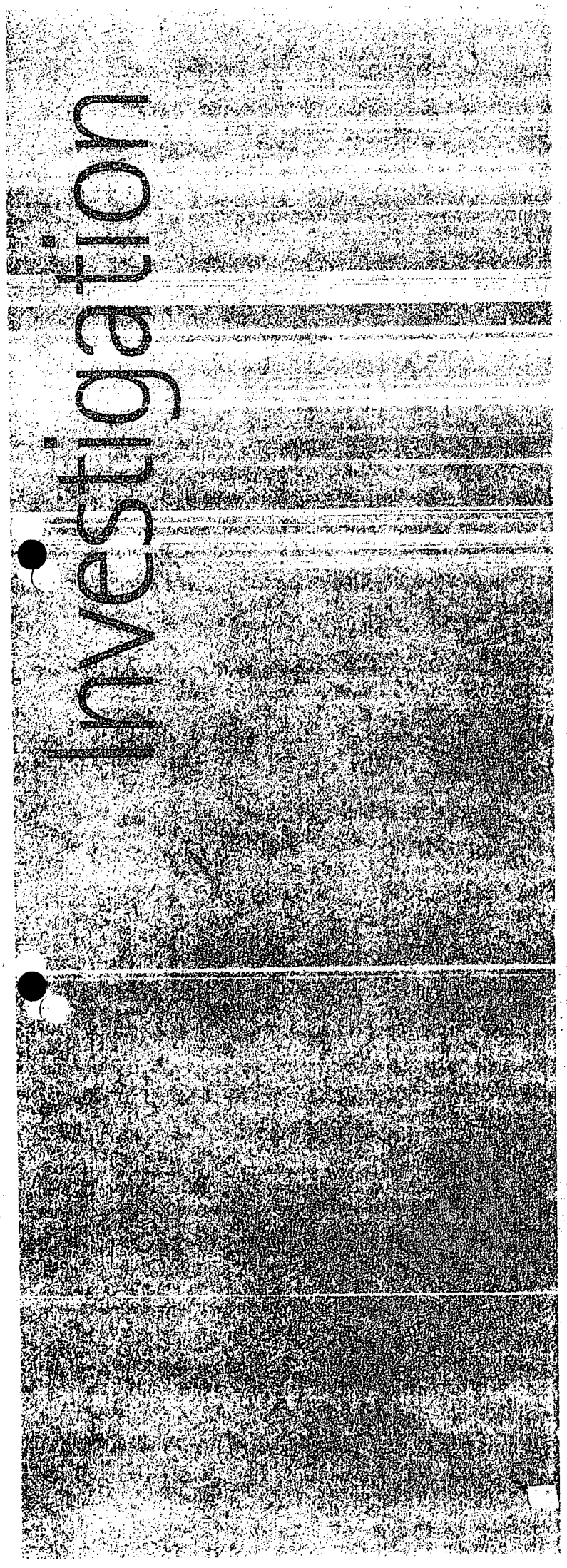

Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital

JULY 2002

CHI

COMMISSION FOR HEALTH IMPROVEMENT

Investigation into the Portsmouth Healthcare NHS Trust

Gosport War Memorial Hospital

JULY 2002

CHI
COMMISSION FOR HEALTH IMPROVEMENT

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- the patients and relatives who contributed either in person, over the phone or in writing. CHI recognises how difficult some of these contacts were for the relatives of those who have died
- staff interviewed by CHI's investigation team (see appendix C) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, General Manager, Caroline Harrington, Corporate Governance Advisor, Max Millett, Chief Executive (until 31 March 2002) and Ian Piper, Chief Executive of Fareham and Gosport Primary Care Trust (since 1 April 2002)
- staff and patients who welcomed the CHI team on to the wards during observation work
- Detective Superintendent John James, Hampshire Constabulary
- the agencies listed in appendix D who gave their views and submitted relevant documents to the investigation

Executive summary

CHI has undertaken this investigation as a result of concerns expressed by the police and others around the care and treatment of frail older people provided by Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. This follows police investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. As part of their investigations, the police commissioned expert medical opinion, which was made available to CHI, relating to a total of five patient deaths in 1998. In February 2002, the police decided not to proceed with further investigations.

Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at Gosport War Memorial Hospital to share their concerns with CHI in August 2001. CHI is grateful to the Hampshire Constabulary for sharing information with us which contributed towards the local and national recommendations CHI makes to improve the care of this vulnerable group of NHS patients.

CHI has conducted a detailed review of the systems in place to ensure good quality patient care. CHI does not have a statutory remit to investigate either the circumstances around any particular death or the conduct of any individual.

Key conclusions

CHI concludes that a number of factors, detailed in the report, contributed to a failure of trust systems to ensure good quality patient care:

- there were insufficient local prescribing guidelines in place governing the prescription of powerful pain relieving and sedative medicines
- the lack of a rigorous, routine review of pharmacy data led to high levels of prescribing on wards caring for older people not being questioned
- the absence of adequate trust wide supervision and appraisal systems meant that poor prescribing practice was not identified
- there was a lack of thorough multidisciplinary total patient assessment to determine care needs on admission

CHI also concludes that the trust now has adequate policies and guidelines in place which are being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Key findings

National and local context (Chapter 3)

- Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team.
- There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation which had not been fulfilled.

Arrangements for the prescription, administration, review and recording of medicines (Chapter 4)

- CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing referred to as the "Wessex guidelines", this was inappropriately applied to patients admitted for rehabilitation.
- Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.
- CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Although the palliative care Wessex guidelines refer to non physical symptoms of pain, the trust's policies do not include methods of non verbal pain assessment and rely on the patient articulating when they are in pain.

Quality of care and the patient experience (Chapter 5)

- Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.
- Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

Staffing arrangements and responsibility for patient care (Chapter 6)

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards.
- There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff.

Lessons learnt from complaints (Chapter 7)

- The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake a review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation, which it was aware of in late 1998.
- Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

Clinical governance (Chapter 8)

- The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

Recommendations

It is clear from a number of CHI recommendations to the Fareham and Gosport Primary Care Trust (PCT) and the East Hampshire PCT, that continued close and effective working relationships between both PCTs will be essential in order to implement the recommendations in this report. CHI is aware of the high level of interdependence that already exists between these two organisations and urges that this continues.
CHI is aware that many of these recommendations will be relevant to emerging PCTs and urges all PCTs to take action where appropriate.

Fareham and Gosport/ East Hampshire Primary Care Trust

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to develop the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should ensure an appropriate performance monitoring tool is in place to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

3. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

4. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

5. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

6. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

7. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

8. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

9. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals.

10. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

11. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

12. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.

13. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

14. The Fareham and Gosport PCT and the East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

15. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

16. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangements, clinical governance responsibilities and training needs.

17. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

18. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

19. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

20. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

21. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

22. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

Hampshire and Isle of Wight Strategic Health Authority

23. Hampshire and Isle of Wight Strategic Health Authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

Department of Health

24. The Department of Health should assist in the promotion of an NHS wide understanding of the various terms used to describe levels of care for older people.

25. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

1 | Terms of reference and process of investigation

1.1 During the summer of 2001, concerns were raised with CHI about the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the Gosport War Memorial Hospital. These concerns were also about the responsibility for clinical care and transfer arrangements with other hospitals.

1.2 On 22 October 2001, CHI launched an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust was responsible at the Gosport War Memorial Hospital. CHI's decision was based on evidence of high risk activity and the likelihood that the possible findings of a CHI investigation would result in lessons for the whole of the NHS.

Terms of reference

1.3 The investigation terms of reference were informed by a chronology of events provided by the trust surrounding the death of one patient. Discussions were also held with the trust, the Isle of Wight, Portsmouth and South East Hampshire Health Authority and the NHS south east regional office to ensure maximum learning locally and for the NHS.

1.4 The terms of reference agreed on 9 October 2001 are as follows:

The investigation will look at whether, since 1998, there had been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within services for older people (inpatient, continuing and rehabilitative care) at Gosport War Memorial Hospital.

i) staffing and accountability arrangements, including out of hours

ii) the guidelines and practices in place at the trust to ensure good quality care and effective performance management

iii) arrangements for the prescription, administration, review and recording of drugs

iv) communication and collaboration between the trust and patients, their relatives and carers and with partner organisations

v) arrangements to support patients and their relatives and carers towards the end of the patient's life

vi) supervision and training arrangements in place to enable staff to provide effective care

In addition, CHI will examine how lessons to improve patient care have been learnt across the trust from patient complaints.

The investigation will also look at the adequacy of the trust's clinical governance arrangements to support inpatient continuing and rehabilitation care for older people.

CHI's investigation team

1.5 CHI's investigation team were:

- Alan Carpenter, Chief Executive, Somerset Coast Primary Care Trust
- Anne Grosskurth, CHI Support Investigations Manger
- Dr Tony Luxton, Consultant Geriatrician, Cambridge City Primary Care Trust
- Julie Miller, CHI Lead Investigations Manager
- Maureen Morgan, Independent Consultant and former Community Trust Nurse Director
- Mary Parkinson, lay member (Age Concern)
- Jennifer Wenborn, Independent Occupational Therapist

1.6 The team was supported by:

- Liz Fradd, CHI Director of Nursing, lead CHI director for the investigation
- Nan Newberry, CHI Senior Analyst
- Ian Horrigan, CHI Analyst
- Kellie Rehill, CHI Investigations Coordinator
- a medical notes review group established by CHI to review anonymised medical notes (see appendix E)
- Dr Barry Tennison, CHI Public Health Adviser

The investigation process

1.7 The investigation consisted of five interrelated parts:

- review and analysis of a range of documents specific to the care of older people at the trust, including clinical governance arrangements, expert witness reports forwarded by the police and relevant national documents (see appendix A for a list of documents reviewed)
- analysis of views received from 36 patients, relatives and friends about care received at Gosport War Memorial Hospital. Views were obtained through a range of methods, including meetings, correspondence, telephone calls and a short questionnaire (see appendix B for an analysis of views received)

- a five day visit by CHI's investigation team to Gosport War Memorial Hospital when a total of 59 staff from all groups involved in the care and treatment of older people at the hospital and trust managers were interviewed. CHI also undertook periods of observation on Daedalus, Dryad and Sultan wards (see appendix C for a list of all staff interviewed)
- interviews with relevant agencies and other NHS organisations, including those representing patients and relatives (see appendix D for a list of organisations interviewed)
- an independent review of anonymised clinical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. The term of reference for this piece of work, the membership of the CHI team which undertook the work, and a summary of findings are attached at appendices E and F. CHI shared the summary with the Fareham & Gosport PCT in May 2002

2 | Background to the investigation

Events surrounding the CHI investigation

Police investigations

2.1 A relative of a 91 year old patient who died in August 1998 on Daedalus ward made a complaint to the trust about her care and treatment. The police were contacted in September 1998 with allegations that this patient had been unlawfully killed. A range of issues were identified by the police in support of the allegation and expert advice sought. Following an investigation, documents were referred to the Crown Prosecution Service in November 1998 and again in February 1999. The Crown Prosecution Service responded formally in March 1999 indicating that, in their view, there was insufficient evidence to prosecute any staff for manslaughter or any other offence.

2.2 Following further police investigation, in August 2001, the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

2.3 Local media coverage in March 2001 resulted in 11 other families raising concerns about the circumstances of their relatives' deaths in 1997 and 1998. The police decided to refer four of these deaths for expert opinion to determine whether or not a further, more extensive investigation was appropriate. Two expert reports were received in December 2001 which were made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices in the trust in 1998.

2.4 In February 2002, the police decided that a more intensive police investigation was not an appropriate course of action. In addition to CHI, the police have referred the expert reports to the General Medical Council, the United Kingdom Central Council (after 1 April 2002, the Nursing and Midwifery Council), the trust, the Isle of Wight, Portsmouth and East Hampshire Health Authority and the NHS south east regional office.

2.5 The police made the trust aware of potential issues around diamorphine usage in December 1998, and were sent the expert witness reports in February 2002.

Action taken by professional regulatory bodies

2.6 The General Medical Council is currently reviewing whether any action against any individual doctor is warranted under its fitness to practice procedures.

2.7 The Nursing and Midwifery Council are considering whether there are any issues of professional misconduct in relation to any of the nurses referred to in police documentation.

Complaints to the trust

2.8 There have been 10 complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards since 1998. Three complaints between August and December 1998 raised concerns which included pain management, the use of diamorphine and levels of sedation on Daedalus and Dryad wards, including the complaint which triggered the initial police investigation. This complaint was not pursued through the NHS complaints procedure.

Action taken by the health authority

2.9 In the context of this investigation, the Isle of Wight, Portsmouth and East Hampshire Health Authority had two responsibilities. Firstly, as the statutory body responsible for commissioning NHS services for local people in 1998 and, secondly, as the body through which GPs were permitted to practice. Some of the care provided to patients at the Gosport War Memorial Hospital, as in community hospitals throughout the NHS, is delivered by GPs on hospital premises.

2.10 In June 2001, the health authority voluntary local procedure for the identification and support of primary care medical practitioners whose practice is giving cause for concern reviewed the prescribing practice of one local GP. No concerns were found. This was communicated to the trust.

2.11 In July 2001, the chief executive of the health authority asked CHI for advice in obtaining a source of expertise in order to reestablish public confidence in the services for older people in Gosport. This was at the same time as the police contacted CHI.

2.12 Following receipt of the police expert witness reports in February 2002, the health authority sought local changes in relation to the prescription of certain painkillers and sedatives (opiates and benzodiazepines) in general practice.

Action taken by the NHS south east regional office

2.13 For the period of the investigation, the NHS regional offices were responsible for the strategic and performance management of the NHS, including trusts and health authorities. The NHS south east regional office had information available expressing concerns around prescribing levels at the Gosport War Memorial Hospital. Information included a report by the Health Service Ombudsman and serious untoward incident reports forwarded by the trust in April and July 2001 in response to media articles about the death of a patient at the Gosport War Memorial Hospital.
The health authority and NHS south east regional office met to discuss these issues on 6 April 2001.

3 | National and local context

National context

3.1 The standard of NHS care for older people has long caused concern. A number of national reports, including the NHS Plan and the Standing Nursing and Midwifery Committee's 2001 annual report found aspects of care to be deficient. National concerns raised include: an inadequate and demoralised workforce, poor care environments, lack of seamless care within the NHS and ageism. The NHS Plan's section *Dignity, security and independence in old age*, published in July 2000, outlined the government's plans for the care of older people, detailed in the national service framework.

3.2 The national service framework for older people was published in March 2001 and sets standards of care for older people in all care settings. It aims to ensure high quality of care and treatment, regardless of age. Older people are to be treated as individuals with dignity and respect. The framework places special emphasis on the involvement of older patients and their relatives in the care process, including care planning.

3.3 National standards called *Essence of Care*, published by the Department of Health in 2001, provide standards for assessing nursing practice against fundamental aspects of care such as nutrition, preventing pressure sores and privacy and dignity. These are designed to act as an audit tool to ensure good practice and have been widely disseminated across the NHS.

Trust background

3.4 Gosport War Memorial Hospital was part of Portsmouth Healthcare NHS Trust between April 1994 and April 2002. The hospital is situated on the Gosport peninsula and has 113 beds. Together with outpatient services and a day hospital, there are beds for older people and maternity services. The hospital does not admit patients who are acutely ill and it has neither an A&E nor intensive care facilities. Portsmouth Healthcare NHS Trust provided a range of community and hospital based services for the people of Portsmouth, Fareham, Gosport and surrounding areas. These services included mental health (adult and elderly), community paediatrics, elderly medicine, learning disabilities and psychology.

3.5 The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In 2001/2002 the trust had a budget in excess of £100 million and over 20% of income spent on its largest service, elderly medicine. All the trust's financial targets were met in 2000/2001.

Move towards the primary care trust

3.6 Portsmouth Healthcare NHS Trust was dissolved on 31 March 2002. Services have been transferred to local primary care trusts (PCTs), including Fareham and Gosport PCT, which became operational as a level four PCT in April 2002. Arrangements have been made for each PCT to host provider services on a district wide basis but each PCT retains responsibility for commissioning its share of district wide services from the host PCT. Fareham and Gosport PCT will manage many of the staff, premises and facilities of a number of sites, including the Gosport War Memorial Hospital. Medical staff involved in the care of older people, including those working at the Gosport War Memorial Hospital, are now employed by the East Hampshire PCT.

Portsmouth Healthcare NHS Trust strategic management

3.7 The trust board consisted of a chair, five non executive directors, the chief executive, the executive directors of operations, medicine, nursing and finance and the personnel director. The trust was organised into six divisions, two of which are relevant to this investigation. The Fareham and Gosport division, which managed the Gosport War Memorial Hospital, and the department of medicine for elderly people.

3.8 CHI heard that the trust was well regarded in the local health community and had developed constructive links with the health authority and local primary care groups (PCGs). For example, in the lead up to the formation of the new PCT, Portsmouth Healthcare NHS Trust's director of operations worked for two days each week for the East Hampshire PCT. Other examples included the joint work of the PCG and the trust on the development of intermediate care and clinical governance. High regard and respect for trust staff was also commented on by the local medical committee, Unison and the Royal College of Nursing.

Local services for older people

3.9 Before April 2002, access to medical beds for older people in Portsmouth (which included acute care, rehabilitation and continuing care) was managed through the department of medicine for elderly people which was managed by the Portsmouth Healthcare NHS Trust. Some of the beds were located in community hospitals such as the Gosport War Memorial Hospital, where the day to day general management of the hospital was the responsibility of the locality divisions of Portsmouth Healthcare NHS Trust. The Fareham and Gosport division of the trust fulfilled this role at the Gosport War Memorial Hospital.

3.10 The department of medicine for elderly people has now transferred to East Hampshire PCT. The nursing staff of the wards caring for older people at the Gosport War Memorial Hospital are now employed by the Fareham and Gosport PCT. Management of all services for older people has now transferred to the East Hampshire PCT.

3.11 General acute services were, and remain, based at Queen Alexandra and St Mary's hospitals, part of the Portsmouth Hospitals NHS Trust, the local acute trust. Though an unusual arrangement, a precedent for this model of care existed, for example in Southampton Community NHS Trust.

3.12 Until August 2001, the Royal Hospital Haslar, a Ministry of Defence military hospital on the Gosport peninsula, also provided acute medical care to civilians, many of whom were older people, as well as military staff.

Service performance management

3.13 Divisional management at Portsmouth Healthcare NHS Trust was well defined, with clear systems for reporting and monitoring. The quarterly divisional review was the principal tool for the performance management of the Fareham and Gosport division. The review considered regular reports on clinical governance, complaints and risk. Fareham and Gosport division was led by a general manager, who reported to the operational director. Leadership at Fareham and Gosport divisional level was strong with clear accounting structures to corporate and board level.

Inpatient services for older people at the Gosport War Memorial Hospital 1998-2002

3.14 Gosport War Memorial Hospital provides continuing care, rehabilitation, day hospital and outpatient services for older people and was managed by the Fareham and Gosport division. In November 2000, as a result of local developments to develop intermediate and rehabilitation services in the community, there was a change in the use of beds at the hospital to provide additional rehabilitation beds.

3.15 In 1998, three wards at Gosport War Memorial Hospital admitted older patients for general medical care: Dryad, Daedalus and Sultan. This is still the case in 2002.

Figure 3.1 Inpatient provision at Gosport War Memorial Hospital by ward

Ward	1998	2002
Dryad	20 continuing care beds. Patients admitted under the care of a consultant, with some day to day care provided by a clinical assistant.	20 continuing care beds for frail elderly patients and slow stream rehabilitation. Patients admitted under the care of a consultant. Day to day care is provided by a staff grade doctor.
Daedalus	16 continuing care beds and 8 for slow stream rehabilitation. Patients admitted under the care of a consultant, some day to day care provided by a clinical assistant.	24 rehabilitation beds: 8 general, 8 fast and 8 slow stream (since November 2000). Patients admitted under the care of a consultant. Day to day care provided by a staff grade doctor.
Sultan	24 GP beds with care managed by patients' own GPs. Patients were not exclusively older patients; care could include rehabilitation and respite care. A ward manager (or sister) managed the ward, which was staffed by Portsmouth Healthcare NHS Trust staff.	The situation is the same as in 1998, except that the nursing staff are now employed by Fareham and Gosport PCT.

Admission criteria

3.13 The current criteria for admission to both Dryad and Daedalus wards are that a patient must be over 65 and be registered with a GP within the Gosport PCG (now a part of Fareham and Gosport PCT). In addition, Dryad patients must have a Barthel score of under 4/20 and require specialist medical and nursing intervention. The Barthel score is a validated tool used to measure physical disability. Daedalus patients must need multidisciplinary rehabilitation, for example following a stroke.

3.14 There was, and still is, a comprehensive list of admission criteria for Sultan ward developed in 1999, all of which must be met prior to admission. The criteria state that patients must not be medically unstable and no intravenous lines must be in situ.

Elderly mental health

3.15 Although not part of the CHI investigation, older patients are also cared for on Mulberry ward, a 40 bed assessment unit comprising Collingwood and Ark Royal wards. Patients admitted to this ward are under the care of a consultant in elderly mental health.

Terminology

3.16 CHI found considerable confusion about the terminology describing the various levels of care for older people in written information and in interviews with staff. For example, the terms stroke rehab, slow stream rehab, very slow stream rehab, intermediate and continuing care were all used. CHI was not aware of any common local definition for these terms in use at the trust or of any national definitions. CHI stakeholder work confirmed that this confusion extended to patients and relatives in terms of their expectations of the type of care received.

KEY FINDINGS

1. Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team. The chief executive was accessible to and well regarded by staff both within the trust and in the local health economy. Good links had been developed with local PCGs.

2. The case note review undertaken by CHI confirmed that the admission criteria for both Dryad and Daedalus wards were being adhered to over recent months and that patients were being appropriately admitted. However, CHI found examples of some recent patients who had been admitted to Sultan ward with more complex needs than stipulated in the admission criteria that may have compromised patient care.

3. There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation that had not been fulfilled.

RECOMMENDATIONS

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to develop the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should ensure an appropriate performance monitoring tool is in place to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. Hampshire and Isle of Wight strategic health authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

3. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

4. The Department of Health should assist in the promotion of an NHS wide shared understanding of the various terms used to describe levels of care for older people.

4 | Arrangements for the prescription, administration, review and recording of medicines

Police inquiry and expert witness reports

4.1 CHI's terms of reference for its investigation in part reflected those of the earlier preliminary inquiry by the police, whose reports were made available to CHI.

4.2 Police expert witnesses reviewed the care of five patients who died in 1998 and made general comments in the reports about the systems in place at the trust to ensure effective clinical leadership and patient management on the wards. The experts' examination of the use of medicines in Daedalus, Dryad and Sultan wards led to significant concern about three medicines, the amounts which had been prescribed, the combinations in which they were used and the method of their delivery. In summary:

- there was no evidence of trust policy to ensure the appropriate prescription and dose escalation of strong opiate analgesia as the initial response to pain. It was the view of the police expert witnesses that a more reasonable response would have been the prescription of mild to moderate medicine initially with appropriate review in the event of further pain followed up
- there was inappropriate combined subcutaneous administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients, leading to death
- there were no clear guidelines available to staff to prevent assumptions being made by clinical staff that patients had been admitted for palliative, rather than rehabilitative care
- there was a failure to recognise potential adverse effects of prescribed medicines by clinical staff
- clinical managers failed to routinely monitor and supervise care on the ward

It is important to emphasise that these reports were not produced for this CHI investigation and CHI cannot take any responsibility for their accuracy. Whilst the reports provided CHI with very useful information, CHI has relied on its own independent scrutiny of data and information gathered during the investigation to reach the conclusions in this chapter.

Medicine usage

4.3 In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. The data relates to medicines issued from the pharmacy and does not include any wastage, nor can it verify the quantity of medicines administered to each patient. As the data does not offer any breakdown of casemix, it is not possible to determine how complex the needs of patients were in each year. Staff speaking to CHI described an increase in the numbers of sicker patients in recent years. A detailed breakdown of medicines issued to each ward is attached at appendix I.

4.4 The experts commissioned by the police had serious concerns about the level of use of these three medicines (diamorphine, haloperidol and midazolam) and the apparent practice of anticipatory prescribing. CHI shares this view and believes the use and combination of medicines used in 1998 was excessive and outside normal practice. The following figures indicate the use of each medicine by ward and year, plotted alongside the number patients treated (finished consultant episodes).

4.5 The trust's own data, provided to CHI during the site visit week, illustrates a marked decline in the usage of diamorphine, haloperidol and midazolam in recent years. This decline has been most pronounced on Dryad ward and is against a rise in FCEs during the same timeframe. The trust's data demonstrates that usage of each of these medicines peaked in 1998/99. On Sultan ward, the use of haloperidol and midazolam have also declined in recent years with a steady increase in FCEs. Diamorphine use, after declining dramatically in 1999/00, showed an increase in 2000/01.

Medicine issued 1997/1998-2000/2001 according to the number of finished consultant episodes per ward, based on information provided by the Portsmouth Healthcare NHS Trust (see appendices H and I)

Figure 4.1 Diamorphine use – Daedalus ward

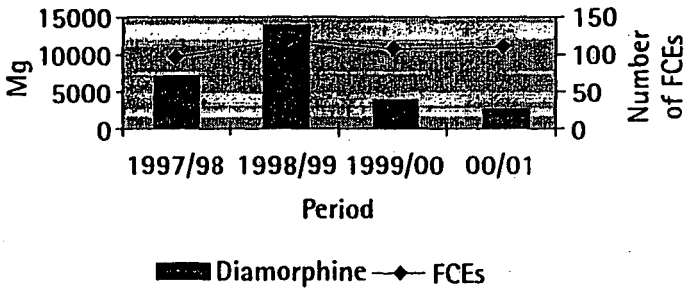


Figure 4.2 Haloperidol use – Daedalus ward

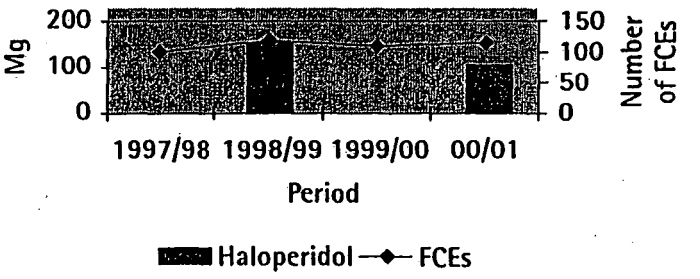


Figure 4.3 Midazolam use – Daedalus ward

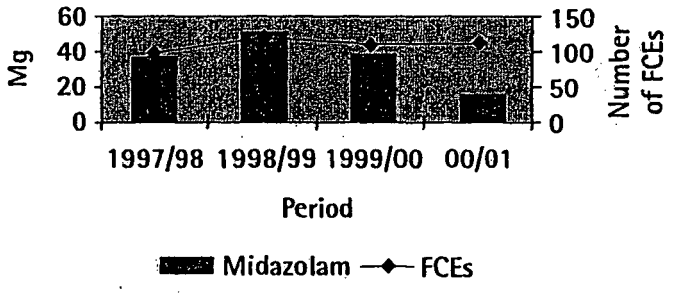


Figure 4.4 Diamorphine use – Dryad ward

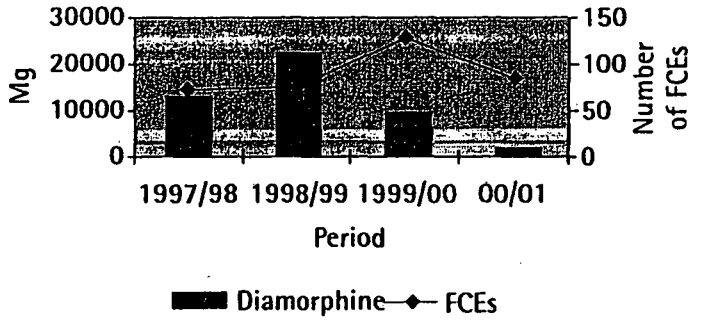


Figure 4.5 Haloperidol use – Dryad ward

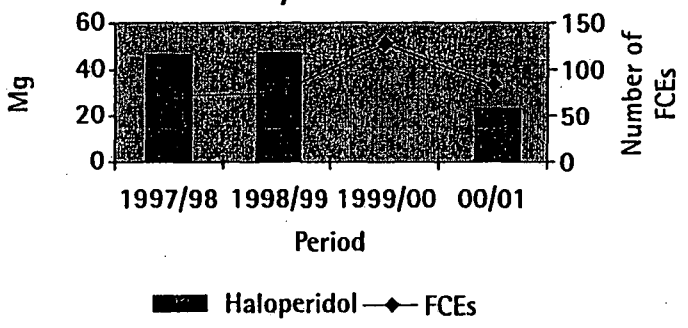


Figure 4.6 Midazolam use – Dryad ward

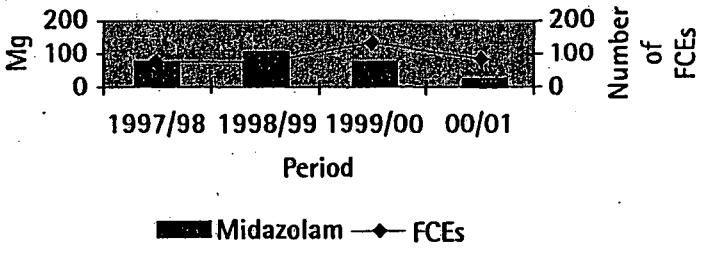


Figure 4.7 Diamorphine use – Sultan ward

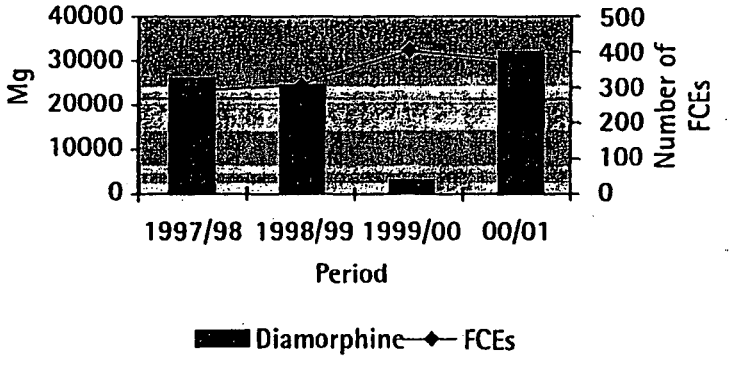


Figure 4.8 Haloperidol use – Sultan ward

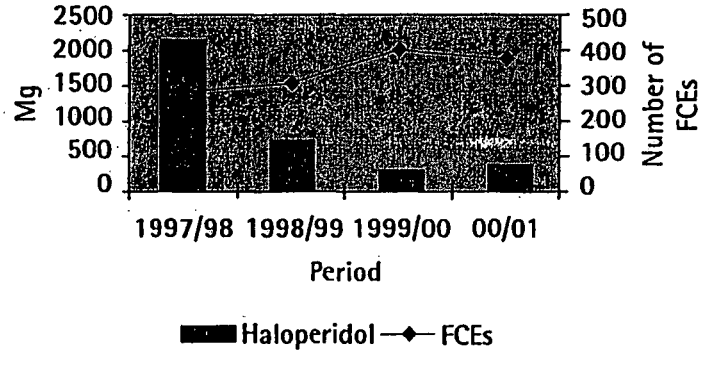
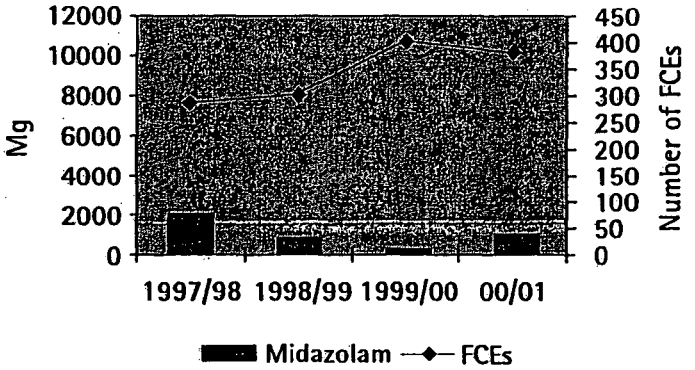


Figure 4.9 Midazolam use – Sultan ward



Assessment and management of pain

4.6 Part of the individual total assessment of each patient includes an assessment of any pain they may be experiencing and how this is to be managed. In 1998, the trust did not have a policy for the assessment and management of pain. This was introduced in April 2001, in collaboration with Portsmouth Hospitals NHS Trust, and is due for review in 2003. The stated purpose of the document was to identify mechanisms to ensure that all patients have early and effective management of pain or distress. The policy placed responsibility for ensuring that pain management standards are implemented in every clinical setting and sets out the following:

- the prescription must be written by medical staff following diagnosis of type(s) of pain and be appropriate given the current circumstances of the patient
- if the prescription states that medication is to be administered by continuous infusion (syringe driver), the rationale for this decision must be clearly documented
- all prescriptions for drugs administered via a syringe driver must be written on a prescription sheet designed for this purpose

4.7 CHI has also seen evidence of a pain management cycle chart and an 'analgesic ladder'. The analgesic ladder indicates the drug doses for different levels and types of pain, how to calculate opiate doses, gives advice on how to evaluate the effects of analgesia and how to observe for any side effects. Nurses interviewed by CHI demonstrated a good understanding of pain assessment tools and the use of the analgesic ladder.

4.8 CHI was told by some nursing staff that following the introduction of the policy, it took longer for some patients to become pain free and that medical staff were apprehensive about prescribing diamorphine. Nurses also spoke of a reluctance of some patients to take pain relief. CHI's case note review concluded that two of the 15 patients reviewed were not prescribed adequate pain relief for part of their stay in hospital.

4.9 Many staff interviewed referred to the "Wessex guidelines". This is a booklet called *Palliative care handbook guidelines on clinical management* drawn up by Portsmouth Healthcare NHS Trust, the Portsmouth Hospitals NHS Trust and a local hospice, in association with the Wessex palliative care units. These guidelines were in place in 1998. Although the section on pain focuses on patients with cancer, there is a clear highlighted statement in the guidelines that states "all pains have a significant psychological component, and fear, anxiety and depression will all lower the pain threshold".

4.10 The Wessex guidelines are comprehensive and include detail, in line with British National Formulary recommendations, on the use, dosage, and side effects of medicines commonly used in palliative care. The guidelines are not designed for a rehabilitation environment.

4.11 CHI's random case note review of 15 recent admissions concluded that the pain assistance and management policy is being adhered to. CHI was told by staff of the previous practice of anticipatory prescribing of palliative opiates. As a result of the pain and assessment policy, this practice has now stopped.

Prescription writing policy

4.12 This policy was produced jointly with the Portsmouth Hospitals NHS Trust in March 1998. The policy covered the purpose, scope, responsibilities and requirements for prescription writing, medicines administered at nurses' discretion and controlled drugs. A separate policy covers the administration of intravenous medicines.

4.13 The policy has a section on verbal prescription orders, including telephone orders, in line with UKCC guidelines. CHI understands that arrangements such as these are common practice in GP led wards and work well on the Sultan ward, with arrangements in place for GPs to sign the prescription within 12 hours. These arrangements were also confirmed by evidence found in CHI's case note review.

Administration of medicines

4.14 Medicines can be administered in a number of ways, for example, orally in tablet or liquid form, by injection and via a syringe driver. Some of the medicines used in the care of older people can be delivered by a syringe driver, which delivers a continuous subcutaneous infusion of medication. Syringe drivers can be an entirely appropriate method of medicine administration that provides good control of symptoms with little discomfort or inconvenience to the patient. Guidance for staff on prescribing via syringe drivers is contained within the trust's policy for assessment and management of pain. The policy states that all prescriptions for continuous infusion must be written on a prescription sheet designed for this purpose.

4.15 Evidence from CHI's case note review demonstrated good documented examples of communication with both patients and relatives over medication and the use of syringe drivers and the application of the trust's policy.

4.16 Information provided by the trust indicates that only two qualified nurses from Sultan ward had taken part in a syringe driver course in 1999. Five nurses had also completed a drugs competencies course. No qualified nurses from Dryad or Daedalus ward had taken part in either course between 1998 and 2001. Some nursing and healthcare support staff spoke of receiving syringe driver information and training from a local hospice.

Role of nurses in medicines administration

4.17 Registered nurses are regulated by the Nursing and Midwifery Council, a new statutory body which replaced the United Kingdom Central Council on 1 April 2002. Registered nurses must work within their code of professional conduct (UKCC, June 1992). The scope of professional practice clarified the way in which registered nurses are personally accountable for their own clinical practice and for care they provide to patients. The standards for the administration of medicines (UKCC, October 1992) details what is expected of nurses carrying out this function.

4.18 Underpinning all of the regulations that govern nursing practice, is the requirement that nurses act in the best interest of their patients at all times. This could include challenging the prescribing of other clinical staff.

Review of medicines

4.19 The regular ward rounds and multidisciplinary meetings should include a review of medication by senior staff, which is recorded in the patient's case notes. CHI recognises the complexity of multidisciplinary meetings. Despite this, a process should be found to ensure that effective and regular reviews of patient medication take place by senior clinicians and pharmacy staff.

Structure of pharmacy

4.20 Portsmouth Healthcare NHS Trust has a service level agreement for pharmacy services with the local acute trust, Portsmouth Hospitals NHS Trust. An E grade pharmacist manages the contract locally and the service provided by a second pharmacist, who is the lead for older peoples' services. Pharmacists speaking to CHI spoke of a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital, together with an increasing workload. Pharmacy staff were confident that ward pharmacists would now challenge large doses written up by junior doctors but stressed the need for a computerised system which would allow clinician specific records. There are some recent plans to put the trust's *A compendium of drug therapy guidelines* on the intranet, although this is not easily available to all staff.

4.21 Pharmacy training for non pharmacy staff was described as "totally inadequate" and not taken seriously. Nobody knew of any training offered to clinical assistants.

4.22 There were no systems in place in 1998 for the routine review of pharmacy data which could have alerted the trust to any unusual or excessive patterns of prescribing, although the prescribing data was available for analysis.

KEY FINDINGS

1. CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing (the "Wessex guidelines") but this was inappropriately applied to patients admitted for rehabilitation.

2. Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.

3. The usage of diamorphine, midazolam and haloperidol has declined in recent years, reinforced by trust staff interviewed by CHI and by CHI's own review of recent case notes. Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998.

4. CHI found some evidence to suggest a recent reluctance amongst clinicians to prescribe sufficient pain relieving medication. Despite this, diamorphine usage on Sultan ward 2000/2001 showed a marked increase.

5. CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Anticipatory prescribing is no longer evident on these wards. Although the palliative care Wessex guidelines refer to non physical symptoms of pain, the trust's policies do not include methods of non verbal pain assessment and rely on the patient articulating when they are in pain.

6. CHI found little evidence to suggest that thorough individual total patient assessments were being made by multidisciplinary teams in 1998. CHI's case note review concluded that this approach to care had been developed in recent years.

7. Pharmacy support to the wards in 1998 was inadequate. The trust was able to produce pharmacy data in 2002 relating to 1998. A system should have been in place to review and monitor prescribing at ward level, using data such as this as a basis.

RECOMMENDATIONS

1. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

2. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

3. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

4. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

5 | Quality of care and the patient experience

Introduction

5.1 This chapter details CHI's findings following contact with patients and relatives. This needs to be put into the context of the 1,725 finished consultant episodes for older patients admitted to the Gosport War Memorial Hospital between April 1998 and March 2001. Details of the methods used to gain an insight into the patient experience and of the issues raised with CHI are contained in appendix B.

Patient expeience

5.2 As with all patients being cared for when they are sick and vulnerable, it is important to treat each person as a whole. For this reason, the total holistic assessment of patients is critical to high quality individual care tailored to each patient's specific needs. The following sections are key elements (though not an exhaustive list) of total assessments which were reported to CHI by stakeholders.

5.3 CHI examined in detail the experience of older patients admitted to the Gosport War Memorial Hospital between 1998 and 2001 and that of their relatives and carers. This was carried out in two ways. Firstly, stakeholders were invited, through local publicity, to make contact with CHI. The police also wrote to relatives who had expressed concern to them informing them of CHI's investigation. Views were invited in person, in writing, over the telephone and by questionnaire. A total of 36 patients and relatives contacted CHI during the investigation.

5.4 Secondly, CHI made a number of observation visits, including at night, to Daedalus, Dryad and Sultan wards during the site visit week in January 2002. Some of the visits were unannounced. Mealtimes, staff handovers, ward rounds and medicine rounds were observed.

Stakeholder views

5.5 The term stakeholder is used by CHI to define a range of people that are affected by, or have an interest in, the services offered by an organisation. CHI heard of a range of both positive and less positive experiences, of the care of older people. The most frequently raised concerns with CHI were: the use of medicines, the attitude of staff, continence management, the use of patients' own clothing, transfer arrangements between hospitals and nutrition and fluids. More detail on each of these areas is given below.

5.6 Relatives expressed concern around a perceived lack of nutrition and fluids as patients neared the end of their lives: "no water and fluids for last four days of life". Comments were also raised about unsuitable, unappetising food and patients being left to eat without assistance. A number of stakeholders commented on untouched food being cleared away without patients being given assistance to eat.

5.7 Following comments by stakeholders, CHI reviewed the trust policy for nutrition and fluids. The trust conducted a trust wide audit of minimum nutritional standards between October 1997 and March 1998, as part of the five year national strategy *Feeding People*. The trust policy, *Prevention and management of malnutrition* (2000), included the designation of an appropriately trained lead person in each clinical area, who would organise training programmes for staff and improve documentation to ensure full compliance. The standards state:

- all patients must have a nutritional risk assessment on admission
- registered nurses must plan, implement and oversee nutritional care and refer to an appropriate professional as necessary
- all staff must ensure that documented evidence supports the continuity of patient care and clinical practice
- all clinical areas should have a nominated nutritional representative who attends training/updates and is a resource for colleagues
- systems should be in place to ensure that staff have the required training to implement and monitor the *Feeding People* standards

5.8 A second trust audit in 2000 concluded that, overall, the implementation of the *Feeding People* standards had been "very encouraging". However, there were concerns about the lack of documentation and a sense of complacency as locally written protocols had not been produced throughout the service.

5.9 CHI's review of recent case notes concluded that appropriate recording of patient intake and output was taking place. CHI was concerned that nurses appeared unable to make swallowing assessments out of hours; this could lead to delays in receiving nutrition over weekends, for example, when speech and language therapy staff were not available.

5.10 Continence management is an important aspect of the care of older people, the underlying objective is to promote or sustain continence as part of the holistic management of care, this includes maintaining skin integrity (prevention of pressure sores). Where this is not possible, a range of options including catheterisation are available and it is imperative that these are discussed with patients, relatives and carers. Some stakeholders raised concerns regarding the 'automatic' catheterisation of patients on admission to the War Memorial. "They seem to catheterise everyone. My husband was not incontinent; the nurse said it was done mostly to save time". Relatives also spoke of patients waiting for long periods of time to be helped to the toilet or for help in using the commode.

5.11 CHI's review of recent case notes found no evidence of inappropriate catheterisation of patients in recent months.

5.12 The use of pain relieving medicines and the use of syringe drivers to administer them was commented on by a number of relatives. One relative commented that her mother "certainly was not in pain prior to transfer to the War Memorial". Although a number of relatives confirmed that staff did speak to them before medication was delivered by a syringe driver, CHI also received comments that families would have liked more information: "Doctors should disclose all drugs, why [they are being used] and what the side effects are. There should be more honesty".

5.13 Many relatives were distressed about patients who were not dressed in their own clothes, even when labelled clothes had been provided by their families. "They were never in their own clothes". Relatives also thought patients being dressed in other patients' clothes was a potential cross infection risk. The trust did apologise to families who had raised this as a complaint and explained the steps taken by wards to ensure patients were dressed in their own clothes. This is an important means by which patients' dignity can be maintained.

5.14 Concern was expressed regarding the physical transfer of patients from one hospital to another. Amongst concerns were lengthy waits prior to transfer, inadequate clothing and covering during the journey and the methods used to transfer patients. One person described their relative as being "carried on nothing more than a sheet". CHI learnt that this instance was acknowledged by Portsmouth Healthcare NHS Trust, who sought an apology from the referring hospital, which did not have the appropriate equipment available.

5.15 Though there were obvious concerns regarding the transfer of patients, during the period of the investigation, the Hampshire Ambulance Service NHS Trust, who were responsible for patient transfers between hospitals, received no complaints relating to the transfer of patients to and from the Gosport War Memorial Hospital.

5.16 Comments about the attitude of staff ranged from the very positive "Everyone was so kind and caring towards him in both Daedalus and Dryad wards" and "I received such kindness and help from all the staff at all times" to the less positive "I was made to feel an inconvenience because we asked questions" and "I got the feeling she had dementia and her feelings didn't count".

Outcome of CHI observation work

5.17 CHI spent time on Dryad, Sultan and Daedalus wards throughout the week of 7 January 2002 to observe the environment in which care was given, the interactions between staff and patients and between staff. Ward staff were welcoming, friendly and open. Although CHI observed a range of good patient experiences this only provides a 'snap shot' during the site visit and may not be fully representative. However, many of the positive aspects of patient care observed were confirmed by CHI's review of recent patient notes.

Ward environment

5.18 All wards were built during the 1991 expansion of the hospital and are modern welcoming and bright. This view was echoed by stakeholders, who were complimentary about the décor and patient surroundings. Wards were tidy, clean and fresh smelling.

5.19 Day rooms are pleasant and Daedalus ward has direct access to a well designed garden suitable for wheelchair users. The garden is paved with a variety of different textures to enable patients to practice mobility. There is limited storage space in Daedalus and Dryad wards and, as a result, the corridors had become cluttered with equipment. This can be problematic for patients using walking aids. Daedalus ward has an attractive, separate single room for independent living assessment with its own sink and wardrobe.

5.20 CHI saw staff address patients by name in a respectful and encouraging way and saw examples of staff helping patients with dressing and holding friendly conversations. The staff handovers observed were well conducted, held away from the main wards areas and relevant information about patient care was exchanged appropriately.

5.21 Mealtimes were well organised with patients given a choice of menu options and portion size. Patients who needed help to eat and drink were given assistance. There appeared to be sufficient staff to serve meals, and to note when meals were not eaten. CHI did not observe any meals returned untouched. Healthcare support workers told CHI that they were responsible for making a note when meals were not eaten.

5.22 There are day rooms where patients are able to watch the television and large print books, puzzles and current newspapers are provided. CHI saw little evidence of social activities taking place, although some patients did eat together in the day room. Bells to call assistance are situated by patients' beds, but are less accessible to patients in the day rooms. The wards have an activities coordinator, although the impact of this post has been limited.

5.23 Daedalus ward has a communication book by each bed for patients and relatives to make comments about day to day care. This is a two way communication process which, for example, allows therapy staff to ask relatives for feedback on progress and enables relatives to ask for an appointment with the consultant.

5.24 CHI observed two medicine rounds, both of which were conducted in an appropriate way with two members of staff jointly identifying the patient and checking the prescription sheet. One member of staff handed out the medicines while the other oversaw the patients as medicines are taken. Medicines are safely stored on the wards in locked cupboards.

Communication with patients, relatives and carers

The trust had an undated user involvement service development framework, which set out the principles behind effective user involvement within the national policy framework described in the NHS Plan. It is unclear from the framework who was responsible for taking the work forward and within what time frame. Given the dissolution of the trust, a decision was taken not to establish a trust wide Patient Advice and Liaison Service (PALS), a requirement of the NHS Plan. However, work was started by the trust to look at a possible future PALS structure for the Fareham and Gosport PCT.

The Health Advisory Service *Standards for health and social care services for older people* (2000) states that "each service should have a written information leaflet or guide for older people who use the service. There should be good information facilities in inpatient services for older people, their relatives and carers". CHI saw a number of separate information leaflets provided for patients and relatives during the site visit.

The trust used patient surveys, given to patients on discharge, as part of its patient involvement framework, although the response rate was unknown. Issues raised by patients in completed surveys were addressed by action plans discussed at clinical managers meetings. Ward specific action plans were distributed to ward staff. CHI noted, for example, that as a result of patient comments regarding unacceptable ward temperatures, thermometers were purchased to address the problem. CHI could find no evidence to suggest that the findings from patient surveys were shared across the trust.

Support towards the end of life

Staff referred to the Wessex palliative care guidelines, which are used on the wards and address breaking bad news and communicating with the bereaved. Many clinical staff, at all levels spoke of the difficulty in managing patient and relative expectations following discharge from the acute sector. "They often painted a rosier picture than justified". Staff spoke of the closure of the Royal Haslar acute beds leading to increased pressure on Queen Alexandra and St Mary's hospitals to "discharge patients too quickly to Gosport War Memorial Hospital". Staff were aware of increased numbers of medically unstable patients being transferred in recent years.

Both patients and relatives have access to a hospital chaplain, who has links to representatives of other faiths. The trust had a leaflet for relatives *Because we care* which talks about registering the death, bereavement and grieving. The hospital has a designated manager to assist relatives through the practical necessities following a death.

KEY FINDINGS

1. Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.

2. Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

3. The ward environments and patient surroundings are good.

4. Some notable steps had been taken on Daedalus ward to facilitate communication between patients and their relatives with ward staff.

5. CHI was concerned, following the case note review, of the inability of any ward staff to undertake swallowing assessments as required. This is an area of potential risk for patients whose swallowing reflex may have been affected, for example, by a stroke.

6. Opportunities for patients to engage in daytime activities in order to encourage orientation and promote confidence are limited.

7. The trust had a strong theoretical commitment to patient and user involvement.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

2. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

3. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals.

4. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

5. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.

6 | Staffing arrangements and responsibility for patient care

Responsibility for patient care

6.1 Patient care on Daedalus and Dryad wards at Gosport War Memorial Hospital for the period of the CHI investigation was provided by consultant led teams. A multidisciplinary, multiprofessional team of appropriately trained staff best meets the complex needs of these vulnerable patients. This ensures that the total needs of the patient are considered and are reflected in a care plan, which is discussed with the patient and their relatives and is understood by every member of the team.

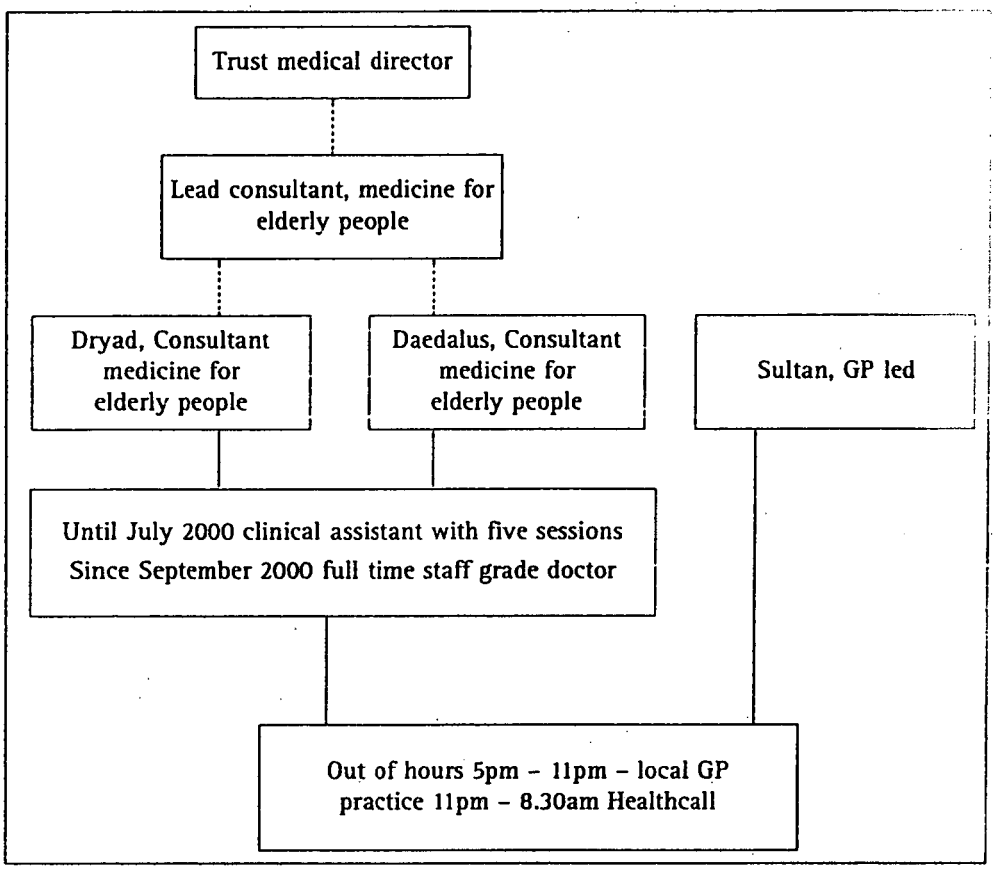
Medical responsibility

6.2 For the period covered by the CHI investigation, medical responsibility for the care of older people in Daedalus and Dryad wards lay with the named consultant of each patient. This is still the case today. All patients on both wards are admitted under the care of a consultant. Since 1995, there has been a lead consultant for the department of medicine for elderly people who held a two session contract (one session equates to half a day per week) for undertaking lead consultant responsibilities. These responsibilities included overall management of the department and the development of departmental objectives. The lead consultant is not responsible for the clinical practice of individual doctors. The post holder does not undertake any clinical sessions on the War Memorial site. The job description for the post, outlines 12 functions and states that the post is a major challenge for "a very part time role".

6.3 Since 2000, two department of elderly medicine consultants provide a total of 10 sessions of consultant cover on Dryad and Daedalus wards per week. Since September 2000, day to day medical support has been provided by a staff grade physician who was supervised by both consultants. Until July 2000, a clinical assistant provided additional medical support. Both consultants currently undertake a weekly ward round with the staff grade doctor. In 1998, there was a fortnightly ward round on Daedalus ward. On Dryad, ward rounds were scheduled fortnightly, though occurred less frequently.

6.4 CHI feels that the staff grade post is a pivotal, potentially isolated post, due to the distance of Gosport War Memorial Hospital from the main department of medicine for elderly people based at Queen Alexandra Hospital, no full time support from medical colleagues on the wards and a difficulty in attending departmental meetings. In 2001, the trust identified the risk of professional isolation and lack of support at Gosport War Memorial Hospital as a reason not to appoint a locum consultant.

Figure 6.1 Line management accountabilities



(* ---------- this line indicates managerial accountability and not clinical accountability)

General practice role and accountability

6.5 Local GPs worked at the Gosport War Memorial Hospital in three capacities during the period under investigation: as clinical assistants employed by the trust, as the clinicians admitting and caring for patients on the GP ward (Sultan) and as providers of out of hours medical support to all patients on each of the three wards.

Clinical assistant role

6.6 Clinical assistants are usually GPs employed and paid by trusts, largely on a part time basis, to provide medical support on hospital wards. Clinical assistants have been a feature of community hospitals within the NHS for a number of years. Portsmouth Healthcare NHS Trust employed a number of such GPs in this capacity in each of their community hospitals. Clinical assistants work as part of a consultant led team and have the same responsibilities as hospital doctors to prescribe medication, write in the medical record and complete death certificates. Clinical assistants should be accountable to a named consultant.

6.7 From 1994 until the resignation of the post holder in July 2000, a clinical assistant was employed for five sessions at the Gosport War Memorial Hospital. The fees for the post were in line with national rates. The job description clearly states that the clinical assistant was accountable to "named consultant physicians in geriatric medicine". The post holder was responsible for arranging cover for annual leave and any sickness absence with practice partners. The trust and the practice partners did not have a contract for this work. The job description does state that the post is subject to the terms and conditions of hospital medical and dental staff. Therefore, any concerns over the performance of any relevant staff could be pursued through the trust's disciplinary processes. CHI could find no evidence to suggest that this option was considered at the time of the initial police investigation in 1998.

Appraisal and supervision of clinical assistants

6.8 CHI is not aware of any trust systems in place to monitor or appraise the performance of clinical assistants in 1998. This lack of monitoring is still common practice within the NHS. The consultants admitting patients to Dryad and Daedalus wards, to whom the clinical assistant was accountable, had no system for supervising the practice of the clinical assistant, including any review of prescribing. CHI found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Staff interviewed commented on the long working hours of the clinical assistant, in excess of the five contracted sessions.

6.9 CHI is aware of work by the Department of Health on GP appraisal which will cover GPs working as clinical assistants and further work to develop guidance on disciplinary procedures.

Sultan ward

6.10 Medical responsibility for patients on Sultan ward lay with the admitting GP throughout the period of the CHI investigation. The trust issued admitting GPs with a contract for working on trust premises, which clearly states "you will take full clinical responsibility for the patients under your care". CHI was told that GPs visit their patients regularly as well as when requested by nursing staff. This is a common arrangement in community hospitals throughout the NHS. GPs had no medical accountablity framework within the trust.

6.11 GPs managing their own patients on Sultan ward could be subject to the health authority's voluntary process for dealing with doctors whose performance is giving cause for concern. However, this procedure can only be used in regard to their work as a GP, and not any contracted work performed in the trust as a clinical assistant. Again, this arrangement is common throughout the NHS.

Out of hours cover provided by GPs

6.12 Between the hours of 8.30am and 5.00pm on weekdays, hospital doctors employed by the trust manage the care of all patients on Dryad and Daedalus wards. Out of hours medical cover, including weekends and bank holidays, is provided by a local GP practice from 5.00pm to 11.00pm, after which, between 11.00pm and 8.30am, nursing staff call on either the patient's practice or Healthcall, a local deputising service for medical input. If an urgent situation occurs out of hours, staff call 999 for assistance.

6.13 Some staff interviewed by CHI expressed concern about long waits for the deputising service, CHI heard that waiting times for Healthcall to attend a patient could sometimes take between three and five hours. However, evidence provided by Healthcall contradicts this. Nurses expressed concern over Healthcall GPs' reluctance to 'interfere' with the prescribing of admitting GPs on Sultan and Dryad wards. The contract with Healthcall is managed by a local practice.

Appraisal of hospital medical staff

6.14 Since April 2000, all NHS employers have been contractually required to carry out annual appraisals, covering both clinical and non clinical aspects of their jobs. All doctors interviewed by CHI who currently work for the trust, including the medical director, who works five sessions in the department of medicine for elderly people, have regular appraisals. Those appraising the work of other doctors have been trained to do so.

Nursing responsibility

6.15 All qualified nurses are personally accountable for their own clinical practice. Their managers are responsible for implementing systems and environments that promote high quality nursing care.

6.16 On each ward, a G grade clinical manager, who reports to a senior H grade nurse, manages the ward nurses. The H grade nurse covers all wards caring for older people and was managed by the general manager for the Fareham and Gosport division. The general manager reported to both the director of nursing and the operations director. An accountability structure such as this is not unusual in a community hospital. The director of nursing was ultimately accountable for the standard of nursing practice within the hospital.

Nursing supervision

6.17 Clinical supervision for nurses was recommended by the United Kingdom Central Council in 1996 and again in the national nursing strategy, *Making a difference*, in 1999. It is a system through which qualified nurses can maintain lifelong development and enhancement of their professional skills through reflection, exploration of practice and identification of issues that need to be addressed. Clinical supervision is not a

managerial activity, but provides an opportunity to reflect and improve on practice in a non judgemental environment. Clinical supervision is a key factor in professional self regulation.

6.18 The trust has been working to adopt a model of clinical supervision for nurses for a number of years and received initial assistance from the Royal College of Nursing to develop the processes. As part of the trust's clinical nursing development programme, which ran between January 1999 and December 2000, nurses caring for older people were identified to lead the development of clinical supervision on the wards.

6.19 Many of the nurses interviewed valued the principles of reflective practice as a way in which to improve their own skills and care of patients. The H grade senior nurse coordinator post, appointed in November 2000, was a specific trust response to an acknowledged lack of nursing leadership at the Gosport War Memorial Hospital.

Teamworking

6.20 Caring for older people involves input from many professionals who must coordinate their work around the needs of the patient. Good teamwork provides the cornerstone of high quality care for those with complex needs. Staff interviewed by CHI spoke of teamwork, although in several instances this was uniprofessional, for example a nursing team. CHI observed a multidisciplinary team meeting on Daedalus ward, which was attended by a consultant, a senior ward nurse, a physiotherapist and an occupational therapist. No junior staff were present. Hospital staff described input from social services as good when available, though this was not always the case.

6.21 Regular ward meetings are held on Sultan and Daedalus wards. Arrangements are less clear on Dryad ward, possibly due to the long term sickness of senior ward staff.

6.22 Arrangements for multidisciplinary team meetings on Dryad and Sultan wards are less well established. Occupational therapy staff reported some progress towards multidisciplinary goal setting for patients, but were hopeful of further development.

Allied health professional structures

6.23 Allied health professionals are a group of staff which include occupational therapists, dieticians, speech and language therapists and physiotherapists. The occupational therapy structure is in transition from a traditional site based service to a defined clinical specialty service (such as stroke rehabilitation) in the locality. Staff explained that this system enables the use of specialist clinical skills and ensures continuity of care of patients, as one occupational therapist follows the patient throughout hospital admission(s) and at home. Occupational therapists talking to CHI described a good supervision structure, with supervision contracts and performance development plans in place.

6.24 Physiotherapy services are based within the hospital. The physiotherapy team sees patients from admission right through to home treatment. Physiotherapists described good levels of training and supervision and involvement in Daedalus ward's multidisciplinary team meetings.

6.25 Speech and language therapists also reported participation in multidisciplinary team meetings on Daedalus ward. Examples were given to CHI of well developed in service training opportunities and professional development, such as discussion g and clinical observation groups.

6.26 The staffing structure in dietetics consists of one full time dietitian based at St James Hospital. Each ward has a nurse with lead nutrition responsibilities able to advise colleagues.

Workforce and service planning

6.27 In November 2000, in preparation for the change of use of beds in Dryad and Daedalus wards from continuing care to intermediate care, the trust undertook an undated resource requirement analysis and identified three risk issues:

- consultant cover
- medical risk with a change in patient group and the likelihood of more patients requiring specialist intervention. The trust believed that the introduction of automated defibrillators would go some way to resolve this. The paper also spoke of "the need for clear protocols...within which medical cover can be obtained out of hours"
- the trust identified a course for qualified nursing staff, ALERT, which demonstrates a technique for quickly assessing any changes in a patients condition in order to provide an early warning of any deterioration

6.28 Despite this preparation, several members of staff expressed concern to CHI regarding the complex needs of many patients cared for at the Gosport War Memorial Hospital and spoke of a system under pressure due to nurse shortages and high sickness levels. Concerns were raised formally with the trust in early 2000 around the increased workload and complexity of patients. This was acknowledged in a letter by the medical director. CHI found no evidence of a systematic attempt to review or seek solutions to the evolving casemix, though a full time staff grade doctor was in post by September 2002 to replace and increase the previous five sessions of clinical assistant cover.

Access to specialist advice

6.29 Older patients are admitted to Gosport War Memorial Hospital with a wide variety of physical and mental health conditions, such as strokes, cancers and dementia. Staff demonstrated good examples of systems in place to access expert opinion and assistance.

6.30 There are supportive links with palliative care consultants, consultant psychiatrists and oncologists. The lead consultant for elderly mental health reported close links with the three wards, with patients either given support on the ward or transfer to an elderly mental health bed. There are plans for a nursing rotation

programme between the elderly medicine and elderly mental health wards. Staff spoke of strong links with the local hospice and Macmillan nurses. Nurses gave recent examples of joint training events with the hospice.

6.31 CHI's audit of recent case notes indicated that robust systems are in place for both specialist medical advice and therapeutic support.

Staff welfare

6.32 Since its creation in 1994, the trust developed as a caring employer, demonstrated by support for further education, flexible working hours and a ground breaking domestic violence policy that has won national recognition. The hospital was awarded Investors in People status in 1998. Both trust management and staff side representatives talking to CHI spoke of a constructive and supportive relationship.

6.33 However, many staff, at all levels in the organisation, spoke of the stress and low morale caused by the series of police investigations and the referrals to the General Medical Council, the United Kingdom Central Council and the CHI investigation. Trust managers told CHI they encouraged staff to use the trust's counselling service and support sessions for staff were organised. Not all staff speaking to CHI considered that they had been supported by the trust, particularly those working at a junior level, "I don't feel I've had the support I should have had before and during the police investigation – others feel the same".

Staff communication

6.34 Most staff interviewed by CHI spoke of good internal communications, and were well informed about the transfer of services to PCTs. The trust used newsletters to inform staff of key developments. An intranet is being developed by the Fareham and Gosport PCT to facilitate communication with staff.

KEY FINDINGS

1. Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards. It was not made clear to CHI how GPs working as clinical assistants and admitting patients to Sultan wards are included in the development of trust procedures and clinical governance arrangements.

2. There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff. Currently, there is effective nursing leadership on Daedalus and Sultan wards, this is less evident on Dryad ward. CHI was concerned regarding the potential for professional isolation of the staff grade doctor.

3. Systems are now in place to ensure that appropriate specialist medical and therapeutic advice is available for patients. Some good progress has been made towards multidisciplinary team working which should be developed.

4. There was a planned approach to the service development in advance of the change in use of beds in 2000. The increasing dependency of patients and resulting pressure on the service whilst recognised by the trust, was neither monitored nor reviewed as the changes were implemented and the service developed.

5. Portsmouth Healthcare NHS Trust should be congratulated for its progress towards a culture of reflective nursing practice.

6. The trust has a strong staff focus, with some notable examples of good practice. Despite this, CHI found evidence to suggest that not all staff felt adequately supported during the police and other recent investigations.

7. Out of hours medical cover for the three wards out of hours is problematic and does not reflect current levels of patient dependency.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangemnts, clinical governance responsibilities and trianing needs.

2. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

3. Fareham and Gosport PCT and East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

4. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

5. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

7 | Lessons learnt from complaints

7.1 A total of 129 complaints were made regarding the provision of elderly medicine since 1 April 1997. These complaints include care provided in other community hospitals as well as that received on the acute wards of St Mary's and Queen Alexandra hospitals. CHI was told that the three wards at Gosport War Memorial Hospital had received over 400 letters of thanks during the same period.

7.2 Ten complaints were made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards between 1998 and 2002. A number raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death, the use of syringe drivers and communication with relatives. Three complaints in the last five months of 1998 expressed concern regarding pain management, the use of diamorphine and levels of sedation. The clinical care, including a review of prescription charts, of two of these three patients, was considered by the police expert witnesses.

External review of complaints

7.3 One complaint was referred to the Health Services Commissioner (Ombudsman) in May 2000. The medical adviser found that the choice of pain relieving drugs was appropriate in terms of medicines, doses and administration. A complaint in January 2000 was referred to an independent review panel, which found that drug doses, though high, were appropriate, as was the clinical management of the patient. Although the external assessment of these two complaints revealed no serious clinical concerns, both the Health Services Commissioner and the review panel commented on the need for the trust to improve its communication with relatives towards the end of a patient's life.

Complaint handling

7.4 The trust had a policy for handling patient related complaints produced in 1997 and reviewed in 2000, based on national guidance *Complaints: guidance on the implementation of the NHS complaints procedure.* A leaflet for patients detailing the various stages of the complaints procedure was produced, which indicated the right to request an independent review if matters were not satisfactorily resolved together with the address of the Health Service Commissioner. This leaflet was not freely available on the wards during CHI's visit.

7.5 Both the trust and the local community health council (CHC) described a good working relationship. The CHC regretted, however, that their resources since November 2000 had prevented them from offering the level of advice and active support to complainants they would have wished. The CHC did continue to support complainants who had contacted them before November 2000. New contacts were provided with a "self help" pack.

7.6 CHI found that letters to complainants in response to their complaints did not always include an explanation of the independent review stage, although this is outlined in the leaflet mentioned above, which is sent to complainants earlier in the process. The 2000 update of the complaints policy stated that audit standards for complaints handling were good with at least 80% of complainants satisfied with complaint handling and 100% of complaints resolved within national performance targets. The chief executive responded to all written complaints. Staff interviewed by CHI valued the chief executive's personal involvement in complaint resolution and correspondence. Letters to patients and relatives sent by the trust reviewed by CHI were thorough and sensitive. The trust adopted an open response to complaints and apologised for any shortcomings in its services.

7.7 Once the police became involved in the initial complaint in 1998, the trust ceased its internal investigation processes. CHI found no evidence in agendas and minutes that the trust board were formally made aware of police involvement. Senior trust managers told CHI that the trust would have commissioned a full internal investigation without question if the police investigation had not begun. In CHI's view, police involvement did not preclude full internal clinical investigation. CHI was told that neither the doctor nor portering staff involved in the care and transfer of the patient whose care was the subject of the initial police investigation were asked for statements during the initial complaint investigation.

Trust learning regarding prescribing

7.8 Action was taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter 4). In addition, CHI learnt that external clinical advice sought by Portsmouth Healthcare NHS Trust in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mg to 200mg a day was poor practice and "could indeed lead to a serious problem". This comment was made by the external clinical assessor in regard to a patient given doses ranging from 20mg to 40mg per day.

7.9 Portsmouth Healthcare NHS Trust correspondence states that there was an agreed protocol for the prescription of diamorphine for a syringe driver with doses ranging between 20mg and 200mg a day. CHI understands this protocol to be the Wessex guidelines. Further correspondence in October 1999, indicated that a doctor working on the wards requested a trust policy on the prescribing of opiates in community hospitals.

7.10 A draft protocol for the prescription and administration of diamorphine by subcutaneous infusion was piloted on Dryad ward in 1999 and discussed at the trust's Medicines and Prescribing Committee in February and April 2000 following consultation with palliative care consultants. This guidance was eventually incorporated into the Portsmouth Healthcare NHS Trust and Portsmouth Hospitals NHS Trust policy for the assessment and management of pain which was introduced in April 2001.

Other trust lessons

7.11 Lessons around issues other than prescribing have been learnt by the trust, though the workshop to draw together this learning was not held until early 2001 when the themes discussed were communication with relatives, staff attitudes and fluids and nutrition. Action taken by the trust since the series of complaints in 1998 are as follows:

- an increase in the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly from February 1999
- the appointment of a full time staff grade doctor in September 2000 which increased medical cover following the resignation of the clinical assistant
- piloting pain management charts and prescribing guidance approved in April 2001. Nursing documentation is currently under review, with nurse input
- one additional consultant session began in 2000, following a district wide initiative with local PCGs around intermediate care
- nursing documentation now clearly identifies prime family contacts and next of kin information to ensure appropriate communication with relatives
- all conversations with families are now documented in the medical record. CHI's review of recent anonymised case notes demonstrated frequent and clear communication between relatives and clinical staff

7.12 Comments recorded in this workshop were echoed by staff interviewed by CHI, such as the difficultly in building a rapport with relatives when patients die a few days after transfer, the rising expectations of relatives and the lack of control Gosport War Memorial staff have over information provided to patients and relatives prior to transfer regarding longer term prognosis.

Monitoring and trend identification

7.13 A key action identified in the 2000/2001 clinical governance action plan was a strengthening of trust systems to ensure that actions following complaints were implemented. Until the dissolution of Portsmouth Healthcare NHS Trust, actions were monitored through the divisional review process, the clinical governance panel and trust board. A trust database was introduced in 1999 to record and track complaint trends. An investigations officer was also appointed in order to improve factfinding behind complaints. This has improved the quality of complaint responses.

7.14 Portsmouth Healthcare NHS Trust offered specific training in complaints handling, customer care and loss, death and bereavement, which many staff interviewed by CHI were aware of and had attended.

KEY FINDINGS

1. The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake an review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation which it was aware of in late 1998.

2. Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

3. Though Portsmouth Healthcare NHS Trust did begin to develop a protocol for the prescription and administration of diamorphine by syringe driver in 1999, the delay in finalising this protocol in April 2001, as part of the policy for the assessment and management of pain, was unacceptable.

4. There has been some, but not comprehensive, training of all staff in handling patient complaints and communicating with patients and carers.

RECOMMENDATIONS

1. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

2. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

3. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

8 | Clinical governance

Introduction

8.1 Clinical governance is about making sure that health services have systems in place to provide patients with high standards of care. The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

8.2 CHI has not conducted a clinical governance review of the Portsmouth Healthcare NHS Trust but has looked at how trust clinical governance systems supported the delivery of continuing and rehabilitative inpatient care for older people at the Gosport War Memorial Hospital. This chapter sets out the framework and structure adopted by the trust between 1998 and 2002 to deliver the clinical governance agenda and details those areas most relevant to the terms of reference for this investigation: risk management and the systems in place to enable staff to raise concerns.

Clinical governance structures

8.3 The trust reacted swiftly to the principles of clinical governance outlined by the Department of Health in *A First Class Service* by devising an appropriate management framework. In September 1998, a paper outlining how the trust planned to develop a system for clinical governance was shared widely across the trust and aimed to include as many staff as possible. Most staff interviewed by CHI were aware of the principles of clinical governance and were able to demonstrate how it related to them in their individual roles. Understanding of some specific aspects, particularly risk management and audit, was patchy.

8.4 The medical director took lead responsibility for clinical governance and chaired the clinical governance panel, a sub committee of the trust board. A clinical governance reference group, whose membership included representatives from each clinical service, professional group, non executive directors and the chair of the community health council, supported the clinical governance panel. Each clinical service also had its own clinical governance committee. This structure had been designed to enable each service to take clinical governance forward into whichever PCT it found itself in after April 2002. Since February 2000, the trust used the divisional review process to monitor clinical governance developments.

8.5 The service specific clinical governance committees were led by a designated clinician and included wide clinical and professional representation. Baseline assessments were carried out in each specialty and responsive action plans prod[illegible] The medical director and clinical governance manager attended divisional review meetings and reported key issues back to the clinical governance panel.

8.6 District Audit carried out an audit of the trust's clinical governance arrangements in 1998/1999. The report, dated December 1999, states that the trust had fully complied with requirements to establish a framework for clinical governance. The report also referred to the trust's document, *Improving quality – steps towards a first class service*, which was described as "of a high standard and reflected a sound understanding of clinical governance and quality assurance".

8.7 Whilst commenting favourably on the framework, the District Audit review also noted the following:

- the process for gathering user views should be more focused and the process strengthened
- the trust needed to ensure that in some areas, strategy, policy and procedure is fed back to staff and results in changed/improved practice. Published protocols were not always implemented by staff; results of clinical audit were not always implemented and reaudited; lessons learnt from complaints and incidents not always used to change practice and that research and development did not always lead to change in practice
- more work needed to be done with clinical staff on openness and the support of staff alerting senior management of poor performance

8.8 Following the review, the trust drew up a trust wide action plan (December 1999) which focused on widening the involvement and feedback from nursing, clinical and support staff regarding trust protocols and procedures, and on making greater use of research and development, clinical audit, complaints, incidents and user views to lead to changes in practice. CHI was told of a link nurse programme to take elements of this work forward.

Risk management

8.9 A trust risk management group was established in 1995 to develop and oversee the implementation of the trust's risk management strategy, to provide a forum in which risks could be evaluated and prioritised and to monitor the effectiveness of actions taken to manage risks. The group had links with other trust groups such as the clinical and service audit group, the board and the nursing clinical governance committee. Originally the finance director had joint responsibility for strategic risk with the quality manager; this was changed in the 2000/2003 strategy when the medical director became the designated lead for clinical risk. The trust achieved the clinical negligence scheme for trusts (CNST) level one in 1999. A decision was taken not to pursue the level two standard assessment due to dissolution of the trust in 2002.

8.10 The trust introduced an operational policy for recording and reviewing risk events in 1994. New reporting forms were introduced in April 2000 following a review of the assessment systems for clinical and non clinical risk. The same trust policy was used to report clinical and non clinical risks and accidents. All events were recorded in the trust's risk event database (CAREKEY). This reporting system was also used for near misses and medication errors. Nursing and support staff interviewed demonstrated a good knowledge of the risk reporting system, although CHI was less confident that medical staff regularly identified and reported risks. CHI was told that risk forms were regularly submitted by wards in the event of staff shortages. Staff shortage was not one of the trust's risk event definitions.

8.11 The clinical governance development plan for 2001/2002 stated that the focus for risk management in 2000/2001 was the safe transfer of services to successor organisations, with the active involvement of PCTs and PCGs in the trust's risk management group. Meetings were held with each successor organisation to agree future arrangements for areas such as risk event reporting, health and safety, infection control and medicines management.

Raising concerns

8.12 The trust had a whistle blowing policy dated February 2001. The Public Interest Disclosure Act became law in July 1999. The policy sets out the process staff should follow if they wished to raise a concern about the care or safety of a patient "that cannot be resolved by the appropriate procedure". NHS guidance requires systems to enable concerns to be raised outside the usual management chain. Most staff interviewed were clear about how to raise concerns within their own line management structure and were largely confident of receiving support and an appropriate response. Fewer staff were aware of the trust's whistle blowing policy.

Clinical audit

8.13 CHI was given no positive examples of changes in patient care or prescribing as a result of clinical audit outcomes. Despite a great deal of work on revising and creating policies to support good prescribing and pain management, there was no planned audit of outcome.

8.14 CHI was made aware of two trust audits of medicines since 1998. In 1999, a review of the use of neuroleptic medicines, which includes tranquillisers such as haloperidol, within all trust elderly care continuing care wards concluded that neuroleptic medicines were not being over prescribed. The same review revealed "the weekly medical review of medication was not necessarily recorded in the medical notes". The findings of this audit and the accompanying action plan, which included guidance on completing the prescription chart correctly, was circulated to all staff on Daedalus and Dryad wards. A copy was not sent to Sultan ward. There was a reaudit in late 2001 which concluded that overall use of neuroleptic medicines in continuing care wards remained appropriate.

8.15 More recently, the Fareham and Gosport PCT has undertaken a basic audit based on the prescription sheets and medical records of patients cared for on Sultan, Dryad and Daedalus wards during two weeks in June 2002. The trust concluded "that the current prescriping of opiates, major tranquilisers and hyocine was within British National Formulary guidelines." No patients were prescribed midazolam during the audit timeframe.

KEY FINDINGS

1. The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

2. Although a system was in place to record risk events, understanding of clinical risk was not universal. The trust had a whistle blowing policy, but not all staff were aware of it. The policy did not make it sufficiently clear that staff could raise concerns outside of the usual management channels if they wished.

RECOMMENDATIONS

1. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

2. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

3. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

4. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

APPENDIX A

Documents reviewed by CHI and/or referred to in the report

A) NATIONAL DOCUMENTS

1. Modern Standards and Service Models, Older People, National Service Framework for Older People, Department of Health, March 2001
2. 'Measuring disability a critical analysis of the Barthel Index', British Journal of Therapy and Rehabilitation, April 2000, Vol 7, No 4
3. The Public Interest Disclosure Act 1998 – whistleblowing in the NHS, NHS Executive, August 1999
4. Guidelines for the administration of medicines, (including press statement) United Kingdom Central Council for Nursing, Midwifery and Health Visiting, October 2000
5. Extension of independent nursing prescribing, items prescribable by nurses under the extended scheme, Department of Health, February 2002
6. Essence of Care: patient-focused benchmarking for healthcare practitioners, Department of Health, February 2001
7. Caring for older people: A nursing priority, integrated knowledge, practice and values, The nursing and midwifery advisory committee, March 2001
8. British National Formulary 41, British Medical Association, Royal Pharmaceutical Society of Great Britiain, 2001
9. Consent – What you have a right to expect: a guide for relatives and carers, Department of Health, July 2001
10. Making a Difference, strengthening the nursing, midwifery and health visiting contribution to health and healthcare, Summary, The Department for Health, July 1999
11. Improving Working Lives Standard, NHS employers commited to improving the working lives of people who work in the NHS, Department of Health, September 2000
12. The NHS plan, a plan for investment, a plan for reform, Chapter 15, dignity, security and independence in old age, The Department of Health, July 2000
13. Standards for health and social care services for older people, The Health Advisory Service 2000, May 2000
14. Reforming the NHS Complaints Procedure: a listening document, The Department of Health, September 2001

B) DOCUMENTS RELATING TO PORTSMOUTH HEALTHCARE NHS TRUST

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2. Annual reports, Portsmouth Healthcare NHS Trust, 2000-2001, 2000, 1998-1999
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APPENDIX B

Views from patients and relatives/friends

METHODS OF OBTAINING VIEWS

i. The investigation sought to establish the views of people who had experience of services for older people at the Gosport War Memorial Hospital since 1998.

ii. CHI sought to obtain views about the service through a range of methods. People were invited to:

- meet with members of the investigation team
- fill in a short questionnaire
- write to the investigation team
- contact by telephone or email

iii. In November 2001, information was distributed about the CHI investigation at Gosport War Memorial Hospital to stakeholders, voluntary organisations and statutory stakeholders. This information included posters advertising stakeholder events, information leaflets about the investigation, questionnaires and general CHI information leaflets. Press releases were issued in local newspapers and radio stations. The Hampshire Constabulary agreed to forward CHI contact details to families who had previously expressed their concerns to them.

iv. The written information was distributed to a large group of potential stakeholders. In total 36 stakeholders and 59 voluntary organisations will have received the above information. These people included:

- Motor Neurone Disease Association, Alzheimer's Society, League of Friends and other community groups such as the Gosport Stroke Club and Age Concern
- Portsmouth and South East Hampshire Community Health Council, Isle of Wight, Portsmouth and South East Hampshire Health Authority, local medical committee, members of parliament, nursing homes, Portsmouth social services and Fareham and Gosport primary care groups

STAKEHOLDER RESPONSES

i. CHI received the following responses from patients, relatives, carers, friends and voluntary organisations.

Letters	Questionnaires	Telephone interviews	*Stakeholder interviews
7	2	10	17

(*stakeholders were counted according to the number of attendees and not based on number of interviews)

ii. A number of people who contacted CHI did so using more than one method. In these cases any other form of submitted evidence, was incorporated as part of the stakeholders contact.

Figure B.1 Concerns about care raised by stakeholders by ward and date

	Dryad	Daedalus	Sultan	GWMH	TOTAL
1998		8		2	10
1999	1	5			6
2000		3	3	1	7
2001		1		1	2
GWMH				2	2
TOTAL	1	17	3	6	27

GWMH – Gosport War Memorial Hospital

ANALYSIS OF VIEWS RECEIVED

i. During the CHI investigation stakeholder views highlighted both positive and less positive experiences of patient care.

Positive experiences

ii. CHI received nine letters from stakeholders commenting on the satisfaction of the care that the patients received and highlighting the excellent level of care and kindness demonstrated by the staff. This was also supported by 400 letters of thanks and donations received by the Gosport War Memorial Hospital. The most frequently recurring positive comments from stakeholders were about staff attitude (five responses) and the environment (five responses). Other positive feedback was received about access to services, transfer, prescribing, end of life arrangements, communication and complaints.

iii. The overall analysis of the stakeholder comments indicated that staff attitude and the environment were most highly commended. Examples of staff attitude included comments such as, "one lovely nurse on Dryad went to say hello to every patient even before she got her coat off" and "as a whole the ward was lovely and there was no complaints against the staff". The environment was described as being tidy and clean with good decor. Another comment recognised the ward's attention to maintaining patient dignity with curtains been drawn reducing attention to the patient. One stakeholder commented on the positive experience they had when dealing with the trust concerning a complaint they had made.

Less positive experiences

iv. A number of less positive experiences of patients/friends and relatives were shared with CHI by stakeholders. The following table outlines the most frequently recurring negative comments that corresponded with CHI's terms of reference.

Figure B.2 Less positive views of patient and relative/friend experiences

View	Frequency of responses
Communication with relatives/carers/friends	14
Patient transfer	10
Nutrition and fluids	11
Prescription of medicines	9
Continence management, catheritisation	8
Staff attitude	8
End of life communication with:	
patients	4
relatives/carers/friends	6
Humanity of care ie access to buzzer, clothing	8

v. Patient transfer. Contacts commented on the state of the patient's health before and during the transfer. Other stakeholders mentioned the time that it took to transfer the patient and also highlighted the inappropriate method of transporting the patient.

vi. Nutrition and fluids. Stakeholders highlighted a lack of help in feeding patients. They commented on how dehydrated the patients appeared and the lack of positive communication between the relative/carer and the staff to overcome the relative/carer's concern about the level of nutrition and fluids.

vii. Humanity of care.

- incontinence management – stakeholders felt that there was limited help with patients that needed to use the toilet
- attitude of staff – stakeholders commented on staff attitude, mentioning the length of time it took for staff to respond. Other comments related to the basic lack of care for patients in their last few days
- provision of bells – stakeholders observed that the bells were often out of the patients reach
- management of clothing – stakeholders commented that the patients were never in their own clothes

viii. Arrangements for the prescription, administration, review and recording of medicines. The majority of concerns were around the prescribing of diamorphine. Others centred on those authorised to prescribe the medication to the patient and how this was communicated to the relatives/carer.

ix. Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations. Interviewees indicated a lack of staff contact with the relatives/carers about the condition of the patient and the patient's care plan. Other interviewees commented on how some of the staff were not approachable. One interviewee referred to the absence of lay terms to describe a patient's condition, making it difficult to understand the patient's status of health.

x. Arrangements to support patients and their relatives and carers towards the end of the patient's life. Stakeholders mainly thought that there was a lack of communication from the staff after their relative had died.

xi. Three of the contacts had made complaints to the trust through the NHS complaints procedure. All were dissatisfied about the trust response.

APPENDIX C

Portsmouth Healthcare NHS Trust staff and non executive directors interviewed by CHI

- Baldacchino, L, Health Care Support Worker
- Banks, Dr V, Lead Consultant
- Code A
- Barker, M, Enrolled Nurse
- Code A
- Brind, S, Occupational Therapist
- Cameron, F, General Manager
- Carroll, P, Occupational Therapist
- Clasby, J, Senior Nurse
- Crane, R, Senior Dietician
- Day, G, Senior Staff Nurse
- Douglas, T, Staff Nurse
- Dunleavy, J, Staff Nurse
- Dunleavy, S, Physiotherapist
- Goode, P, Health Care Support Worker
- Hair, Revd J, Chaplain
- Hallman, S, Senior Staff Nurse (until 11 September 2000)
- Code A
- Haste, A, Clinical Manager
- Hooper, B, Project Director
- Humphrey, L, Quality Manager
- Hunt, D, Staff Nurse (until 6 January 2002)
- Jarrett, Dr D, Lead Consultant
- Code A
- Jones, J, Corporate Risk Advisor
- Jones, T, Ward Clerk
- King, P, Personnel Director
- King, S, Clinical Risk Advisor
- Landy, S, Senior Staff Nurse
- Langdale, H, Health Care Support Worker
- Law, D, Patient Affairs Manager

- Lee, D, Complaints Convenor & Non Executive Director
- Lock, J, Sister (retired 1999)
- Loney, M. Porter
- Lord, Dr A, Lead Consultant
- Mann, K, Senior Staff Nurse
- Melrose. B. Project Manager – Complaints
- Millett, M, Chief Executive (until 31 March 2002)
- Monk, A, Chairman
- Nelson, S, Staff Nurse
- [redacted] Code A
- O'Dell, J, Practice Development Facilitator
- Parvin, J, Senior Personnel Manager
- Peach, J, Service Manager
- Peagram, L, Physiotherapy Assistant
- Pease, Y, Staff Nurse
- Phillips, C, Speech & Language Therapist
- Piper, I, Operational Director
- Qureshi, Dr L, Consultant
- Ravindrance, Dr A, Consultant
- Reid, Dr I, Medical Director
- Robinson, B, Deputy General Manager
- Scammel, T, Senior Nurse Coordinator
- Taylor, J, Senior Nurse
- Thomas, Dr E, Nursing Director
- Thorpe, M, Health Care Support Worker
- Tubbitt, A, Senior Staff Nurse
- Walker, F, Senior Staff Nurse
- Wells, P, District Nurse
- Wigfall, M, Enrolled Nurse
- Wilkins, P, Senior Staff Nurse
- Williams, J, Nurse Consultant
- Wilson, A, Senior Staff Nurse
- Wood, A, Finance Director
- Woods, L, Staff Nurse
- Yikona, Dr J, Staff Grade Physician

CHI is grateful to Caroline Harrington for scheduling interviews.

APPENDIX D

Meetings or telephone interviews with external agencies with an involvement in elderly care at Gosport War Memorial Hospital

- Portsmouth Hospitals NHS Trust

  Jill Angus, Clinical Discharge Coordinator

  Wendy Peckham, Discharge Planner for Medicine

  Clare Bownass, Ward Sister

  Sonia Baryschpolec, Staff Nurse

  Sam Page, Bed Manager, Royal Haslar Hospital

  Sally Clark, Patient Transport Manager

  Julie Sprack, Senior Nurse

  Jeff Watling, Chief Pharmacist

  Vanessa Lawrence, Pharmacist

- Hampshire Ambulance Service NHS Trust

  Alan Lyford, Patient Transport Service Manager

- Isle of Wight, Portsmouth & South East Hampshire Health Authority

  Penny Humphris, Chief Executive

  Dr Peter Old, Director of Public Health

  Nicky Pendleton, Progamme Lead for Elderly Care Services

- NHS Executive south east regional office

  Dr Mike Gill, Regional Director of Public Health

  Dr David Percy, Director of Education and Training

  Harriet Boereboom, Performance Manager

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- Hampshire Constabulary

  Detective Superintendent John James

- Portsmouth Social Services

  Sarah Mitchell, Assistant Director (Older People)

  Helen Loten, Commissioning and Development Manager

- Hampshire Social Services

  Tony Warns, Service Manager for Adults

- Alverstoke House Nursing and Residential Care Home

  Sister Rose Cook, Manager

- Glen Heathers Nursing and Residential Care Home

  John Perkins, Manager

Other

- League of Friends

  Mary Tyrell, Chair

  Geoff Rushton, Former Treasurer

- Motor Neurone Disease Association

  Mrs Fitzpatrick

- Members of Parliament

  Peter Viggers, MP for Gosport

  Sydney Rapson, MP for Portsmouth North

- Primary Care Groups

  John Kirtley, Chief Executive, Fareham and Gosport Primary Care Groups

  Dr Pennells, Chairperson, Gosport Primary Care Groups

- Portsmouth Local Medical Committee

  Dr Stephen McKenning, Chairman

- Gosport War Memorial Hospital medical committee

  Dr Warner, Chairman

- Local representative for the Royal College of Nursing

  Betty Woodland, Steward

  Steve Barnes, RCN Officer

- Local representative for Unison

  Patrick Carroll, Branch Chair

- Local general practitioners

  Dr J Barton, Knapman Practice

  Dr P Beasley, Knapman Practice

  Dr S Brook, Knapman Practice

APPENDIX E

Medical case note review team: terms of reference and membership

Terms of reference for the medical notes review group to support the CHI investigation at Gosport War Memorial Hospital

PURPOSE

The group has been established to review the clinical notes of a random selection of recently deceased older patients at the Gosport War Memorial Hospital in order to inform the CHI investigation. With reference to CHI's investigation terms of reference and the expert witness reports prepared for the police by Dr Munday and Professor Ford, this review will address the following:

(i) the prescription, administration, review and recording of drugs

(ii) the use and application of the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs

(iii) the quality of nursing care towards the end of life

(iv) the recorded cause of death

METHOD

The group will review 15 anonymised clinical notes supplied by the trust, followed by a one day meeting at CHI in order to produce a written report to inform the CHI investigation. The group will reach its conclusions by 31 March 2002 at the latest.

MEMBERSHIP

- Dr Tony Luxton, Geriatrician
  Cambridge City PCT
  (CHI doctor team member and chair of the group)
- Maureen Morgan, Independent Management Consultant
  (CHI nurse member)
- Professor Gary Ford, Professor of Pharmacology of Old Age
  University of Newcastle and Freeman Hospital
- Dr Keith Munday, Consultant Geriatrician
  Frimley Park Hospital
- Annette Goulden, Deputy Director of Nursing
  NHS Trent regional office and formerly
  Department of Health Nursing Officer for elderly care

FINDINGS OF GROUP

The findings of the group will be shared with:

(i) the CHI Gosport investigation team

(ii) CHI's Nurse Director and Medical Director and other CHI staff as appropriate

(iii) the trust

(iv) relatives of the deceased (facilitated by the trust) if requested, on an individual basis

The final report of the group will be subject to the rules of disclosure applying to CHI investigation reports.

APPENDIX F

Report of the Gosport investigation medical notes review group

PURPOSE

CHI undertook a review of the anonymised medical notes of a random selection of 15 patients who had died between 1 August 2001 and 31 January 2002 on Daedalus, Dryad or Sultan wards at Gosport War Memorial Hospital.

CHI's intention for this piece of work was to determine whether the policies and systems put in place by the Portsmouth Healthcare NHS Trust since the events of 1998, to address prescribing practices are being implemented and are impacting on the quality of care patients are now receiving. CHI's review also considered the nursing notes for each patient and looked at the quality of nursing care as documented in the notes. Finally, the review considered whether the cause of death recorded in the notes was appropriate.

METHODOLOGY

The group received 15 sets of anonymised medical notes from the trust, which related to the last admission of 15 patients. Five patients were randomly selected from each of the following wards: Daedalus, Dryad and Sultan. A total of 49 patients had died whilst on these wards during the sample timeframe.

FINDINGS

(i) *Use of medicines*

Prescription

The group considered that the volume and combination of medicines used was appropriate for this group of patients and was in line with accepted good practice and British National Formulary guidelines. Single prescription. PRN and syringe driver prescribing was acceptable. There was no evidence of anticipatory prescribing.

The case notes suggested that the use of the trust's 'analgesic ladder' to incrementally increase and decrease pain relief in accordance to need was being followed. The group saw no evidence to suggest that patients had been prescribed large amounts of pain relief, such as diamorphine on admission where this was not necessary. Co-codamol had been prescribed in a number of cases as an initial analgesic, with progression to alternative medicines as and when more pain relief was needed. The use of the analgesic ladder was less evident in Sultan ward.

However, in two cases, the group saw evidence of unacceptable breakthrough pain, and six hourly rather than four hourly prescriptions, which could have allowed this to happen. There was also some evidence of the simultaneous prescribing of co-codamol and fentanyl, which was not thought by the group to be the most effective combination of medicines.

Administration

Syringe drivers had been used to deliver medication to six of the patients reviewed. Appropriate use of syringe drivers as a method of medicine administration was observed, with documented discussions with families before use.

Appropriate administration of medicines by nursing staff was evident. Prescriptions issued over the telephone by GPs on Sultan ward were appropriately completed in accordance with trust policy.

Review and recording of medicines

Evidence of consistent review of medication was seen, with evidence to suggest that patients and relatives were involved in helping to determine levels of pain. Nursing staff had appropriately administered medicines in line with medical staff prescriptions. Prescription sheets had been completed adequately on all three wards. Generally, record keeping around prescribing was clear and consistent, though this was not as clear on Sultan ward.

Based on the medical notes reviewed, the group agreed that the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs were being adhered to.

(ii) *Quality of nursing care towards the end of life*

The team found a consistently reasonable standard of care given to all patients they reviewed. The quality of nursing notes was generally adequate, although not always of consistent quality. There was some evidence to suggest a task oriented approach to care with an over emphasis on the completion of paperwork. This left an impression of a sometimes disjointed rather than integrated individual holistic assessment of the patient. The team saw some very good, detailed care plans and as well as a number of incidences where no clear agreed care plan was evident.

The team was concerned that swallowing assessments for patients with dysphagia had been delayed over a weekend because of the lack of availability of suitably trained nursing staff. Nurses could be trained to undertake this role in order not to compromise patient nutrition. Despite this, the trust's policies regarding fluid and nutrition were generally being adhered to. Though based on the nursing notes, a number of patients had only been weighed once, on admission.

There was evidence of therapy input, but this had not always been incorporated into care plans and did not always appear comprehensive. There was some concern that despite patients being assessed as at risk of pressure sores, it was not clear how this had been managed for some patients.

There was thorough, documented evidence to suggest that comprehensive discussions were held with relatives and patients towards the end of the patient's life. Do not attempt resuscitation decisions were clearly stated in the medical records.

Recorded cause of death

The group found no cause for concerns regarding any of the stated causes of death.

GENERAL COMMENTS

Admission criteria

The team considered that the admission criteria for Daedalus and Dryad wards was being adhered to. However there were examples of patients admitted to Sultan ward who were more dependent than the admission criteria stipulates. There is also an issue regarding patients who initially meet the admission criteria for Sultan ward who then develop complications and become more acutely sick.

Elderly medicine consultant input and access to specialist advice

Patients on Daedalus and Dryad wards received regular, documented review by consultant staff. There was clear evidence of specialist input, from mental health physicians, therapists and medical staff from the acute sector.

Out of hours cover

There was little evidence of out of hours input into the care of patients reviewed by CHI, though the team formed the view that this had been appropriate and would indicate that the general management of patients during regular hours was therefore of a good standard.

APPENDIX G

An explanation of the dissolution of services into the new primary care trusts

Figure G.1 Arrangements for hosting clinical services

Department	Portsmouth City PCT	East Hampshire PCT	Fareham & Gosport PCT	West Hampshire NHS Trust
Elderly medicine		●		
Elderly mental health		●		
Community paediatrics	●			
Adult mental health services	● For Portsmouth patients			● For Hampshire patients
Learning disability services			●	
Substance misuse	●			
Clinical pyschology	●			
Primary care counselling				●
Specialist family planning	●			
Palliative care		●		

(Source: *Local health, local decisions*, consultation document, September 2001, NHS Executive South East Regional Office, Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Health Authority)

APPENDIX H

Patient throughput data 1997/1998 – 2000/2001

Figure H.1 Throughput data 1997/1998 – 2000/2001

Financial year	Ward	Finished consultant episodes
1997/1998	Daedalus	97
1997/1998	Dryad	72
1997/1998	Sultan	287
	Total	456
1998/1999	Daedalus	121
1998/1999	Dryad	76
1998/1999	Sultan	306
	Total	503
1999/2000	Daedalus	110
1999/2000	Dryad	131
1999/2000	Sultan	402
	Total	643
2000/2001	Daedalus	113
2000/2001	Dryad	86
2000/2001	Sultan	380
	Total	579

(Source: 1997/1998 – trust ward based discharge data, 1998/1999, 1999/2000 and 2000/2001 – trust patient administration system (PAS) data).

APPENDIX I

Breakdown of medication in Dryad, Sultan and Daedalus wards at Gosport War Memorial Hospital

Figure I.1 Summary of medicine usage 1997/1998-2000/2001 (Mar 2002)

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	5mg	5	0	5	0	3
	Dryad	5mg	5	0	0	0	6
	Sultan	5mg	5	6	5	0	10
	Total			6	10	0	19
Diamorphine via syringe driver	Sultan	5mg	1	0	10	0	0
	Total			0	10	0	0
Diamorphine injection	Daedalus	10mg	5	21	34	27	19
	Dryad	10mg	5	40	57	56	20
	Sultan	10mg	5	67	36	24	35
	Total			128	127	107	74
Diamorphine via syringe driver	Dryad	10mg	1	0	17	0	0
	Sultan	10mg	1	0	20	0	0
	Total			0	37	0	0
Diamorphine injection	Daedalus	30mg	5	16	27	15	7
	Dryad	30mg	5	34	51	40	4
	Sultan	30mg	5	67	43	14	31
	Total			117	121	69	42
Diamorphine via syringe driver	Dryad	30mg	1	0	5	0	0
	Total			0	5	0	0
Diamorphine injection	Daedalus	100mg	5	2	11	1	2
	Dryad	100mg	5	12	13	2	0
	Sultan	100mg	5	20	27	0	31
	Total			34	51	3	33

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	500mg	5	0	1	0	
	Dryad	500mg	5	0	2	0	
	Sultan	500mg	5	1	1	0	
	Total			1	4	0	
Haloperidol injection	Daedalus	5mg/5ml	10	0	3	0	0
	Dryad	5mg/5ml	10	1	1	0	0
	Sultan	5mg/5ml	10	43	15	6	0
	Total			44	19	6	0
Haloperidol injection	Daedalus	5mg/5ml	5	0	0	0	4
	Dryad	5mg/5ml	5	0	0	0	1
	Sultan	5mg/5ml	5	0	0	0	16
	Total			0	0	0	21
Midazolam	Daedalus	10mg/2ml	10	37	51	39	17
	Dryad	10mg/2ml	10	75	108	75	19
	Sultan	10mg/2ml	10	21	9	2	11
	Total			133	168	116	47

(Source: Portsmouth Healthcare NHS Trust)

Dose: a single measured quantity of medicine

Pack: a collection of single doses, the packaging in which medicines are dispatched from the pharmacy

APPENDIX J

Glossary

accountability responsibility, in the sense of being called to account for something.

action plan an agreed plan of action and timetable that makes improvements to services.

acute care/ trust/hospital short term (as opposed to chronic, which means long term).
Acute care refers to medical and surgical treatment involving doctors and other medical staff in a hospital setting.
Acute hospital refers to a hospital that provides surgery, investigations, operations, serious and other treatments, usually in a hospital setting.

allied health professionals professionals regulated by the Council for Professions Supplementary to Medicine (new Health Professions Council). This includes professions working in health, social care, education, housing and other sectors. The professions are art therapists, music therapists and drama therapists, prosthetists and orthotists, dieticians, orthoptists, occupational therapists, physiotherapists, biomedical scientists, speech and language therapists, radiographers, chiropodists and podiatrists, ambulance workers and clinical scientists. Also called professionals allied to or supplementary to medicine.

analgesia medicines prescribed to reduce pain.

anticipatory prescribing to prescribe a drug or other remedy in advance.

antipsychotics A group of medicines used to treat psychosis (conditions such as schizophrenia) and sometimes used to calm agitation. Examples include haloperidol. Also called major tranquillisers or neuroleptics.

appraisal an assessment or estimate of the worth, value or quality of a person or service or thing.

Association of Chief Police Officers (ACPO) an association whose members hold the rank of Chief Constable, deputy Chief Constable or Assistant Chief Constable or their equivalents. They provide a professional opinion to the Government and appropriate organisations.

audit, clinical audit an examination of records to check their accuracy. Often used to describe an examination of financial accounts in a business.
In clinical audit those involved in providing services assess the quality of care. Results of a process or intervention are assessed, compared with a preexisting standard, changed where necessary, and then reassessed.

Barthel score a validated tool used to measure physical disability.

benzodiazepines a diverse group of medicines used for a range of purposes. Some reduce anxiety, others are used as sleeping tablets. Some, such as *midazolam*, act as strong sedatives and can be accompanied by memory loss whilst the medicine is active.

British National Formulary publication that provides information on the selection and use of medicines for healthcare professionals.

carers people who look after their relatives and friends on an unpaid, voluntary basis often in place of paid care workers.

casemix the variety and range of different types of patients treated by a given health professional or team.

catheter a hollow tube passed into the bladder to remove urine.

catheterisation use of a catheter.

CHI see Commission for Health Improvement.

clinical any treatment provided by a healthcare professional. This will include, doctors, nurses, AHPs etc. Non clinical relates to management, administration, catering, portering etc.

clinical assistant usually GPs, employed and paid by a trust, largely on a part time basis, to provide medical support on hospital wards and other departments.

clinical governance refers to the quality of health care offered within an organisation.
The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." It's about making sure that health services have systems in place to provide patients with high standards of care.

clinical governance review a review of the policies, systems and processes used by an organisation to deliver high quality health care to patients. The review looks at the way these policies work in practice (a health check for a health organisation).

clinical oncologist a doctor who specialises in the treatment of cancer patients, particularly through the use of radiotherapy, but who may also use chemotherapy.

clinical risk management understanding the various levels of risk attached to each form of treatment and systematically taking steps to ensure that the risks are minimised.

clinician/clinical staff a fully trained health professional – doctor, nurse, therapist, technician etc.

clinical negligence scheme for trusts (CNST) an 'insurance' scheme for assessing a trust's arrangements to minimise clinical risk which can offset costs of insurance against claims of negligence. Successfully gaining CNST 'standards' (to level one, two, three) reduces the premium that the trust must pay.

Commission for Health Improvement (CHI) independent national body (covering England and Wales) to support and oversee the quality of clinical governance in NHS clinical services.

co-codamol a medicine consisting of paracetamol and codeine phosphate, used for the relief of mild to moderate pain.

community care health and social care provided by health care professionals, usually outside hospital and often in the patient's own homes.

community health council (CHC) a statutory body sometimes referred to as the patients' friend. CHCs represent the public interest in the NHS and have a statutory right to be consulted on health service changes in their area.

consultant a fully trained specialist in a branch of medicine who accepts total responsibility for specialist patient care. (For training posts in medicine see specialist registrar, senior house officer and preregistration house officer.)

continence management The practice of promoting or sustaning the ability to control urination and defecation.

continuing care a long period of treatment for patients whose recovery will be limited.

defibrillator a piece of equipment which sends an electric current through the heart to restore the heart beat.

diamorphine A medicine used to relieve severe pain.

do not attempt resuscitation (DNAR) or do not resuscitate (DNR) an instruction, which says that if a patient's health suddenly deteriorates to near death, no special measures will be taken to revive their heart. This instruction should be agreed between the patient and doctor or if a patient is not conscious, then with their closest relative.

dysphagia difficulty swallowing.

fentanyl a medicine prescribed to patients who require control of existing pain.

finished consultant episode (FCE) a period of continuous consultant treatment under a specific consultant. If a patient is transferred from one consultant to another it will be counted as two FCEs.

formulary a list of preferred medicinal drugs which are routinely available in a hospital or GP surgery.

General Medical Council (GMC) the professional body for medical doctors which licenses them to practice.

general practitioner (GP) a family doctor, usually patients' first point of contact with the health service.

geriatrician a doctor who specialises in diagnosis and treatment of diseases affecting older people.

haloperidol see antipsychotics.

health authority (HA) statutory NHS body responsible for assessing the health needs of the local population, commissioning health services to meet those needs and working with other organisations to build healthy local communities.

health community or health economy all organisations with an interest in health in one area including the community health councils, and voluntary and statutory organisations.

Health Service Ombudsman investigates complaints about failures in NHS hospitals or community health services, about care and treatment, and about local NHS family doctor, dental, pharmacy or optical services. Anyone may refer a complaint but normally only if a full investigation through the NHS complaints system has been carried out first.

holistic a method of medical care in which patients are treated as a whole and which takes into account their physical and mental state as well as social background rather than just treating the disease alone.

hyocine a medicine to relieve nausea and sickness.

Improving Working Lives a Department of Health initiative launched in 1999. It includes standards for developing modern employment services, putting in place work/life balance schemes and involving and developing staff.

incident reporting system a system which requires clinical staff to report all matters relating to patient care where there has been a special problem.

independent review stage two of the formal NHS complaints procedure, it consists of a panel, usually three members, who look at the issues surrounding a complaint.

intermediate care a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.

intranet an organisation's own internal internet which is usually private.

investigation – by CHI an in depth examination of an organisation where a serious problem has been identified.

Investors in People a national quality standard which sets a level of good practice for improving an organisation's performance through its people.

lay member a person from outside the NHS who brings an independent voice to CHI's work.

local medical committee (LMC) a group of local GPs, elected by the entire local GP population who meet with the health authority to help plan resources and inform decisions.

locum a temporary practitioner who stands in for the permanent one.

medical the branches of medicine concerned with treatment through careful use of medicines as opposed to (surgical) operations.

medical director the term usually used for a doctor at trust board level (a statutory post) responsible for all issues relating to doctors and medical and surgical issues throughout the trust.

midazolam see benzodiazepines.

multidisciplinary from different professional backgrounds within healthcare (e.g. nurse, consultant, physiotherapist) concerned with the treatment and care of patients.

multidisciplinary meetings meetings involving people from different professional backgrounds.

multiprofessional from different professional backgrounds, within and outside of healthcare (e.g. nurse, consultant, social worker) concerned with the care or welfare of people.

National Service Framework (NSF) guidelines for the health service from the Department of Health on how to manage and treat specific conditions, or specific groups of patients e.g. Coronary Heart Disease, Mental Health, NSF for older people. Their implementation across the NHS is monitored by CHI.

neuroleptic see antipsychotics.

neurology a branch of medicine concerned with medical treatment of disorders of the nervous system.

NHS regional office

NHS trust a self governing body in the NHS, which provides health care services. They employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc.

Nursing and Midwifery Council The Nursing Midwifery Council (NMC) is an organisation set up by Parliament to ensure nurses, midwives and health visitors provide appropriate standards of care to their patients and clients. All qualified nurses, midwives and health visitors are required to be members of the NMC in order to practice.

nursing director the term usually used for a nurse at trust board level responsible for the professional lead on all issues relating to nurses and nursing throughout the trust.

occupational therapist a trained professional (an allied health professional) who works with patients to assess and develop daily living skills and social skills.

ombudsman see national health service ombudsman above.

opiates a group of medicines containing or derived from opium, that act to relieve severe pain or induce sleep.

opioid a description applied to medicines that cause similar effects in the body to opiates.

outpatient services provided for patients who do not stay overnight in hospital.

pain management a particular type of treatment that concentrates on managing a patient's pain – rather than seeking to cure their underlying condition – and complements their treatment plan.

palliative a term applied to the treatment of incurable diseases, in which the aim is to mitigate the sufferings of the patient, not to effect a cure.

palliative care care for people with chronic or life threatening conditions from which they will not recover. It concentrates on symptom control and family support to help people have as much independence and quality of life as is possible.

patient administration system (PAS) a networked information system used in NHS trusts to record information and inpatient and outpatient activity.

patient advice and liaison service (PALS) a new service proposed in the July 2000 NHS plan due to be in place by 2002, that will offer patients an avenue to seek advice or complain about their hospital care.

patient centred care a system of care or treatment is organised around the needs of the patient.

patient involvement the amount of participation that a patient (or patients) can have in their care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.

primary care family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

PCG Organisations now almost completely replaced by primary care trusts. Set up in 1997, PCGs were new organisations (technically Health Authority committees) that brought together all primary care practices in a particular area. PCGs were led by primary care professionals but with lay and social services representation. PCGs were expected to develop local primary health care services and work to improve the health of their populations. Some PCGs additionally took responsibility for commissioning secondary care services.

PCT Organisations that bring together all primary care practices in an area. PCTs are diverse and complex organisations. Unlike PCGs, which came before them, they are independent NHS bodies with greater responsibilities and

powers. They were set up in response to the Department of Health's *Shifting the Balance of Power* and took over many health authority functions. PCTs are responsible for

- improving the health of their population
- integrating and developing primary care services
- directly providing community health services
- commissioning secondary care services

PCTs are increasingly working with other PCTs, local government partners, the voluntary sector, within clinical networks and with 'shared service organisations' in order to fulfil their roles.

level four PCT brings together commissioning of secondary care services and primary care development with the provision of community health services. They are able to commission and provide services, run community health services, employ the necessary staff, and own property.

PRN (Pro re nata) prescribing medication as and when required.

protocol a policy or strategy which defines appropriate action.

psychiatrist a doctor who specialises in the diagnosis and treatment of mental health problems.

regional office see NHS regional office above.

rehabilitation the treatment of residual illness or disability which includes a whole range of exercise and therapies with the aim of increasing a patient's independence.

resuscitation a range of procedures used when someone has suddenly become seriously ill in a way that threatens their life.

risk assessment an examination of the risks associated with a particular service or procedure.

risk management understanding the various risks involved and systematically taking steps to ensure that the risks are minimized.

Royal College of Nursing (RCN) the world's largest professional union of nurses. Run by nurses, it campaigns on the part of the profession, provides higher education and promotes research, quality and practice development through the RCN [illegible]

sensory disabilities people who have problems hearing, seeing, smelling or with touch.

specialist a clinician most able to progress a patient's diagnosis and treatment or to refer a patient when appropriate.

speech and language therapist professionally trained person who assists, diagnoses and treats the whole spectrum of acquired or developmental communication disorders.

staff grade a full qualified doctor who is neither a General Practitioner nor a consultant.

staff grade doctors doctors who have completed their training but do not have the qualifications to enable them to progress to consultant level. Also called trust grade doctors.

stakeholders a range of people and organisations that are affected by, or have an interest in, the services offered by an organisation. In the case of hospital trusts, it includes patients, carers, staff, unions, voluntary organisations, community health councils, social services, health authorities, GPs, primary care groups and trusts in England, local health groups in Wales.

statutory/statute refers to legislation passed by Parliament.

strategic health authority organisations that will replace health authorities and some functions of Department of Health regional offices in 2002. Unlike current health authorities, they will not be involved in commissioning services from the NHS. Instead they will performance manage PCTs and NHS trusts and lead strategic developments in the NHS. Full details of the planned changes are in the Department of Health document, Shifting the Balance of Power, July 2001.

strategy a long term plan for success.

subcutaneous beneath the skin.

swallowing assessments the technique to access the ability of the patient to swallow safely.

syringe driver a device to ensure that a syringe releases medicine over a defined length of time into the body.

terminal care care given in the last weeks of life.

terms of reference the rules by which a committee or group does its work.

trust board a group of about 12 people who are responsible for major strategy and policy decisions in each NHS trust. Typically comprises a lay chairman, five lay members, the trust chief executive and directors.

Unison Britain's biggest trade union. Members are people working in the public services.

United Kingdom Central Council (UKCC) on 1 April 2002 the UKCC ceased to exist. Its successor body is The Nursing and Midwifery Council (NMC). Its purpose was to protect the public through establishing and monitoring professional standards.

ward round A regular review of each patient conducted by a consultant, often accompanied by nursing, pharmacy and therapy staff.

Wessex palliative care guidelines local guidance to help GPs, community nurses and hospital staff as well as specialist palliative care teams. It provides a checklist for management of common problems in palliative care, with some information on medical treatment. It is not a comprehensive textbook.

whistle blowing the act of informing a designated person in an organisation that patients are at risk (in the eyes of the person blowing the whistle). This also includes systems and processes that indirectly affect patient care.

whistle blowing policy a plan of action for a person to inform on someone or to put a stop to something.

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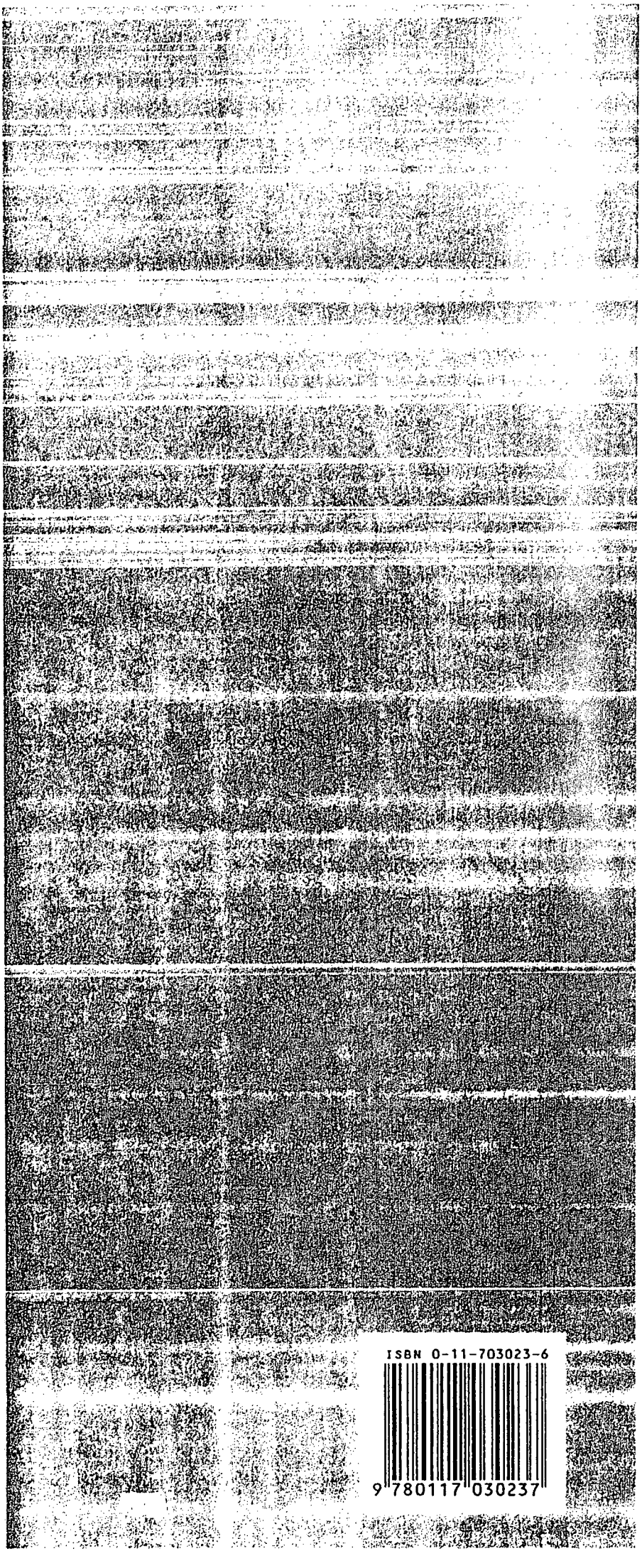

Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital - July 2002

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NURSING & MIDWIFERY COUNCIL

Preliminary Proceedings Committee

24 September 2002

Private and Confidential

Agenda Item Part 1 - New Case – No allegations served yet

Name: a) b) c) d) e) **Code A**

Case Reference Number: a) 11978 b) 12010 c) 12011 d) 12012 e) 12013

PIN and Date of Birth: UNIDENTIFIED

Council's solicitor: none

Complainant: Mrs M Jackson & Mrs A Reeves & Mr Page.

Date of incident(s): 1998 - 1999

Date complaint received: 11 June 2002

Summary of Allegations:

Papers attached:

Allegations	Section A, page 1
Professional Conduct report	Section B, pages 1-5
Solicitor's report	Section C, none
Statements supporting the complaint	Section D, pages 1 - 218
Practitioner's response	Section E, none

Professional Conduct Report
For the meeting of the
Preliminary Proceedings Committee
On

24 September 2002

Case Name:	a) b) c) d) e)	Code A
Case Ref:	a) b) c) d) e)	11978 12010 12011 12012 12013

The complaints were received from Mrs Jackson, Mrs Reeves and Mrs Page concerning the above named practitioners who were employed at Gosport War Memorial Hospital. The complaints relate to events in 1998 and 1999. The practitioners have not yet been identified on the register.

A detailed report has been compiled by Code A and this is attached for the committee's attention (pages 2 – 5).

Supporting documents can be found at section D pages 1 – 218. These documents have been referred to throughout the attached report and are annexed as follows :

Annexe 1	pages 1 – 3
Annexe 2	pages 4 – 42
Annexe 3	pages 43 – 46
Annexe 4	page 47
Annexe 5	pages 48 – 121
Annexe 6	pages 122 - 218

No allegations have been served on the practitioner at this stage and the committee are invited to consider whether or not the case should be further investigated and if so to draught a summary of allegations to be forwarded to the Council's solicitors.

NURSES AT GOSPORT WAR MEMORIAL HOSPITAL

We have received complaints about several nurses working at Gosport War Memorial Hospital relating to events in 1998 and 1999 when the deaths of five elderly patients were the subject of a police investigation. Two of the complaints relate to two of those patients, Mrs Alice Wilkie who died on 21 August 1998 and Mrs Eva Page who died on 3 March 1998.

A further complaint concerns Mrs Elsie Devine who died on 21 November 1999. and whose case was not part of the police investigation.

Philip Beed

Philip Beed, who still works for the Trust, has been reported to the NMC by Mrs Jackson, Alice Wilkie's daughter. The allegations she makes have been summarised below, and the full letter of complaint is attached as **Annexe 1.**

She alleges, amongst other things, that in caring for her mother Alice Wilkie, Philip Beed:

1. Failed to explain to Mrs Wilkie's daughter the actions that were being taken in relation to her mother.

2. Made an inaccurate record in the nursing notes that Mrs Wilkie's daughter had agreed that active treatment for her mother was inappropriate, and that she agreed to the setting up of a syringe driver.

3. Delayed in attending to Mrs Wilkie when he was informed that she was in pain, and then failed to examine her.

4. Failed to query with the doctor the dose of 30 mg of diamorphine which he had administered to Mrs Wilkie.

Furthermore, Mrs Jackson has concerns about matters not directly related to Mr Beed but about the general nursing care given to her mother. These matters include the poor state of the nursing records. She cites an incident where her mother's records were muddled up with those of another patient. She was also concerned that there had been a failure to record fluid balance and a failure to record that there was blood in her mother's catheter bag.

During the police investigation, medical expert opinion was sought and one of those medical experts, Dr Ford, although not singling out Code A had criticisms of the drug regime in existence at the time. He comments on Mrs Wilkie's care as follows:

He said that there was no clear evidence that Mrs Wilkie was in pain although she was commenced on opiate analgesics. There was no information recorded in the nursing or medical notes to explain why Mrs Wilkie was commenced on diamorphine and hyoscine infusions. In his opinion there was no indication for diamorphine and hyoscine in Mrs Wilkie, and that other oral analgesics such as paracetamol and mild opiate drugs could and should have been tried first.

He considered that the medical and nursing notes were inadequate, not sufficiently detailed and did not provide a clear picture of Mrs Wilkie's condition. Copies of Mrs Wilkie's medical and nursing notes are attached at **Annexe 2**

He went on to say that medical and nursing staff had a duty of care to deliver medical and nursing care and to monitor and document the effect of drugs prescribed to Mrs Wilkie. In his opinion the duty of care was not met. Furthermore, in his opinion the prescription of subcutaneous diamorphine and midazolan was inappropriate and may have hastened her death, although he notes that she was very frail, with dementia and was at high risk of developing pneumonia.

Code A

The other complaint received concerned Code A Code A still employed by the Trust.

The complaint was made by Mrs Reeves, daughter of Mrs Elsie Devine who died on 21 November 1999. Mrs Devine was not one of the patients who was the subject of the police experts' reports. The allegations have been summarised as follows and the letter of complaint is attached as **Annexe 3.**

In relation to Code A, Mrs Reeves expresses concern about the administration of drugs, and she alleges that Code A failed to keep the family informed as to her mother's condition, and failed to maintain nursing records.

In relation to Code A she was concerned about her failure to discuss medication with the family.

She made no specific allegations relating to the Staff Nurse Barker and Enrolled Nurse Bell but expressed general concerns about the nursing care given to her mother.

Code A **and others**

Mr Page, son of Eva Page, made generalised complaints against all the nursing staff in relation to the care of his mother including Code A whom he names, and his letter is enclosed as **Annexe 4.** His mother's case was reviewed by Dr Ford who, whilst having concern about the prescription of subcutaneous diamorphine,midazolam and hyoscine, which he felt caused Mrs Pages' respiratory depression, concluded that 'the medical and nursing care she received was appropriate and of adequate quality.'

Police Investigation

The police investigated the practices at Gosforth War Memorial hospital as there was concern that there may have been unlawful killing of patients by the use of the particular regime of sedation. However, in February 2002, the police concluded that there was no evidence to support a conviction against any individual. In the course of their investigations, they had obtained two medical experts reports which they sent to the NMC and CHI, amongst other bodies, for review. The medical experts' reports relating to 5 patients including Alice Wilkie, are attached as **Annexe 5.**

CHI Investigation

The full report of the investigation by CHI has been included and is attached at **Annexe 6**. In the Executive summary its key conclusions were set out as follows;

Key conclusions

i) There were insufficient local prescribing guidelines in place, governing the prescription of powerful pain relieving and sedative medicines.

ii) There had been a lack of a rigorous routine review of pharmacy data, which led to high levels of prescribing on wards caring for older people and this wasn't being questioned.

iii) There was an absence of Trust wide supervision and appraisal systems, which meant that poor prescribing practices were not identified.

iv) There was a lack of thorough multidisciplinary total patient assessment to determine care needs on assessment.

CHI also concluded that the trust now has adequate policies and guidelines in place, which are being adhered to in respect of the prescription and administration of pain relieving medicines to older patients.

Summary

The cases are in Part 1 of the agenda for the committee to decide whether or not the case should be further investigated. If so, solicitors can be instructed to review the material with a view to bringing allegations of misconduct against the nurses.
The committee should note that the second complaint concerning Mrs Devine did not form part of the police investigation, and we have not yet received consent from the complainant to obtain the medical and nursing notes.

Account must be taken of the serious shortcomings identified by CHI in relation to the prescribing practice and the care of elderly patients admitted for rehabilitation. These shortcomings were found to be trust-wide as well as involving individual members of staff. CHI has considered current nursing practice and has found that many changes have been effected and that they now have 'no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan Wards.'

Account must also be taken of the view of both medical experts that there was inappropriate combined administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients leading to death. The police concluded that there was no evidence to support any criminal charges.

Meeting of the Preliminary Proceedings Committee
at 23 Portland Place, London, W1N 4JT
on 24 September 2002

Agenda

PART 1 **New cases to decide whether to:**

1 **decline to proceed with the matter**
2 **require further investigation to be conducted**
3 **adjourn consideration of the matter**
4 **refer the matter to the professional screeners**
5 **take the advice of a solicitor**
6 **require a complaint to be verified by a statutory declaration**
7 **issue a Notice of Proceedings**

1 [redacted]

Case Ref [redacted]
PIN [redacted]
RMN (Part 3 of the register)

Summary of allegations: Failure to provide nursing care to patients; failed to administer CPR to patient; left the ward without qualified staff; failed to complete patient notes.

Decision **to issue a Notice of Proceedings after a solicitors investigation**

2a Code A

Case Ref [redacted]
UNIDENTIFIED

Decision **to adjourn consideration of the matter**

2b Code A

Case Ref [redacted]
UNIDENTIFIED

Decision **to adjourn consideration of the matter**

142

2c Code A

Case Ref [redacted]
UNIDENTIFIED

Decision **to adjourn consideration of the matter**

2d Code A

Case Ref [redacted]
UNIDENTIFIED

Decision **to adjourn consideration of the matter**

2e Code A

Case Ref [redacted]
UNIDENTIFIED

Decision **to adjourn consideration of the matter**

3 [redacted]

Case Ref [redacted]
EN(MH) (Part 6 of the register)

Summary of allegations: Administered unprescribed medication to clients, failure to record administration of medication.

Decision **to decline to proceed**

4 [redacted]

PIN [redacted]
EN(M) (Part 4 of the register)

Summary of allegations: Incorrect administration of medication, falsified entry in controlled drug register.

Decision **to decline to proceed**

5 [redacted]

Case Ref: [redacted]
PIN [redacted]
RGN (Part 1 of the register)
RHV (Part 11 of the register)

Summary of allegations: Failure to visit clients; failure to keep adequate records; inappropriately referred client to counselling.

Decision **to issue a Notice of Proceedings**

OPERATION ROCHESTER

Investigation Overview 1998-2006.

Background.

Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed during much of the period under investigation by the Fareham and Gosport Primary Care Trust. The hospital fell under the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002 when services were transferred to the local Primary Care Trust.

The hospital operates on a day-to-day basis by nursing and support staff employed by the PCT. Clinical expertise was provided by way of visiting general practitioners and clinical assistants, consultant cover being provided in the same way.

Elderly patients were generally admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who in 1988 took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000.

Police Investigations.

Operation ROCHESTER was an investigation by Hampshire Police into the deaths of elderly patients at GWMH following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at levels or under circumstances that hastened or caused death. There were

further concerns raised by families of the deceased that the general standard of care afforded to patients was often sub-optimal and potentially negligent.

Most of the allegations involved a particular General Practitioner directly responsible for patient care Doctor Jane BARTON.

Two allegations (SPURGIN and PACKMAN) were pursued in respect of a consultant Dr Richard REID.

Of 945 death certificates issued in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Doctor BARTON.

The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Dr BARTON.

The General Medical Council also heard evidence during Interim Order Committee Hearings to determine whether the registration of Dr BARTON to continue to practice should be withdrawn. On each of the three occasions that the matter was heard the GMC was satisfied that there was no requirement for such an order and Dr BARTON continued to practice under voluntary restrictions in respect of the administration of Opiate drugs.

<u>The First Police Investigation.</u>

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS aged 91 years.

Mrs. Richards died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs. Richards two of her daughters, Mrs. MACKENZIE and Mrs. LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs. MACKENZIE contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

The Reviewing CPS Lawyer determined that on the evidence available he did not consider a criminal prosecution to be justified.

Mrs. MACKENZIE then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs. MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

Hampshire Police commenced a re-investigation into the death of Gladys RICHARDS on Monday 17th April 2000.

Professor Brian LIVESLEY an elected member of the academy of experts provided medical opinion through a report dated 9th November 2000 making the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys RICHARDS in a manner as to cause her death."

- "Mr. Code A were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs. RICHARDS was unlawfully killed."

A meeting took place on 19th June 2001 between senior police officers, the CPS caseworker Paul CLOSE, Treasury Counsel and Professor LIVESLEY.

Treasury Counsel took the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs. RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

Professor LIVESLEY provided a second report dated 10th July, 2001 where he essentially underpinned his earlier findings commenting:-

- "It is my opinion that as a result of being given these drugs Mrs RICHARDS death occurred earlier than it would have done from natural causes."

In August 2001 the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH as a result four more cases were randomly selected for review.

Expert opinions were sought of a further two medical professors FORD and MUNDY who were each provided with copies of the medical records of the four cases in addition to the medical records of Gladys RICHARDS.

The reports from Professor FORD and Professor MUNDY were reviewed by the Police and a decision was taken not to forward them to the CPS as they were all of a similar nature to

the RICHARDS case and would therefore attract a similar response as the earlier advice from counsel. A decision was then made by the Police that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October 2001 the Commission for Health Improvement (CHI) launched an investigation into the management provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible at GWMH interviewing 59 staff in the process.

A report of the CHI investigation findings was published in May 2002 concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality patient care.

The CHI further reported that the Trust post investigation had adequate policies and guidelines in place that were being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer Sir Liam DONALDSON commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Professor BAKER. Immediately following the meeting nurse Anita TUBBRITT (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

The documents were copies of memos letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including :-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol).
- Particular concerns regarding the conduct of Dr BARTON in respect of prescription and administration of Diamorphine.

Nurse TUBRITT'S disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19th September 2002 the following decisions being made:-

- Examine the new documentation and investigate the events of 1991.
- Review existing evidence and new material in order to identify any additional viable lines of enquiry.
- Submit the new material to experts and subsequently to CPS.
- Examine individual and corporate liability.

A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

On 23rd September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients that had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns (including the five original cases)

In addition Professor Richard BAKER during his statistical review of mortality rates at GWMH identified 16 cases which were of concern to him in respect of pain management.

14 further cases were raised for investigation through ongoing complaints by family members between 2002 and 2006.

A total of 92 cases were investigated by police during the third phase of the investigation.

A team of medical experts (key clinical team) were appointed to review the 92 cases completing this work between September 2003 and August 2006.

The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

The terms of reference for the team were to examine patient notes initially independently and to assess the quality of care provided to each patient according to the expert's professional discipline.

The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1- Optimal care.
Category 2- Sub optimal care.
Category 3- Negligent care.

The cases were screened in batches of twenty then following this process the experts met to discuss findings and reach a consensus score.

Each expert was briefed regarding the requirement to retain and preserve their notations and findings for possible disclosure to interested parties.

All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN to further inform the police decision that there was no basis for further criminal investigation.

Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly were referred to the General Medical Council and Nursing and Midwifery Council for their information and attention.

Fourteen Category 3 cases were therefore referred for further investigation by police. Of the fourteen cases, four presented as matters that although potentially negligent in terms of standard of care were cases where the cause of death was assessed as entirely natural. Under these circumstances the essential element of causation could never be proven to sustain a criminal prosecution for homicide.

Notwithstanding that the four cases could not be prosecuted through the criminal court they were reviewed from an evidential perspective by an expert consultant Geriatrician Dr David BLACK who confirmed that the patients were in terminal end stage of life and that in his opinion death was through natural causes.

Accordingly the four cases ...Were released from police investigation in June 2006:-

- Clifford HOUGHTON.
- Thomas JARMAN.
- Edwin CARTER.
- Norma WINDSOR

The final ten cases were subjected to full criminal investigation upon the basis that they had been assessed by the key clinical team as cases of 'negligent care that is to day outside the bounds of acceptable clinical practice, and cause of death unclear.'

The investigation parameters included taking statements from all relevant healthcare staff involved in care of the patient, of family members and the commissioning of medical experts to provide opinion in terms of causation and standard of care.

The expert witnesses, principally Dr Andrew WILCOCK (Palliative care) and Dr David BLACK (Geriatrics) were provided guidance from the Crown Prosecution Service to ensure that their statements addressed the relevant legal issues in terms of potential homicide.

The experts completed their statements following review of medical records, all witness statements and transcripts of interviews of Dr Reid and Dr Barton the

healthcare professionals in jeopardy. They were also provided with the relevant documents required to put the circumstances of care into 'time context' The reviews were conducted by the experts independently.

Supplementary expert medical evidence was obtained to clarify particular medical conditions beyond the immediate sphere of knowledge of Dr's BLACK and WILCOCK.

A common denominator in respect of the ten cases was that the attending clinical assistant was Dr Jane BARTON who was responsible for the initial and continuing care of the patients including the prescription and administration of opiate and other drugs via syringe driver.

Dr BARTON was interviewed under caution in respect of the allegations.

The interviews were conducted in two phases. The initial phase was designed to obtain an account from Dr BARTON in respect of care delivered to individual patients. Dr BARTON responded during these interviews through provision of prepared statements and exercising her right of silence in respect of questions asked.

During the second interview challenge phase (following provision of expert witness reports to the investigation team) Dr BARTON exercised her right of silence refusing to answer any questions.

Consultant Dr Richard REID was interviewed in respect of 2 cases (PACKMAN and SPURGIN) following concerns raised by expert witnesses. Dr REID answered all questions put.

Full files of evidence were incrementally submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.

- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

Additional evidence was forwarded to the CPS through the compilation of generic healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

The ten category three cases were:-

1. Elsie DEVINE 88yrs. Admitted to GWMH hospital 21st October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died 21st November 1999, 32 days after admission cause of death recorded as bronchopnuemonia and glomerulonephritis.

2. Elsie LAVENDER 83yrs. Admitted to GWMH 22nd February 1996 with head injury brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Died 6th March 1996, 14 days after admission cause of death recorded as cerebrovascular accident.

3. Sheila GREGORY 91yrs. Admitted to GWMH 3rd September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died 22nd November 1999, 81 days after admission cause of death bronchopnuemonia.

4. Robert WILSON. 74 yrs. Admitted to GWMH 14th October 1998 with fractured left humerus and alcoholic hepatitis. Died 18th October 1998 4 days after admission cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Enid SPURGIN 92 yrs. Admitted to GWMH 26th March 1999 with a fractured neck of the femur. Died 13th April 1999 18 days after admission cause of death recorded as cerebrovascular accident.

6. Ruby LAKE 84 yrs. Admitted to GWMH 18th August 1998 with a fractured neck of the femur, diarrhea atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Died 21st August 1998 3 days after admission cause of death recorded as bronchopneumonia.

Code A

8. Helena SERVICE 99 yrs. Admitted to GWMH 3rd June 1997 with many medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died 5th June 1997 2 days after admission cause of death recorded as congestive cardiac failure.

9. Geoffrey PACKMAN 66yrs. Admitted to GWMH 23rd August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died 3rd September 1999 13 days after admission cause of death recorded as myocardial infarction.

10. Arthur CUNNINGHAM 79 yrs. Admitted to GWMH 21st September 1998 with Parkinson's disease and dementia. Died 26th September 1998 5 days after admission cause of death recorded as bronchopneumonia.

Dr David WILCOCK provided extensive evidence in respect of patient care concluding with particular themes 'of concern' in respect of the final 10 category ten cases including:-

- *'Failure to keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues Including:-*

  Enid Spurgin – orthopaedic surgeon, microbiologist

  Geoffrey Packman – general physician, gastroenterologist

  Helena Service – general physician, cardiologist

  Elsie Lavender – haematologist

  Sheila Gregory – psychogeriatrician

  Code A

  Arthur Cunningham – palliative care physician.

Many of the concerns raised by Dr WILCOCK were reflected by expert Geriatrician Dr David BLACK and other experts commissioned, the full details being contained within their reports.

There was however little consensus between the two principal experts Drs BLACK and WILCOCK as to whether the category 3 patients were in irreversible end stage terminal decline, and little consensus as to whether negligence more than minimally contributed towards the patient death.

As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that Doctors were negligent to criminal standard.

Whilst the medical evidence obtained by police was detailed and complex it did not prove that drugs contributed substantially towards death.

Even if causation could be proved there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of conviction.

Family group members of the deceased and stakeholders were informed of the decision in December 2006 and the police investigation other than referral of case papers to interested parties and general administration was closed.

David WILLIAMS.
Detective Superintendent 7227
Senior Investigating Officer.
16th January 2007.

GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Wednesday 15 April 2009

The Guildhall,
Guildhall Square,
Portsmouth,
PO1 2AJ

BEFORE:

Mr Anthony Bradley
Coroner for North Hampshire
Assistant Deputy Coroner for South East Hampshire

In the matter of Mr Leslie Pittock & 9 Ors

(DAY EIGHTEEN)

MR ALAN JENKINS QC, instructed by **, appeared on behalf of Dr Jane Barton.
MR JAMES TOWNSEND, Counsel, instructed by the Royal College of Nursing, appeared on behalf of a number of nurse witnesses.
MS BRIONY BALLARD, Counsel, instructed by **, appeared on behalf of the acute trust and the PCT.
MR TOM LEIPER, Counsel, instructed by Messrs Blake Lapthorn, Solicitors, appeared on behalf of the families of Brian Cunningham, Michael Packman, Elsie Devine and Sheila Gregory.
MR PATRICK SADD, Counsel, (instructed from 23/03/09) appeared on behalf of the Wilson family.

(Transcript of the Official Recording by T A Reed & Co Ltd
13 The Lynch, Hoddesdon, Herts, EN11 8EU
Tel No: 01992 465900)

INDEX

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(In the absence of the jury)

THE CORONER: Right, we are making progress. Anything anyone wants to say to me? (Nothing indicated) We will have the jury in, please.

Does anyone have any representations on cause of death? I was proposing to take the jury through anyway.

(The jury returned to the hearing room)

Ladies and gentlemen, good morning. Welcome back. I hope you enjoyed the break; now you have some hard work to do. The procedure I will take today is that I will explain one or two bits and pieces to you. What will then happen is that I will take you to one or two specific directions and then add some of the evidence, of which there is plenty. I propose doing that as per deceased, so each deceased will have a section of evidence, so hopefully you will be able to put that into some kind of working order.

You will have your notes of evidence; you will have things that you think are relevant. The important thing is that the next couple of days are about you. You are the fact finders; you are the people who will make the decisions here. I can guide you; I can give you what support you need. If during the course of your deliberations there is anything you are not clear about and you want to ask any questions that will be done in here, in open court. OK? All documentation will be available to you, so all the hospital records, anything that you want to look at, the drug history – and that is available to you when you retire.

There is there a pack of 20th century – I hope it will be 21st very soon – that contains the inquisitions. It also contains attached to each inquisition a questionnaire that comprises three questions. The format of the inquisition is different from the one I gave you. The format there is far more straightforward. Do look at it; it is there for you. The questions are reduced in the light of the legal arguments we have had and the discussions that we have had. In each case you will be asked those three questions, and it is a question of replying to those, and they are yes/no points; but they are crucial.

The first matter I have to deal with this morning is cause of death, and if you look on the back of the bundle – the most difficult job you may have for the next couple of days is reading my handwriting, but I was defeated by the machinery this morning, so it is handwritten. You will see that I have taken the deceased in chronological order of the dates on which they died, and the first one is Mr Pittock. What you have – you are looking slightly lost. It is something that looks like that. (Indicating) It is on the back; that is it. We have various opinions as to cause of death, and for Mr Pittock, as certified through the registry, and as the doctor certified, was 1(a) bronchial pneumonia. Professor Black actually took a differing view, and said, 1(a) sepsis, 1(b) chest infection, 1(c) drug-induced Parkinsonism, and 2, severe depression. Dr Wilcock gave us 1(a) bronchial pneumonia. It seems sensible that you look at bronchial pneumonia, but again that is a matter for you. You may wish to note the list as you go through.

Death certification is not a precise science. The way that it is put together is: is it more likely than not? What is the likely pathology that has led to a terminal event? In this case of Mr Pittock it is almost certainly bronchial pneumonia. Professor Black gives chest infection

and sepsis; it is not far off the mark, so I am quite happy with that.
For Elsie Lavender: 1(a) cerebral vascular accident. For Professor Black he gives high cervical cord injury, and Dr Wilcock gives sepsis. Difficult, that one. The approach that a coroner will take is the most likely cause of death on the background that we have. I have to say that I found Professor Black quite compelling, the way that he put his argument together for all four quarters being effectively paralysed, being symptomatic of a neck injury, the kind of effect you get from a neck injury. Dr Wilcock on the other hand was sepsis; it is an informed guess, and you will need to take a view. The cerebral vascular accident is as likely; that was diagnosed in life, and that is something that you may wish to take note of. The argument against that, that Professor Black gave, was that the paralysis that you would expect, the droop that you would expect, would be one-sided, and what he saw was a complete effective paralysis. But that was diagnosed in life, so that might be quite compelling, and you may prefer that, because somebody actually saw him in life. Professor Black did not; Professor Wilcock did not.

Helena Service: 1(a), congestive cardiac failure. Professor Black gives congestive cardiac failure, ischaemic heart disease, and there is a 2, cerebral vascular disease. Let me explain perhaps the significance of the 1 and 2. The 1 is the part that immediately gives rise to death; it is the triggering event, it is the terminal event. The 2 is an underlying condition that I should have regard to when I certify death. So when you look at Professor Black saying congestive cardiac failure and ischaemic heart disease as a 1(a) and 1(b), and then 2, cerebral vascular disease, that would have affected the situation but it is not the immediate precipitating event. Dr Wilcock gives congestive cardiac failure. Yes, let us go with congestive cardiac failure; I do not think there is any doubt about that; everybody is agreed.

Ruby Lake: 1(a) bronchial pneumonia. Professor Black, myocardial infarction, ischaemic heart disease, and 2, the fractured neck of femur repaired 5.9.98; and Dr Wilcock, 1(a) bronchial pneumonia. Quite difficult, because Professor Black draws away from bronchial pneumonia. I do not think I would have any difficulty with that, but what I would like to see as a coroner is the 1(a) bronchial pneumonia and 2, fractured neck of femur repaired 5.9.98, because I think that is significant for the immobility that then gives rise to the bronchial pneumonia. So I think probably you are looking at 1(a) bronchial pneumonia, and 2, fractured neck of femur.

Cunningham: 1(a) bronchial pneumonia and 2, Parkinson's Disease and sacral ulcer; that is what was certified. Professor Black gives us sepsis, 1(b) end stage Parkinson's disease, and 2, myelodysplasia and diabetes mellitus. Dr Wilcock gives is 1(a) bronchial pneumonia, 2 sacral ulcer and Parkinson's disease. I think I would go with that; I think the two rank – part 2 of the death certification, rank equally, so it is not a 1(a) and 1(b) or 2(a) and 2(b); so I do not think there is any problem with the 1(a) bronchial pneumonia and 2, sacral ulcer and Parkinson's disease.

Mr Wilson: congestive cardiac failure and renal failure were what was certified. Professor Black gave us alcoholic liver disease, and Dr Wilcock gave congestive cardiac failure, and 2, alcoholic cirrhosis. Quite difficult, and I thought quite long and hard about that, and I think you are certainly looking at a congestive cardiac failure as a mode of death, cause of death, but I think you have to reflect the alcoholic liver disease at some point. I would bring it in as a 2, either as alcoholic liver disease or alcoholic cirrhosis – and my spelling of 'cirrhosis' is correct.

Enid Spurgeon: you have 1(a), cerebral vascular accident as certified; Professor Black comes infected wound, 1(b) fractured right hip, repaired 20.3.99, similarly Professor Wilcock comes with that; and that I think is exactly right; it is the infected wound that has caused the death. There may well have been some brain event, but I do not think it is significant in looking at the actual cause of death.

Packman: 1(a), myocardial infarction. Professor Black gives gastrointestinal haemorrhage, with 2, pressure sores and morbid obesity. Dr Wilcock, gastrointestinal haemorrhage. I do not think there is any doubt about that. The point that I put to Dr Barton was that the continuation of the stools would be an indicator that that bleed was going on. She took the view that it was probably still passing through the system, and that it was not continuing. I think from the expert evidence we have that that is not right; I think the bleed has continued, and I think that is where we are on the cause of death, and I would look at that as a gastrointestinal bleed.

Elsie Devine: you have 1(a), chronic renal failure, and 1(b), glomerular nephritis. Professor Black gives us the acute on chronic nephritis, and the IgA proteinemia. I think that is going to be a question really of looking at the renal failure; I do not think there is any doubt about that. Dr Wilcock was quite clear on the amyloidosis and the IgA. I think that is going to be a question for you on the evidence that you have read, and how you interpret that. But certainly Dr Wilcock, I would not have any disagreement with as giving causes of death, and I think those hang together quite easily.

Anne Gregory: 1(a), bronchial pneumonia. Professor Black gives pulmonary embolus, cardiac failure, fractured neck of femur. Dr Wilcock gives pulmonary embolus or bronchial pneumonia; he could not make his mind up either. So I think you would be quite safe to look at either of those – bronchial pneumonia or the PE – pulmonary embolus. As a precipitating event it may well be that you would look at the pulmonary embolus, but this is all after the event; it is very difficult to piece it together. If in doubt you can leave it all where it is; you can leave the deaths as certified, if you are content that that reflects the situation, but it is a question of fact on the evidence that you have heard. In fact, any findings that you have have to be on the evidence.

As you go through each deceased – and I will ask you to deal with the deceased individually – but you will take all ten with you when you go, because how you deal with one may reflect on how you deal with another. But there are ten inquests, you have ten inquisitions, and each one needs to be assessed on the evidence.

Let me remind you that this is not a trial of anybody, least of all Dr Barton. It is an inquisition; it is ascertaining how the deaths came about. You cannot in any way deal with liability; the questions have been phrased for you particularly to avoid dealing with liability, and you may query why they appear as they appear; but let me tell you we thought long and hard about it, and that is how they are, and that is the job.

The verdict – you will see boxes 3 and 4 on the inquisitions, says "See attached". Do not complete boxes 3 and 4, just complete the questions on the back of the inquisitions.

The basis on which you will complete those is: is it more likely than not? It is the balance of

probabilities. Lawyers know what it means; nobody else ever understands it; but we throw the words out and people say "Oh, really!" But is it more likely than not that that was the position? Those three questions should be amenable to that test.

The documents, as I say, will be available to you when you retire. I think the first thing you need to do is to appoint a foreman when you retire, and you need to look at these systematically. As I say, I have dealt with them throughout with the chronological date of death, and if you look at each one, assess it, then move on to the next one, assess it, move on to the next one, and try not to cross over, because the minute you cross over you become very confused. Take it from me – I have been at this for a very long time and I can get confused with this very, very easily. That is really for you to decide your proceedings once you retire, but it really is just a hint to say do it systematically. When you have got through all ten then you can go through them again, if there is anything you are not clear about, anything you do not agree about; but I anticipate that you should be able to agree because the matters are fairly straightforward, although bulky.

The weight of evidence is something that you need to consider, and I addressed this with Sister Hamblin, that you have had an awful lot of written statements read to you. Sister Hamblin wanted to be here but cannot be here. The evidence that she gave in her written statements may have been contentious in parts. In assessing the weight of evidence, let me repeat to you that the evidence that you have been able to test, or that has been tested here – and you have listened to people being examined, being questioned, you have seen them, you have – another lawyers' speak – observed the demeanour of the witness, and you think "It's honest, it's clear". On paper that does not come across quite so easily, does it? So you really do need to look at interpretation if there is a conflict of evidence, and you have a witness in the witness box having taken the oath, as against rule 37, where the balance may be slightly weighed in favour of the witness.

The final caveat I will give you before I get into the massive job of summing up the evidence is the experts. You have had Dr Dudley, you have had Professor Black, you have had Dr Wilcock, Dr Petch – they will all be referred to. Bear in mind that none of them saw the deceased. The live witnesses, the doctors that you have had, and the nurses, actually were nursing or treating the deceased. They had live patients in front of them; they were making the assessments. What you have with the experts is that that has almost become squeaky clean, has it not? Everything is definite, and it is all so clear, whereas you have not actually got somebody in front of you that is fading in front of your very eyes. You need to bear in mind particularly the way in which the evidence was given and the approach that the witnesses took. It was very matter of fact, it was not glorified, it was not in any way made into something it was not. That is what they did. That is what the hospital was about; that is what happened.

So some ten years after the event it is still quite clear; there is no side to it, there is no massive presentation. So think about that when you are looking at the evidence, because we are looking at 1996 to 1999.

Right, here we go!

Leslie Pittock: The first thing you had on him was Linda Wiles. Her statement was read to you. He suffered from severe depression all his life, he had various admissions to hospital,

Elsie Devine: born Code A died 21 November 1999. You remember Ann Reeves gave evidence. Her mother was generally in good health, although she did damage her knee and that caused ongoing problems. She was also deaf – and that is significant – having 30 per cent hearing in one ear and almost completely deaf in the other. Notwithstanding that she was extremely independent, much loved. She had had two burglaries, which seemed to have affected her, at a time when her daughter was working abroad. Her mother rode a bicycle up to 1986, at which stage she had to stop; she either walked or used public transport. She suffered water retention for many years, had suffered from swelling ankles.

There was some question of diagnosis of multiple myeloma, although this was never concerned. That is a nice red herring. However, she was referred to Dr Stephens at the renal clinic and there was an ongoing problem with kidney function. There comes a point at which Mrs Reeves is due to go on holiday, at which point her brother is supposed to be looking after Mrs Devine. That arrangement falls apart, and on 9 October after a family dispute directly involving Mrs Devine biscuits are found all over the floor at home, and cups and saucers laid out for tea, and Mrs Devine seems to have difficulty passing water. Her behaviour is abnormal and Mrs Reeves is concerned about her mother.

It is agreed that she should have a spell at QA, and on looking into continuing care concern was expressed because of Mrs Devine's nocturnal activities and restlessness. A bed was found for her at St Christopher's but that was unacceptable; the family did not want her to be there.

On 21 October 1999 Mrs Devine is discharged from QA and sent to Dryad Ward at Gosport. On 22 October she is reported as being "fine", although there were some disagreements with staff about ward discipline. On 28 October Mrs Reeves sees her mother, and while she has some observations about her care, she is not at that stage critical. It seems there was some concern about her having to leave the ward because her mother was going to have tea, and she did not like the treatment she received from the ward staff – so a bit of conflict there.

On 4 November Mrs Devine is reported as being well, although tearful; and on the 11th Mrs Reeves visits and finds that her mother's clothes are folded and stacked, and is told that this is a regular occurrence. Her mother is apparently in the bath and comes after the event fully dressed but with no stockings or slippers on, and with wet hair. At that stage Mrs Reeves is concerned that her mother is not getting the care that she would want her to have, and as a result of ward discipline she was not having quality time with her mother. So it is not fitting in.

On 19 November the family are given the news that Mrs Devine is in kidney failure and is not expected to survive. They drive down to Gosport from Hammersmith where Mr Reeves has been undergoing the treatment for bone marrow transplant. On the same day Dr Barton sees them and indicates that she has come in especially to see them. At this point it is said that Dr Barton says she has multiple myeloma. In her evidence Dr Barton had no explanation for that and, in fairness, no memory of it. At 8 p.m. that evening the family are asked to leave by the nursing staff and there is some comment made about switching the television off, when Mrs Devine would have preferred it to be left on. The family intended staying the night but that was not realistic, and accordingly they returned to Mrs Devine on Saturday 20 November. It is at that stage she is noted to have stopped breathing for protracted periods, then suddenly take a sharp, deep breath. Mr Leiper suggested that is as a result of opiate overdose.

Nursing staff expressed to the family that Mrs Devine is dying, and will they see Pastor Mary. The family decide that they have to go back to London on 21 November, and receive a call from Gosport at about 8.30 to say that Mrs Devine has died.

The statement of Gillian Hamblin was read. She refers to the ward round by Dr Reid and the referral to Dr Lusznat, who is the psychiatrist, and to the fact that Dr Reid prescribes thioridazine, which is a sedative. On 19 November, marked deterioration in the aggressive episode that she has described, as a result of which she is administered chlorpromazine, and she is then given a syringe driver containing diamorphine 40 mg, midazolam 40 mg, and it is at this stage that the fentanyl patch that she had been given earlier was removed. In fact, it is not; it is some three and a half hours later that the fentanyl patch comes off.

Mrs Devine's kidneys are failing, as evidenced by the recent blood test. Sister Hamblin goes on to say "Don't use fentanyl patch and diamorphine together", and it was Dr Barton's concern not to cause withdrawal, so the fentanyl patch is left in position for some three hours after the diamorphine is started. It is then noted on 20 November that Mrs Devine's condition remains poor. Consideration was being given to transferring Mrs Devine, but it was felt not to be appropriate.

Dr Reid gave evidence. He saw Mrs Devine on three occasions, the first being 25 October 1999. He notes during his ward round that she "washes with supervision, dresses herself, is continent, mildly confused, blood pressure 110/70, normochromic renal failure, was living with her daughter and son-in-law, believes son-in-law awaiting bone marrow transplant. Need to find out more regarding son-in-law", et cetera. He does not know if Dr Barton was present during his ward round. On 1 September he sees her again during the ward round and notes that she is physically independent but needs supervision with washing, dressing, bathing. She is continent, quite confused and disorientated. For example, undresses during the day. Is unlikely to get much social support at home, therefore try home visit to see if functions better in own home". That is something referred to in subsequent evidence: that if she is disoriented, it may be better to put her into her home environment, and that may orientate her.

MR LEIPER:(?) Apologies, sir, it was 1 September, not 1 November.

THE CORONER: Yes, it was indeed. I am sorry.

The third consultation is 15 November, and she notes:

> "Very aggressive at times, very restless. Needed thioridazine. On treatment for urinary tract infection, mid-stream specimen sent because blood and protein in urine.
>
> On examination, pulse rate 100, regular temperature, jugular venous pulse not seen. Hepato-jugular reflux negative. Oedema(?) gross extending to thighs, heart sounds nil, added chest clear, bowels regular. Rectal examination 13.11.99 revealed rectum empty but good bowel action since asked Dr Lusznat to see".

Clear evidence she is aggressive and restless, and this is the result of the instruction to see Dr Lusznat that Dr Barton puts the entry in "Dear Rosie", and the instruction.

A significant part of Dr Reid's statement was that he did not see Elsie Devine on 22 November because she died on the 21st, and that was the next day. He says that he would have asked about her because the turnover of patients on Dryad Ward was relatively low, and he would have expected to see her the following week after his ward round.

Anita Turbritt gave evidence – senior staff nurse at Gosport. She notes there were six entries relating to diamorphine administered to Mrs Devine on 19, 20 and 21 November. Describes a prescription of 40-80 mg subcutaneously over the 24 – is it 40 *and*---

MR LEIPER: It is 40 on the 19th, on the 20th and on the 21st, and that is diamorphine and midazolam.

THE CORONER: Thank you.

She also deals with the formalities of administering controlled drugs, and procedures for disposing of those that are surplus to requirements.

Lynne Barrett gave evidence. She was involved with Elsie Devine. Noted that on 21 October she was admitted in the afternoon to QA.

> "Increasing confusion and aggression. Aggression now resolved. Still seems confused at times. Needs minimal assessment with activities of daily living, assistance. Pleasant lady. Her appetite on the whole is not good, and can be a little unsteady on her feet. Quite cold on admission, and both feet swollen. Seen by Dr Barton, see treatment chart for drug regime."

She actually recalls Mrs Devine as being a fairly small lady who would rummage around in other people's lockers, taking sweets, biscuits, et cetera. It is she who recounts the events one morning outside the main day room when she is holding Debbie Barker by both wrists, trying to push her against a rail attached to the wall. She pushes her up against a door frame but then hits Lynne Barrett around the face, knocking her glasses off. She was beyond reason and shouting loudly, and this went on for half to three-quarters of an hour. So a fairly major incident, and she remembers it. Dr Barton arrives and prescribes a sedative for Elsie, but not before she kicks Lynne Barrett's legs and produces nail marks on her right arm. Lynne Barrett gives her the injection, at which point she is still shouting. After that Liz Bell and Debbie Barker sit with her for most of the morning until she calms down; and you will remember Dr Wilcock took the view that that was a fairly serious situation; it was nursing two to one – to special her.

It was pointed out to Mrs Barrett that Mrs Devine was almost completely deaf, but Mrs Barrett did not remember that. She did say that it was very rare to use a syringe driver if the patient was able to swallow; however, if the only way they could get medication into a patient was by syringe driver, then that is what would be used. She was quite clear that she would have questioned a starting dose of 125 mg of morphine, but she does not remember thinking anything was abnormal with Mrs Devine.

It was accepted that the nomenclature, if the patient was "terminally ill" one would use the expression "poorly condition" not "condition poor". Latterly Elsie was immobile, not eating

A or drinking, and had no verbal communication. She acknowledged that there was some pressure on hospital beds, particularly from QA, and I think it was Mrs Barrett, was it not, who said it was not so bad at Haslar, but QA was really the one that was feeling the pressure. They did have patients that they could move on, but mostly they were long-term patients. Any change in condition would be reported to Dr Barton and recorded in the notes.

B She never had any concerns about patients because of overdose of medication. Had she had those concerns then she would have voiced them or noted them. She remembered clearly the events of 19 November when Mrs Devine was assaulting the nurse on the ward. It was certainly a situation which was out of the norm. She would have recorded it and should have made a note in the incident book. She remembers clearly that Mrs Devine kicked her and left nail marks on her arm. Staff would have been aware of medication from the previous 24 hours, the fact that she had had a fentanyl patch, although she did not remember specifically what that was – does not remember the actual mechanics of it.

C She was not concerned about analgesia; that did not cause her concern. Confirmed in response to Mr Jenkins that the syringe driver was written up on 19 November, then a marked deterioration although she continued to be aggressive.

D Dr Barton gave her evidence, and she confirmed that Elsie Devine was 88, transferred from QA on 21 October, had been transferred with a series of diagnoses, goes straight to the multiple myeloma. Chronic renal failure, secondary nephrotic syndrome, vascular dementia. She is seen by a consultant renal physician, Dr Stephens, who said that it was likely to be a long-standing glomerular nephritis. She had been admitted to QA on 9 October 1999 with confusion, aggression, and wondering "possibly caused by UTI". She did respond well to the treatment, although her behaviour remained aggressive. She is referred to Dr Lusznat on 13 October, who suggests that she is referred to social services for placement in residential

E care, somewhere experienced in dealing with confused patients. She diagnoses severe dementia.

F Because of the family problems Elsie was then transferred to Dryad at Gosport on 21 October 1999, and Dr Barton clerks her in. She notes her as being "acutely confused, with previous medical history of dementia, myeloma, hyperthyroidism, barthel score of one, so far continent". Needs help with daily living, with a barthel of eight. Care plan is to get to know her, to assess her rehabilitation potential, and that she will probably be for rest home in due course. Although she does not recall it, Dr Barton would have seen Mrs Devine each morning, but she does not make any specific entry because there is nothing of note. There seems to have been an initial improvement. Dr Barton confirms the ward round details given by Dr Reid on 25 October. Her condition generally improves, although her creatinine level, whilst reduced, is still considerably raised at 172.

G Dr Barton notes the first biochemical indicator of deterioration is on 9 November when the creatinine level is 200. Evidence of confusion, and she is found wondering around the ward and refusing night sedation. She is started on thioridazine on 11 November, which is an antibiotic used in UTI.

H A SPEAKER: Thioridazine is a tranquiliser, different from trimethoprim; trimethoprim is the antibiotic.

THE CORONER: Trimethoprim. Thank you; my mistake. Deterioration in her behaviour is noted in Dr Reid's notes and gives rise to further consultation with Dr Lusznat and Dr Farr, who confirms her letter to Dr Lusznat:

> "Dear Rosie
>
> Thank you so much for seeing Elsie. I gather she is well known to you. Her confusional state has increased in the past few days to the point where we are using trimethoprim. Her renal function is down, her mid-stream urine showed no growth. Can you help? Many thanks."

The report she gets back is:

> "Thank you.
>
> This lady has deteriorated and has become more restless and aggressive again. She is confusing medication and not coping well. She does not seem to be depressed and her physical condition is stable. I will arrange for her to go on the waiting list for Mulberry Ward."

That is the reference to Mulberry Ward, although she never got there.

Blood tests produced on 18 November show a creatinine level of 360, and Dr Barton considers that at that point transfer would not be appropriate, even if a bed had become available, and her medical condition was deteriorating significantly accompanied by marked restlessness and agitation. It is at that point that she decides to commence fentanyl 25 mg, the lowest level of patch available. I do not know that we ever got to the bottom of that, either.

MS BALLARD: (?) Sorry, sir, I do not mean to correct you, but you said that is why she commenced the fentanyl patch, but in fact these blood test results were not available that morning, so it is not possible that that is the reason why.

THE CORONER: No – no. It is at that point she decides to commence fentanyl 25 mg, not on the basis of the blood test; it is at that point that she decides – makes that decision.

MS BALLARD: Well ---

THE CORONER: I am not having a conversation with you. It is at that point that she makes a decision; not consequent on the blood test results.

MS BALLARD: Sorry; the way you read it implied that.

THE CORONER: That is when she makes the decision.

Dr Barton is quite clear that it was an attempt to calm her down, make her more comfortable, and to enable nursing care. She was not eating and drinking well, she did not feel that Elsie was responding to a subcutaneous infusion, driver, she would simply remove it. You may be as confused as I am about the fentanyl patch, but that is what it is, and it is put on there, and you then have the subsequent events.

A

She revisits the events of 19 November, the aggression, and that Elsie is administered 50 mg of chlorpromazine. After the administration of that it is decided to remove the fentanyl patch, although it was acknowledged that there would be some time to take effect. Dr Barton acknowledged that she would have been on a high dose of opiates for a comparatively short period, but it was a case of patient management. She asked for a meeting with Mr Devine to discuss the deterioration; she says that she told Mr Devine that his mother was terminally ill.

B

It was quite clear that Mr Devine said that he would tell his sister, so that she was aware of the situation. Again, a communication problem within the family.

Dr Barton makes a note later that day:

> "Marked deterioration overnight. Confused, aggressive, creatinine 360, fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs subcutaneous analgesia and midazolam. Son seen and aware of diagnosis. Please make comfortable. I am happy for nursing staff to confirm death."

C

Notwithstanding that conversation with Mr Devine Dr Barton was asked to return to the hospital later that day to discuss with the family the prognosis and Mrs Devine's situation.

D

On the following day Mrs Devine's condition noted as: "Remaining poor". She continues to deteriorate, and dies peacefully on 21 November at 20.30. Dr Barton prepared the death certificate recording renal failure, which was not accepted by the registrar, as I confirmed with Dr Barton, and the kidney condition was therefore added.

Dr Barton was examined at length by Mr Leiper but was quite clear that the fentanyl patch was appropriately applied and that she was fully aware of the side effects, of the requirements

E

for contraindications. However, she was also aware that these were guidelines, and that she had to dispense for her patient, or prescribe for her patient, as she found her. She acknowledged in her evidence that she had given it outside the product licence; but you will recall that the product licence is for the producer and not for the consumer or the doctor prescribing. But it must operate as a guideline.

F

She acknowledged that there had been concerns in 1991, and meetings with night staff to discuss the use of opiates in terminal care and palliative care. She said on 19 November Elsie was in need of palliative care, she would not have transferred her to an elderly mental unit, she was likely to die from her renal function and dementia. She acknowledged that trimethoprim can itself cause a rise in creatinine levels, and whilst the drug itself may have caused the rise in creatinine, there was no doubt that the level was causing concerns of itself. In fact I think Dr Wilcock goes on and deals with that. She was quite clear that the rising level was a result of a failing renal function.

G

The question of raised creatinine levels at QA was put to her, but she said she was not aware of the levels at QA; and whilst they may have been in the notes, she was not aware of that. However, by 16 September a level of 360, and that was clearly very significant. Is it September?

H

MR LEIPER: Sir, the position is it should be November, and she got the results at lunchtime on 18 November.

THE CORONER: Thank you.

By 16 November the level is 360, the results coming through on the 18th. It was clearly very significant. She was also quite convinced that trimethoprim was the best antimicrobial that was available for Elsie. She said that Elsie was increasingly difficult to manage and that her physical and mental conditions were both unstable. Her condition was controlled and managed.

Dr Barton explained that she had discussed Elsie's condition with the family, and in particular that she had spoken to Mr Devine. Any reference to not discussing specifics with him was because creatinine levels would not have meant anything to him, and he was not medical. I think that is the reference to why he was not spoken to.

Elsie had been admitted for continuing care and Dr Barton was quite clear that it was not for respite care. In talking to Mrs Reeves she said that Elsie Devine had multiple myeloma, but that was only from the discharge notes from QA. She has no idea why she mentioned that. She did not refer Elsie back to Dr Stephens; there was no point in such referral; there was nothing Dr Stephens could do; the best they could obtain was being aware of Elsie's condition. She took the view that Elsie was in need of palliative care, for which purpose opioids are best. She was agitated and distressed, and the nurses could not manage her. That agitation and distress would be a condition that needed to be treated. She tried that with the fentanyl patch, and that did not deal with the problem. Whilst there was no evidence of physical pain, there was clearly mental pain by way of agitation, fear, aggression, and all the matters that she was demonstrating. Dr Barton was quite clear that the fentanyl patch would not have caused her to kick off.

It was put to Dr Barton that Mrs Devine had started on four times the starting dose for diamorphine, but her concerns were the delivery of the drug and the dosage then required. So far as the chlorpromazine was concerned, she admitted half the recommended dose for an adult, and again there was a slight difficulty with that.

She acknowledged that Professor Black had said 20 mg of midazolam was appropriate as a starting dose, and that she had started on 40, but she felt that it was appropriate for her to do that. There was a risk that Mrs Devine may not survive that dosage that she was given; but in response to Mr Jenkins Dr Barton confirmed that the aggressive behaviour on 19 November was as a result of Elsie's medical condition and not the patch. She had a history of aggression and it was well documented. You may recall there was a report from Dr Dudley. In his statement he said that Elsie Devine was dying from amyloidosis, renal failure and dementia. He said that the death was inevitable and that she was in a confusional state, and Dr Barton agreed with that. But there was the caveat in Dr Dudley's report that the assessment was for patients coming off dialysis; that is his reference in that report.

Professor Black said it was one of the most complex and challenging conditions. Dr Barton said it was quite clear that Elsie Devine was out of distress for the last 58 hours of her life, and in response to a question from you, Dr Barton confirmed that the conditional medication, i.e. the opiates, would not have caused the patient to be agitated, and she had never seen that. I think there was an acknowledgement that it could be true, but she looked upon it as a theoretical argument, was how I think she put it. The fentanyl patches are used occasionally

A but were not her drug of choice, and the syringe driver gave better control.

Professor Black gave evidence that the drug management at Gosport was sub-optimal. The prescription of fentanyl in the notes is not explained, and there is a three-hour overlap between the prescription for the subcutaneous diamorphine and midazolam and the removal of the fentanyl patch. You will recall that Dr Barton said that she did not want to cause withdrawal; and in response to my point said that it was a planned removal. The effect of B higher than standard dosage of diamorphine and midazolam may have had the effect of shortening her life; however, he accepted that that she was already terminally ill and was receiving good palliative care for her symptoms. He did not find there was any negligence or culpability.

Dr Wilcock in his evidence looked at the history of Mrs Devine's condition, and in particular C he was concerned that the fentanyl patch was administered, and considered it completely unjustified and/or excessive. He considered that the chlorpromazine and midazolam were quite justifiable because of Mrs Devine's confusion but that the dosages were excessive. His evidence was affected by whether Mrs Devine naturally entered the terminal phase of her illness or if her condition was capable of treatment. Nothing in the medical notes gave that kind of pointer. You will remember he was almost going down the two paths at once, that "If this was her terminal condition, then that is right; if it is not, then it is not", and there was D nothing that took him to that dividing path.

For her condition he would have expected a gradual decline – the question of her creatinine level. He accepted that it could possibly have been raised by the trimethoprim, but the rise in level was far greater than he would have expected – which was the point that I picked up on that. That seemed to be a clear indicator that she was in renal failure.

E Mr Jenkins put it to him that Professor Dudley considered that she was suffering from amyloidosis, renal failure and dementia, but Dr Wilcock considered that there was also an unidentified infection. He felt her confusional state was in keeping with the renal failure, which would be characterised by drowsiness leading to coma. He did indicate that he would not have used opioids. It was accepted by Professor Black, who said that Mrs Devine was terminally ill, but Dr Wilcock felt that it was particularly important that sufficient time was allowed for the nursing staff to provide proper care for the dying and their families. In F response to Ms Ballard he indicated that he would have medicated this particular case differently; and as with all other cases he would have tried to identify a specific problem and medicate accordingly, but every time he said "No, go to the issue, go to the problem. Should you be treating that problem? Are you assessing that problem?"

Dr Wilcock believed that Mrs Devine was in a terminal condition, and he agreed with chlorpromazine and the midazolam but did not understand why she was given diamorphine. G Mr Leiper was concerned at the dosage of medication, and produced a table – a copy of which you have. People could have varying reactions to opioids, and the higher the dose, the greater the risk. Mrs Devine presented the greatest risk with regard to her medical condition, her age and her frailty. When asked about the medication he confirmed that small doses should have been used, perhaps every six hours instead of every four hours; but he certainly took the view that the diamorphine dose was excessive. He again confirmed the view that he could not understand the use of the fentanyl patch. He remained fairly consistent in his view that he H could not see the justification initially for the level of opioid medication, and again

considered it excessive. He certainly took the view that if the need was urgent, the last thing you would use was a fentanyl patch, and I think the evidence we have is it could be 22-24 hours before it got up to dosage.

Dealing with the events of 19 November, Mrs Devine's extreme behaviour was dealt with by 50 mg of chlorpromazine, and he considered that was double the recommended dose, as opposed to Dr Barton who says it is half the adult dose. However, he accepted that she was a danger to herself and others, but would still apply the drugs in a managed way. When she gets the midazolam 40 mg he is not clear that she has entered the terminal phase of her life. If she had, then it is a suitable and appropriate dose; if not, he would have administered a smaller dose p.r.n, and the dose is about four times what he would have given. Further, it is not documented why the diamorphine has been administered, and if it had been justified he would have started at 10 mg. There would have been an overlap with the fentanyl patch and the diamorphine which may have given as much as four times the recommended dose. He did not think the patch was a major issue, did not think the level of opioids would be sufficient to sedate Mrs Devine, but it may have aggravated her condition.

He did not consider her to be in the terminal condition, and would have expected a slower decline, although he accepted Dr Dudley's evidence that she was in the terminal stages of her renal condition.

He was taken to the question of the creatinine level and trimethoprim. He did not feel that that was the sole reason to assess whether she was in the terminal stages of her illness. He was clear that a level of 360 was even higher than might be expected from the previous experiences, then goes to the incremental level.

His view on her behaviour on the 19th was uncertain. If Mrs Devine was in the terminal stages of her illness then that would account for the behaviour; if not, it could be accounted for by the level of opioids she was receiving. He was concerned that if she had been on thioridazine then why not continue that? It had been prescribed p.r.n., and if she required it, it was available. He disagreed with Dr Dudley on the issue of the fentanyl patch, but accepted that Dr Dudley was the renal expert. It was accepted that the previous history of myeloma was incorrect. Dr Dudley was quite clear that Mrs Devine was dying, but not from myeloma. She had been under the renal physician, Dr Stephens. Dr Wilcock would have gone back to Dr Stephens for an opinion and felt that the treating doctor was duty-bound to seek specialist help. There was a consultant physician, and the consultant was aware of the situation; why not go back there?

He was asked if she was in a drug-induced coma. He felt that drugs may have played a part in it, but it was more likely that she was dying naturally and would not have entertained the question of hydration or nutrition if she was in the terminal phase. As a matter of course the breathing pattern changes on death – and then went on to describe Chain-Stokes, which is interrupted breaths.

All right, anything on Devine?

I do not want to change that now.

(End of CD3/track 2)

GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Monday 20 April 2009

The Law Courts
Winston Churchill Avenue
Portsmouth,
PO1 2DQ

B E F O R E:

Mr Anthony Bradley
Coroner for North Hampshire
Assistant Deputy Coroner for South East Hampshire

In the matter of Mr Leslie Pittock & 9 Ors

(DAY TWENTY-ONE)

MR ALAN JENKINS QC, instructed by **, appeared on behalf of Dr Jane Barton.
MR JAMES TOWNSEND, Counsel, instructed by the Royal College of Nursing, appeared on behalf of a number of nurse witnesses.
MS BRIONY BALLARD, Counsel, instructed by **, appeared on behalf of the acute trust and the PCT.
MR TOM LEIPER, Counsel, instructed by Messrs Blake Lapthorn, Solicitors, appeared on behalf of the families of Brian Cunningham, Michael Packman, Elsie Devine and Sheila Gregory.
MR PATRICK SADD, Counsel, (instructed from 23/03/09) appeared on behalf of the Wilson family.

(Transcript of the Official Recording by T A Reed & Co Ltd
13 The Lynch, Hoddesdon, Herts, EN11 8EU
Tel No: 01992 465900)

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(In the presence of the jury)

THE CORONER: Good morning and welcome back. I am going to ask you to retire again for the moment. There is the question of room availability and you may find that there will be delays coming in and going out because of alternative uses of this room. Without putting any pressure on you and without requiring you to answer the question, is there any question we might finish today? Are you close enough to a decision to give that indication? It is questionable? [Yes]

I will ask you to retire and if there is anything further you need, let the usher know.

(The jury bailiff was sworn)

(The jury further retired to consider their verdict)

THE CORONER: Ladies and gentlemen, you have a clear indication there of a long day.

(The court was adjourned)

(In the presence of the jury)

THE CORONER: What I will do is I will ask you if you have reached a verdict on each case. I will ask you if that is a unanimous verdict. I will ask you for the cause of death. I will ask you for the answers to the three questions. If there are dissenters I will ask you all to sign the inquisition but if there are dissenters to note by their names that they are dissenting from the verdict. I will give you an inquisition as we go through each one.

Can we take Mr Pittock first? You have decided on a cause of death?

THE FOREMAN OF THE JURY: We have.

THE CORONER: What is it?

THE FOREMAN OF THE JURY: 1(a) bronchial pneumonia and (2) severe depression.

THE CORONER: In response to the questions: (1) Did the administration of any medication contribute more than minimally or negligibly to the death of the deceased?

THE FOREMAN OF THE JURY: No.

THE CORONER: I will give you that inquisition which I have signed. If you could each sign that, please. Any dissenters if you could just put after your name "dissenting", please. (Pause)

THE CORONER: Elsie Lavender – can we do a bit of multi-tasking?

THE FOREMAN OF THE JURY: Yes, certainly.

THE CORONER: Cause of death for Elsie?

THE FOREMAN OF THE JURY: 1(a) high cervical cord injury.

THE CORONER: Nothing else?

THE FOREMAN OF THE JURY: No.

THE CORONER: In response to the question the administration of medication contributing more than minimally or negligibly to the death of the deceased?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was the medication given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given appropriately for the condition or symptoms?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Helena Service: cause of death?

THE FOREMAN OF THE JURY: Congestive cardiac failure.

THE CORONER: Anything else?

THE FOREMAN OF THE JURY: No.

THE CORONER: In response to the question: the administration of medication contribute?

THE FOREMAN OF THE JURY: No.

THE CORONER: Ruby Lake: cause of death?

THE FOREMAN OF THE JURY: 1(a) bronchial pneumonia and (2) fractured neck of femur repaired on 5/8/98.

THE CORONER: And in response to the questions: the administration of medication?

THE FOREMAN OF THE JURY: No.

THE CORONER: Arthur Cunningham: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) bronchial pneumonia; 1(b) sacral ulcer and (2) Parkinson's disease.

THE CORONER: In response to the questions: the medication contributing to the death?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Robert Wilson: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) congestive cardiac failure and (2) alcoholic cirrhosis.

THE CORONER: Given as a (2)?

THE FOREMAN OF THE JURY: As a (2).

THE CORONER: The medication – did it contribute minimally or negligibly to death?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition?

THE FOREMAN OF THE JURY: No.

THE CORONER: Enid Spurgeon: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) infected wound and 1(b) fractured right hip repaired 20/3/99.

THE CORONER: Medication: did it contribute to death?

THE FOREMAN OF THE JURY: No.

THE CORONER: Geoffrey Packman: cause of death?

THE FOREMAN OF THE JURY: 1(a) gastrointestinal haemorrhage.

THE CORONER: Anything else?

THE FOREMAN OF THE JURY: No.

THE CORONER: On the question of medication, did it contribute?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition and symptoms?

THE FOREMAN OF THE JURY: No.

THE CORONER: Elise Devine: cause of death?

THE FOREMAN OF THE JURY: 1(a) chronic renal failure; 1(b) ameloidosis and 1(c) IgA paraproteinaemia.

THE CORONER: In response to the question medication contributing to the death?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition and symptoms?

THE FOREMAN OF THE JURY: No.

THE CORONER: Finally, Sheila Gregory: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) pulmonary embolus and (2) fractured neck of femur.

THE CORONER: In response to the questions did the medication contribute?

THE FOREMAN OF THE JURY: No.

THE CORONER: Thank you. Ladies and gentlemen, can I say that you have my undying admiration. To unscramble all that was quite extraordinary. I am sorry it was presented to you in that way but I could not think of any other way of putting ten together and taking generic evidence and the personal evidence and the expert evidence in one lump, as it were, but you have done a sterling job. Thank you very much indeed. You really have served us very well. I will formally discharge you and I sincerely hope that you never have to do a job like this again. It is the only time I have ever done one like this and it is the only time that I have had to face those issues. I do not think I will do one again either. Thank you for what you have done, I am very grateful.

That completes the proceedings. Unless there is anything anyone wants to say, I will formally conclude. Ladies and gentlemen, thank you very much indeed. My sympathy to the family members; I am sure it has been very difficult for you to sit through this but I am glad you have and I hope you have achieved something.

(The inquest was concluded)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 8 June 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: MS Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY ONE)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T. A. Reed & Co Ltd.
Tel No: 01992 465900)

THE CHAIRMAN: We will now have the reading of the allegation. As I indicated previously, doctor, you do not need to stand for this; you have identified yourself to the gathering.

CHARGES

THE PANEL SECRETARY: The Panel will inquire into the following allegation against Jane Ann Barton, BM BCh 1972 Oxford University:

That being registered under the Medical Act 1983, as amended,

1. At all material times you were a medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital ("GWMH"), Hampshire;

2. (a) (i) Patient A was admitted to Dryad Ward at the GWMH on 5 January 1996 for long term care,

(ii) between 5 and 10 January 1996 you prescribed Oramorphine 5mg 5 times daily, as well as diamorphine with a dose range of 40 - 80 mg over a twenty four hour period to be administered subcutaneously ("SC") on a continuing daily basis,

(iii) on 11 January 1996 you prescribed diamorphine with a dose range of 80 - 120 mg and midazolam with a range of 40 - 80 mg to be administered SC over a twenty four hour period,

(iv) on 15 January 1996 a syringe driver was commenced at your direction containing 80 mg diamorphine and 60 mg midazolam as well as hyoscine hydrobromide,

(v) on 17 January 1996 the dose of diamorphine was increased to 120 mg and midazolam to 80 mg,

(vi) on 18 January 1996 you prescribed 50 mg Nozinan in addition to the drugs already prescribed,

(b) In relation to your prescriptions described in paragraphs 2(a)(ii) and 2(a)(iii),

(i) the lowest doses prescribed of diamorphine and midazolam were too high,

(ii) the dose range was too wide,

(iii) the prescription created a situation whereby drugs could be administered to Patient A which were excessive to the patient's needs,

(c) The doses of diamorphine administered to the patient on 15 and 17 January 1996 were excessive to the patient's needs,

(d) Your prescription described at paragraphs 2(a)(vi) in combination with the other drugs already prescribed were excessive to the patient's needs,

(e) Your actions in prescribing the drugs as described in paragraphs 2(a)(ii), (iii), (iv), (v), and (vi) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient A;

3. (a) (i) Patient B was admitted to Daedalus Ward at the GWMH on 22 February 1996,

(ii) on 24 February 1996 you prescribed the patient morphine Slow Release Tablets (MST) 10 mg twice a day,

(iii) on 26 February 1996 you increased the prescription for MST and prescribed diamorphine with a dose range of 80 mg - 160 mgs and midazolam with a dose range of 40 - 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

(iv) on 5 March 1996 you prescribed diamorphine with a dose range of 100 - 200 mg and midazolam with a dose range of 40 mg - 80 mg over a twenty four hour period to be administered SC and a syringe driver was commenced containing diamorphine 100 mg and midazolam 40 mg,

(b) In relation to your prescriptions for drugs described in paragraphs 3(a) and (iv),

(i) the lowest commencing doses prescribed on 26 February and 5 March 1996 of diamorphine and midazolam were too high,

(ii) the dose range for diamorphine and midazolam on 26 February and on 5 March 1996 was too wide,

(iii) the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs described in paragraphs 3(a)(ii), (iii) and/or (iv) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient B,

(d) In relation to your management of Patient B you,

(i) did not perform an appropriate examination and assessment of Patient B on admission,

(ii) did not conduct an adequate assessment as Patient B's condition deteriorated,

(iii) did not provide a plan of treatment,

(iv) did not obtain the advice of a colleague when Patient B's condition deteriorated,

(e) Your actions and omissions in relation to your management of patient B were,

(i) inadequate,

(ii) not in the best interests of Patient B;

4. (a) (i) on 27 February 1998 Patient C was transferred to Dryad Ward at GWMH for palliative care,

(ii) on 3 March 1998 you prescribed diamorphine with a dose range of 20mg - 200mg and midazolam with a dose range of 20 - 80mg to be administered SC over a twenty four hour period on a continuing daily basis,

(b) In relation to your prescription for drugs described in paragraph 4(a)(ii),

(i) the dose range of diamorphine and midazolam was too wide,

(ii) the prescription created a situation whereby drugs could be administered to the patient which were excessive to the Patient C's needs,

(c) Your actions in prescribing the drugs described in paragraph 4(a)(ii) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of your patient;

5. (a) (i) on 6 August 1998 Patient D was transferred to Daedalus Ward at GWMH for continuing care observation,

(ii) on or before 20 August 1998 you prescribed diamorphine with a dose range of 20mg - 200mg and midazolam with a dose range of 20mg - 80mg to be administered SC over a twenty four hour period on a continuing daily basis,

(b) In relation to your prescription for drugs as described in paragraph 5(a)(ii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient D which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs as described in paragraph 5(a)(ii) were,

(i) inappropriate,

(ii) potentially hazardous,
(iii) not in the best interests of Patient D;

6. (a) (i) Patient E was admitted to Daedalus Ward at GWMH on 11 August 1998 after an operation to repair a fractured neck of femur at the Royal Haslar Hospital,

(ii) on 11 August 1998 you prescribed 10 mg Oramorphine 'prn' (as required),

(iii) on 11 August 1998 you also prescribed diamorphine with a dose range of 20 mg - 200 mg and midazolam with a dose range of 20 mg - 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

(b) In relation to your prescription for drugs described in paragraph 6(a)(iii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient E which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs described in paragraph 6(a) (ii) and/or (iii) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient E;

7. (a) (i) Patient F was admitted to Dryad Ward at GWMH on 18 August 1998 for the purposes of rehabilitation following an operation to repair a fractured neck of femur at the Royal Haslar Hospital,

(ii) on 18 August 1998 you prescribed Oramorphine 10 mg in 5 ml 'prn' (as required),

(iii) between 18 and 19 August 1998 you prescribed diamorphine with a dose range of 20 - 200 mg and midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

(b) In relation to your prescription for drugs described in paragraph 7(a)(iii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient F which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs described in paragraphs 7(a) (ii) and/or (iii) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient F;

8. (a) (i) Patient G was admitted to Dryad Ward at GWMH on 21 September 1998 with a painful sacral ulcer and other medical conditions,

(ii) on 21 September 1998 you prescribed diamorphine with a dose range of 20 - 200 mg and midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

(iii) on 25 September 1998 you wrote a further prescription for diamorphine with a dose range of 40 - 200mg and midazolam with a dose range of 20 – 200mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis,

(b) In relation to your prescriptions for drugs described in paragraphs 8(a)(ii) and/or (iii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs described in paragraphs 8(a) (ii) and/or (iii) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient G,

(d) You did not obtain the advice of a colleague when Patient G's condition deteriorated;

9. (a) (i) Patient H was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation suffering from a fracture of the left upper humerus, liver disease as a result of alcoholism and other medical conditions,

(ii) on 14 October 1998 you prescribed Oramorphine 10 mg in 5 ml, with a dose of 2.5 ml to be given every four hours thereafter as needed, following which regular doses of Oramorphine were administered to the patient,

(iii) on or before 16 October 1998 you prescribed diamorphine with a dose range of 20 mgs - 200 mgs to be administered subcutaneously over a twenty four hour period on a continuing daily basis,

(iv) on or before 17 October 1998 you prescribed midazolam with a range of 20 mgs - 80 mgs to be administered SC over a twenty-four hour period on a continuing daily basis,

(b) In light of the Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph (9)(a)(ii) was,

(i) inappropriate,

(ii) potentially hazardous,

(iii) likely to lead to serious and harmful consequences for Patient H,

(iv) not in the best interests of Patient H,

(c) In relation to your prescription described in paragraph (9)(a)(iii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient H which were excessive to the patient's needs,

(d) Your actions in prescribing the drugs described in paragraphs 9(a)(ii), (iii) and/or (iv) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient H.,

(e) You did not obtain the advice of a colleague when Patient H's condition deteriorated;

10 (a) (i) Patient I was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital,

(ii) on 12 April 1999 you prescribed diamorphine with a dose range of 20 - 200 mgs and midazolam with a dose range of 20 - 80 mgs to be administered SC over a twenty four hour period on a continuing daily basis,

(iii) on 12 April 1999 a syringe driver with 80 mgs diamorphine and 20 mgs midazolam over twenty-four hours was started under your direction but later the dose was reduced to 40 mgs by Dr Reid,

(b) You did not properly assess Patient I upon admission. This was,

(i) inadequate,

(ii) not in the best interests of Patient I,

(c) In relation to your prescription for drugs described in paragraph 10(a)(ii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient I which were excessive to the patient's needs,

(d) Your actions in prescribing the drugs described in paragraph 10(a)(ii) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient I,

(e) The dosage you authorised/directed described in paragraph 10(a)(iii) was excessive to Patient I's needs. This was,
(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient I;

11 (a) (i) Patient J was admitted to Dryad Ward at GWMH on 23 August 1999 following his treatment at the Queen Alexandra Hospital where the patient had been admitted as an emergency following a fall at home,

(ii) on 26 August 1999 you gave verbal permission for 10 mg of diamorphine to be administered to Patient J,

(iii) you saw Patient J that day and noted 'not well enough to transfer to the acute unit, keep comfortable, I am happy for nursing staff to confirm death',

(iv) you did not consult with anyone senior to you about the future management of Patient J nor did you undertake any further investigations in relation to Patient J's condition,

(v) on 26 August 1999 you prescribed diamorphine with a dose range of 40 - 200 mg and midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

(vi) on 26 August 1999 you also prescribed Oramorphine 20 mg at night'

(b) In relation to your prescription for drugs described in paragraph 11(a)(v),

(i) the lowest doses of diamorphine and midazolam prescribed were too high,

(ii) the dose range was too wide,

(iii) the prescription created a situation whereby drugs could be administered to Patient J which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs described in paragraphs 11(a)(ii) and/or (v) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient J,

(d) Your failure to obtain medical advice and/or undertake further investigation described in paragraph 11(a)(iv) was,

(i) inappropriate,

(ii) not in the best interests of Patient J;

12 (a) (i) Patient K was admitted to Dryad Ward at GWMH for continuing care on 21 October 1999 from Queen Alexandra Hospital She was reported to be suffering from chronic renal failure and multi infarct dementia,

(ii) on admission you prescribed morphine solution 10mg in 5 ml as required,

(iii) on 18 and 19 November 1999 there was a deterioration in the Patient K's condition and on 18 November 1999 you prescribed Fentanyl 25 µg by patch,

(iv) on 19 November 1999 you prescribed diamorphine with a dose range of 40 - 80 mg midazolam with a dose range of 20 to 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

(b) The prescription on admission described in paragraph 12(a)(ii) was not justified by the patient's presenting symptoms,

(c) In relation to your prescription for drugs described in paragraph 12(a)(iv),

(i) the lowest doses of diamorphine and midazolam prescribed were too high,

(ii) the dose range was too wide,

(iii) the prescription created a situation whereby drugs could be administered to Patient K which were excessive to the patient's needs,

(d) Your actions in prescribing the drugs described in paragraphs 12(a)(ii), (iii) and/or (iv) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient K,

(e) You did not obtain the advice of a colleague when Patient K's condition deteriorated;

13 (a) (i) Patient L was admitted to Daedalus Ward at GWMH on 20 May 1999 following a period of treatment at the Haslar Hospital for a stroke,

(ii) on 20 May 1999 you prescribed,

(a) Oramorphine 10 mgs in 5 mls 2.5-5mls,

(b) Diamorphine with a dose range of 20 to 200 mgs to be administered SC over a twenty-four hour period on a continuing daily basis,

(c) Midazolam with a dose range of 20 to 80 mgs to be administered SC,

(iii) you further prescribed Oramorphine 10 mgs in 5 mls 4 times a day and 20 mgs nocte (at night) as a regular prescription to start on 21 May 1999,

(iv) doses of Oramorphine, diamorphine and midazolam were subsequently administered to the patient [on] 21 and 22 May 1999,

(b) In relation to your prescription for drugs described in paragraph 13(a)(ii) and/or (iii),

(i) there was insufficient clinical justification for such prescriptions,

(ii) the dose range of diamorphine and midazolam was too wide,

(iii) the prescriptions created a situation whereby drugs could be administered which were excessive to the patient's needs,

(iv) your actions in prescribing the drugs described in paragraph 13(a)(ii) and or (iii) were,

(a) inappropriate,

(b) potentially hazardous,

(c) not in the best interests of patient L,

(c) You did not obtain the advice of a colleague when Patient L's condition deteriorated;

14 (a) You did not keep clear, accurate and contemporaneous notes in relation to Patients A, B, C, D, E, F, G, H, I, J K and/or L 's care and in particular you did not sufficiently record,

(i) the findings upon each examination,

(ii) an assessment of the patient's condition,

(iii) the decisions made as a result of examination,

(iv) the drug regime,

(v) the reason for the drug regime prescribed by you,

(vi) the reason for the changes in the drug regime prescribed and/or directed by you,

(b) Your actions and omissions in relation to keeping notes for Patients A, B, C, D, E, F, G, H, I, J, K and/or L were,

(i) inappropriate,

(ii) not in the best interests of your patients;

15 (a) In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K, L,

(b) Your failure to assess the patients in paragraph (a) appropriately before prescribing opiates was not in their best interests.

And that in relation to the facts alleged you have been guilty of serious professional misconduct.

THE CHAIRMAN: Thank you, Panel Secretary.

Mr Kark, Mr Langdale, it will have been apparent to both of you during the reading of the allegation that there has been a small typographical error at paragraph 13(a)(iv) in that the word "in": "administered to the patient in 21 and 22 May 1999" should of course be "on". May I take it that we can simply make that amendment without further discussion? (Agreed) That amendment is made. The paragraph in question now reads: "were subsequently administered to the patient on 21 and 22 May 1999". Mr Kark, I can see you are on your feet already.

MR KARK: There are a number of others as well.

THE CHAIRMAN: Yes, please.

MR KARK: It may have been in the reading, and I hope your Panel Secretary will not take undue criticism for that because these are very long. First of all, in head of charge 2(e), if it is not there already, may I ask to insert the word "or" after "and" where it reads: 2(a)(ii), (iii), (iv), (v), and", it should be "and/or (vi)", and that is consistent with the other charges.

THE CHAIRMAN: Yes, that certainly was not in the one I have got.

MR KARK: That was not in the reading and that is certainly our fault.

THE CHAIRMAN: Mr Langdale, any objection to that?
MR LANGDALE: No.

THE CHAIRMAN: Very well. In relation to paragraph 2e, the header, of the final line of that header should read: "as described in paragraphs 2(a)(ii), (iii), (iv), (v), and/or (vi)".

MR KARK: I am grateful.

THE CHAIRMAN: Thank you.

MR KARK: In 3(b) the Panel Secretary did not read out 3(a)(iii) but, as long as that is there, it is fine. So 3(b) reads: "In relation to your prescriptions for drugs described in paragraphs 3(a)(iii) and (iv)" I think that appears.

THE CHAIRMAN: Yes, that does appear. If it was an error of omission, it was only in the spoken word, it is in the written record.

MR KARK: Thank you. Yes. In paragraph 9(b), this is our fault it reads: "In light of the Patient H's history", could we take out the word "the" so that it reads: "In the light of Patient H's history."

THE CHAIRMAN: Yes. Mr Langdale, no objection?

MR LANGDALE: No objection.

THE CHAIRMAN: Very well. So 9(b), header now reads: "In light of Patient H's history", the word "the" having been removed.

MR KARK: Paragraph 12(a), there should I think be a full stop after "Queen Alexandra Hospital", the third line down, just to make sense of it.

THE CHAIRMAN: Yes, indeed. There is following capitalisation.

MR KARK: Yes.

THE CHAIRMAN: 12(a)(i), that paragraph is divided into two sentences, a full stop being placed after Queen Alexandra Hospital.

MR KARK: Thank you. Yes, 12(a)(iii), we have an extra "the" in front of "Patient K's condition". Again, could we excise that?

THE CHAIRMAN: Yes, this is the same principle, Mr Langdale.

MR LANGDALE: Yes.

THE CHAIRMAN: 12(a)(iii) now reads: "On 18 and 19 November 1999 there was deterioration in Patient K's condition", the word "the" having been omitted.

MR KARK: In 12(a)(iv), just to make better sense of it, it is right as it is, but it reads at the moment, 12(a)(iv): "On 19 November 1999 you prescribed diamorphine with a dose range of 40 - 80 mg..." and then it goes straight on to midazolam. I think we should insert an "and" just to make better sense of it: "and midazolam with a dose range of 20 to 80 mg..."

THE CHAIRMAN: Are you happy with that, Mr Langdale?

MR LANGDALE: Yes.

THE CHAIRMAN: Very well. Paragraph 12(a)(iv) on the second line after the words "dose range of 40 - 80 mg" insert the word "and" before "midazolam".

MR KARK: In 13(a)(iii) it was read as follows: "You further prescribed Oramorphine 10 mgs in 5 mgs", I think that does read "millilitres".

THE CHAIRMAN: Yes, it does. It should be and it does read "5 millilitres".

MR KARK: Then finally in 15(a), could we ask for the insertion of the words "and/or" after the letter "K": "In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K and/or L" which is on consistent with the way that we have put it in 14(a).

MR LANGDALE: Yes.

THE CHAIRMAN: Thank you, Mr Langdale.

MR KARK: I am sorry for all of these corrections.

THE CHAIRMAN: These things happen no matter how hard we try to eliminate them.

MR KARK: I am grateful.

THE CHAIRMAN: Only in the press do we find that they somehow manage to be free of them. Certainly within the GMC we never do. 15(a), between Patients "K" and "L" we insert the words "and/or".

MR KARK: Before the admissions are made by Dr Barton, could we also hand to the Panel the patient identification sheet which will give the names of all these patients?

THE CHAIRMAN: I was going to ask for one of those. That is very helpful. Thank you. (Same handed)

MR KARK: We are going to use this hereafter. Thank you very much.

THE CHAIRMAN: Mr Langdale, can could I ask you to confirm the doctor's full name and GMC number?

MR LANGDALE: As it stands it is correct I am told.

THE CHAIRMAN: That is GMC reference number 1587920.

MR LANGDALE: That I understand is correct.

THE CHAIRMAN: Are there any matters admitted?

MR LANGDALE: Sir, yes. May I assist the Panel with certain admissions? It involves a little bit of the detail because of the wording of some of the charges and obviously, as you have seen, there are quite a large number of figures involved. I think it is going to assist the whole Panel if I indicate the areas where there is not any dispute. These are matters with regard to admissions, which are made at this stage. May I turn first of all to allegation 2, which relates to Patient A?

THE CHAIRMAN: Is allegation 1 admitted?

MR LANGDALE: Of course, sorry. It was so obvious that I omitted to mention it. Patient A who, as you will have seen, is Mr Pittock from the identification schedule that has been given to you. In relation to 2(a), (i) to (vi), in other words the history of the prescribing or administration, that is not in dispute. Sir, if it turns out that there is some error with regard to a particular date or a particular amount, all of that can be corrected at a later stage, but those are admitted. In relation to the same patient at 2(b), an admission is made that in respect of 2(b)(iii), "the prescription created a situation whereby drugs could be [and I am emphasising deliberately could be] administered to Patient A which were excessive", that is admitted.

Then in relation to that same patient, 2(e), in relation to the drugs described in paragraph 2(a)(iii), it is confined to that, 2(a)(iii), it is admitted that (e)(ii) potentially hazardous. Again, I stress the word "potentially". With regard to 2(e), drugs prescribed in 2(a)(iii) potentially hazardous as at (e)(ii).

Then heading 3, Patient B, Elsie Lavender, again with regard to 3(a), (i) to (iv), the actual prescriptions, and so on, set out there, admitted. At 3(b)(ii) admitted that the dose range was too wide. That is the dose range is admitted as being too wide. Then 3(b)(iii), "the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to the patient's needs", again, "could be administered" admitted. Then 3(c) with regard to the drugs prescribed in paragraph 3(a)(iii) and/or (iv), admitted as being potentially hazardous. So 3(c)(ii) admitted as potentially hazardous with regard to the drugs in paragraphs 3(a)(iii) and 3(a)(iv). Moving on, still the same instance, at 3(d), it is admitted at 3(d)(iv), "did not obtain the advice of a colleague"; that is admitted as a fact.

A

I move on to Patient C, Eva Page, in relation to 4(a) admitted. 4(b), the dose range at (b)(i) too wide, admitted. Creating a situation whereby drugs could be administered which were excessive, 4(b)(ii) admitted. Similarly 4(c), at 4(c)(ii), it is the same allegation of potential hazard, potentially hazardous, admitted.

B

Moving on to Patient D, Alice Wilkie, 5(a) is admitted. In relation to 5(b), admitted with regard to (b)(ii) and (b)(ii), the dose range was too wide and the prescription created a situation whereby drugs could be administered to Patient D which were excessive. Similarly, at 5(c)(ii), again, the allegation of being potentially hazardous on the same basis admitted. So (c)(ii) is admitted.

C

Then Patient E, Gladys Richards, 6(a) is admitted. 6(b)(i) is admitted, the dose range was too wide. Similarly, 6(b)(ii) is admitted, the situation whereby drugs could be administered which were excessive. Then in relation to 6(c), and confining it to the drugs described in paragraph 6(a)(iii), so confining it to 6(a)(iii), admitted potentially hazardous.
Patient F, Ruby Lake, 7(a) is all admitted. 7(b), which deals with a prescription set out in 7(a)(iii), admitted: dose range too wide, and creating a situation whereby drugs could be administered which were excessive. Looking at 7(c) admitted with regard to (c)(ii), potentially hazardous, but only in relation to the drugs prescribed in paragraph 7(a)(iii). So in relation to 7(a)(iii), admitted as being potentially hazardous.

D

I move on to Patient G, Arthur Cunningham, 8, 8(a) is all admitted and 8(b) is admitted, dose range too wide, creating a situation, et cetera, so (b)(i) and (ii) admitted. With regard to 8(c), 8(c(ii), potential hazard, admitted. 8(d), not obtaining the advice of a colleague, is an admitted fact.

E

Then Patient H, Robert Wilson, 9(a) is admitted. I move on to 9(c), which is making an allegation with regard to the prescription at 9(a)(iii), it is admitted the dose range was too wide and creating a situation where drugs could be administered which were excessive. So (c)(i) and (ii) admitted. Then in respect of 9(d), with regard to the drugs prescribed in paragraphs 9(a)(iii) and/or (iv), so not 9(a)(ii), confining the admission to 9(a)(iii) and/or (iv), potentially hazardous, as at 9(d)(ii). Similarly with regard to this allegation, 9(e), you did not obtain the advice of a colleague, that is an admitted fact.

F

Patient I, allegation 10, Enid Spurgin, admitted 10(a), in terms of the history. Moving on to 10(c), which relate to the drugs described in paragraph 10(a)(2), admitted the dose range was too wide and the creation of a situation, and so on, so 10(c)(i) and (ii) admitted. At 10(d), the potentially hazardous point, 10(d)(ii), is admitted.

G

I move on to Patient J, Geffrey Packman, the history set out at 11(a) is admitted. At 11(b), where there is an allegation with regard to the prescription described in paragraph 11(a)(v), it is admitted, at (ii) and (iii) of (b), that the dose range was too wide and a situation was created whereby drugs could be administered which were excessive; so (b)(ii) and (iii) admitted. Then moving on to 11(c), and confining it to the drugs described in paragraph 11(a)(v), so excluding 11(a)(ii), in relation to 11(a)(v), an admission that prescription was potentially hazardous.

H

Paragraph 12, Patient K, Elsie Devine, 12(a), the history is admitted. Moving on to the last

part of the allegation, with regard to that particular patient, at 12(e), admitted did not obtain the advice of a colleague in the same way as the other admissions that have been made.

Lastly in terms of patients, at 13, Patient L, Jean Stevens, the history again, 13(a) is admitted. In relation to 13(b), the dose range at 13(b)(ii), of diamorphine and midazolam, too wide, is admitted. The next allegation at (b)(iii), the creation of a situation, admitted. Then at 13(b)(iv), confining it to the drugs prescribed and described in paragraph 13(a)(ii)(b) – sorry, 13(a)(ii)(b), I am sorry, this is one of the worst ones for confusion on these paragraph numbers. The potentially hazardous point is admitted with regard to 13(a) -

THE CHAIRMAN: 13(b)---

MR LANGDALE: - (ii)(b), which is the diamorphine prescription. I am afraid it is an error in my own notes which led me to believe it related to the Oramorphine. It is the diamorphine at 13(ii)(b), potentially hazardous. Again, a similar factual admission in that case of 13(c), did not obtain the advice of a colleague, that is admitted.

Sir, turning to the last two numbered paragraphs, 14 and 15, with regard to the paragraph for allegation 14, this is an allegation with regard to the failure to keep clear, accurate and contemporaneous notes relation to the patients. There are admissions there: (i), (ii) and (iii) are admitted, and (v) and (vi) are admitted. Then turning to 14(b), "Your actions and omissions in relation to keeping notes for [the] Patients ... were, (i) inappropriate", admitted; "not in the best interests of your patients", admitted. So all of those allegations in that paragraph concern the failure to keep clear, accurate and contemporaneous notes.

Those are the admissions that are made on behalf of Dr Barton.

THE CHAIRMAN: Right, Mr Langdale, you have presented me with quite a challenge.

MR KARK: Sir, before the Panel reads out the matters that have been admitted and found proved, can I just indicate, we are going to ask for a little time in any event. I am not complaining about it, this is the first time we have heard those admissions and it may that be with some further amendment, we could encourage more admissions as it were. If that were to help you, you do have a bit of a task now, and I was going to ask for 20 minutes in any event. I just thought I would mention that now in case that assisted you.

THE CHAIRMAN: Yes. I think what I will attempt to do is to deal with what we have heard first from Mr Langdale. Then we will break. We would be breaking around now in any event. Will that break be sufficient for you also to break or would you wish to extend that?

MR KARK: I am afraid I do not know at the moment because my suggestion may fall on deaf ears as it were but if we need more time, can we pass a message through?

THE CHAIRMAN: Yes, please do, and in any event it would be useful as a matter of housekeeping, I will say this on an ongoing basis, throughout this hearing to update us as to what effect any changes like this are likely to have on the overall timetable. That would also be helpful.

Very well. Mr Langdale, paragraph 1 has been admitted and is found proved. Paragraph 2(a)

has been admitted in its entirety and is found proved. Paragraph 2(b)(iii) has been admitted and is found proved. Then paragraph 2(e)(ii) is admitted only in respect of actions in prescribing the drugs as described in paragraph 2(a)(iii).

MR LANGDALE: That is right.

THE CHAIRMAN: Paragraph 3(a) – sorry, I should say therefore: and is found proved. Paragraph 3(a) is admitted in its entirety and is therefore found proved. Paragraph 3(b)(ii) is admitted and found proved. 3(b)(iii) is admitted and found proved. Paragraph 3(b), (c)(ii) is admitted only in respect of drugs described in paragraphs 3(a) (iii) and/or (iv).

MR LANGDALE: That is right.

THE CHAIRMAN: And on that basis is found proved.

MR LANGDALE: That is right.

THE CHAIRMAN: I should say therefore and is found proved. Paragraph 3(a) is admitted in its entirety and therefore found proved. Paragraph 3(b)(ii) is admitted and found proved. Paragraph 3(b)(iii) is admitted and found proved. Paragraph 3(b)(c)(ii) is admitted only in respect of drugs described in paragraphs 3(a)(iii) and/or (iv).

MR LANGDALE: That is right.

THE CHAIRMAN: And on that basis is found proved. Paragraph 3(d)(iv) is admitted and found proved.

Paragraph 4(a) is admitted in its entirety and found proved. Paragraph 4(b) is admitted in its entirety and found proved. Paragraph 4(c)(ii) is admitted and found proved.

MR LANGDALE: Yes.

THE CHAIRMAN: Paragraph 5(a) is admitted in its entirety and found proved. Paragraph 5(b) is admitted in its entirety and found proved. Paragraph 5(c)(ii) is admitted and found proved. Paragraph 6(a) is admitted in its entirety and found proved.

Paragraph 6(b) is admitted in its entirety and found proved. Paragraph 6(c)(ii) is admitted only in respect of actions in prescribing the drugs described in paragraph 6(a)(iii).

MR LANGDALE: Yes.

THE CHAIRMAN: And is on that basis only found proved.

Paragraph 7(a) is admitted in its entirety and is found proved. Paragraph 7(b) is admitted in its entirety and is found proved. Paragraph 7(c)(ii) is admitted but only in respect of actions in prescribing the drugs described in paragraphs 7(a)(iii) and on that basis only is found proved.

MR LANGDALE: That is right.

THE CHAIRMAN: Paragraph 8(a) is admitted in its entirety and is found proved. Paragraph 8(b) is admitted in its entirety and is found proved. Paragraph 8(c)(ii) is admitted and found proved. Paragraph 8(d) is admitted and found proved.

Paragraph 9(a) is admitted in its entirety and found proved. Paragraph 9(c) is admitted in its entirety and found proved. Paragraph 9(d)(ii) is admitted only in respect of those actions in prescribing the drugs described in paragraphs 9(a)(iii) and/or (iv) is admitted and therefore in that respect only found proved. Paragraph 9(e) is admitted and found proved.

Paragraph 10(a) is admitted in its entirety and is found proved. Paragraph 10(c) is admitted in its entirety and is found proved. Paragraph 10(d)(ii) is admitted and found proved.

MR LANGDALE: Yes.

THE CHAIRMAN: Paragraph 11(a) is admitted in its entirety and is found proved. Paragraph 11(b)(ii) is admitted and found proved. Paragraph 11(b)(ii) is admitted and found proved.
I think I may be going wrong here. As I read it paragraph 11(c)(ii) is admitted only in respect of actions in prescribing the drugs described in paragraphs 11(a)(v).

MR LANGDALE: That is correct.

THE CHAIRMAN: So that is admitted and therefore found proved. Paragraph 12(a) is admitted in its entirety and is found proved. Paragraph 12(e) is admitted and found proved.

MR LANGDALE: Yes.

THE CHAIRMAN: Paragraph 13(a) is admitted in its entirety and is found proved. Paragraph 13(b)(ii) is admitted and found proved. Paragraph 13(b)(iii) is admitted and found proved. Paragraph 13(b)(iv)(b) is admitted only in respect of those actions in prescribing the drugs described in paragraph 13(a)(ii).

MR LANGDALE: Yes.

THE CHAIRMAN: That is admitted in that respect only and found proved.

MR LANGDALE: That is (a)(ii)(b).

THE CHAIRMAN: Thank you. And paragraph 13(c) is admitted and found proved.

MR LANGDALE: Yes.

THE CHAIRMAN: Paragraph 14(a)(i), (ii) and (iii) are admitted and found proved. And 14(a)(v) and (vi) are admitted and found proved.

MR LANGDALE: That is correct.

THE CHAIRMAN: Paragraph 14(b) is admitted in its entirety and is therefore found proved.

MR LANGDALE: That is correct.

THE CHAIRMAN: Thank you very much indeed, Mr Langdale. We will break now for an initial 20 minutes, partly so that everybody can refresh themselves but also so that some discussion can take place between counsel. If you do require further time please inform our Panel assistant or Panel Secretary and I will grant you that time.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Kark.

MR KARK: Sir, first of all, thank you for that short extra time. We did have discussions but we decided that the best thing is to get on with the opening, so it did not resolve anything.

Sir, it now falls to me to open this case and I want to confirm, of course, that at this point there should be no witnesses in the public gallery from here on in.

THE CHAIRMAN: Can I confirm that there are no potential witnesses now with us?
(Confirmation of no witnesses in the hearing room)

MR KARK: Sir, this case concerns the treatment provided to 12 patients at the Gosport War Memorial Hospital, all of whom were inpatients there between 1996 and 1999.

Dr Barton was employed during the period as a clinical assistant which meant that she had day to day care of the patients on the two relevant wards which were Daedalus and Dryad.

The Hampshire Primary Care Trust boasted four hospitals at the relevant time in the Portsmouth area. The Queen Alexandra Hospital has a number of sites clustered around the top of Portsmouth. St. Mary's Hospital is in Portsmouth itself. There is the Royal Haslar Hospital, which was once the Royal Naval Hospital, the first version of which was built in the middle of the 18th century. Finally, there is the Gosport War Memorial Hospital known as the GWMH within your heads of charge. The GWMH was opened in 1923 and since then it has occasionally been extended, but at the relevant time you will be asked to consider it was acting effectively as a cottage hospital in terms that it would receive patients who required longer term or rehabilitative care.

Prior to the period that we are considering the GWMH had been spread around a number of sites but by the relevant time period it was centred in a single large building. It did not have an acute ward, nor did it have any emergency facilities.

Originally palliative care patients or those terminally ill were cared for in part of the GWMH called the Redcliff Annex, which was some miles from the main hospital. That was a geriatric ward for patients who could not cope on their own and that was closed in around 1995 and those patients were sent to Dryad Ward.

Dryad Ward was one of the three wards which you are likely to hear about – the two elderly care wards being called Daedalus and Sultan. Emergencies which arose on the wards at GWMH would have to be transferred by ambulance to one of the local hospitals where

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday 20 August 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY FORTY-NINE)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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DETERMINATION

The Panel continued to deliberate in camera and convened on the following days

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Monday 17 August	Day 46
Tuesday 18 August	Day 47
Wednesday 19 August	Day 48

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Welcome back, everyone. For the record I should say now that when we last met, the Panel received the Legal Assessor's advice in writing. We have, of course, read that advice and we read it before we started our discussions.

Also for the record, I should indicate that during the course of those discussions it was not necessary for us to seek any further legal advice. That is why it was not necessary to call you back.

I am going to read the determination which, as you would expect in a case of this length, we having already marked up some two and half thousand pages of transcript, is somewhat lengthy. In the circumstances, I am asking the Panel Secretary to give the parties in advance what should be regarded as a draft determination, so that they can, as it were, read along with me. I should, though, make it very clear that it is but a draft. What counts is what I actually say. If I get anything wrong – and that is highly possible – the first person whose role it is to try to put me right will be the Legal Assessor but if anybody picks up a mis-reading and it is not picked up by the Legal Assessor, please do feel free and I will correct it hopefully there and then. We will pass those out now. (Draft determination distributed)

Dr Barton, I am not going to ask you to stand while this very lengthy document is read, but I would appreciate it if you could position yourself so that you and eye can maintain some sort of eye contact as this is formally directed to you.

DETERMINATION

Dr Barton

This case centres on 12 patients, all of whom died between 1996 and 1999 on wards where

you were employed as a Clinical Assistant. In order to reach conclusions on the facts alleged it has been necessary for the Panel to build up a clear picture of the practices, procedures, pressures and personalities that characterised the situation on those wards at the time. It has done this through the reception of a great deal of evidence adduced by both parties, and through its own searching, and sometimes challenging questions.

The process has been hampered by the very considerable passage of time since the events in question, the inevitable dimming of memories over that period, the equally inevitable unavailability of some witnesses, and the admitted deficiencies in your own notes, and to some extent those of the nursing staff.

Counsel have reflected on a number of general points which, though they might not form a part of specific allegations, nonetheless require the Panel to have evaluated them before they rule on the facts.

This determination falls into three parts and one annexe. The Panel will deal, firstly, with those general issues which have required consideration during the course of the case. The Panel will, secondly, set out its formal findings as to fact. Thirdly, the Panel will set out its determination as to whether the proved or admitted facts would be insufficient to support a finding of serious professional misconduct. Attached to this determination will be an annexe detailing the final and definitive heads of charge which take account of each and every amendment made since this session commenced on 8 June of this year.

PART ONE

1. Inappropriate transfers onto Dryad and Daedalus wards

i. The Panel heard and accepted evidence from many witnesses that at the time in question there was a sense among the nursing and medical staff at Gosport War Memorial Hospital (GWMH) that, due to pressure on bed space in the acute wards of Queen Alexandra and Royal Haslar Hospitals, some patients were being transferred to Dryad and Daedalus wards when their medical condition was insufficiently stable to warrant such a move. Further, that such patients were often transferred in circumstances where their medical and nursing needs were beyond the staffing and equipment capabilities of the receiving wards.

ii. The Panel received and accepted evidence that in a number of the cases before it there was an apparent incongruity between patients' discharge notes and the assessments of nursing and medical staff when the patients arrived at Dryad or Daedalus wards.

iii. The Panel also heard and accepted evidence that some patients and their families were given the impression by some staff at the transferring hospitals that the purpose of the transfer and the role of the receiving wards were more optimistic than patients' true prognoses allowed.

2. Propensity to sudden deterioration, the effects of transfer and the appropriateness of investigation

i. The Panel heard and accepted evidence from many sources, including the General Medical Council's (GMC) medical expert, Professor Gary Ford, that elderly patients with a range of co-morbidities, such as those routinely found in Dryad and Daedalus wards at the time in question, had a natural propensity toward sudden deterioration and even death, no matter how well cared for.

ii. Further, the Panel heard and accepted evidence from those sources that the physical and mental stress to such patients when

A subjected to inter-hospital or even inter-ward transfer, was frequently followed by deterioration in the patient. The Panel heard and accepted evidence that such deterioration occurred no matter how short and comfortable the transfer, and that the deterioration might turn out to be temporary or permanent.

B

iii. Whilst the Panel is of the view that early assessment of a patient is always necessary, the above made it clear that there may well be need for further re-assessments and/or investigations after an initial period of observation.

C

iv. The Panel noted that there appeared to be agreement among the experts that when a patient was on the terminal pathway, it would be inappropriate to subject the patient to unnecessary investigation.

D

3. Your dealings with patients' relatives

i. The Panel heard a large amount of evidence from health professionals who witnessed your interactions with patients' relatives, and also from patients' relatives and even patients themselves. Most characterised your approach to relatives as caring and compassionate, and the Panel heard that you would frequently come into the hospital in your own time to meet with relatives.

E

F

ii. Some relatives did not have such a positive recollection of their meetings with you, describing you as 'brusque', unfriendly and indifferent. The Panel heard evidence from some nurses who, while generally supportive of you, indicated that you had a tendency toward plain speaking. One said that you 'did not suffer fools gladly', and another that you 'called a spade a spade'.

G

H

iii. The Panel also heard evidence from you and other health professionals that your meetings with relatives were sometimes made more difficult by the fact that the relatives had been given unrealistic expectations of the progress that the patient might be expected to make at GWMH, and were often shocked by sudden deterioration in the patient, particularly when this was manifested on or shortly after transfer.

iv. The Panel concluded that your straightforward approach was not appreciated by all relatives, and that to some you might at times appear distant or even unfeeling, albeit that this was far from your intention. The Panel further concluded that the stress experienced by relatives meeting with the doctors of a loved one who was fast approaching death frequently prevented them from taking in all that they were told. It was inevitable in such circumstances that some relatives would leave a meeting with an incomplete or inaccurate view of what had taken place.

4. 'Happy for nurses to confirm death.'

i. The Panel heard considerable discussion about the significance to be attached to the use of this phrase in your notes on individual patient records. It has accepted the view of Professor Ford and numerous other witnesses that the vast majority of patients being admitted onto Dryad and Daedalus wards at the time in question would have had a natural potential to deteriorate rapidly and without warning.

ii. The Panel further accepted Professor Ford's view that it was appropriate for medical staff in these circumstances to delegate the task of confirmation of death to nurses, and that this delegation might usefully have been noted at the time of a patient's admission onto the ward. The Panel also noted his observation that "one would prefer to have a policy for a unit rather

than it being done on individual patients."

5. The role of note-taking in clinical care

i. You made a number of admissions in respect to the inadequacy of your note-taking. However, Mr Kark observed "it has been suggested on numerous occasions to witnesses that Dr Barton simply did not have the time. It was a case of either looking after the patient and not making a note about it, or making copious notes but not actually looking after the patient."

ii. Professor Ford told the Panel: "with any important clinical contact where there is a major change of patient status or a major change in treatment I think it is difficult to say one is too busy to write a three, four, five line summary of what has happened. It only takes a short time to write a brief summary."

iii. The Panel notes paragraph 3 of 'Good Medical Practice' 1995 edition which states under the heading *Good Clinical Care*: "In providing care you must....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 treatment prescribed..."

iv. The Panel further notes the acceptance by Professor Karol Sikora, your own medical expert, that note-taking is an integral part of clinical care, and that "any suggestion that on the one hand you will take care of the patient, and then you will do the notes, is by definition inappropriate."

6. The absence of notes of specific events

i. The Panel has heard that medical students are frequently taught that 'if it isn't recorded it didn't happen.' However, as Mr Langdale

pointed out in his closing remarks, you are of undisputed good character, and that adage cannot be applied to the Panel's consideration of the facts.

ii. The Panel recognises that the admitted inadequacies in your note-taking mean that while you may on certain occasions lack the corroboration that an appropriate note might have afforded you, the lack of such a note gives the Panel no assistance one way or another in deciding whether or not a claimed event took place. Accordingly, where you have said that you failed to record it but it did happen, the Panel has afforded your evidence the same weight as any other statement as to fact by a person of good character.

7. Allegations that you did not sufficiently record the drug regime in respect of specific patients

i. Mr Kark advanced the view that any failure to reduce into writing instructions governing the circumstances and required procedures in relation to the administration of anticipatory prescriptions was serious. He argued that such failure in respect of a prescription which gave nurses the authority to initiate syringe drivers at an unspecified date, and loaded with a variable dose of Diamorphine / Midazolam mix was especially serious as it reduced the ability of the prescriber to safeguard patients' interests against inappropriate action by nursing staff.

ii. The Panel observed that in managing risk it is necessary to consider not only what might happen when the best, most highly trained and experienced nurses were on duty, but also to consider what might happen when the least trained and experienced nurses were on duty. In the absence of a clear written protocol governing the administration of anticipatory prescriptions – especially those for opiates delivered by syringe driver – patients were entitled

to expect that clear written instructions would be available to all those who might be expected to administer the prescription. The Panel noted with concern that nurses had used their own discretion to start a higher dose than the minimum prescribed dose, and that a nurse had doubled the existing dose of Midazolam at a time when the corresponding dose of Diamorphine had been halved on the instruction of a consultant because of over-sedation.

iii. The Panel noted the evidence that nurses would have been aware of your wishes in this respect because they would have attended verbal handover sessions on each occasion before they started on the ward. While recognising the value and importance of handover sessions, the Panel did not accept that this was a safe or prudent way of ensuring that prescriptions were administered appropriately.

8. Euphemisms relating to end of life status

i. The Panel has heard that throughout the health service at the time in question, health professionals routinely shied away from the use of direct and plain language when recording judgments relating to the palliative care of patients close to death. The Panel noted that even today phrases such as 'on the terminal pathway' are used to indicate that a patient is expected to die within a matter of days. At the time in question:

a. 'For TLC', an acronym for 'tender loving care' was widely used as a euphemism to note that the patient was now to be treated palliatively, and frequently carried the additional connotation that the patient was close to death.

b. 'Make comfortable' meant the same as TLC.

c. The Panel also heard from numerous sources that an entry on the notes indicating

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that a patient had been started on a syringe driver with a combination of at least Diamorphine and Midazolam was a clear indication that the patient had entered the terminal pathway and was expected to die within a matter of days.

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9. Guidelines and the Analgesic Ladder

The Panel heard that the British National Formulary (BNF) is the definitive evidence-based guide for doctors on the prescribing of drugs. It gives clear advice on prescribing in specific

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situations such as *Prescribing in Palliative Care* and in *Prescribing for the Elderly* where extra care needs to be exercised.

The Panel also heard evidence about the Palliative Care Handbook (The Wessex Protocol)

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which was in local use at the time of the allegations, and which you told the Panel you kept in your pocket when you were on the wards.

These documents contain Conversion Charts which show, for example, the equivalency of

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dose between oral morphine and subcutaneous Diamorphine.

Both expert witnesses gave evidence about the World Health Organisation's *Analgesic Ladder* which emphasises the importance of using analgesics appropriate to the severity of

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pain, and of moving from weaker to stronger analgesics in a step-wise fashion. Professor Ford encapsulated this principle as "start low, go slow".

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10. Opiates in the treatment of distress, restlessness, agitation and pain

i. The Panel heard a range of opinion as to the appropriate use of opiates in patients of advanced age with a range of co-morbidities. While there was no dispute that opiates

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provided effective analgesia for high levels of pain, there was a divergence of view as to the appropriateness of its use in the control of

distress, restlessness, and/or agitation in the presence or absence of pain.

ii. Your experience, supported by Dr Logan, other consultants with whom you worked and Professor Sikora was that the euphoric and other properties of opiates rendered them helpful in dealing with terminal distress, restlessness and agitation, whether or not pain was also present.

iii. Professor Ford did not share this view. He conceded that there might be geriatricians who would give Diamorphine to patients who were not in pain, but he noted that such a course is neither promoted nor recommended in the palliative care literature and guidelines.

11. Side effects/adverse consequences of opiates

i. The Panel heard considerable evidence on this subject. In particular, it heard that opiates are extremely powerful drugs, especially in the treatment of the elderly who tend to be particularly sensitive to their effects.

ii. The Panel heard that common side-effects or adverse consequences of opiate use include, but are not limited to:

- Drowsiness, potentially leading to unconsciousness
- Respiratory depression, potentially leading to unconsciousness and ultimately death
- Confusion
- Agitation
- Restlessness
- Hallucination
- Nausea

iii. Professor Ford told the Panel that, when dealing with elderly patients, it was incumbent on prescribers to exercise extreme caution in determining dosage to protect the patient from over-sedation. He cited the Analgesic Ladder, the BNF and the Wessex Protocol as sources of guidance on appropriate usage and dosage of opiates.

iv. You told the Panel that you were well aware of each of these sources and of the side effects and potential adverse consequences of opiate use.

v. The Panel heard a range of evidence on the difficulty of distinguishing agitation and restlessness from pain, especially in cases of dementia and unrousable or unconscious patients. The Panel concluded that in such cases the distinction was a difficult one, and that even medical and nursing staff with considerable experience of opiates in palliative care would not always be able to make that distinction.

vi. The Panel heard that it would be extremely hard to tell whether such symptoms were occurring as a natural part of the dying process or whether they were occurring as a side effect of the opiates themselves. The Panel noted your view that when a patient was on a syringe driver drug their unconsciousness would be constant if it was induced by the medication, whereas it would fluctuate if it was natural.

12. The Diamorphine/Midazolam mix

i. You told the Panel that in your experience a combination of Diamorphine and Midazolam was an effective means of controlling pain, agitation and restlessness in patients who were on a terminal pathway. You and Professor Sikora both accepted that Midazolam has a powerful sedating effect, and that one has to be doubly cautious using Midazolam in combination with

Diamorphine.

ii. Professor Sikora accepted that if a patient is on a terminal pathway, that does not avoid the necessity of using the Analgesic Ladder or guidelines so as to ensure that one is not over-sedating, because the danger otherwise is that one can end up with a patient who is unnecessarily unconscious or dead.

13. Prescribing opiates outside the guidelines

i. The Panel heard evidence from both medical experts and from a number of consultants and other medical staff that in order to relieve pain they had had occasion to prescribe opiates at levels which exceeded the guidelines contained in publications such as the BNF and the Wessex Protocol, sometimes at very high doses.

ii. It was generally accepted that such a course may be justified, and that, within reasonable limits and in the absence of other evidence, it is a matter for the judgment of the clinician on the ground who is frequently best able to assess whether the analgesic needs of the patient in question require it.

iii. The general view appeared to be that departures from the guidelines were exceptional rather than routine. However, it appeared to the Panel that when placing patients on syringe driver you routinely prescribed outside those guidelines in order to ensure that the patient would not experience pain.

iv. You told the Panel that you were familiar with the guidelines in both the BNF and the Wessex Protocol. However, when asked about judging accurately a patient's needs for analgesics Professor Sikora told the Panel that "the only way is to be with the patient and see

what happens after a given dose of an analgesic … is given." In your experience, you told the Panel, the doses you prescribed were necessary if the anticipated analgesic needs of the patient were to be met.

v. The Panel also heard and accepted evidence from Professor Sikora that the response to opiates varied widely from patient to patient and that "that is why the teaching is '*Look at the patient and see what happens*', rather than use any pre-conceived dosage or formula."

vi. The Panel noted that the evidence indicated that it was also accepted that when clinicians deliberately depart from the guidelines it is important that they record in the medical notes precisely what they have done and their reasons for doing so.

vii. Mr Langdale advanced the view that in the absence of such a note, no Panel could properly form the view that you had acted inappropriately. The Panel concluded that in deciding specific allegations that you had prescribed inappropriately they were required to review all the evidence and then ask themselves whether they could be sure on the basis of that evidence that you had prescribed inappropriately.

14. Anticipatory prescribing and the delegation of powers

i. The Panel heard a great deal of evidence about anticipatory prescribing and the delegation of powers. It heard that the practice of prescribing a drug in anticipation that it might be required, but before it is actually required is not uncommon, especially in the management of pain. The justification for such a practice is said to be that, if and when the immediate administration of the prescription becomes necessary, nursing staff have the discretion to administer it without having to wait for a doctor to respond to a call to come to prescribe it. If it is never required, it is never administered.

ii. The value of such a practice in the swift treatment of pain is obvious. The Panel heard evidence from both Professors Ford and Sikora, as well as from the consultants who gave evidence, that they had all engaged in anticipatory prescribing.

iii. It was acknowledged that one risk attendant on anticipatory prescribing is that nursing staff might decide to administer the prescription at a time when it was not clinically justified.

iv. It was further acknowledged that this risk became of particular significance on Dryad and Daedalus wards when the prescription included variable doses of a mix of Diamorphine and Midazolam to be delivered by syringe driver. As previously noted, it was generally accepted that the starting of a syringe driver loaded with such a mix was a clear indication that the patient was now on the terminal pathway and expected to die in a matter of days. Further, and also as previously noted, Mr Kark advanced the view that one means of providing patients with some safeguard against the inappropriate administration of such a prescription would have been the provision of clear written instructions.

v. There was some inconsistency in the evidence as to the extent to which nursing staff on Dryad and Daedalus would seek approval from medical staff before starting a patient on syringe driver and the Panel received evidence of occasions when syringe drivers had been started at the sole discretion of nursing staff. In any event, you gave clear evidence that you trusted your nursing staff to exercise their discretion appropriately, and that while you would expect them to seek approval, in the event that they were unable to reach a doctor to obtain that approval it was "their prerogative" to proceed without it.

vi. The Panel heard that the risk of inappropriate exercise of discretion to administer a prescription generally was adequately safeguarded by the fact that drugs could only be administered by two fully qualified nurses

working together; and that the nurses on Dryad and Daedalus were of a calibre that rendered the risk acceptable.

vii. The Panel also heard that it was not unusual for anticipatory prescribing to allow for a range of doses. The reason for this was to enable the trained nurses administering the drug(s) to exercise their discretion as to the dose currently required by the patient before them. The Panel heard that it was usual for nurses to begin administration of a prescription by starting at the lowest dose prescribed, though it was accepted that they were able to administer at a higher rate if they determined that it was appropriate to do so; and the Panel received evidence of occasions when they did so.

viii. The Panel noted with concern your apparent assumption when prescribing on an anticipatory basis that the required dose would increase. As a consequence, the lowest dose prescribed by you in an anticipatory range would be set at a higher level than whatever was the current dose at the time of prescription, despite the fact that when you wrote the prescription you had no way of knowing when it would be administered. The Panel has seen from the specific cases with which it is concerned that the delay between prescription and administration could be anything from a matter of hours to a matter of days.

ix. It follows that the danger was, if at the time of administration the prescribed minimum dose was too high, that excessive dose was likely to be administered anyway. Indeed, if the nurses were to form the view that the lowest dose in the variable range was too high, in the anticipated event that they were unable to obtain assistance from a doctor, their choice of action was limited to not administering the medication at all or administering it at what they judged to be too high a dose. In the Panel's view, the appropriate safeguard would have been for you, whenever you were anticipatorily prescribing a variable range of Diamorphine, to match the lowest dose in the range to the

equivalent of the dose the patient was on at the time of prescription. In the case of an opiate naïve patient, the Panel accepted Professor Ford's view that a prescription in line with the Analgesic Ladder referred to at paragraph 9 above would be appropriate.

x. So far as the prescription of Midazolam in combination with Diamorphine is concerned, the Panel noted that both drugs have a sedative effect and that particular care should be exercised to take account of this when prescribing them in combination.

xi. The Panel accepted Professor Ford's view that in anticipatory prescribing a dose range which allowed for an increase of more than 100 per cent from the lowest to the highest parameter was too wide.

xii. You told the Panel that, where a dose of subcutaneous analgesia was not controlling the pain or other symptoms, you would in general terms follow the practice of "doubling up". The Panel noted that this would be almost certain to prevent the manifestation of breakthrough pain. However, it also greatly increased the risk of over-sedation and adverse side-effects.

xiii. In the Panel's view, this practice demonstrated your approach to protecting patients from pain even at the cost of protecting them from over-sedation and adverse side-effects.

xiv. Mr Langdale advanced the argument that although you admitted that there were occasions when the range of doses you had prescribed was too wide, the doses actually administered never reached the highest dose that the prescriptions allowed for, and were frequently a good deal lower. The Panel takes the view that while this was fortunate, the fact remains that this method of prescribing gave rise to the risk that the highest doses could be administered. This is a matter which the Panel is obliged to take into account when considering the appropriateness of the

prescribing and whether or not it was in the best interests of the patient.

15. Syringe Drivers

i. The Panel received a great deal of evidence on this subject. The Panel heard that syringe drivers are used to deliver a wide variety of medications, both in the community and in hospitals. It concluded that their principal value lies in the fact that they are capable of delivering medication at a continuous and even rate over periods of up to 24 hours per load. This is particularly important in cases where, for whatever reason, oral medication is not appropriate. This is because the use of a syringe driver:

a) spares patients the discomfort and inconvenience of four hourly injections and
b) in the relief of pain, avoids the 'peaks and troughs' associated with a regular but discontinuous course of injections.

ii. The Panel found that the use of syringe drivers on Dryad and Daedalus wards at the time in question had particular significance because of two factors:

a) They tended to be loaded with combinations of drugs which included Diamorphine and Midazolam, frequently at starting doses of 20 mg of each, (with doses routinely doubling every 24 hours.)
b) There were no facilities on either ward for intra-venous hydration, and the reality was that patients who were unable to swallow, whether because they were unconscious or otherwise, did not receive hydration. Continued lack of hydration would ultimately lead to death.

iii. It was in this context that medical and nursing staff on these wards recognised that starting a patient on a syringe driver was an acknowledgment of the fact that the patient was now on a terminal pathway and not

A expected to live beyond a matter of days.

16. Syringe drivers and the immediate relief of pain

B i. The Panel heard that such use of syringe drivers was not an effective means of providing immediate analgesia because the continuous rate of infusion meant that it would take some hours before the amount of analgesia in the patient's blood stream would reach the optimum level at which it would then be maintained. Professor Ford

C told the Panel:

> "if a patient is not already stable on a previous dose of oral morphine or injected subcutaneous morphine or diamorphine you will not see the full effect

D of that infusion until quite some time later, twenty hours or more."

ii. You expressed surprise that there should be such a delay. You told the Panel that your experience was that on your usual dosing Diamorphine/Midazolam mixes took effect a lot quicker than that.

E iii. When asked about the potential for dealing with immediate pain by single injection rather than by placing the patient directly onto a syringe driver you told Mr Kark:

> "I was not in the habit of using intramuscular or subcutaneous Diamorphine in that way."

F Mr Kark replied:

> "Instead of which what you effectively did was you handed the nurses the power to start the path for this lady's death."

G Your response: 'I did.'

17. Titration and the use of syringe drivers

i. Professor Ford told the Panel that to ensure a patient did not suffer during the syringe driver's

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build-up period it was necessary to provide additional alternative analgesia first.

ii. The Panel heard that, depending on the circumstances, opiates could be delivered by a variety of routes:

- Orally (eg liquid Oramorph which will reach peak effect between 30 to 60 minutes, or sustained release tablets which will reach peak effect in a matter of hours)
- Transdermally (eg Fentanyl patch which will reach peak effect after about 24 hours)
- Intravenously (eg morphine injection which will reach peak instantly)
- Intra muscularly or subcutaneously (eg Diamorphine injections which will reach peak between about 15 and 30 minutes, or syringe driver which will peak after 20 hours or more)

iii. In Professor Ford's view:

- When treating an opiate naïve patient, the first issue would be establishing the level of analgesia required to render the patient pain free whilst remaining alert and free of adverse side effects. This could most effectively be achieved by means of titration i.e. treating the patient with a series of escalating doses and observing the effect until a daily dose which completely controlled the pain was found. Ideally this might be through the use of Oramorph, but where oral opiates were not an option individual injections could be used. Once the correct level of analgesia is established a starting dose or bolus could then be administered to cover the delay in the syringe driver taking full effect.
- When treating a patient already receiving opiates, the first issue would be to determine the equivalent dose for delivery by syringe driver. This would be done by reference to the conversion charts in the BNF or Wessex Protocol. The second issue would be how to achieve the transition from the existing delivery method to the syringe driver without either increasing or decreasing the level of analgesic cover during the period of transition. This would require calculations to be made based on a comparison between the start-up times of the driver and the end of efficacy times of the previous analgesia. The Panel heard evidence that nursing staff were equipped with the appropriate conversion charts and so would have been capable of calculating and delivering the appropriate dose.

iv. When asked by Mr Kark about the need for titration prior to commencing a syringe driver, Professor Sikora said:

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"That would be the ideal situation to go for; to have either oral morphine or long-acting morphine, or in four-hour injections, work out over a two or three day period what the dose is, set that and then give the subcutaneous morphine."

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He stated that, unless you did that, there was a serious danger that you are either going to start too low or too high.

v. By contrast, you evinced a marked reluctance to titrate doses before commencing patients on syringe drivers. You told the Panel:

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"we simply did not have the level of staffing to do that on a ward of 24 people."

When pressed by Mr Kark, you said that your patients did not suffer from a lack of nurses, but that:

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"... they would have if two trained staff had been tied up titrating and drawing up and giving injections of Diamorphine, even every four hours, let alone every hour."

You also accepted that titrating doses is a basic standard medical principle. Mr Kark asked you:

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"And you are saying that under your watch that simply was not being done throughout these three years?"

F

You replied:

"I am saying that. I was not taught it. I was not familiar with using it....it was not practical....it just was not feasible."

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18. The effect of staffing pressures on your prescribing practice

i. The Panel received evidence from a wide range of witnesses that the impression given to the visitor to Dryad and Daedalus wards was that the wards were well run and that

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patients were taken good care of. You were full of praise for your nursing staff and the job they did. You were clear that the quality of nursing care that your patients received was not compromised by staffing pressures: you stated that opiates were never started earlier, or at a higher rate, because of inadequate staffing; you told the Panel that that would have been quite inappropriate. Your view on the effect of staffing pressures was borne out by Sister Joines and a large number of other witnesses.

ii. In terms of your own prescribing practices, however, you told the Panel that staffing pressures did have some effect. You told the Panel that, in addition to reducing the time you had available to make notes in patient records, your system of anticipatorily prescribing wide ranges of opiates for delivery by syringe driver with what some might view as a high starting dose, and in the absence of titration, was a direct and necessary result of staffing pressures.

iii. Mr Langdale asked Professor Sikora:

> "What effect does ... reduction of staff levels in terms of the availability of numbers and time have on the choices available to a doctor in Dr Barton's position with regard to the pharmacological route?"

He replied:

> "It means there is not going to be the level of observation that would, perhaps, be optimal on an individual patient in distress and pain. Therefore using the pharmacological route at a higher dose, starting dose and a higher upper limit, would seem a reasonable proposition under those circumstances."

The Panel noted that such a strategy might conversely create the need for a higher level of observation if patients are to be adequately protected in the event that adverse consequences

manifest themselves.

19. The role of consultants

The Panel heard that, at the time in question, the presence of consultants on Dryad and Daedalus wards was extremely limited. Although the consultants who gave evidence before the Panel were supportive of you, their evidence tended to suggest that they had not critically examined your prescribing practice, and in many instances had not appreciated your admitted prescribing failures. Had they done so, this should have resulted in appropriate changes being made to your prescribing practice.

20. Mr Langdale's argument that the very fact that senior medical staff and the visiting pharmacist did not object indicated that you were doing nothing wrong

i. As stated above, the Panel took the view that the consultants on the ward systematically failed to critically examine your prescribing practice. While the effect of this failure might have been to reinforce your view that you were not acting inappropriately, it in no way rendered your inappropriate conduct appropriate. The Panel noted that as a medical practitioner you retained ultimate responsibility for your own actions.

ii. In respect of the pharmacist, the Panel has not had the advantage of receiving any evidence from her. In the circumstances the Panel is unable to draw any conclusions with respect to your actions or inactions as a consequence of her actions or inactions. However, the Panel noted your admissions with regard to your own prescribing deficiencies, and that it has heard no evidence that these were detected and acted upon by the pharmacist.

21. The principle of double effect

i. The Panel heard from Professor Ford that:

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"The principle of double effect is that one may need to palliate symptoms, and that the treatment one needs to give to palliate symptoms may lead to a shortening of life through adverse effects. That is well accepted as being a reasonable and appropriate aspect that may happen when one adequately palliates symptoms."

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ii. Professor Ford told the Panel:

"One has to give drugs and doses that are reasonable and appropriate to palliate symptoms. Then, with certain groups of drugs like sedatives, the issue is giving excessively high doses which have an effect which go beyond what the patient needed to palliate their symptoms."

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D

iii. The Panel has examined, in respect of each patient, the issue of the prescribing of drugs which have or might have an effect which goes beyond what the patient needed to palliate their symptoms. The Panel noted that the importance of this issue is partly explained by Professor Ford's evidence on sedation therapy.

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iv. Professor Ford told the Panel that:

"Sedation therapy, it has been commented, is open to misuse – I am not saying it was misused, but the problem is, because they are so powerful at producing respiratory depression, one systematic review of sedation in end of life care comments that it can ostensibly be used to relieve distress but with the manifest intent of hastening death. I am not saying that was the intent here, I am saying that is the concern about why one needs to document very carefully the use of sedation in an end of life setting, that it is used appropriately to control patients' symptoms."

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v. The Panel considered that the importance of this issue is further explained by the view that in addition to the right to be provided with

appropriate analgesia, the patient has a balancing right to be kept as alert and conscious as proper management of their pain allows. On the issue of balancing the need to be pain-free with the ideal of being free from side-effects, Professor Sikora told the Panel:

> "...usually it is achievable, to get pain-free without troubles from the side effects of the medication – including over-sedation side effects – by judicious use of the drugs..."

vi. You were clearly aware of the principle of double effect. For example:

a. Mr Langdale asked you in relation to your treatment of Patient A:

> "What about the concern that this (high dose) was going to cause respiratory depression or lowering his conscious level?"

You replied:

"I accepted that that was a price that we might have to pay in exchange for giving him adequate pain and symptom relief."

Mr Langdale asked:

> "Why not leave it because of the risk of it having an adverse effect?"

You replied:

> "At that point I was not concerned about any potential adverse effect. I wanted Mr Pittock comfortable and free of all these wretched symptoms."

b. With regard to Patient B you told the Panel:

> "The judgment is that I wanted to give her adequate pain relief and relief of her symptoms, of what were now becoming terminal restlessness, so I was minded to give her adequate analgesia and sedation to control those, and I was accepting that she might well be over-sedated."

c. With regard to Patient C you were asked whether there was any risk of over-sedation or respiratory depression because of the

declining effects of Fentanyl. You replied:

> "There would always [be] a risk. I was prepared to accept that risk in order to give her adequate analgesia and to add in the Midazolam. I thought that the risk was acceptable in this particular patient."

With respect to Patient B, Mr Langdale asked you why you did not reduce the level of medication so that while managing your patient's pain you also kept her alert. Your response was: "More alert to feel more pain."

vii. The Panel took the view that this final response gave a clear insight into how you viewed the desirability of balancing pain relief with the desirability of keeping the patient as free as practicable from the side effects of opiates.

PART TWO

At the outset of the hearing, Mr Langdale admitted a number of parts of the allegation on your behalf and the Panel found them proved.

In respect of the unadmitted parts of the allegation, the Panel has considered all of the evidence and has taken account of Mr Kark's submissions on behalf of the GMC and those made by Mr Langdale on your behalf.

The Panel has borne in mind that the burden of proof rests on the GMC and that the standard of proof applicable in these proceedings is the criminal standard, namely that the Panel must be sure beyond reasonable doubt.

Having considered each of the remaining allegations separately, the Panel has made the following findings:

Head 1 has been admitted and found proved.

A **Mr Leslie Pittock (Patient A)**

Head 2a in its entirety has been admitted and found proved.

B **Head 2b i in relation to head 2a ii (in relation to Diamorphine only, as Midazolam was not prescribed) has been found proved.**

The Panel has accepted the evidence of Professor Ford that the appropriate lowest dose in the

C range for this opiate naïve patient would at this stage have been 15 mg of Diamorphine. The lowest dose of Diamorphine that you prescribed was 40 mg.

Head 2b i in relation to head 2a iii in relation to the Diamorphine has been found

D **proved.**

The Panel noted that, at the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. The Panel had regard to paragraph 14 ix above, and

E applying the appropriate conversion rate, calculated that the anticipatory prescription provided for an increase in the equivalent level of analgesia provided for in the existing prescription and was therefore too high.

F **Head 2b i in relation to head 2a iii in relation to the Midazolam has been found proved.**

The Panel first reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of

G Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 above regarding the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest

H dose of Midazolam prescribed was too high.

Head 2b ii in relation to head 2a ii has been found not proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range did not offend against that principle.

Head 2b ii in relation to head 2a ii has been found not proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range did not offend against that principle.

Head 2b ii in relation to head 2a iii has been found not proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range did not offend against that principle.

Head 2b iii has been admitted and found proved.

Head 2c has been found not proved.

The Panel had regard to paragraph 13 above, in respect of prescribing outside the guidelines. The Panel noted that you attended the patient in person on both occasions and exercised your own clinical judgment in assessing the appropriate dose. Having reviewed all the evidence, the Panel cannot be sure that the doses administered were excessive to the patient's needs.

Head 2d has been found proved.

The Panel noted paragraphs 12 i and 14 x above which indicate that great care should be exercised in prescribing Diamorphine and Midazolam in combination, as both have sedative effects. The Panel also notes that this prescription contained a combination of Diamorphine, Midazolam, Haloperidol and Nozinan. The Panel notes your admission that, as Haloperidol and Nozinan both have sedative effects, you should have discontinued the Haloperidol when you introduced the Nozinan.

Heads 2e i – iii in relation to head 2a ii have been found proved.

In the light of the Panel's findings that the lowest prescribed dose of Diamorphine was too high and that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, the Panel concluded that this prescription was inappropriate, potentially hazardous and not in the best interests of the patient.

Heads 2e i and iii in relation to head 2a iii have been found proved.

Head 2e ii in relation to head 2a iii has been admitted and found proved.

Having found that the lowest doses prescribed were too high, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and your having admitted and the Panel having found that the prescription was potentially hazardous, the Panel concluded that this prescription was inappropriate and not in the best interests of the patient.

Heads 2e i and iii in relation to head 2a iv have been found not proved.

Head 2e ii in relation to head 2a iv has been found proved.

Heads 2e i and iii in relation to head 2a v have been found not proved.

Head 2e ii in relation to head 2a v has been found proved.

Given that the charge relating to the doses of Diamorphine administered on both 15 and 17 January 1996 was not found proved the Panel could not be sure that the prescription was either inappropriate or not in the best interests of Patient A although, by the nature of the prescription, the Panel did conclude that it was potentially hazardous.

Heads 2e i – iii in relation to head 2a vi have been found proved.

Having found that the prescription of 18 January 1996, in combination with other drugs already prescribed, was excessive to the patient's needs and, given the sedative effect of the prescribed drugs in combination, the Panel was satisfied that the prescription was inappropriate, potentially hazardous and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Elsie Lavender (Patient B)

Heads 3a i – iv in their entirety have been admitted and found proved.

Head 3b i in relation to head 3a iii in relation to the Diamorphine has been found proved.

The Panel noted that, at the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. The Panel had regard to paragraph 14 ix above, and applying the appropriate conversion rate, calculated that the anticipatory prescription provided for an increase in the level of analgesia the patient was on at the time of prescription, and was therefore too high.

Head 3b i in relation to head 3a iii in relation to the Midazolam has been found proved.

The Panel first reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 above regarding the overall

sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Head 3b i in relation to head 3a iv in relation to the Diamorphine has been found not proved.

The Panel had regard to paragraph 13 above, in respect of prescribing outside the guidelines. The Panel noted that you attended the patient in person prior to issuing this prescription, and that you exercised your own clinical judgment in assessing the appropriate dose. Having reviewed all the evidence, the Panel cannot be sure that the lowest dose prescribed was too high.

Head 3b i in relation to head 3a iv in relation to the Midazolam has been found proved.

In reaching this finding, the Panel has accepted Professor Ford's evidence that Midazolam is not indicated for pain. Further, the Panel reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 x above in relation to the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Heads 3b ii and iii have been admitted and found proved.

Heads 3c i - iii in relation to head 3a ii have been found not proved.

The Panel noted Professor Ford's opinion that the prescription of Morphine Slow Release Tablets (MST) 10 mg twice a day might be acceptable. Accordingly, the Panel could not be sure that this prescription was inappropriate, potentially hazardous and not in the best interests of Patient B.

Heads 3c i and iii in relation to head 3a iii have been found proved.

Head 3c ii in relation to head 3a iii has been admitted and found proved.

On 26 February 1996 you increased the prescription for MST from 10 mg to 20 mg twice a day and prescribed a variable dose combination of Diamorphine and Midazolam on syringe driver. The Panel considers that the increased dose of MST was in itself high. The Panel has noted that at the outset of the hearing you admitted that this prescription was too wide, potentially hazardous and created a situation whereby drugs could be administered which were excessive to the patient's needs. Further, and having regard to paragraphs 11–14 above, in relation to the prescription of opiates, their side-effects and effect in combination with Midazolam, the Panel is satisfied that your actions in issuing this prescription were inappropriate and not in the best interests of Patient B.

Heads 3c i and iii in relation to head 3a iv have been found proved.

Head 3c ii in relation to head 3a iv has been admitted and found proved.

The Panel had regard to paragraphs 12 – 14 above in relation to prescribing opiates outside

the guidelines and the effects of opiates in combination with Midazolam. In addition, you admitted that your prescription for Diamorphine and Midazolam in combination was too wide, was potentially hazardous, and created a situation whereby drugs could be administered which were excessive to the patient's needs. Accordingly the Panel has found that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Head 3d i has been found not proved.

In reaching this finding, the Panel noted Mr Kark's concession in his closing submissions that Professor Ford found no fault with your management of the patient at the time of her admission and that your examination of her was appropriate.

Head 3d ii has been found proved.

The Panel accepted Professor Ford's view that you should have addressed the question of the cause of pain complained of by the patient. Your continuing failure to address the reason why she was experiencing pain rendered your assessment of her, as her condition deteriorated, inadequate.

Head 3d iii has been found not proved.

The Panel has noted that you saw the patient's family on 26 February 1996 and that they were aware of your assessment that she was now on the terminal pathway. Other than this, your clinical notes did not include a treatment plan beyond the need for a Pegasus mattress and analgesia if necessary. Nonetheless, whether adequate or not, there was a treatment plan.

Head 3d iv has been admitted and found proved.

Heads 3e i and ii have been found proved.

In the light of the Panel's multiple findings against you in relation to your management of the patient, the Panel concluded that your actions and omissions were inadequate and not in the patient's best interests.

Heads 14a i - iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Eva Page (Patient C)

Heads 4a and b in their entirety have been admitted and found proved.

Heads 4c i and iii have been found proved.

Head 4c ii has been admitted and found proved.

The Panel has had regard to paragraphs 12, 14 x, 16 and 17 above in relation to the combination of Diamorphine and Midazolam and the use of syringe drivers. In the light of your admission that the dose range of Diamorphine and Midazolam was too wide, that its prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your actions in prescribing them were potentially hazardous, the Panel found that your actions in prescribing them were also inappropriate and not in the best interests of the patient. The Panel further noted that at the time you made this prescription you had also prescribed a Fentanyl patch.

Heads 14a i –iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Head 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Alice Wilkie (Patient D)

Heads 5a and b in their entirety have been admitted and found proved.

Heads 5c i and iii have been found proved.

Head 5c ii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

Further, the Panel noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous.

Heads 14a i-iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing

staff.

Heads 14a v and vi have been admitted and found proved.

Heads14b i and ii have been admitted and found proved.

Heads 15a and b have been found proved.

The Panel has received no documentary evidence to indicate that you assessed this opiate naïve patient prior to prescribing opiates. You told the Panel that you could not be sure that you had formally assessed the patient, as you might have been away around that time. You told the Panel that on your return to the ward on about 17 August 1998 that "we had mayhem occurring", and that though you might have seen the patient, you would have relied on the verbal reporting of assessments made by nursing staff. It follows that this prescription to an opiate naïve patient was not based on an appropriate assessment by you and that your failure was not in the patient's best interests.

Mrs Gladys Richards (Patient E)

Heads 6a and b in their entirety have been admitted and found proved.

Heads 6c i – iii in relation to head 6a ii have been found proved.

You conceded that although this patient had experienced an earlier adverse reaction to Morphine, she was effectively opiate naïve on admission to Daedalus ward on 11 August 1998. At this time her pain was being managed by Co-codamol. Accordingly, the Panel had regard to paragraphs 9 and 14 ix above as to guidelines and the Analgesic Ladder and the equivalence of doses and accepted the view of Professor Ford that you should

have followed the Analgesic Ladder in prescribing for this patient.

Heads 6c i and iii in relation to head 6a iii have been found proved.

Head 6c ii in relation to head 6a iii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient and the Panel had regard to paragraphs 9-14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects and anticipatory prescribing. The Panel accepted Professor Ford's view that you should have followed the Analgesic Ladder in prescribing for this patient.

In addition, the Panel noted that you admitted that the dose range was too wide, the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a, it follows that head 15b must fall.

Mrs Ruby Lake (Patient F)

Heads 7a and b in their entirety have been admitted and found proved.

Head 7c i in relation to head 7a ii has been found not proved.

The Panel noted that you prescribed Oramorphine in response to complaints of pain by an opiate naïve patient. The Panel further noted that it is your view that this was justified, as you considered her to be exhibiting symptoms of congestive cardiac failure. In the circumstances, the Panel could not be satisfied that this prescription was inappropriate.

Head 7c ii in relation to head 7a ii has been found proved.

This was an anticipatory prescription for an opiate naïve patient and the Panel had regard to paragraphs 9-14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects and anticipatory prescribing. The Panel noted that by its very nature, any prescription of opiates is potentially hazardous.

Head 7c iii in relation to head 7a ii has been found not proved.

The Panel concluded that the prescription may by its nature be potentially hazardous, but nonetheless in the best interests of the patient, and not inappropriate. That was the case here.

Heads 7c i and iii in relation to head 7a iii have been found proved.

Head 7c ii in relation to head 7a iii has been admitted and found proved.

You admitted that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs and that the prescription was potentially hazardous. In the circumstances, the Panel concluded that this prescription was inappropriate and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a, it follows that head 15b must fall.

Mr Arthur Cunningham (Patient G)

Heads 8a and b have been admitted and found proved.

Heads 8c i and iii in relation to head 8a ii have been found proved.

Head 8c ii in relation to head 8a ii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient and the Panel had regard to paragraphs 9-14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects and anticipatory prescribing.

In addition, the Panel noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs and that the prescription was potentially hazardous.

Heads 8c i and iii in relation to head 8a iii have been found proved.

Head 8c ii in relation to head 8a iii has been admitted and found proved.

The Panel had regard to paragraphs 12 – 14 above as to combining Diamorphine and Midazolam, prescribing opiates outside the guidelines and anticipatory prescribing, and noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs and that your actions in prescribing the drugs were potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing these drugs were inappropriate and not in the best interests of the patient.

Head 8d has been admitted and found proved.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a, it follows that head 15b must fall.

Mr Robert Wilson (Patient H)

Head 9a in its entirety has been admitted and found proved.

Heads 9b i, ii and iv in relation to head 9a ii have been found proved.

Head 9b iii in relation to head 9a ii has been found not proved.

The Panel noted that this was a prescription for immediate administration and the Panel had regard to paragraph 13 above with reference to prescribing opiates outside the guidelines. The Panel noted, however, that the patient's alcohol related liver disease fundamentally altered the prescribing situation. The Panel accepted Professor Ford's view that "best practice would have been to go through

the Analgesic Ladder through a moderate opioid to begin with, with paracetamol ..."

The Panel further accepted Professor Ford's view that, if Oramorphine became appropriate, it would have been important to have started with a low dose, bearing in mind the increased risks the prescription of opiates posed to a patient with alcohol related liver disease.

In all the circumstances the Panel concluded that the prescription at this time was:

- inappropriate;
- potentially hazardous, in that it had the potential to lead to serious and harmful consequences for the patient. The Panel was unable to be sure, however, that the prescription was likely to lead to serious and harmful consequences for the patient;
- not in the best interests of the patient.

Head 9c in its entirety has been admitted and found proved.

Heads 9d i – iii in relation to head 9a ii have been found proved.

The Panel relies on its findings above in relation to heads 9b i – iii.

Heads 9d i and iii in relation to head 9a iii have been found proved.

Head 9d ii in relation to head 9 a iii has been admitted and found proved.

At the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. The Panel had regard to paragraph 14 ix above concerning equivalence of doses and, applying the appropriate conversion rate, noted that the anticipatory prescription did provide for an increase in the lowest level of analgesia, and was therefore too high. The Panel further noted your admissions in relation to your prescription that the dose range was

too wide, the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your action in prescribing the drug was potentially hazardous.

Heads 9d i and iii in relation to head 9a iv have been found proved.

Head 9d ii in relation to head 9 a iv has been admitted and found proved.

The Panel concluded that in the light of the patient's alcohol related liver disease, the prescription of even a small amount of Midazolam was inappropriate and not in the best interests of the patient, especially given that the patient had already been prescribed a significant dose of Diamorphine. The Panel further noted your admission that your actions in prescribing Midazolam were potentially hazardous.

Head 9e has been admitted and found proved.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Enid Spurgin (Patient I)

Head 10a in its entirety has been admitted and found proved.

Head 10b in its entirety has been found not proved.

The Panel noted that Dr Reid had assessed the patient shortly before her transfer to the ward. The Panel also noted Professor Ford's view that it would not have been necessary for you to investigate the cause of the patient's pain at the time of admission; albeit that he felt such an investigation would have been necessary at a later stage. In the circumstances, the Panel could not be satisfied that your assessment of the patient on admission was either inadequate or not in her best interests.

Head 10c in its entirety has been admitted and found proved.

Heads 10d i and iii in relation to head 10a ii have been found proved.

Head 10d ii in relation to head 10a ii has been admitted and found proved.

In the light of your admission that the dose range of Diamorphine and Midazolam was too wide, that its prescription created a situation whereby drugs could be administered which

were excessive to the patient's needs, and that your actions in prescribing them were potentially hazardous, the Panel found that your actions in prescribing them were also inappropriate and not in the best interests of the patient.

Heads 10e i – iii in relation to head 10a iii have been found proved.

The Panel had regard to paragraph 13 above relating to prescribing opiates outside the guidelines. However, it noted that when Dr Reid saw this patient on his ward round, he observed that she was over-sedated and that the width of dosage range was too wide. He ordered the dosage of Diamorphine to be reduced by 50 per cent. In the circumstances the Panel was sure that the dosage authorised/directed by you was excessive to the patient's needs and was inappropriate, potentially hazardous and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried

A out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

B **Mr Geoffrey Packman (Patient J)**

Head 11a in its entirety has been admitted and found proved.

Head 11b i in relation to head 11a v in relation to the Diamorphine has been found not
C **proved.**

The Panel noted that, at the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. Having regard to paragraph 14 above concerning
D equivalence of doses, and applying the appropriate conversion rate, the Panel calculated that the anticipatory prescription did not provide for an increase in the equivalent level of analgesia provided for in the existing prescription, and was not therefore too high.

E **Head 11b i in relation to head 11a v in relation to Midazolam has been found proved.**

The Panel first reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of
F Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 above regarding the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was
G sure that the lowest dose of Midazolam prescribed was too high.

Heads 11b ii and iii have been admitted and found proved.

H **Heads 11c i – iii in relation to head 11a ii have been found not proved.**

Professor Ford was not critical of you for giving verbal permission for 10 mg of Diamorphine to be administered to the patient on 26 August 1999. In his closing submissions, Mr Kark conceded that in the light of Professor Ford's concession in respect of this head, the Panel might think it appropriate that it should fall. The Panel accepted that view.

Heads 11c i and iii in relation to head 11a v have been found proved.

Head 11c ii in relation to head 11a v has been admitted and found proved.

The Panel has found that the lowest dose of Midazolam prescribed was too high, and you have admitted that the dose range of Diamorphine and Midazolam was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your action in prescribing the drugs was potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Heads 11d i and ii in relation to head 11a iv have been found proved.

The Panel had regard to paragraph 2 iv above in relation to investigating the patient's condition. It noted Professor Ford's view that:

> "...there would have to be a clear senior decision in a man like this ... to make a decision not to undertake active intervention for his problem...".

The Panel noted with concern your assertion that it would have made no difference to this patient's care/condition if you had obtained further medical advice and/or undertaken further investigations. In the Panel's view you should have done both before making the decision to

put the patient onto the syringe driver. Accordingly, the Panel has concluded that your failure was inappropriate and not in the patient's best interests.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Elsie Devine (Patient K)

Head 12a in its entirety has been admitted and found proved.

Head 12b has been found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to

paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

The Panel noted Professor Ford's view that your prescription was not justified in the light of the patient's presenting symptoms, i.e. confused and agitated but no complaint of pain. The Panel accepted his view that if there were to be an anticipatory prescription for this opiate naïve patient, 2.5 mg would be the appropriate starting dose and 10 mg would be high. In all the circumstances, the Panel concluded that this prescription was not justified.

Head 12c i in relation to head 12a iv has been found proved.

The Panel noted that there had been no attempt at titration, and that even the lowest doses of Diamorphine and Midazolam would have been likely to induce a very powerful sedative effect with a consequent risk of respiratory depression.

The Panel had regard to paragraphs 11, 13 ii, 16 and 17 above in relation to the side-effects/adverse consequences of opiates, prescribing opiates outside the guidelines, and the use of syringe drivers. The Panel accepted Professor Ford's view that the lowest doses of Diamorphine and Midazolam would have had a profoundly sedating effect, especially in combination with the Fentanyl which was already prescribed. Professor Ford told the Panel that when the syringe driver started the level of Fentanyl already in the patient's blood stream would have been at its peak. The Panel took the view that, as a consequence, this prescription put the patient at severe risk of respiratory depression, coma and premature death. The Panel noted that the patient lapsed into unconsciousness shortly after the syringe driver commenced at 09:25 on 19 November and that she remained unconscious until her death at 20:30 on 21 November.

Head 12c ii in relation to head 12a iv in relation to Diamorphine has been found not proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range did not offend against that principle.

Head 12c ii in relation to head 12a iv in relation to Midazolam has been found proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range offended against that principle.

Head 12c iii in relation to head 12a iv has been found proved.

It follows from the Panel's finding that the lowest doses of Diamorphine and Midazolam prescribed were too high that your prescribing created a situation whereby drugs could be administered which were excessive to the patient's needs.

Heads 12d i – iii in relation to head 12a ii have been found proved.

In the light of the Panel's finding that your prescription of Morphine solution was not justified, the Panel concluded that your actions in prescribing it were inappropriate, potentially hazardous (by the very nature of the drug prescribed) and not in the best interests of the patient.

Heads 12d i – iii in relation to head 12a iii have been found proved.

A

The Panel accepted Professor Ford's view that, given the patient's condition, especially her dementia, and the potential side-effects of Fentanyl on such a patient, made it an inappropriate and potentially hazardous prescription which was not in the best interests of the

B patient.

Heads 12d i – iii in relation to head 12a iv have been found proved.

C The Panel having found that the lowest doses of Diamorphine and Midazolam prescribed were too high, that the dose range in respect of the Midazolam was too wide, and that the prescription created a situation whereby drugs could be administered which were excessive to

D the patient's needs, the Panel concluded that your actions in prescribing these drugs were inappropriate, potentially hazardous and not in the best interests of the patient.

Head 12e has been admitted and found proved.

E

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

F The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

G **Heads 14a v and vi have been admitted and found proved.**

Heads 14b i and ii have been admitted and found proved.

H **Heads 15a and b have been found not proved.**

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

A

Mrs Jean Stevens (Patient L)

Head 13a has been admitted in its entirety and found proved.

B

Head 13b i in relation to head 13a ii has been found proved.

The Panel noted that, at the time of this anticipatory prescription, the patient had already been receiving low levels of opiates. The Panel had regard to paragraph 14 ix above in relation to

C

equivalence of doses, and applying the appropriate conversion rate, calculated that the anticipatory prescription provided for an increase in the equivalent level of opiates which the patient had already been receiving. Consequently, there was insufficient clinical justification for this prescription of the opiates.

D

With regard to the anticipatory prescription for Midazolam, the Panel noted Professor Ford's view that there was no clear evidence that the patient was suffering terminal restlessness. Further, the Panel had regard to paragraphs 12 and 14 x above concerning the caution

E

required before prescribing Midazolam for a patient who was already receiving opiates. The Panel concluded that in light of the inherent dangers in prescribing Midazolam in conjunction with opiates, and its acceptance of the view that there was no clear evidence that the patient

F

was suffering from terminal restlessness, there was insufficient clinical justification for the prescription of Midazolam.

Heads 13b ii and iii in relation to head 13a ii have been admitted and found proved.

G

Heads 13b iv a – c in relation to head 13a ii have all been found proved, save for head 13b iv b which in relation to Diamorphine has been admitted and found proved.

H

You admitted and the Panel found proved that the dose range of Diamorphine and Midazolam was too wide, that the prescriptions

created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription of the Diamorphine was potentially hazardous. The Panel further found that there was insufficient clinical justification for the prescriptions. In all the circumstances, the Panel concluded that your actions in prescribing the drugs were inappropriate, potentially hazardous and not in the best interests of the patient.

Head 13b i in relation to head 13a iii has been found proved

The Panel having found that there was no clinical justification for the 20 May prescription of Oramorphine, and there being no evidence of relevant change in the patient's condition at the time of this regular prescription for Oramorphine, it follows that there was insufficient clinical justification for this prescription also.

Heads 13b ii and iii in relation to head 13a iii have been admitted and found proved.

Heads 13b iv a – c in relation to head 13a iii have been found proved.

You admitted and the Panel found proved that this prescription created a situation whereby drugs could be administered which were excessive to the patient's needs. The Panel further found that there was insufficient clinical justification for this prescription. In all the circumstances, the Panel concluded that your action in prescribing the Oramorphine was inappropriate, by its nature potentially hazardous, and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

PART THREE

The Panel has made multiple findings that your conduct has been inappropriate, potentially hazardous and/or not in the best interests of your patients. It has concluded that the facts found proved (both admitted and otherwise) would not be insufficient to support a finding of serious professional misconduct.

The Panel will invite Mr Kark to adduce evidence, if he wishes to do so, as to the circumstances leading up to the facts which have been found proved, the extent to which those facts indicate serious professional misconduct on your part and as to your character and previous history. The Panel will then invite Mr Langdale to address it on your behalf in relation to those matters and also to

adduce evidence in mitigation, if he wishes to do so. Counsel should refer to the GMC's Indicative Sanctions Guidance (April 2009 edition, with 7 August 2009 revisions) when making submissions in relation to sanction.

Thereafter, the Panel will proceed to consider whether you have been guilty of serious professional misconduct in respect of the facts that have been found proved and, if so, they will go on to consider whether or not they should make any direction regarding your registration.

Mr Kark, Mr Langdale, I am acutely conscious of the fact that the time remaining for this Panel currently scheduled runs out at approximately five o'clock tomorrow afternoon. In the circumstances, what are you wishes? Mr Kark first.

MR KARK: The reality is, sir, there seems very little prospect of finishing this case in this session. That is the first comment to make. Before addressing you we, on behalf of the GMC, would like a little time to review your findings and consider the precise submissions that we make.

You may find it unattractive, I expect, to receive submissions on sanction and serious professional misconduct now and mitigation now if are you then going to have to adjourn for what may be a considerable period before everybody can be brought together again in order to continue the process.

THE CHAIRMAN: I can say that we would find that quite inappropriate.

MR KARK: Then the real question, I suppose, is when we all meet again. I know that your Panel Secretary has been making inquiries. Unfortunately I gather the date may be some time in the far future. I do not know if Mr Langdale agrees with me.

THE CHAIRMAN: Mr Langdale, do you have any observations at this stage?

MR LANGDALE: Sir, in the circumstances I cannot do anything else but agree with what Mr Kark has said.

THE CHAIRMAN: Very well. What I propose is that we explore now the potential for resuming at a later date and that once we have managed that, we will adjourn until such date.

MR KARK: I do not know whether you want to conduct that exercise now in public, or whether that should be done administratively with your Panel Secretary.

THE CHAIRMAN: I think it can be done partly administratively, but first it would be helpful if we could have indications from the parties as to how much time they would feel we should

be seeking to schedule.

MR KARK: That is rather difficult. I know approximately how long I will be, I think, in addressing you. I will probably be a little longer than I would have been if I had been addressing you now, as it were, because there may be an element of review. I would certainly hope to be no longer than two hours, and I would have thought very much shorter than that. Being as realistic as possible, I would have thought one ought to say an hour, up to two for me. I am sure that Mr Langdale and I would both finish our submissions well within half a day, and I see Mr Langdale nodding in agreement with that.

The question then is, how long you will be, and you will have to deal with two elements, of course; the first is serious professional misconduct. The second, if you do find serious professional misconduct, is the sanction and then you will have to write out your determination.

I had in my mind something in the region of five days for that but what we have to avoid, if I may say so, is any possibility whatever of going part heard again, so I think we should be pessimistic about how long it is going to take you rather than optimistic.

THE CHAIRMAN: I think that is very sensible. Mr Langdale, do you have any observations or assistance that you can offer in regard to timing?

MR LANGDALE: I agree with Mr Kark, that in terms of anything we respectively seek to say to the Panel, that can be dealt with within half a day. There is a certain amount of material I shall be seeking to place before the Panel. I do not intend to go through it all in the course of what I seek to say. It will certainly involve the Panel in having to spend some time looking at it. It is not an enormous amount of material but it is substantial rather than insignificant. It is impossible for us to make any judgment about how long the Panel want to consider our submissions of this sort of material, but I would have thought that if one says a week for the entire process, to be on the safe side, that would be sensible.

THE CHAIRMAN: Depending upon when this is to take place, there is also the matter of the Panel getting back up to speed. We would need to factor in time for the Panel to simply re-read a number of crucial documents and put ourselves in a position where we are able to do both the GMC and the doctor justice in making our considerations. Given the volume of material that it involved, that is by no means a short matter.

I think it fair to say that the Panel, out of an abundance of caution and particularly with regard to Mr Kark's point that whatever happens we must run no risk of running out of time again, would be wishing to indicate to those who schedule two working weeks, or ten days, on the basis that two of them might very well be taken up with preparation on our part before we ask you to address us.

MR KARK: We are certainly not going to disagree with that, I think, because there is so much of he element the Panel brings to that. That is important. Our submissions can be very short, as we have indicated, but we wholly understand that you will need time to read in. The longer away that we find those adjourned proceedings to be, the longer you will need to read into it.

I do not know if it is appropriate now to discuss the dates.

THE CHAIRMAN: I can certainly tell you that the earliest opportunity at which the entirely Panel is able to re-assemble is I the final two weeks of January.

MR KARK: Right.

THE CHAIRMAN: I should say that thereafter there are further difficulties, and we are currently looking at April before the next occasion when we can all reassemble.

MR KARK: It is in everybody's interest, both I would have thought Dr Barton's, those members of the public who are interested and relatives. Obviously, we should take the earliest possible that we can. It is unfortunately, of course, that it is as far forward as January.

I know for my part that I am in fact then doing a case here in London, fortunately. I will have to ask my chairman, as it were, to allow me not to be present for, I suppose, about half a day. I would certainly be grateful to know at some stage how much reading time you are going to need so that I schedule that appearance in front of you as accurately as I can.

THE CHAIRMAN: That would be an administrative matter that can certainly be handled.

MR KARK: Thank you.

THE CHAIRMAN: Mr Langdale?

MR LANGDALE: Again, what my learned friend says is absolutely right: the sooner the better from everybody's point of view.

THE CHAIRMAN: Very well, then. What I propose is that we will adjourn now. We are going to adjourn at this stage on the basis that it is the intention that we, as a Panel, return at the beginning of the third week in January, and that we are going to ask for a total of ten room-days to be made available to us. I very much hope that we will run a lot shorter than that, but as previously indicated this is not a matter on which we should take any risks at all. The date can be put forward now to the administration if it is a date with which all parties are content. We shall put that forward, and it will be a matter of administration in due course whether that is confirmed. I would hope that it will be.

MR KARK: Can it be underlined that that must be in London?

THE CHAIRMAN: Yes.

MR KARK: I have known cases be transferred.

THE CHAIRMAN: Yes. I think we can certainly make a very strong case for that, not least because this is a case which has attracted a considerable attendance from interested parties, in particular relatives of patients concerned. By definition, one would expect most of them to be living in the South rather than in the Midlands. It would be really most unfortunate if it were to be transferred. In so far as we can, we will underline the request that we would wish there to be no transfer.

MR KARK: I am grateful.

THE CHAIRMAN: That it would take place here. Are there any other matters? Very well. Thank you very much indeed, ladies and gentlemen, for your patience and forbearance. All being well, we will resume in January. This matter is adjourned.

(The Panel adjourned to a date to be confirmed)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday, 29 January 2010

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Duncan Smith

CASE OF:

BARTON, Jane Ann

(DAY FIFTY-SEVEN)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.
(Mr Tom Kark was not in attendance for the Determination).

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was not present.
(Mr Timothy Langdale QC was not in attendance for the Determination).

(Transcript of the shorthand notes of T A Reed & Co. Ltd.
Tel No: 01992 465900)

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STRANGERS HAVING BEEN READMITTED

DETERMINATION

THE CHAIRMAN: Good morning everybody.

Mr Jenkins, the Panel has considered Dr Barton's case in accordance with the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 (Old Rules). As a consequence, when determining whether the facts alleged had been proved, the Panel applied the criminal standard of proof. This means that it had to be satisfied beyond reasonable doubt of the facts alleged before it could find them proved.

The Panel wishes to make clear at this stage that it is not a criminal court and that it is no part of its role to punish anyone in respect of any facts it may find proved.

At the outset of the hearing Mr Langdale QC admitted a number of parts of the allegation on Dr Barton's behalf and the Panel found those facts proved. The Panel made further findings in relation to the un-admitted parts of the allegation and gave detailed reasons for those findings in its earlier determination on the facts.

Serious Professional Misconduct

The task for the Panel at this stage of the hearing is first, to determine whether, on the basis of the facts found proved, Dr Barton has been guilty of Serious Professional Misconduct. If the Panel finds that she has been guilty of Serious Professional Misconduct it is then required to consider what action, if any, to take in respect of that misconduct.

In making this first decision, the Panel has considered whether the actions and omissions found proved in relation to Dr Barton's care of the 12 patients who have featured in this case amounted to misconduct which offends against the professional standards of doctors. If it did, the Panel has then determined whether that misconduct was serious.

The Panel has taken into account all the evidence it has heard and read throughout this hearing. It has referred to its determination on the facts found proved and the reasons for its findings, as well as the GMC's publication *Good Medical Practice* (1995 edition) which was

applicable at the time. Further, the Panel has had regard to the context and circumstances in which Dr Barton was then working.

The Panel considered the submissions made by Mr Kark on behalf the General Medical Council (GMC) and by Mr Langdale and yourself on Dr Barton's behalf, and accepted the advice of the Legal Assessor.

Mr Kark submitted that Serious Professional Misconduct should be viewed historically. He reminded the Panel that while there is no definition of serious professional misconduct the test to apply is whether, when looking at all the facts that have been admitted and found proved, Dr Barton's conduct amounts to a serious falling below the standard which might be expected of a doctor practising in the same field of medicine in similar circumstances.

Mr Langdale concurred.

The Panel took account of the above and exercised its own judgment, having regard to the principle of proportionality and the need to balance the protection of patients, the public interest and Dr Barton's own interests.

The Panel made multiple findings of fact which were critical of Dr Barton's acts and omissions. These included but were not limited to:

- The issuing of prescriptions for drugs at levels which were excessive to patients' needs and which were inappropriate, potentially hazardous and not in the patients' best interests;
- the issuing of prescriptions for drugs with dose ranges that were too wide and created a situation whereby drugs could be administered which were excessive to the patient's needs;
- the issuing of prescriptions for opiates when there was insufficient clinical justification;
- acts and omissions in relation to the management of patients which were inadequate and not in their best interests. These included failure to conduct adequate assessments, examinations and/or investigations and failure to assess appropriately patients' conditions before prescribing opiates;

- failure to consult colleagues when appropriate;
- acts and omissions in relation to keeping notes which were not in the best interests of patients, including failure to keep clear, accurate and contemporaneous notes in relation to patients, and in particular, in relation to examinations, assessments, decisions, and drug regimes.

The Panel has concluded that Dr Barton failed to follow the relevant edition of 'Good Medical Practice' in relation to the following aspects of her practice:

- Undertaking an 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 treatment where necessary;
- referring the patient to another practitioner where indicated;
- enabling persons not registered with the GMC to carry out tasks that require the knowledge and skills of a doctor;
- keeping clear accurate and contemporaneous patient records;
- keeping colleagues well informed when sharing the care of patients;
- ensure suitable arrangements are made for her patients' medical care when she is off duty;
- prescribing only the treatment, drugs or appliances that serve patients' needs;
- being competent when making diagnoses and when giving or arranging treatment;
- keeping up to date;
- maintaining trust by:
    - listening to patients and respecting their views;
    - treating patients politely and considerately;
    - giving patients the information they ask for or need about their condition, treatment and prognosis;
    - giving information to patients in a way they can understand;
    - respecting the right of patients to be fully informed in decisions about their care;
    - respecting the right of patients to refuse treatment;
    - respecting the right of patients to a second opinion;
- abusing her professional position by deliberately withholding appropriate investigation, treatment or referral.

Further, Dr Barton failed to recognise the limits of her professional competence.

The Panel has already commented at length on Dr Barton's defective prescribing practices, her inadequate note taking and her failures with regard to consultation, assessment, examination and investigation. It does not refrain from emphasising and holding her to account for creating the risks and dangers attendant upon such conduct and omissions.

As a consequence of the Panel's findings of fact as outlined above, Dr Barton's departures from *Good Medical Practice* as outlined above, and the attendant risks and dangers previously commented on, the Panel has concluded that she has been guilty of multiple instances of Serious Professional Misconduct.

The Panel then went on to consider, in the light of those findings, what, if any action, it should take. The Panel considered:

- the submissions made by both counsel;
- the advice of the Legal Assessor;
- the facts found proved;
- the aggravating and mitigating features of those facts;
- the passage of time between the events giving rise to the complaint and the determination of the issues;
- Dr Barton's good character and other matters of personal mitigation including the bundle of testimonials submitted on her behalf.

Punishment

The Panel accepted the advice of the Legal Assessor that it is neither the role of this Panel nor the purpose of sanctions to punish, though sanctions may have that effect.

Proportionality

The Panel accepted the advice of the Legal Assessor that "This is a balancing exercise", where Dr Barton's interests must be weighed against the public interest in order to produce a fair and proportionate response.

The public interest

Both the Legal Assessor and Mr Kark addressed the Panel on the meaning to be ascribed to the phrase, "the public interest". The Panel accepted that the public interest includes:

- the protection of patients;
- the maintenance of public confidence in the profession;
- the declaring and upholding of proper standards of conduct and behaviour;
- on occasions, the doctor's safe return to work, but bearing in mind that neither the GMC nor the Panel has any responsibility for the rehabilitation of doctors.

The ambit of enquiry

The Panel accepted the Legal Assessor's advice that its task is to make judgments in the case against Dr Barton alone. It is no part of this Panel's role to make findings in respect of other persons who might have been the subject of criticism during the course of the evidence.

The Panel further accepted the Legal Assessor's advice that Dr Barton's actions should not be judged in isolation. An injustice would occur were she to be judged the scapegoat for possible systemic failings beyond her control. Her actions must be judged in context. The Panel has had the benefit of hearing a great deal of evidence in that regard, and is well placed to define that context. This in no way detracts from Dr Barton's own personal responsibilities as a medical practitioner however.

Looking to the future

The Panel accepted the advice of the Legal Assessor that where the Panel has found Serious Professional Misconduct it must look forward when considering the appropriate response to those findings, and is open to the criticism that it is exercising retributive justice if it fails to do so.

Matters found proved

As indicated above, the Panel made multiple adverse findings of fact in respect of Dr Barton's prescribing practices, note-keeping, consulting colleagues, assessments, examinations and investigations. Further, the Panel concluded that she had been guilty of multiple instances of Serious Professional Misconduct.

Aggravating and mitigating features

In accordance with the Legal Assessor's advice the Panel went on to consider both the aggravating and the mitigating features of the facts found proved. It took into account also the evidence contained in the testimonials and character evidence called.

i. Aggravating (offence)

- Although Dr Barton conceded that, with hindsight, she should have refused to continue to work in a situation that was becoming increasingly dangerous for patients she insisted that, in the circumstances of the time, her actions had been correct.

- She told the Panel that were the situation and circumstances of the time to repeat themselves today, she would do nothing different.

- The Panel concluded that this response indicated a worrying lack of insight. It was particularly concerned by Dr Barton's intransigence over matters such as the issue of balancing the joint objectives of keeping a patient both pain-free and alert.

- This, combined with her denigration of senior colleagues and guidelines, produced an image of a doctor convinced that her way had been the right way and that there had been no need to entertain seriously the views of others.

ii Mitigating (offence)

- The Panel noted that the nature and volume of Dr Barton's work and responsibilities increased greatly between the date of her appointment and the time with which this Panel is concerned.

- In particular, the Panel notes that increased and often inappropriate referrals from acute wards to her own put Dr Barton, her staff and resources under unreasonable pressure.

- The Panel noted that Dr Barton was operating in a situation where she was denied the levels of supervision and safeguard, guidance, support, resources and training necessary to ensure that she was working within safe limits. Even when there was Consultant cover it was often of a calibre which gave rise to criticism during the course of evidence.

- The Panel accepted Mr Langdale's submission that the response of hospital management and senior colleagues to complaints against Dr Barton was such that she did, quite reasonably, feel that she was acting with the approval and sanction of her superiors.

- Dr Barton's practice of anticipatory prescribing of variable doses of diamorphine for delivery by syringe driver was validated by a protocol evidenced in a letter from Barbara Robinson, Senior Manager at Gosport War Memorial Hospital dated 27 October 1999.

iii Personal mitigation

- Over a period of ten years since the events in question Dr Barton has continued in safe practice as an NHS GP;

- She has already been under what has been described by GMC counsel as her "own voluntary sanction" for eight years, and for the last two years under formal conditions imposed by the Interim Orders Panel of the GMC;

- The bundle of testimonials from colleagues and patients as to her current working practices and her positive good character.

The passing of time

In considering the appropriate response to its findings of Serious Professional Misconduct the Panel recognised that it was faced with a most unusual set of circumstances:

- There had been a gap of ten years between the events in question and the date of this hearing;
- during that period Dr Barton had continued in safe practice as a GP in the community;
- for the first eight of the ten years she practised under self-imposed conditions of her own devising; for the latter two years, under conditions directed by the GMC's Interim Orders Panel;
- the Panel had received a large bundle of testimonials on Dr Barton's behalf which attested to details of her safe working practice in that period.

In the circumstances the Panel considered it to be important that it receive advice on the appropriate weight that should be attached to the issue of elapsed time, the principles to be applied to its consideration in these circumstances and whether any binding authority could be found. None was.

Mr Kark submitted that the Panel should follow the *Indicative Sanctions Guidance* and that no party should be disadvantaged by reason of the delay.

You submitted that:

- The Panel should consider the misconduct in the context of the guidance and standards applicable at the time.
- Dr Barton's working conditions at the relevant time differed from any that a hospital doctor would be expected to accept today. You suggested that clinical governance has moved on dramatically since then and that the Panel could conclude that in that respect Dr Barton could no longer pose any risk to patients.

The Legal Assessor advised that the passing of time served the Panel well in that it provides a context in which Dr Barton's attitudes and practices could be viewed and judged. It allowed the Panel to judge the efficacy of conditions as a workable sanction by opening a ten year window through which to view it.

Response

The Legal Assessor advised that in determining the appropriate response to Dr Barton's Serious Professional Misconduct the Panel should consider:

- the aggravating and mitigating features of the facts found proved;
- the passing of time between the events which gave rise to the findings against her and the date of this hearing;
- her performance during that time;
- the *Indicative Sanctions Guidance*;
- the protection of patients and the public interest.

i. No action or Reprimand

- Having found that Dr Barton has been guilty of multiple instances of Serious Professional Misconduct, the Panel considered whether in all the circumstances it would be sufficient, appropriate and proportionate either to take no action or to issue her with a reprimand.

- The Panel had no hesitation in concluding that given the seriousness and multiple instances of her professional misconduct it would be insufficient, inappropriate and not proportionate either to take no action or to issue her with a reprimand.

ii. Conditions

The protection of patients

Mr Kark submitted that Dr Barton has demonstrated neither remorse nor insight in respect of the matters found proved and that her departures from the principles set out in *Good Medical Practice* were particularly serious. He submitted that, in those circumstances she presented a continuing risk to patients, and urged the Panel to conclude that, despite the long delay, her case should be dealt with by way of erasure.

Mr Langdale submitted that:

- Dr Barton presents no continuing risk to patients. He said this was proved by her safe practice as a GP throughout the ten years since her departure from the Gosport War Memorial Hospital.

- This view was further supported by the many testimonials of both patients and professional colleagues who commented on her current working practices as well as her qualities as a GP.

- The authors of the nearly 200 written testimonials were informed in that they were aware of the allegations against Dr Barton, the findings of the Panel, and indeed the adverse publicity this case has attracted.

The Panel accepted that it was unrealistic to consider that Dr Barton could ever again find herself in the situation she faced at the Gosport War Memorial Hospital.

Given the seriousness of the Panel's multiple findings against Dr Barton and the aggravating features of those findings noted above, in particular her intransigence and lack of insight, the Panel was unable to accept that she no longer posed any risk to patients.

However, the Panel did accept that in the light of the mitigating features listed above, and the fact that she has been in safe practice for ten years – with eight of them operating under conditions of her own devising and two under conditions imposed by the GMC's Interim Orders Panel – it might be possible to formulate conditions which would be sufficient for the protection of patients.

The maintenance of public confidence in the profession.

Mr Langdale submitted that public trust and confidence in the profession meant the trust and confidence of the informed public. He said that while the authors of the testimonials received by the Panel were informed members of the public, this case has attracted much media attention and that there have been ill-informed and unjustified media comparisons with an unrelated but infamous case involving a doctor accused of deliberately causing multiple patient deaths.

A The Panel wishes to make it clear that this is not such a case. However, the GMC have alleged and the Panel has found proved that there have been instances when Dr Barton's acts and omissions have put patients at increased risk of premature death.

B The Panel takes an extremely serious view of any acts or omissions which put patients at risk. It had no hesitation in concluding that Dr Barton's Serious Professional Misconduct was such that it is necessary, even after ten years of safe and exemplary post-event practice, to take action against her registration in order to maintain public confidence in the profession.

C The Panel considered that taking action against Dr Barton's registration would send a message to the public that the profession will not tolerate Serious Professional Misconduct.

The declaring and upholding of proper standards of conduct and behaviour.

D For the same reasons and having carefully considered all the circumstances, the Panel is satisfied that it might be possible to formulate a series of conditions which would be sufficient both to maintain public confidence in the profession and uphold proper standards of conduct and behaviour.

E **The public interest in preserving the services of a capable and popular GP.**

The Panel was greatly impressed by the many compelling testimonials which detailed Dr Barton's safe practice over the last ten years and the high regard in which she is held by

F numerous colleagues and patients.

The Panel noted Mr Langdale's assurance that the authors of the testimonials were either colleagues and/or patients who were aware of the allegations against Dr Barton, this Panel's findings on facts, and the media coverage of the case.

G

The Panel was mindful of the fact that neither the GMC nor the Panel has any responsibility for the rehabilitation of doctors. However, the Panel was satisfied that there is an informed body of public opinion which supports the contention that preserving Dr Barton's services as a GP is in the public interest.

H

Order

The Panel has formulated a series of conditions. In all the circumstances, the Panel is satisfied that it is sufficient for the protection of patients and is appropriate and proportionate to direct that Dr Barton's registration be subject to conditions for a period of three years.

The following conditions relate to Dr Barton's practice and will be published:

1 She must notify the GMC promptly of any post she accepts for which registration with the GMC is required and provide the GMC with the contact details of her employer and the PCT on whose Medical Performers List she is included.

2 At any time that she is providing medical services, which require her to be registered with the GMC, she must agree to the appointment of a workplace reporter nominated by her employer, or contracting body, and approved by the GMC.

3 She must allow the GMC to exchange information with her employer or any contracting body for which she provides medical services.

4 She must inform the GMC of any formal disciplinary proceedings taken against her, from the date of this determination.

5 She must inform the GMC if she applies for medical employment outside the UK.

6. (a) She must not prescribe or administer opiates by injection. If she prescribes opiates for administration by any other route she must maintain a log of all her prescriptions for opiates including clear written justification for her drug treatment. Her prescriptions must comply with the BNF guidelines for such drugs.

(b) She must provide a copy of this log to the GMC on a six monthly basis or, alternatively, confirm that there have been no such cases.

7. She must confine her medical practice to general practice posts in a group practice of at least four members (including herself).

(There was a general outcry of disapproval from members of the public who then left the hearing chamber)

(The Chairman continued)

8. She must obtain the approval of the GMC before accepting any post for which registration with the GMC is required.

9. She must attend at least one CPD validated course on the use of prescribing guidelines within three months of the date from which these conditions become effective and forward evidence of her attendance to the GMC within one week of completion.

10. She must not undertake Palliative Care.

11. She must inform the following parties that her registration is subject to the conditions, listed at (1) to (10), above:

(a) Any organisation or person employing or contracting with her to undertake medical work;
(b) Any locum agency or out-of-hours service she is registered with or apply to be registered with (at the time of application);
(c) Any prospective employer or contracting body (at the time of application);
(d) The PCT in whose Medical Performers List she is included, or seeking inclusion (at the time of application);
(e) Her Regional Director of Public Health.

In deciding on the length of conditional registration, the Panel took into account the fact that Dr Barton has been practising safely in general practice for the past ten years. During that time she has complied with the prescribing restrictions which she initiated and which were subsequently formalised by the GMC's Interim Orders Panel. This Panel is satisfied, looking forward, that the conditions it has directed provide further safeguards for the protection of patients, and therefore concluded that it was appropriate and proportionate to impose the conditions for the maximum period.

Shortly before the end of the period of conditional registration, Dr Barton's case will be reviewed by a Fitness to Practise Panel. A letter will be sent to her about the arrangements for that review hearing. Prior to the review hearing Dr Barton should provide the GMC with copies of her annual appraisals from the date of this hearing.

The effect of the foregoing direction is that unless Dr Barton exercises her right of appeal her registration will be made subject to conditions 28 days from the date on which written notice of this decision is deemed to have been served upon her.

Dr Barton is the subject of an interim order of conditions. The Panel proposes, subject to any submissions to the contrary, in accordance with Rule 33A of the 1988 Rules, to vary the existing order by substituting its conditions with the conditions contained in this determination.

Mr Fitzgerald, do you have any submissions on that subject?

MR FITZGERALD: No, sir.

THE CHAIRMAN: Mr Jenkins?

MR JENKINS: Nor I sir, thank you.

THE CHAIRMAN: That is what will happen and that concludes the case. Thank you all very much indeed for your attendance.

11 JUN 2002

New

Code A

Mrs M Jackson
[redacted]

01 June 2002

UKCC For Nursing, Midwifery and Health Visiting
23 Portland Place
LONDON

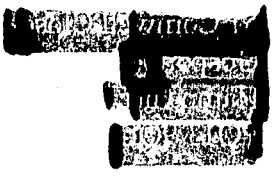
Dear Sir / Madam

FORMAL COMPLAINT

I am writing to make a formal complaint regarding the appalling level of care given to my mother Mrs Alice Wilkie prior to her death in August 1998 at the Gosport War Memorial Hospital. I understand from Hampshire Constabulary that you have already been sent copies of the police medical files regarding this case.

To summarise briefly the events which took place, my mother was taken from Addenbrooke Nursing Home on 31 July 1998 to Queen Alexandra Hospital in Portsmouth as a result of a Urinary Tract Infection. My mother stayed at Queen Alexandra for five days and appeared to be making good progress. Subsequently, she was sent to the Gosport War Memorial Hospital for 'Assessment and Rehabilitation'.

At the Gosport War Memorial Hospital my mother appeared increasingly sleepy, weak and unwell, she couldn't stand or walk unaided. When I queried this with the ward sister I was simply told "yes, she was deteriorating". I was given no explanation as to why or what actions were being taken to help her. The ward sister's attitude was completely ambivalent. Incidentally there is no record on her notes that we had expressed our concern about my mother's health or of any concerns from the nursing staff. Just a few days later I was called into Code A office and was advised that my mother was dying and there was nothing that the hospital could do to help her. I thought this was strange at the time as she had entered the Gosport War Memorial for rehabilitation and assessment, not to die. At this point I was again given no further explanation as to why this deterioration had taken place and why nothing could be done. I told Code A hat I did not wish for my mother to suffer but that was the depth of our conversation at this time. There was no explanation of what actions would be taken with my mother regarding her care. I was subsequently horrified when I received my mother's medical file to see a note written by Code A suggesting that I had agreed to a syringe driver for my mother and that active treatment was not appropriate. This conversation NEVER took place and I am appalled that an outright lie has been written into my mother's medical file and I would like an explanation for Code A 's actions. When I received my mother's medical file I was surprised to see the note from Code A suggesting that my mother was dying as there is no corresponding note from a doctor. I do not believe that it is the responsibility of



nursing staff to decide whether or not a patient is dying or that active treatment was not appropriate. Who made this decision?

Whilst visiting on August 20th I noticed that my mother appeared to be in pain. When I mentioned this to the nursing staff they were dismissive and said that they could see no evidence of this. I had to ask twice and waited for over an hour for Phillip Beed to come and see me. He did not examine my mother at this stage and did nothing to ascertain the level of pain she was in, but he did say that he would arrange for some pain relief that would make her sleepy. I left the hospital at 13:55 and at this point nothing had been done to alleviate my mother's discomfort despite the fact that her notes state she was placed on a syringe driver at 13:50. I had not left the hospital at this time so where does this discrepancy come from? I telephone my daughter as I was very concerned about my mother and asked her to go to the hospital to find out what was happening. When my daughter arrived, the nurse said to her in a very rude manner "your mother **SEEMS** to think that your grandmother is in pain". What sort of care is this? By the time I returned to the hospital at eight o'clock that evening my mother had been placed on a syringe driver administering Diamorphine drugs into her system. She was already unconscious and never regained it. She died the next evening. Why did the nursing staff not do any examination or summon a doctor to my mother? There is no note on the medical file to say that she had been assessed by any of the nursing staff or any doctor. How did it get from the nursing staff appearing unaware of my mother being in pain to being unconscious as a result of the Diamorphine?

I have many questions that have never been answered regarding this. Why was my mother placed on Diamorphine via a syringe driver, when only that afternoon, the nursing staff appeared unaware and unconcerned that she was in any pain? Why were other drugs not tried first to relieve her discomfort and why was the Diamorphine administered in 30mg quantities? I believe that 5 to 10 mg's would be a normal dosage and why did the nursing staff not query this level of drug?. I cannot understand why Diamorphine was used when no other drugs had been tried first. Why was no investigation done to find out where my mother's pain was and the cause of it. I suggest that it could have been a simple problem that could have been resolved with less severe pain relief.

I was persuaded to go home for some food and a change of clothes late in the afternoon of the 21st. I expressed my concern about leaving her to Code A as I did not wish for her to be alone. I was assured by Code A that should any change take place then he would contact us immediately. However, when I returned a short while later Code A entered my mother's room in front of us and told us that she had just died. However, I do not believe that she died upon our return, but I believe that she died alone and had not been monitored in our absence. Code A tried to tell us that my mother had waited until she heard our voices before passing away, however, it was quite obvious that she had died much earlier than this. My mother's records state that her daughter and granddaughter were present, but I dispute this. I would like for Code A to explain why a patient was left for that amount of time without being monitored.

I am appalled by the state of my mother's medical file. The file in itself appears to be incomplete and the details contained within it are sadly lacking to say the least. Apart

from the 'alleged' conversation where I agreed to a syringe driver, which I repeat did NOT take place, I also have a number of other concerns. There appears to be a mix up on the records of my mother and another patient Mrs Gladys Richards. A note stating that my mother was given Oromorph was crossed out with a note saying that this was written on the wrong notes. Was this drug given to my mother in error? And how did the notes come to be mixed up in the first place? Also, the time of death on my mother's files says 18:30 and 21:20. How can she die twice? After speaking with Gladys Richard's daughter she has confirmed that the 21:20 time is when her own mother passed away. The notes had obviously been mixed up yet again (days after the last time) and I would have expected a nurse such as Sylvia Roberts, who wrote the incorrect times on the file, should have known better after 25 years of experience in Nursing. This is gross incompetence on behalf of the nursing staff and the nurses concerned should be accountable for their actions. The notes themselves are incomplete and there are whole days when nothing is written on them and there is no record of what, if anything, she was given to eat or drink. I would expect that if she had a UTI, was catheterised and dehydrated then there should be a note of both her intake and her urinary output. There was a note on her file to say that her catheter bag was emptied on 21st August but no note to say that it was full of blood which both my daughter and myself had noticed. I wonder why this was not done? Just what sort of care did my mother receive when she was in the Gosport War Memorial Hospital. It was neglectful and uncaring to say the very least.

I believe that my mother died as a direct result of the drugs given to her and the abuse she received from the nursing staff in relation to their appalling lack of any sort of care. She did not even get basic care and the nursing staffs couldn't care less attitude is shocking. I will not rest until the nursing staff are held accountable for their actions and changes are made to ensure that this never happens again.

I look forward to hearing from you shortly.

Yours sincerely

Code A

Mrs M Jackson

NURSING & MIDWIFERY COUNCIL

Protecting the public through professional standards

Private and confidential

Mrs M Jackson

[redacted]

27 September 2002
PRE/DEC/20/Code A 2053
Direct Line : Code A
Fax : 0207 636 2903
Email : conduct@nmc-uk.org

Dear Mrs Jackson

Nurses at Gosport War Memorial Hospital

I write concerning the above named, whose case was placed before the Preliminary Proceedings Committee of the Council at its recent meeting.

After careful consideration of the papers before it, the Committee members came to the following decision:-

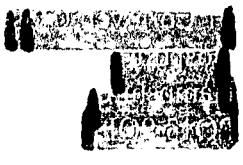
That the matter should be adjourned in order to await the outcome of investigations by the Crown Prosecution Service.

The case will be considered by the Preliminary Proceedings Committee in due course after which time you will be informed of the outcome.

Code A

23 Portland Place, London W1B 1PZ
Telephone 020 7637 7181 Fax 020 7436 2924 www.nmc-uk.org

284



MR 200

GWM HOSPITAL

HISTORY SHEET

UNIT NO S.M.W. M.I

Name WILKIE ALICE.
(Surname First)

Address

Date of Birth 2.9.10.

Family Dr.

DATE	CLINICAL NOTES (Each entry must be signed)
4/8/98	Δ - See Problem Sheet.
	NTS 0/10 - usually quiet & withdrawn Bantrel 1/10. B/ Cultures - Gm +ve cocci. CXR ECG / NAD.
	Catheterised - RV 500 mls. Pressure areas vulnerable.
	Plan:
1)	Ct. oral Augmentin.
2)	SC fluids.
3)	Overall prognosis poor, + too dependant to return to Attenborough's
4)	Transfer to Dacorum NOTS Continuing care on 6/8/98 Am → for 4-6/52 observation & then decide on placement.
5)	Keep Cct at Attenborough's.
	DNR
6.8.98	Transferred from Pulling Ward, for 4-6/52 obs. on Augmentin for UTI

285

WWG 518

DATE	CLINICAL NOTES (Each entry must be signed)
10/8/98	Barthel 2/20. Eating + drinking better. Confused & slow - Give up place at Attenborough's - RIW in 1/12 - if no specialist medical or nursing problems D & a NH home. - Stop Fluoxetine. RIW.
24/8/98	Marked deterioration over last few days. SL analgesia commenced yesterday Family aware and happy JMB
21/8/98 1830	~~1830~~ Pulse & Breathing Absent. No heart sounds Pupils fixed Death confirmed. RMN Staff Nurse Family present - For cremation.

PORTSMOUTH HealthCare TRUST

Patient Name ALICE WINKIE

Contact Record

Date	Problem No.	Time	Record of contact, with, Signature and designation
6/8/98			SIB Dr. Peters + cleaked on Clerce
17/8/98		4pm	Condition has generally deteriorated over the weekend.
		7.45pm	Daughter seen - aware that mums condition is worsening; agrees active treatment not appropriate & to use of syringe driver / Morphine is in pain.
21/8/98		12:55	Condition deteriorating during morning. Daughter and granddaughters visited + stayed. Patient comfortable & and pain free Clerce
21/8/98		18.30	Death Confirmed at 18.30 Family present

NMC

Page

PORTSMOUTH
HealthCare
NHS
TRUST

WILKIE
ALICE

B

PRESCRIPTION SHEET

for the safety of the patient

DOCTOR

1. Use approved names, BLOCK LETTERS, and metric dosage.
2. Be specific in indicating the timing and route:-
   (a) For regular prescriptions tick (✓) the appropriate boxes and indicate time in blank space.
   (b) For drugs which are likely to have frequently changing doses, use the section at "Daily Review Prescriptions" on back of sheet.
3. Any CHANGES in your drug therapy MUST be ordered by a NEW PRESCRIPTION: do NOT alter existing instructions.
4. Discontinue a drug by clearly crossing out the discontinued drugs (viz TETRACYCLINE) draw line through the unused recording panels and sign in with full name.
5. Prescribe INFUSION THERAPY and any drugs to be added on the INFUSION CHART.
6. Take home drugs will be written up on form MR15 which then will be placed in the appointment and prescription record card.
7. All prescriptions must be signed in full.
8. The following should be used to indicate route.

   S.C. ..... Subcutaneous
   I.M. ..... Intramuscular
   I.V. ..... Intravenous
   Sub Ling ..... Sublingual
   Intrathecal
   Oral
   Rectal
   Topical
   P.V. - per vaginum

9. Put date prescription needs to be reviewed in "review" box of Regular Prescription Section.

NURSE

1. Initial the administration in the appropriate box. (This must be done by the Senior Nurse).
2. Check all sections to avoid omission.
3. Use the top continuation sheet only for recording administration.
4. If a dose is missed write "X" in the box and give the reason in the Exceptions to Prescribed Orders.

If for some reason **all** the drugs prescribed for a certain time are not given, e.g. patient fasting, patient absent, there is no need to itemise each drug. Enter date, time and write **ALL** in name and dose column.

ADDITIONAL CHARTS	ANTICOAGULATION	
	INTRAVENOUS FLUIDS	
	INTRAVENOUS INFUSIONS	
	288	

GWMH. Daedalus.

MR411 Sheet No.

CONSULTANT 1 AL 2

Hospital ~~G. H~~ Ward ~~Ainly~~

ALLERGIES AND DRUG SENSITIVITIES

Unit No.

SURNAME (Block letters) WILKIE

First Names ALICE

Date of Birth 2/9/16 Wt.

FIX CONTINUATION MR411 (E) HERE

Date	Time	ONCE ONLY AND PRE-MEDICATION DRUGS	Route	Dose	Signature	Given

AS REQUIRED PRESCRIPTION

Administration Record FIX CONTINUATION MR411 (B) HERE

Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose	Given
8/8/16	20:45	2.5 mg	KS												

DRUG (Approved Name) PROMAZINE syrup

Route O | Dose 25mg | Date 31/7/38 | Pharm. [illegible]

SIGNATURE [signature]

SPECIAL DIRECTIONS PRN

DRUG (Approved Name) HALOPERIDOL

Route SIC | Dose 2.5-10mg | Date 1/8/16 | Pharm S

SIGNATURE BQuilson

SPECIAL DIRECTIONS MAX 60MG IN 24HRS AS REQUIRED

DRUG (Approved Name) MAGNESIUM HYDROXIDE mg (OM)2

Route PO | Dose 10ml | Date 4/8 | Pharm S

SIGNATURE BQuilson

SPECIAL DIRECTIONS AS REQUIRED

DRUG (Approved Name)

Route | Dose | Date | Pharm.

SIGNATURE

SPECIAL DIRECTIONS

289

REGULAR PRESCRIPTION	Administration Record FIX CONTINUATION MR 411 (C) HERE

1998 Month JULY → AUGUST

Date → 31 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14

DRUG (Approved Name): FLUOXETINE PROZAC syrup
Route: O | Dose: 20 mg | Start Date: 31/7/98 | Review Date: | Pharm.: 1.85
SIGNATURE:
Time: 8 ✓
31st KS | 1 KS | 2 KS | 3 KS | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14

DRUG (Approved Name): Co-DANTHRAMER
Route: J | Dose: 5-10 ml | Start Date: 31/7/98 | Review Date: | Pharm.: S
SIGNATURE:
Time: 22 ✓
2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14

DRUG (Approved Name): ZOPICLONE
Route: O | Dose: 3.75 mg | Start Date: 31/7/98 | Review Date: | Pharm.:
SIGNATURE:
Time: 22 ✓
1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14

DRUG (Approved Name): LACTULOSE
Route: O | Dose: 10 ml | Start Date: 31/7/98 | Review Date: | Pharm.: S
SIGNATURE:
Time: 8 ✓
31st KS | 1 KS | 2 KS | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14

DRUG (Approved Name): PROMAZINE syr
Route: O | Dose: 25 mg | Start Date: 31/7/98 | Review Date: | Pharm.:
SIGNATURE:
Time:
31st | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14

DRUG (Approved Name): AUGMENTIN
Route: IV | Dose: 1.2 Gm | Start Date: 1-8- | Review Date: | Pharm.:
SIGNATURE:
Time: 08.00 ✓ | 14.00 ✓ | 22.00 ✓
31st | 1 X | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14

WWG 508

REGULAR PRESCRIPTION

Administration Record

FIX CONTINUATION MR. 411C HERE

Harlow W5974

1998 Month JULY →

Date →

Aug 98: 16 17 18 19

DRUG (Approved Name)	Route	Dose	Start Date	Pharm.	Signature	Time	✓
PROZAC (FLUOXETINE syrup)	O	20 mg	31/7/98	1.98	[signature]	8⁰⁰	✓
CO-DANTHRAMER	O	5-10 ml	31/7/98	S	[signature]	22⁰⁰	✓
ZOPICLONE	O	3.75 mg	31/7/98	NKST 13/8	[signature]	22⁰⁰	✓
LACTULOSE	O	10 ml	31/7/98	S	[signature]	8⁰⁰	✓
PROMAZINE syr	O	25 mg	31/7/98		[signature]		
AUGMENTIN	IV	1.2 Gm	1.8.		B Wilson	08.00, 14.00, 22.00	✓

REGULAR PRESCRIPTION	TURN OVER FOR DAILY REVIEW PRESCRIPTIONS Administration Record FIX CONTINUATION MR 411 (C) HERE

19 Month → Aug

Date → 2 3 4 5 6 7 8 9

DRUG (Approved Name) ELIXIR AUGMENTIN

Route	Dose	Start Date / Review Date	Pharm.
PO	625 mg	2.8	

SIGNATURE BRWilson

Time	✓
08:00	✓
14:00	✓
22:00	✓

DRUG (Approved Name) (IN FRIDGE) ELIXIR AUGMENTIN

Route	Dose	Start Date / Review Date	Pharm.
PO	500/125 mg	2.8	NDS 2CP

SIGNATURE BRWilson

Time								
08:00	✓							
14:00	✓							
22:00	✓							

DRUG (Approved Name)

Route	Dose	Start Date / Review Date	Pharm.

SIGNATURE

Time

DRUG (Approved Name)

Route	Dose	Start Date / Review Date	Pharm.

SIGNATURE

Time

DRUG (Approved Name)

Route	Dose	Start Date / Review Date	Pharm.

SIGNATURE

Time

DRUG (Approved Name)

Route	Dose	Start Date / Review Date	Pharm.

SIGNATURE

Time

DAILY REVIEW PRESCRIPTIONS

REGULAR PRESCRIPTION

Date →	20/8/75		21/8									
Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
DRUG (Approved Name) Morphine 200 mg	1350 30mg	BS	30mg	BS								
Route: Sc in 24hrs												
Pharmacist:												
SIGNATURE												

Date →	20/											
Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
DRUG (Approved Name) Hyoscine 200-800 mg												
Route: Sc in 24hrs												
Pharmacist:												
SIGNATURE												

Date →	20/8/75		21/8/75									
Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
DRUG (Approved Name) Metaclopramide 20 mg	1350 20mg	BS	20mg	BS								
Route: Sc in 24hrs												
Pharmacist:												
SIGNATURE												

Date →												
Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
DRUG (Approved Name)												
Route:												
Pharmacist:												
SIGNATURE												

Date →												
Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
DRUG (Approved Name)												
Route:												
Pharmacist:												
SIGNATURE												

FOR NURSING USE ONLY – EXCEPTIONS TO PRESCRIBED ORDERS

Date	Time	Drug Name and Dose	Reason	SIGNATURE
31/7/98	22.00	2 oxycodone syrup	NO Stock	[signature]
1/8/98	22.00	2 oxycodone syrup	No Stock	[signature]
21/8/98				

The United Kingdom Council for Nursing,Midwifery and Heath Visiting
The Directorate of Conduct
23 Portland Place
London
WIB 1P

11 JUN 2002

Mrs. A Reeves
[redacted]

June 6th 2002

Dear Sir or Madam

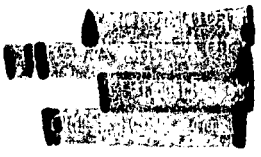
Re: FORMAL COMPLAINT

I wish to make a Formal Complaint against the following Nurses: Code A Hamblin, Staff Nurse Code A and the named nurses Code A all who worked at the Gosport War Memorial Hospital in November 1999.

This complaint is with regard to the care received by my Mother Mrs Elsie Devine who died at the Gosport War Memorial Hospital on the 21st November 1999 .

My complaint over the Doctor concerned is at present being investigated by the General Medical Council, but I now understand that this does not cover Nurses. We took our complaint to Independent Review and 16 months later we are now beginning to understand why those involved never had the courage to tell us exactly what happened that Friday morning for reasons still only known to them, which led to our Mother being heavily sedated. This was abuse, to my Mother and to my family.

Sister Hamblin's evidence was extremely disturbing for all the family. She was a nurse of 12 years; 9 of which as a Ward Sister. In her statement on page 15 of the Independent Report she confirms that Mrs Devine woke and dressed herself by 5:30am but was more agitated than usual. -- At this point I would say that none of the Family had ever seen our Mother agitated or aggressive at the Gosport War Memorial. -- Our Mother then, apparently pushed one nurse across the room and another up against a book case. This was our frail disabled Mother who had difficulty standing as one of her knees had gone completely over. They then persuaded her to sit in an armchair and 50mg of Chlorpromazine was given to our Mother by a nurse initals L.B. while still wearing a Fentanyl Patch, which Jill Hamblin had applied the day before - for the pain she was not in!
It took 4 nurses to hold our Mother down while they administered this drug and our dear Mother must have been terrified. We are still trying to ascertain if Dr. Barton was actually present before and during this injection or was the drug wrote up afterwards?



Less than one hour later they administered a Morphine Syringe Driver with 40mg morphine/40mg Midazolam. Code A does not remove the Fentanly Patch until 12:30pm which is 3 hours after the syringe driver is in place. Contradictory to Dr Barton who in the report states that it was removed before the syringe driver was put in place. Two nurses then walked our Mother around the ward until she settled in an armchair, even though she could hardly have walked without the cocktail of drugs. They must have dragged her around. Code A had phoned my sister-in-law at 8:15am and told her that our Mother was standing in the corridor confused, my sister-in-law said that her husband was visiting at 1pm, however did she want him to come now, was it an emergency? No, she said 1pm was fine. But we all now have learnt differently and it has taken an Independent Review to find out some of the true happening of that Friday morning. By 1pm when my brother arrived, our dear Mother was completely unconscious and we would never be able to speak to her again.

However, Code A and the nurses involved then went on with their lives with not even a thought for our family or our dearest Mother as she lay dying. It is a disgrace and the cruelest thing not to have told us what was happening. I have to wonder what sort of person Code A is and what her reasoning was behind keeping the family away? Our dearest Mother should have been able to have drawn some comfort from having her family around her. So what were they thinking about? Are these nurses unaware that even the strongest of men would have succumbed to such a combination of drugs. All those involved in our Mother's care are inhumane and a poor representation of the medical profession.

Sister I Code A also states that there was tension between Mr. Devine (my Brother) and myself regarding his wife. This is an extremely unprofessional statement and if this were the case, what has this got to do with our Mother's medical condition? My late Brother and I were wanting answers at various meetings, of which not one did she attend. But even if this was the case with regards to my sister-in-law then why leave it until the Independent Review? It must have been bothering her so much 16 months later, that she found it necessary to discuss it at the Independent review, yet she cannot find it in herself to apologise for the disgusting way she kept her nursing notes on my Mother. I am trying to understand this statement regarding my dear brother and his wife and the tension she states. I would appreciate her clarifying her source of information, as my late brother and I were extremely close. Sister Code A can find something to write that has nothing to do with our Mother's care, yet our Mother's care notes can go for days without anything being written in them, or the drug chart written up. I would like to know why they have photocopied the first page of the drug chart twice and why was oramorph written up on my Mother's admission? What were her intentions for the use of this drug?

Although the staff at the Gosport War Memorial state that they knew our Mother was deteriorating they continued to bathe and wash her hair excessively, apparently because our Mother requested it. Even two days before her death our dear Mother had her hair washed twice. She also states that they left our Mother to bathe until she requested it and, it is a good thing that our confused Mother, as they state, did request to bathe, yet nothing is written up for this in our Mother's notes.

Our Mother was 88 years old and it was her routine that she bathed every night. Stating in her notes on the 3rd November that our Mother could not climb stairs and has not been able to for sometime is also total rubbish! Who is she talking about? Our only fear was our Mother falling down the stairs should she not have her knee brace on and nobody being there with her. On our return from Hammersmith Hospital we found her knee brace with clothes that Sister Code A sent home that were considered too good for my Mother's stay. Our Mother was terribly unhappy in the Gosport War Memorial and never having been into Hospital before she found her life turned upside down. She was given sleeping tablets which she refused to take. which we believe were given solely to keep her in bed. Is this why they then treated her with Morphine Patches - that were the cause of her confusion that Friday morning.

When a relative asked if she could take my Mother to the hospital restaurant she was told NO! which did upset our Mother and no explanation was given to her. Yet when patients requested to go to the bathroom hospital staff told them that they did not want to go and let them wet themselves instead. This was confirmed by my brother at a NHS meeting, as he witnessed it during a visit to see our Mother.

Dr Barton states that although our Mother was diagnosed with a kidney infection on the 15th November 1999 and on the 11th and 12th November 1999 Antibiotics were started, yet it was not written up in the notes. So what exactly was Sister Code A doing? Was she administering these and forgetting to write them in the notes or did our Mother not get them at all? If she did her job properly instead of worrying about private family matters perhaps our Mother would be alive today.

I consider Freda Shaw also to be an accomplice in the detrimental care of our Mother. She never explained to me or my family about our Mother's medication and on arrival at the Gosport War Memorial when we asked her what had happened regarding our Mother's sudden deterioration, she stated that she could not comment as she had just come on duty. Do they not have hand-overs? She had come on duty and was then directly responsible for our Mother who was dying and also the other patients but, with her attitude how was she going to care for them? She states in her evidence that she does remember asking Mrs Reeves (my son was present with me) if I understood what I was being told, and I had said, "I did and that I was going to sit with my Mother." However, in the same statement she states she could not recall my emotional state or what was said, which was very confusing for everybody. So what was she trying to say? I can categorically tell you that this was not true as she discussed nothing with the family because she did not know anything having just come on duty.

C.H.I. and their investigation will not unfold these terrible misdoings Code A and Code A statement are nothing less than a fabrication of the truth to cover themselves for the disgusting, inhumane and unprofessional way in which they practice nursing.

Let us all hope that they never have to endure the same level of care as they gave to our dear Mother.

Yours sincerely

Code A

Ann Reeves

NURSING & MIDWIFERY COUNCIL

Protecting the public through professional standards

Private and Confidential
Mrs A Reeves
[redacted]

2 July 2002
PRE/6/Code A/12010-3
Direct Line : Code A
Direct Fax :
E-mail : conduct@nmc-uk.org

Dear Mrs Reeves

Code A

Thank you for your letter of 6 June 2002. Please accept my sincere apologies for the delayed response.

In accordance with the Nurses, Midwives and Health Visitors (Professional Conduct) Rules, 1993, this matter will be placed before the Preliminary Proceedings Committee of the Council in due course.

The members will decide, on the documentary evidence available to them, whether the matter should proceed to a hearing with a view to the practitioner's name being removed from the register.

To assist the Preliminary Proceedings Committee, it will be helpful if you would provide a copy of the Independent Review Report. I would be grateful if you could also provide your consent to approach the Gosport War Memorial Hospital for the practitioners' registration details and for copies of the investigatory notes, your mother's medical records, any witness statements and all other relevant documentation.

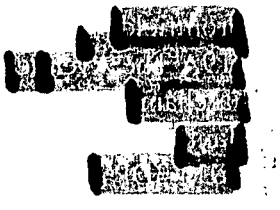
I enclose the booklet *Complaints about Professional Conduct.*

Thank you for bringing this matter to the Council's attention and I look forward to hearing from you as soon as possible or at least within the next 21 days.

Yours sincerely

Code A

23 Portland Place, London W1B 1PZ
Telephone 020 7637 7181 Fax 020 7436 2924 www.nmc-uk.org



NURSING & MIDWIFERY COUNCIL

Protecting the public through professional standards

Private and confidential
Mrs A Reeves
[redacted]

27 September 2002
PRE/DEC/20/Code A 12053
Direct Line : Code A
Fax : 0207 636 2903
Email : conduct@nmc-uk.org

Dear Mrs Reeves

Nurses at Gosport War Memorial Hospital

I write concerning the above named, whose case was placed before the Preliminary Proceedings Committee of the Council at its recent meeting.

After careful consideration of the papers before it, the Committee members came to the following decision:-

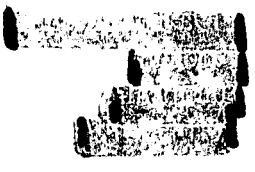
That the matter should be adjourned in order to await the outcome of investigations by the Crown Prosecution Service.

The case will be considered by the Preliminary Proceedings Committee in due course after which time you will be informed of the outcome.

Code A

300

23 Portland Place, London W1B 1PZ
Telephone 020 7637 7181 Fax 020 7436 2924 www.nmc-uk.org



Patient Name: [illegible]

HealthCare

Summary

Summary of Significant Events *(Including Relevant Medical History)*

Date	
21.10.99	Admitted this pm from F3 Ward.
	Was admitted there with increasing confusion and aggression. The aggression has now lessened. Still seen confused at times also CPE.
	Needs minimal assistance with ADL's.
	A very pleasant lady. Has apetite as she thinks is not good and can be a little unsteady on her feet.
	Urine clear on admission and both feet swollen.
	S/E Dr Barton. See treatment chart for drug regime.
25.10.99	S/E Dr Reid – to continue. for bloods to be taken.
1.11.99	S/E Dr Reid – commence amiloride 5mgs OD. to be weighed twice weekly, for home visit. to see Dr.
3.11.99	Left message for Mrs Dasing, for her or her husband to contact ward re: home visit. S. Hallam
Pm	See Contact Record.
15.11.99	Seen by Dr Reid. Referral made for Dr. Ingram. Continue Mirtazapine.
16.11.99	Mavis deteriorated over last 24 hours. Extremely aggressive has an offering all help from all staff. Chlorpromazine 50 mgms given IM at 05.30 – taken. 2 staff & special syringe driver

Page

PORTSMOUTH HealthCare TRUST

Patient Name [illegible]

Summary

Summary of Significant Events *(Including Relevant Medical History)*

Date	
	Commenced at 09:15 Diamorphine 40 mgs
	+ Haldol 10 mgs Fentanyl Patch commenced
	Mrs Dell ... was seen by Dr Gunn at
	13.00 + advised that Diamorphine + Haldol
	the will continue but Ativan dose Reduced
	to 1mg 4 hrly + Clinical Psychologist
	to still visit daily
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
20.11.99	Consultant reviews Mrs Dell has written
	a list of family members seen by
	Psych Nurse
	[illegible]
	[illegible]
	[illegible]
	[illegible]
21.11.99	condition continues to deteriorate slowly, family have
4pm	visited all cares continue to offer support
22.11.99	Patient died peacefully at 20.35, no post mortem
	family notified & Mrs Dell's death Pronounced in the absence
	of the Coroner for burial or cremation

NMC

Page

Director of Conduct
23 Portland Place
London
W1B 1PZ

[redacted]

25 JUN 2002

Tel [redacted]

19th June 2002.

Dear Sir,

I am writing to register a formal complaint as to the nursing care that my mother, Mrs Dulcie Middleton, received while in The Gosport Memorial Hospital from 29th May 2001 until 16th August 2001.

My mother was of sound mind and body before her stroke on 10th May 2001, completly self-sufficient and very active.

Haslar Hospital stabilized her after the stroke, and brought her to the position where she was sufficiently fit for rehabilitation, when she was transferred to the Memorial Hospital, she was very positive and optimistic about recovery.

When she was first there she appeared to be making progress, sitting out of bed, going into the day room in a wheel chair, and having her hair washed and set.

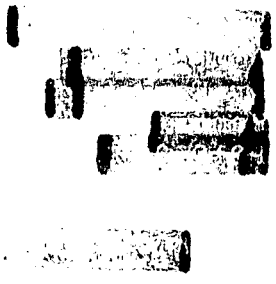
Eating and drinking were her biggest problems, we were told by her doctor that she must have help at all times, especially with meals, as she had trouble swallowing and was very slow, but help was not forthcoming.

On one of my visits, which were every day, apart from around six missed days in three and a half months, I found my mother laying in bed, she had not been sat up, her meal was in front of her and too far away for her to reach, cutlery was missing and the bell was out of her reach on the wall so she could not call for assistance, and the meal was cold so she could not eat it.

Given the above conditions you would not expect anyone to recover, subsequently she lost weight and dehydrated, and was then administered a fluid drip and a nasal feeding tube, I am sure that none of this would have been needed if the proper nursing care had been provided.

At one point too much fluid was given, she had a fluid overload, how can this happen with a catheter in situ, and a drip, why was she not being properly monitored?

As a result of this on 4th July 2001 my mother had congestive cardiac failure, this was confirmed with examinations and chest X-Ray. Her heart, lungs and and both legs were damaged



because of the fluid, which bloated her, her legs were bleeding with the skin split open, she was bandaged from feet to knees until she died.

On entering the Hospital the staff knew that my mother was being treated by her own Doctor for blood pressure and angina, so fluid overload should have been avoided at all cost.

Due to the state that she was now in she did not leave her bed again. Physiotherapy for her legs had to stop, and I don't believe that she had physio for chest and lungs etc, which she needed as she lay in bed week after week, deteriorating and growing weaker.

The next moves were a nebulizer, diuretics and potassium, to put back what she had lost. One evening when an impatient nurse was in a hurry to give my mother (who had a problem with swallowing) her potassium, she told my mother to "hurry up or I won't put your nebulizer on" which frightened and panicked my mother and didn't help her to swallow. I reported this incident to the nurse in charge.

Some time later she was transferred back to Haslar for a stomach Peg, this did not help, she was in great pain, her tummy swelled and rumbled, and she was very uncomfortable and sick.

On one visit that I made I found her in the ward on her own sitting in a PVC chair with a sick bowl in front of her, and another used bowl on the table, (so the nursing staff knew that she was unwell), she was choking whie being sick, covered in sweat, her hair wet through. She could not ring for help, as the bell was out of reach on the wall as usual, I called a nurse who called a doctor, we put a sheet behind her to get her body off the chair. The doctor examined her and decided to do an X-Ray which showed a blocked bowel, this was dealt with on the ward, which was very unpleasant and humiliating for my mother and I had to leave the room, as I could not stand to hear my mothers cries of pain. After this my mother asked me to take her away from the Hospital. I did ask, and I had asked before, but was unable to.

Would you please tell me if you think that three quarters of an hour is acceptable to make an eighty five year old lady wait for a bed pan? After asking three times I was told that my mother had a pad on the bed and she could use that, I don't think so, I told the nurse to bring a bed pan now, which she did.

My mother was a very clean person and worried that she smelt due to the catheter, so she mentioned her worry to a nurse, the reply was "don't worry, all old ladies smell." This was a totally inappropriate and thoughtless remark.

Patients well-being is not taken into consideration, sitting out of bed for long periods causes the elderly to feel the cold, my mothers clothes were not able to be pulled around her legs as she usually sat in a sling, her legs were bare even though I provided socks and asked that a blanket be put around

her legs, there were lots of blankets for this purpose.

I am also worried as to what drugs my mother was given, she behaved very strangely some days.

My final complaint is the poor standard of nursing care, some nurses were uncaring and had an unprofessional attitude to vulnerable helpless patients, who may be elderly but still have dignity and belong to families who value and love them.

Furthermore, in my view nurses failed to carry out doctors orders and lacked humanity, where is the caring profession going, it is failing the elderly.

I hope you have gathered from this letter that I am very distressed and annoyed about care at Gosport Memorial Hospital, and hope to get some answers from the investigations that are in progress.

I await your reply,

Yours Sincerely

Code A

NURSING & MIDWIFERY COUNCIL

Protecting the public through professional standards

Private and Confidential
Mrs M Bulbeck
[redacted]

3 July 2002
PRE/6 Code A 12053

Direct line: Code A
Fax No: 020 7636 2903
Email: conduct@nmc-uk.org

Dear Mrs Bulbeck

Nursing Care at Gosport Memorial Hospital

Thank you for your letter of 19 June 2002.

Please find enclosed a copy of the Council's advisory document:
- *Complaints about professional conduct.*

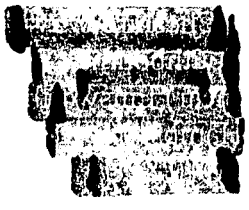
In accordance with the Nurses, Midwives and Health Visitors (Professional Conduct) Rules, 1993, this matter may be placed before the Preliminary Proceedings Committee of the Council.

The members will decide, on documentary evidence available to them, whether the matter should proceed to a hearing with a view to a practitioner's name being removed from the register. The Council can only consider allegations of misconduct against individual practitioners and not nursing care generally. Allegations must be specific incidents, must be witnessed directly and must be so serious as to constitute misconduct likely to lead to removal from the register.

To assist with your complaint I should be grateful if you would provide the following information:

Detailed witness statements to each incident
Names of individual nurses, if possible
Copies of any correspondence between yourself and the hospital

It is important you establish whether the witnesses who provide statements would, if necessary, be prepared to make formal statements to the Council's solicitors and to appear in person before the Professional Conduct Committee.



Thank you for bringing this matter to the Council's attention and I look forward to hearing from you as soon as possible or at least within the next 21 days.

Code A

Enclosure: Complaints about professional conduct.

Your Ref. PRE/6/12053

[redacted]

12th August 2002

Dear Code A

With reference to my telephone conversation with you on Friday 2nd August, I thought that it would be appropriate to put in writing that I would like my complaints to be investigated where possible.

You have my formal complaint of 19th June, and you can see when I was present and witnessed the events that I have complained about, but I cannot name individual nurses.

I am sure that you have been able to read the Commission for Health Improvement report into the Gosport Hospital issued on 3rd July 2002. I was very pleased with the report as it proved that the points I had made were true.

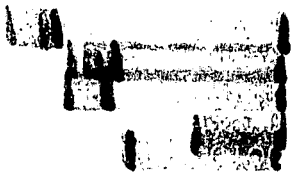
I have enclosed a copy of the letter dated 18th July from Fareham and Gosport NHS Primary Care Trust, in which is contained the offer of help from Jane Williams to go through my mothers medical file with me,which we have now done. I therefore hope that in the not too distant future I will have a closure to this dreadful situation, so that I can get on with my life, it has been a very stressful time since my mother died nearly a year ago.

I am seeking justice for my mother, someone has to be named and proved responsible for the poor nursing care.

Yours Sincerely

Code A

Mrs Majorie Bulbeck.



Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 OFH

Tel: 01329 233447
Fax: 01329 234984

Mrs Bulbeck
[redacted]

Our Ref: FC/ld

18th July 2002

Dear Mrs Bulbeck

Further to our telephone conversation last week, I am writing to confirm that we have agreed that I will commission an investigation into the concerns you raised to the Nursing and Midwifery Council in your letter of 19th June 2002.

The investigating officer will be Jane Williams who is a Consultant Nurse Stroke Care and she will be contacting you shortly to discuss your concerns with you. Once you have met with Jane, she will capture those concerns and that will form the basis, along with the letter to the NMC, of your complaint to us.

I hope this meets with your approval. However, if you have any queries, please do not hesitate to contact me.

Yours sincerely

Code A

Fiona Cameron
Operational Director

05 SEP 2002

The United Kingdom Council for Nursing, Midwifery and Heath Visiting
23 Portland Place
London
W1B 1P

12053

Mrs M. Bulbeck
[redacted]

02 September 2002

Dear Code A

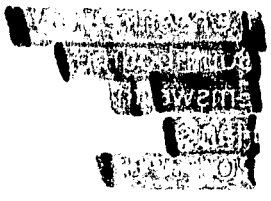
Re: Gosport War Memorial Hospital

When reading my personal copy of the formal complaint I made to the Nursing and Midwifery Council on 19th June 2002, I noted that I had failed to name the clinical manager Philip Beed, who was responsible for the appalling care my Mother received whilst at the Gosport War Memorial Hospital. Please accept this letter as part of my original complaint.

Your sincerely

Code A

Mrs Marjorie Bulbeck.



NURSING & MIDWIFERY COUNCIL

Protecting the public through professional standards

Private and confidential
Marjorie Bulbeck
[redacted]

27 September 2002
PRE/DEC/20/Code A/12053
Direct Line : Code A
Fax : 0207 636 2903
Email : conduct@nmc-uk.org

Dear Mrs Bulbeck

Nurses at Gosport War Memorial Hospital

I write concerning the above named, whose case was placed before the Preliminary Proceedings Committee of the Council at its recent meeting.

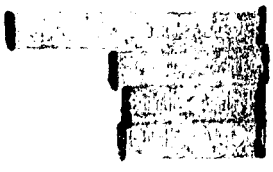
After careful consideration of the papers before it, the Committee members came to the following decision:-

That the matter should be adjourned in order to await the outcome of investigations by the Crown Prosecution Service.

The case will be considered by the Preliminary Proceedings Committee in due course after which time you will be informed of the outcome.

Code A

23 Portland Place, London W1B 1PZ
Telephone 020 7637 7181 Fax 020 7436 2924 www.nmc-uk.org



Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 OFH

Tel: 01329 233447
Fax: 01329 234984

15 OCT 2002

Mr Code A
Case Officer
Nursing Midwifery Council
23 Portland Place
LONDON
W1B 1PZ

FC/YB

14 October 2002

Dear Code A

Further to my letter to my letter of 8 July 2002 I am now in a position to respond regarding the complaint you have received from Mrs Bulbeck concerning her mother Mrs Middleton and her treatment in Gosport War Memorial Hospital during the 29 May 2002 and 16 August 2002.

I commissioned an investigation into the complaint and the investigating officer subsequently met with Mrs Bulbeck to enable us to manage her complaint through the Primary Care Trust complaints process. I am enclosing for your information a summary of the investigation report and the Trust's response to Mrs Bulbeck, as you will see the investigation raised a number of issues which the Trust is currently addressing.

Please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely

Code A

Fiona Cameron
Operational Director

Encs

Fareham and Gosport NHS
Primary Care Trust

Summary of Complaint Investigation

An investigation into the nursing care of Mrs D Middleton deceased.

Investigating Officer: **Jane Williams**
Nurse Consultant Stroke Care/Older People

Commissioning Officer: **Fiona Cameron**
Operational Director
Fareham & Gosport Primary Care Trust

Background to Investigation

Mrs Middleton was a patient on Daedalus Ward, Gosport War Memorial Hospital between 29th May 2001 and 16th August 2001. She was admitted from the Royal Hospital Haslar following a stroke on 10th May 2001. Mrs Middleton was subsequently transferred to Gosport War Memorial Hospital, Daedalus Ward on 29th May. She subsequently died on 2nd September 2001.

This report and the investigation upon which this is based were instigated as a consequence of a letter of complaint written to the Nursing and Midwifery Council in June 2002. This letter was sent to the Primary Care Trust requesting a response to the issues raised.

The investigation was commissioned by Fiona Cameron and was undertaken by Jane Williams, Nurse Consultant Stroke Care. Mrs Williams is an employee of East Hampshire Primary Care Trust and works primarily in Elderly Medicine Wards. Her speciality is in Elderly Stroke Care.

The following are the results of the investigation related to the specific issues raised by Mrs Bulbeck in her letter.

1. Nutrition and Hydration

The investigation concluded that the nutritional screening form usually completed at the admission of a patient was absent from Mrs Middleton's notes. There were however daily summaries in the contact records referring to nutritional and fluid intake. Food and fluid charts commenced on 1st June were found not to be an accurate record of intake and output.

The Investigating Officer identified that towards the end of her stay in Royal Hospital Haslar, Mrs Middleton's recorded nutritional intake had significantly

reduced prior to her transfer to Daedalus Ward.

Mrs Middleton's weight was recorded regularly and there was significant input from both Speech & Language Therapy and Dietetic departments. It was noted that despite written requests from the dietician within the notes, food and fluid charts were not accurately maintained. Subcutaneous fluids were prescribed to supplement oral fluid intake.

The Investigating Officer concluded that nursing documentation was inadequate in relation to the assessment, planning and evaluation of care provision with regard to nutrition and hydration. However, the Investigating Officer also concluded that from meetings with the staff, there was general concurrence between interviewees regarding the amount of input Mrs Middleton received and that there had been a genuine attempt to meet both Mrs Middleton and Mrs Bulbeck's needs.

It should also be noted that the Clinical Manager was addressing this issue with the development of a "user friendly " charting system.

2. Fluid Overload

At her meeting with Mrs Bulbeck, the Investigating Officer indicated that there was some confusion over the use of the words "fluid overload". It is believed that a review of Mrs Middleton's medical notes undertaken by an independent medical practitioner with Mrs Bulbeck had alleviated her concerns regarding this.

3. Attitude of nurse in relation to nebuliser

The Investigating Officer could find no evidence to support or conclude this event and there was no record of it being reported to the nurse in charge. I am unable to offer any reasonable explanation for this. However, all the staff on the ward agree that this would have been an unacceptable comment.

4. Incident by patient's bed

The investigation confirmed that this event did take place and there is no reasonable explanation for the fact that Mrs Middleton was alone. She was subsequently examined by the doctor in the four-bedded room. This would be normal practice on this type of ward.

5. Sitting out of bed for long periods & wait for bed pan

At this time Daedalus Ward was a 24 bed rehabilitation ward. Mrs Middleton was admitted for active rehabilitation. It would be standard practice for patients to be dressed in their own clothes and sitting in the chair for the major part of any day. There is no reasonable explanation as to why Mrs Middleton had to wait for such a long period of time for a bed pan.

6 General attitude of nursing staff and lack of response to relative complaint

The Investigating Officer concluded that staff had failed to pick up Mrs Bulbeck's very serious concerns despite their remembering many interactions with Mrs Bulbeck.

During her visit to Mrs Bulbeck, the Investigating Officer summarised her main issues of concern as being

the inadequacy of information and communication with Mrs Bulbeck

nursing attitudes towards patients and relatives,
the nursing management of nutrition and fluids,
who is accountable for patient care,
concerns raised by Mrs Bulbeck were not documented and followed through

Fiona Cameron
Operational Director
3 October, 2002

3rd October, 2002

Mrs M Bulbeck
[redacted]

Dear Mrs Bulbeck

I am writing to you following the completion of the investigation undertaken by Consultant Nurse Williams in respect of the concerns you raised to the NMC regarding the care your late mother received at Gosport War Memorial Hospital.

During her interview with you, Consultant Nurse Williams summarised the main areas of your concern to which you agreed:

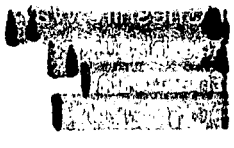
Nursing management of nutrition and fluids, skin care and continence
Information and communication
Attitudes - towards patients and relatives
Who was accountable for the care
Complaints procedure - picking up the clues that a relative is unhappy
Documentation - concerns were not documented

I will try to cover each of these points based on the findings of the investigation.

Consultant Nurse Williams concluded that the nutritional screening form usually completed on admission was absent from your mother's medical records. However, there were daily summaries in the contact records which refer to nutritional and fluid intake. The food and fluid charts commenced on 1st June were found not to be an accurate record of intake and output.

Your mother's weight was recorded regularly and there was significant input from both Speech & Language Therapy and Dietetic departments. It was noted that despite written requests from the dietician within the medical records, food and fluid charts were not accurately maintained. Subcutaneous fluids were prescribed to supplement oral fluid intake.

In summary, the Investigating Officer concluded that nursing documentation was inadequate in relation to the assessment, planning and evaluation of care provision with regard to nutrition and hydration.



There is no reasonable explanation for the lack of documentation, which is clearly not acceptable. The Clinical Manager had been attempting to address this issue with the development of a "user friendly" charting system. Documentation is central to good quality patient care and in this instance fell well below the standard we would expect. A great deal of work is currently underway in relation to improving the documentation skills of nurses at Gosport War Memorial Hospital. Specifically:

- increased training for junior qualified staff in the planning of care
- appointment of a senior nurse (for 6 months) to work with staff developing their documentation skills
- the application of a set of national standards entitled Essence of Care, one of which specifically relates to documentation

I realise this does not in any way alleviate your concerns in relation to your mother but hope that you will appreciate that lessons are being learned and action is being taken to improve care.

In respect of the concerns you raised relating to staff attitude, the Investigating Officer could find no evidence to support or deny this because the nursing documentation does not record any of the discussions and issues raised. It is clear that staff had failed to pick up on your very serious concerns, despite their remembering many interactions with you. However, the Investigating Officer did conclude from her interviews with staff, that there was general concurrence regarding the amount of input your mother received and that there had been a genuine attempt to meet both your mother's and your own needs.

In relation to accountability, each doctor and nurse is accountable for their actions in respect of care of individual patients.

All the staff involved have been interviewed as part of this investigation and regret the distress you and your family are feeling.

Training events in respect of complaints handling are being arranged in order that staff will develop a better understanding in respect of identifying both patient and relative concerns and how to deal with them.

I appreciate this has been a very difficult time for you and your family and am genuinely sorry that you have been left feeling this way.

I am sorry that the care provided to your mother at this time did not come up to the standards we would hope to provide.

If there are issues about which you would like further clarification, please do not hesitate to contact me. If it would be helpful to meet to discuss your complaint further I would be happy to do so.

Yours sincerely

Alan Pickering
Acting Chief Executive

MR 200

HOSPITAL

HISTORY SHEET

UNIT NO [illegible] S.M.W. M F

Name (Surname First) [illegible]

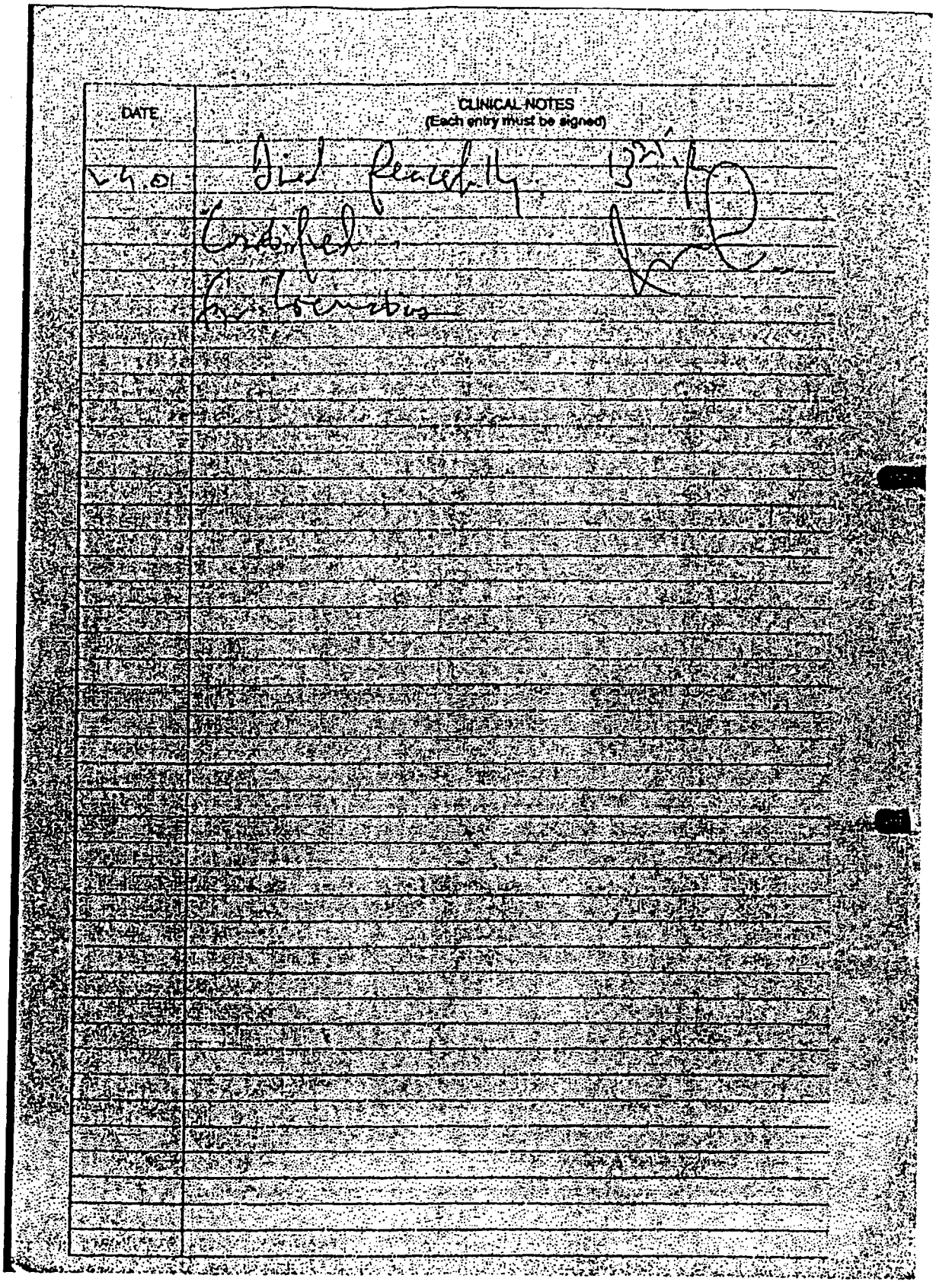
Address [illegible]

Date of Birth 21.8.11

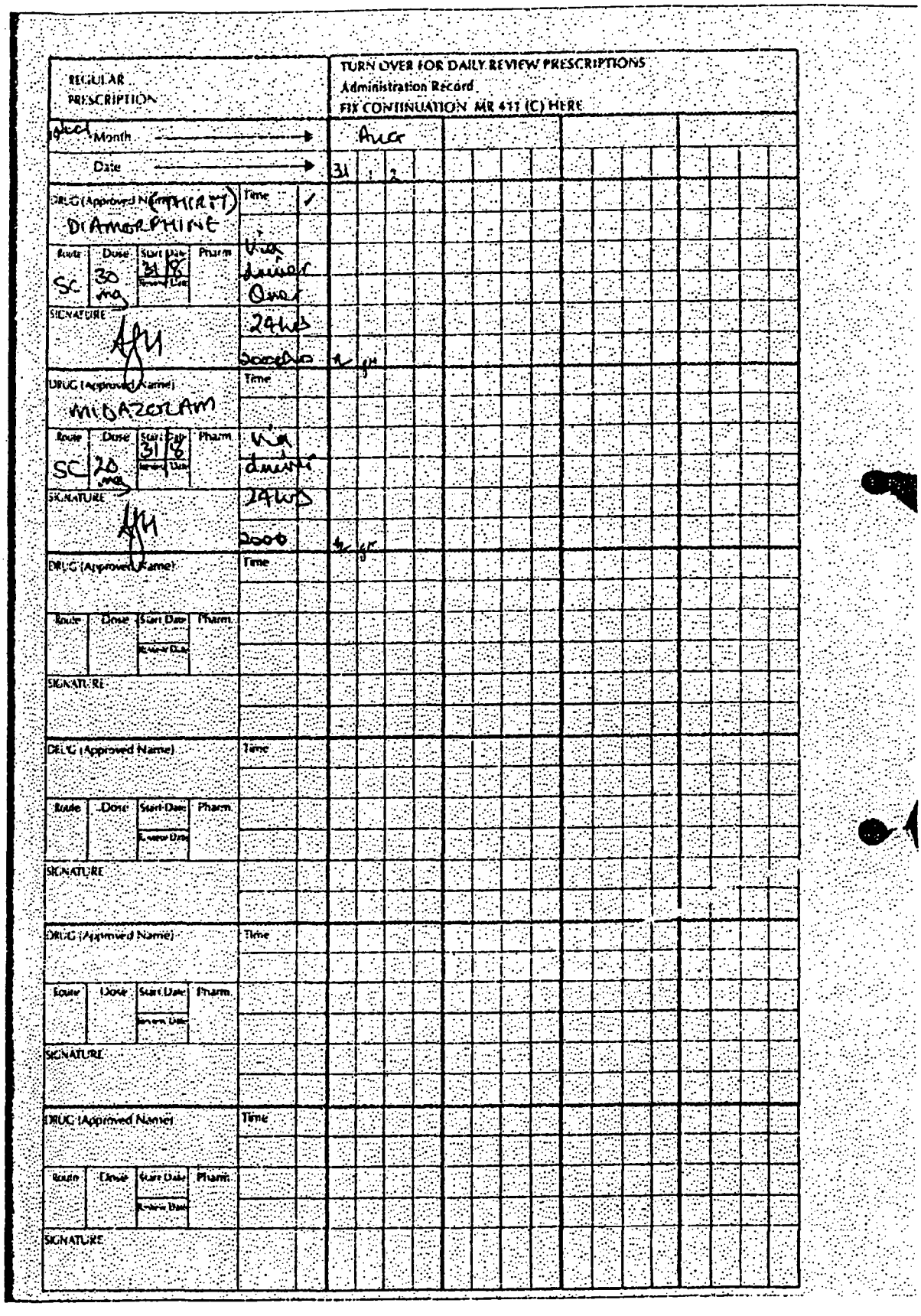
Family Dr. [illegible]

DATE	CLINICAL NOTES (Each entry must be signed)
28/8/01	Thank you I would admission under MRI from benign cranial abnormalities Thanks I would that pre facilitation action can be taken Peng Teck Neurosurgeon Stroke May.01 Ch + xd 20.5.01 fractures (R) cerebellar + Brainstem C.O/ clots from / clivus fract (on Dilantin Drip : ; 20y/24 h. [signature]
31.8.01	Vomit reflex and in pain Dilantin to 30mg Add Midazolam 20mg Submit [signature]

MD 58



DATE	CLINICAL NOTES (Each entry must be signed)
24.01	Did recently, 32 hp Credited - Kmp for training



REGULAR PRESCRIPTION

TURN OVER FOR DAILY REVIEW PRESCRIPTIONS
Administration Record
FIX CONTINUATION MR 411 (C) HERE

Month → Aug

Date → 31 1 2

DRUG (Approved Name) DIAMORPHINE

Route: SC | Dose: 30 mg | Start Date: 31/8 | Review Date | Pharm

SIGNATURE

Time: 1 | 24hrs | Doses

DRUG (Approved Name) MIDAZOLAM

Route: SC | Dose: 20 mg | Start Date: 31/8 | Review Date | Pharm

SIGNATURE

Time: 24hrs | Doses

DRUG (Approved Name)

Route | Dose | Start Date | Review Date | Pharm

SIGNATURE

Time

DRUG (Approved Name)

Route | Dose | Start Date | Review Date | Pharm

SIGNATURE

Time

DRUG (Approved Name)

Route | Dose | Start Date | Review Date | Pharm

SIGNATURE

Time

DRUG (Approved Name)

Route | Dose | Start Date | Review Date | Pharm

SIGNATURE

Time

[redacted]

23 AUG 2002

[redacted]

22/8/02

Formal Complaint.

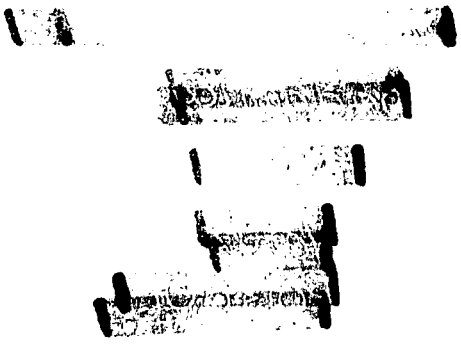
Dear Sir/madam

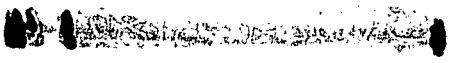
I wish to make a formal Complaint against nursing Staff at the gosport war memorial when my husband was in theire care. after Looking at my husbands medecal records it does Show that there was Complete negligence by Staff nurse Code A and also Code A and also Code A which Lead to the Sudden death of My Husband. I do have all the proof of this in my husbands medecal notes. Please do not hesitate to Contact me IF you require further details.

(R.E. CARBY)

yours Sincerely

Code A





18 NOV 2002

Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 OFH

Tel: 01329 233447
Fax: 01329 234984

Code A
The Nursing & Midwifery Council
23 Portland Place
LONDON
W1B 1PZ

Our Ref: FC/ld

15th November 02

Dear Code A

I am writing further to your letter of 5th September requesting an investigation into a complaint you have received from a Mrs R E Carby (not Conley as in your letter).

Following receipt of your letter, I asked for a review of the records of the late Mr Carby by a senior nurse, specifically with regard to the allegation of complete negligence in relation to the named staff.

I am enclosing a copy of the report from Professor Jean Hooper in this regard. You will note that in conclusion, Professor Hooper is unable to find any specific reason to indicate that nurses were negligent in the care and management of Mr Carby.

Professor Hooper also notes that Mr Carby was given a significant dose of sedative shortly before he died. I would like to point out that the drugs prescribed were prescribed by a syringe driver and I am enclosing excerpts from the Ward Controlled Drugs Record Book in relation to Mr Carby. You will see that whilst the syringe driver was set up with 40 mgs of Diamorphine at 12.15 pm on 27th April, the syringe driver was subsequently discontinued at 13.20 pm on the same day and 9.5 of the original 10 mls of fluid discarded.

I hope this information is helpful. However, if you should require any further information, please do not hesitate to let me know.

Yours since

Code A

Fiona Cameron
Operations Director

22.10.02.

Code A

Chief Executive
Fareham and Gosport PCT.

Dear Ian,

I am pleased to enclose the report of my review of the records of the late Mr. Carby in relation to the complaint which Mrs. Carby has lodged with the Nursing and Midwifery Council against nursing staff at Gosport War Memorial Hospital. Please contact me if I can be of further assistance.

Yours sincerely

Code A

Professor Jean Hooper CBE, Hon. Dsc, MSc, RGN.

CONFIDENTIAL REPORT FOR FAREHAM AND **GOSPORT** PRIMARY CARE TRUST OCTOBER 21ST 2002.

Review of the nursing records of the late Mr. Stanley Carby.

Background. Mr. Stanley Carby died at 13.00 on 27th April 1999 following an extension of his cerebrovascular accident, having suffered an earlier episode on 14th April 1999. He had been an inpatient at Royal Hospital Haslar prior to his transfer to Gosport War Memorial Hospital on 26th April 1999 for rehabilitation, following assessment by Dr. Tandy, consultant geriatrician, on 20th April 1999.
Mr. Carby had multiple pathology, in addition to his recent cerebrovascular accident, and both his Barthel and Waterlow assessments confirmed that he was a high risk patient in terms of his nursing needs.
According to the notes available to me, it appears that Mrs. Carby lodged with the Nursing and Midwifery Council, the allegation that Mr. Carby died as a result of "complete negligence" by Staff Nurse Code A Code A The letter from the NMC of 5th September 2002 to Mrs. Cameron, Operational Director at the PCT, indicates that there had been earlier communication with the NMC from Mrs. Carby, but there is no record of this in the file.
Mrs. Carby's letter of 22 August 2002 states that she has "all the proof" of the alleged "complete negligence" by the three nursing staff, in her late husband's medical notes.
These notes form the basis of my review of the nursing records.

REVIEW.

The staff would have been at a disadvantage from the onset as it appears that no records were sent from Royal Hospital Haslar with Mr. Carby at the time of his transfer, apart from a nursing review by D. P. Wilcock, Registered Nurse,dated 26 April,1999. The Haslar records were not requested until Mr. Carby's sudden deterioration on 27 April.

1. Mr. Carby's summary on admission was written by his named nurse, Janet Neville, but his detailed assessment sheets were completed by another nurse. None of these sheets are signed; it is therefore not possible for me to identify them with any of the nurses against whom the complaint is lodged.
The outcome of his initial assessment confirms a very low Barthel score and a very high Waterlow score, indicating that Mr. Carby was a patient with high nursing dependency. His Mental Study was not undertaken, but

in view of his speech difficulties this seems to be a reasonable decision at the time of admission.

2. Mr. Carby's blood sugar records were maintained regularly and remained within normal limits until the 10.a.m. recording on 27 April, at which time he had become acutely ill.

3. There is some discrepancy in relation to the state of Mr. Carby's skin and pressure areas on transfer. There is no reference to this in the transfer letter from Haslar. On the Waterlow sheet his skin is recorded as "discoloured"; on the Nutritional Assessment tool, as 4 = red/ broken/ wound; on Code A s record on the Handling Profile as"intact"

4 Nursing reports

These records have discrepancies. The initial summary is written on the 26April and not signed. The next entry is dated 27 April ,the signature is illegible and the content indicates that it refers to Mr. Carby's first day in the ward ie. 26 April. There is no identifiable nursing report for overnight care on 26- 27 April. The next written report by ? Code A dated 27 April but with no time recorded, indicates that Mr. Carby was less well, with marked swallowing difficulties. This nurse correctly contacted the oncall doctor, Dr. Barton at 10 a.m., who was due to attend within one hour. The family were also notified of Mr. Carby's condition.

Dr. Barton attended and assessed Mr. Carby's very serious condition and discussed his care with the family who were present. She prescribed drugs to "make him comfortable" as Mrs. Carby felt that her husband was in pain. It is recorded that she thought that he would not survive this episode.

A nurse (not clear from initials who this was) administered diamorphine 40mgm and mixazolan 40mgm at 12.15 p.m. and Mr. Carby was confirmed dead by Code A at 13.00 hours. The family were present and were "very distraught and distressed".

It should be noted that these drugs are recorded as being administered on 26 April at 12,15p.m. Clearly it must have been on the 27th.

CONCLUSION

I am unable to find any specific reason through review of the notes to indicate that the nurses were negligent in their care and management of Mr. Carby during the 24 hours that he was an inpatient at Gosport War Memorial Hospital. Mrs. Carby herself did not feel that her husband would survive this second episode. However Mr. Carby was given a very significant dose of sedative shortly before he died, and this may now be

influencing Mrs. Carby in her assessment of her husband's care. It is unusual that there has been such a long time lapse if this is so.

I am concerned at the discrepancies in the records in terms of dates and times. This must reduce the level of confidence of relatives having access to the files.
I therefore strongly recommend that:
Staff be required to complete all records with date and time when making any recording;
Names should be signed legibly and in full;
Drugs must be recorded in the correct space;
Two signatures should be recorded in situations such as this where the patient was clearly close to death when the drugs were administered.

Code A

22.10.02

Code A

Code A

Code A

Code A

PORTSMOUTH HealthCare NHS TRUST

Patient Name ... Stanley Carey

Contact Record

Date	Problem No.	Time	Record of contact, with, Signature and designation
27/4/99		pm	Very tired on admission. Visited by wife & daughter - provisional care plan explained. Very agitated after family left. Pulling himself down in bed, throwing any bed objects left in reach. Small amount of supper eaten with assistance.
27/4/99			Unable to get Stan to swallow any fluid (thickened) due to patient holding his head back and not appearing to be alert enough to swallow. Unable to assess swallowing - referred to speech and language therapists Dr. Hand contacted, suggests that we give 2.5mg Midazolam and sub-cutaneous fluids, and Dr. Baxton to see at lunchtime.
27/4/99			Patient's breathing very shallow - colour poor peripheral cyanosis B/P 90/50 Glucocheck 14.8. Dr. Baxton contacted - notes requested from Haslar.
		10am	Dr Baxton aware & will attend in approx 1 hour Wife & daughter notified & coming in

NR10

PORTSMOUTH HealthCare TRUST

Patient Name STANLEY CARBY.

Contact Record

Date	Problem No.	Time	Record of contact, with, Signature and designation
27/4/99.			S/B Dr. Barton. Family spoken too regarding previous Strokes and probably extension of this CVA. Patient extremely cyanosed and very clammy. Who thinks he will not survive this episode, this conferred as the probable outcome. Decision made with family to make the patient comfortable who feel that Mr. Carby is in pain because he is gripping her hand. Difficult to tell if this is so but sub-cutaneous analgesia commenced, together with Midazolam. Joyce
27/4/99			Patient died at 15.00. death confirmed by S.N. Neville & S.N. Joyce. Family present and were very distressed and distraught about the Father's death. Wife present and aware. Information given to relatives. No bereavement

REGULAR PRESCRIPTION

TURN OVER FOR DAILY REVIEW PRESCRIPTIONS
Administration Record
FIX CONTINUATION MR 411 (C) HERE

19 Month → Apr 1
Date → 26 27 28 29

DRUG (Approved Name) ENALAPRIL 20mg | Time | ✓
Route: oral | Dose: 1 tab | Start Date: 26/4/19 | Review Date | Pharm. TJ
Time: 0800
SIGNATURE
Time: 1300

DRUG (Approved Name) FINASTERIDE 5mg | Time
Route: oral | Dose: 1 tab | Start Date: 26/4/19 | Review Date | Pharm.
Time: 0800
SIGNATURE

DRUG (Approved Name) PANTOPRAZOLE 40-20mg | Time
Route: SC | Dose: in 24hrs | Start Date | Review Date | Pharm.
Time: 12.15 40 mg IV
SIGNATURE

DRUG (Approved Name) MIRTAZAPINE 40-30mg | Time
Route: SC | Dose: in 24hrs | Start Date | Review Date | Pharm.
Time: 12.15 40 mg IV
SIGNATURE

DRUG (Approved Name) | Time
Route | Dose | Start Date | Review Date | Pharm.
SIGNATURE

DRUG (Approved Name) | Time
Route | Dose | Start Date | Review Date | Pharm.
SIGNATURE

21 MAY 2002

[redacted]

Friday 17th May 2002

Tel: Home [redacted]
Work [redacted]
Ext. [redacted]

The Director
The Nursing and Midwifery Council
(NMC)
23 Portland Place
London
W1B 1PZ

RE: GOSPORT WAR MEMORIAL – DEATH OF Mrs E I PAGE

I wish to make a formal complaint against Nursing staff working at The Gosport War Memorial in Gosport, Hampshire, during the time that my mother was in their care.
The nurses concerned are Code A

My mother was admitted from Queen Alexandra's Hospital, Portsmouth on 27th Feb 1998 and died the evening of the 3rd of March 1998.

The events leading up and including her death were investigated in a serious crime investigation carried out by The Major Incident Complex, Portsmouth. Her case was serious enough to be sent to medical experts for opinion, I believe this report substantiates concern in her treatment. I also believe you have a copy and am aware of this case.

It is important to note that I was first made aware that there was concern in the treatment of elderly patients during 1998, when Mrs Gillian MacKenzies's case made local press news. At that time I wrote a letter to the police stating that I had concern relating to my mother, this was on the 9th April 2001. I was told that my mother's case would be investigated. I heard nothing until the 13 February 2002. At that time I was invited with other concerned relatives to a meeting with the head of the enquiry team who explained the events of the investigation and the reasons as to why no further action would be taken. At this meeting I first learnt that my mother's case was one of four cases investigated and expert opinions sought. I was also told at this meeting that these reports, which were highly critical of the care given to these patients, would be available to me. This promise was rescinded, and I was later told later that a Court Order would be required, and that this may well be refused.

I subsequently obtained my mothers notes and after perusal with a professional opinion, I found several areas of grave concern. I now understand from Mrs Ann Reeves (another unhappy relative) that these police reports were sent to you as an area of concern. A copy was also sent to the General Medical Council who I believe are investigating further as regards the doctors concerned.

I am annoyed that throughout this time I have been kept in the dark by the police as to any investigation made, and the investigating officer's decision to take no further criminal action, and his subsequent withdraw of the offer to release the medical opinions. I am presently making a formal complaint to The Chief Constable, Hampshire Police.

I trust you are able to assist me in this very serious matter.

Yours truly,

Code A

Bernard Page

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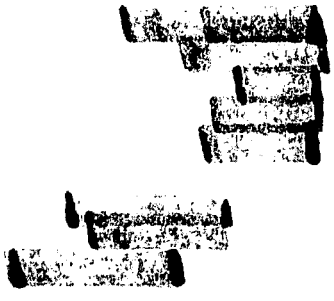

NURSING & MIDWIFERY COUNCIL

Protecting the public through professional standards

Private and Confidential

Mr Bernard Page

[redacted]

12 June 2002
Code A KM/GEN
PAGE

Direct Line: Code A
Fax Number: 020 7636 2903
Email: conduct@nmc-uk.org

Our ref: PPC/Code A Gosport

Dear Mr Page

Gosport War Memorial Hospital

Thank you for your letter of 17 May 2002 concerning the above and the care received by your mother Mrs E I Page.

The Nursing and Midwifery Council is the regulatory organisation for the professions of nursing and midwifery. This means that we keep the register for the professions, sets standards for practice and also have the power to remove from the register the names of any nurse who is not fit to practice because of professional misconduct.

The Nursing and Midwifery Council does not have the power to investigate the overall care received by Mrs Page whilst at Gosport, but only to investigate the specific practise of the nurses involved. We also cannot help you to obtain the documents that you require.

I enclose the Nursing and Midwifery Council booklet Complaints about professional conduct. This sets out in more detail what happens when a complaint is made and I hope that you will find it helpful.

I confirm that the Nursing and Midwifery Council have received from the police a copy of Professor Ford's report which includes an examination of the care your mother received whilst at Gosport War Memorial Hospital. The report whilst raising a concern about the prescription of medication on one occasion finds the care provided by the nurses adequate.

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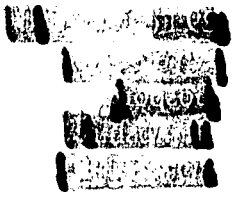

Therefore if you wish the Nursing and Midwifery Council to proceed with an investigation into the conduct of any nurse it would be helpful if you would specify what your concerns are. I note that you have received a professional opinion, it would be helpful in understanding your concerns if we could receive a copy of any report or letter that you have received from the expert you have consulted.

Thank you for bringing this matter to our attention and we look forward to hearing from you. For your information I am leaving the NMC on 14 June and therefore any reply should be directed to Code A giving the reference above.

Yours sincerely

Code A

NURSING & MIDWIFERY COUNCIL

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Private and confidential

Bernard Page

[redacted]

27 September 2002
PRE/DEC/20/Code A/12053
Direct Line : Code A
Fax : 0207 636 2903
Email : conduct@nmc-uk.org

Dear Mr Page

Nurses at Gosport War Memorial Hospital

I write concerning the above named, whose case was placed before the Preliminary Proceedings Committee of the Council at its recent meeting.

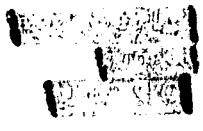
After careful consideration of the papers before it, the Committee members came to the following decision:-

That the matter should be adjourned in order to await the outcome of investigations by the Crown Prosecution Service.

The case will be considered by the Preliminary Proceedings Committee in due course after which time you will be informed of the outcome.

Code A

23 Portland Place, London W1B 1PZ
Telephone 020 7637 7181 Fax 020 7436 2924 www.nmc-uk.org



MR 200

Cwm HOSPITAL

HISTORY SHEET

UNIT NO S.M.W. M.F.

Name PAGE EVA
(Surname First)

Address

Date of Birth

Family Dr.

DATE	CLINICAL NOTES (Each entry must be signed)
25/2/98	Confused + some agitation towards afternoon → evening. Says she's frightened - not sure why. Tends to scream at night. Not in pain.
	- Try Hs Thio v fragile.
	- Sch in Gosport ∴ transfer to NHS c/c GWMH - 27/2 or early next wk.
	- Hemineurin for night (17 Thio v fragile / inadequate).
	all other drugs stopped by Dr Lee
	Transfer to Byass ward Continuing Care
27/2/98	Δ of LA bronchus made on CXR on admission/2 - Generally unwell off legs, not eating Bronchoscopy not done Re Extubated needs help + eating + drinking needs hoisting Bowels O

WWG 518

DATE	CLINICAL NOTES (Each entry must be signed)
	Case discussed with [illegible] Family seen. Overall made good progress. Openly communicated. Very happy for my flag to say 'no resuscitation'
28-2-18	asked to see - confused feels 'lost' - agitated esp at night / evening. not in pain. to give Haloperidol 2.5mg tds regular Benzodiazepine prn. Dr Laing (Duty G.P.)
1-3-18	no improvement on Haloperidol. Haloperidol adequate dose to control [illegible] and pain. Son to be seen by Dr Laing today.
2/3/18	Spitting out Thioridazine. Quieter - on prn SC Diamorphine. Fentanyl Patch started today. Agitated & calling out when alone. Staff present. Δ i) Ca Bronchus. ii) ? Cerebral Metastases. - Cx. Fentanyl Patches. (Cont.
2/3/18	Son seen. Concerned about deterioration today. Explained about agitation & that hyperacusis was probably due in part to Diamorphine. He accepts that his mother is dying & agrees we continue present plan of Rx. (Cont.

MR 200

..... HOSPITAL

HISTORY SHEET

UNIT NO S.M.W. M.F.

Name .....
(Surname First)

Address .....

Date of Birth .....

Family Dr. .....

DATE	CLINICAL NOTES (Each entry must be signed)
3.3.98	
	Patient [illegible] & delivered of Dead person safely on 31 3.98.
	Health looked by Staff Nurse I.M. DARLINGTON. Son informed. [illegible] Dr. for Circulation

WWG 518

DAILY REVIEW PRESCRIPTIONS

~~REGULAR~~ PRESCRIPTION PRN

Date →													
Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
DRUG (Approved Name) 20-80 Diamorphine	10:50	20 mg IM												
Route s.c in 24h	Pharmacist													
SIGNATURE														

Date →													
Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
DRUG (Approved Name) 200-800 Hyoscine														
Route s.c in 24h	Pharmacist													
SIGNATURE														

Date →	3/3/98												
Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
DRUG (Approved Name) 20-80 Diamorphine	10:50	20 mg IM.												
Route s.c in 24h	Pharmacist													
SIGNATURE														

Date →													
Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
DRUG (Approved Name)														
Route	Pharmacist													
SIGNATURE														

Date →													
Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
DRUG (Approved Name)														
Route	Pharmacist													
SIGNATURE														

NURSING & MIDWIFERY COUNCIL

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Dr Eileen Thomas
Acting Nursing Director
Fareham and Gosport PCT
Newbridge
Cadnam
SO40 2NW

29 April 2002
PPC\Code A
Direct line: Code A
Fax No: 020 7636 2903
Email: Conduct@nmc-uk.org

Dear Dr Thomas

Gosport War Memorial Hospital

I am writing further to our recent conversation concerning an investigation by Hampshire Constabulary into care of patients admitted to Daedalus and Dryad Wards, Gosport War Memorial Hospital.

Hampshire Constabulary have sent me a copy of Professor Livesley's and Rochford report which concluded that in five cases in 1998 subcutaneous infusions of diamorphine and in combination with sedative drugs were administered to older people who were mostly admitted for rehabilitation.

Clearly these issues concerned medical decisions but there were also issues surrounding the accountability of the nurses caring for these patients. There were no nurses named in the report.

Professor Livesley concerns about nursing care are summarised below.

1. Case of patient Gladys Richards

This case has previously been considered by the Preliminary Proceedings Committee of the UKCC who decided to close the case in relation to E Code A Unless there is new evidence or evidence against other practitioners no further action can be taken.

2. Case of patient Arthur Cunningham

1. A decision was made to administer Oramorph but there was no clear recording in the nursing notes that he was in pain or the site of pain;

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Telephone 020 7637 7181 Fax 020 7436 2924 www.nmc-uk.org

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2. Nursing staff may not have considered the possibility that Mr Cunningham's respiratory symptoms may have been due to opiate and benzodiazepine respiratory depression;
3. Nursing staff failed to appreciate that the agitation Mr Cunningham experienced on 23 September at 2300hrs may have been due to Midazolam and Diamorphine;
4. Nursing notes were variable and at times inadequate;
5. Nursing notes suggest that diamorphine and midazolam infusions were commenced because of Mr Cunningham's behaviour recorded on 22 September;
6. Hyoscine commenced on 23 September after Mr Cunningham had become chesty overnight. There is no record of medical examination in relation to this;
7. On 23 September Midazolam appears to have been tripled without reference to medical staff;
8. Denial of fluids and diet and administration of high doses of diamorphine and midazolam may have contributed to Mr Cunningham's death.

3. Case of patient Alice Wilkie

1. Nursing notes were inadequate in that there were no clear recordings of respiratory observation so it was difficult to know whether respiratory depression was present;
2. There was a failure to monitor affect of drugs prescribed.

4. Case of patient Robert Wilson

1. When patient's condition deteriorated neither medical nor nursing staff appeared to consider that this was due to the high doses of medication Mr Wilson was administered;
2. There was a failure to record respiratory rate;
3. There is no clear reason for the prescribing of Midazolam when the nursing notes record that he was comfortable;
4. Administration of high doses of diamorphine and midazolam was poor practice and may have contributed to his death.

5. Case of patient Eva Page

No concerns about nursing care.

As you will know it is not within the remit of the NMC to investigate general concerns about nursing care on a ward or unit but to consider allegations of professional misconduct against particular nurses, midwives or health visitors in relation to issues which could result in removal from the register.

I am aware that you will have received Professor Livesley report and conducted your own investigation and it would be most helpful to have your comments on the issues outlined above and in particular whether there is concern about the conduct of any particular registered practitioner. Could I also request the following:

- Copies of the relevant pages from the nursing medical notes of Arthur Cunningham, Alice Wilkie and Robert Wilson.
- Copies of any report or document that you are able to provide arising out of your own investigation.
- Details of any disciplinary action taken against any registered practitioner.

Thank you for your assistance in this matter and I look forward to hearing from you.

Yours sincerely

Code A

Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 OFH

Tel: 01329 233447
Fax: 01329 234984

17 MAY 2002

Code A
Professional Conduct
Nursing & Midwifery Council
23 Portland Place
LONDON
W1B 1PZ

Our Ref: ET/LD

15th May 02

Dear Code A

Thank you for your letter of 29th April outlining information requirements in relation to the police investigation into the care of patients on Daedalus and Dryad Wards at Gosport War Memorial Hospital.

I will respond using the numbers contained in your letter.

1. I note that the NMC will not be further considering the case of Gladys Richards. In relation to points 2 through 4, I am enclosing the records that you have requested relating to Arthur Cunningham, Alice Wilkie and Robert Wilson which will help to address the issues you have raised. It should be noted that the reports from the expert witnesses, from which I assume these issues were taken, are the interpretations reached by the expert witnesses themselves.

   In relation to the reports, questions have been raised about the factual accuracy of some of the content and they are compromised in that the expert witnesses never spoke to the staff concerned or senior clinicians/managers in the Trust. Furthermore, none of the expert witnesses came from a nursing background and no review by a nurse was undertaken as part of the police investigation.

5. I am also enclosing a copy of our own investigation which was generated following the police expert witness reports received first by the Trust in February 2002. As you know, this was the first sight we had of these expert witness reports.

   You will see from the report relating to our investigation that we agree that record keeping at Gosport War Memorial Hospital was inadequate in 1998/99. In contextual terms however, this hospital was in 1998 a cottage hospital, very similar to most others in the country (as reported by the Audit Commission at that time).

Since 1998 and the appointment of myself and key nursing leaders in the division responsible for Gosport War Memorial, the Trust has invested considerably in the development of nurses and nursing practice.

During 1997/1998, there were nursing shortages at Gosport War Memorial which is on the Gosport peninsula with all the attendant difficulties associated with nursing recruitment. The Trust also took steps to increase staff and clinical leadership, and implemented in 1998 one of the first and highly acclaimed Clinical Nursing Development Programmes.

While these factors are relevant, they do not condone the sub optimal practice of nurses. In response to this, the Trust's investigation led to interviews with three key nurses on the ward at the time of the incident in 1998. They were clear that while they agreed totally that their practice was below the standard required by the Trust and their code of conduct, there were mitigating circumstances. I have already outlined some of these and enclosed the investigation reports.

Since the investigation, the report recommendations are all being systematically and rigorously implemented in the PCT. This is being supervised and evaluated by Fiona Cameron, Operational Director for Community Services who is a senior experienced nurse and who was a key appointment to provide leadership to nursing in the area. The PCT is also applying for a nurse consultant to work within community hospitals in the Fareham and Gosport area to further strengthen nursing leadership in the Trust.

I hope this adequately covers the issues that you raised. However, if you have any further questions or concerns, please do not hesitate to contact me again. As I am sure you are aware, this has been an extremely traumatic time for the staff as Gosport War Memorial Hospital was the subject of a CHI investigation earlier this year and this report is still awaited. This trauma has been enduring over a long period of time and has greatly affected the morale of staff at Gosport War Memorial Hospital.

Yours sincerely

Code A

Dr Eileen Thomas
C/o Fareham & Gosport PCT

Encs.

Portsmouth Healthcare NHS Trust

Notes of meetings to discuss the actions of nurses referred to the UKCC following events at Gosport War Memorial Hospital, 1998-1999.

1. Purpose

A meeting was convened in response to requests made by the Trust's Clinical Governance Panel meeting. During this, Panel members asked for reassurance that the Trust had taken appropriate action towards the nurses named in the police Expert Witness report sent to the UKCC and received by the Trust for the first time in February 2002. Although the focus of the UKCC investigation was not yet known, and in order to assure Panel members, Dr Thomas and Mrs Cameron were asked to investigate and report back at the next available meeting.

2. Two meetings were held as part of the investigation process.

Meeting One: Mrs Cameron, Dr Thomas, Mrs Woodland (RCN), Mrs Peach and Mrs Bennett.

This indicated that:

- Nursing documentation relating to the four patients in question was inadequate in several key areas; the recording of nutrition, hydration, pain assessment and evaluation, skin integrity and communications with relatives. Action: an independent audit of current nursing documentation.
- The nurses named in the police Expert Witness Report, were primarily the nursing team leaders during the period in question.
- Although extensive training initiatives have been implemented over the intervening years, it was not known if this has applied to the nurses specifically named in the Expert Witness report sent to the UKCC. Action: a review of the training records of the nurses involved and the training programmes available to all staff.
- It was considered important to be clear about the safety and competency of the nurses involved. Action: statements from managers and a review of IPR's would be undertaken.
- There were staff shortages during the time of the incidents. Action: Detailed information regarding increases in staff numbers and skill mix would be obtained.

Those present at the meeting were of the unanimous opinion that, had events occurred now, the usual processes would be invoked and the staff suspended subject to an investigation. There was also total agreement about the inadequacy of record keeping but that no action against the named nurses was indicated at the present time.

3. Meeting Two: Mrs Cameron, Dr Thomas, Mrs Woodland (RCN), Mrs Parvin, Mrs Peach, Mrs Bennett.

3.1.1 The independent audit of current nursing documentation was undertaken. This demonstrated that, while there were some excellent examples of documentation practice, there remained weaknesses in general. This in part, may relate to the structure of the record system used but there remained a training issue for staff. The record keeping of the named nurses was considered satisfactory.
Recommendation: The PCT should investigate the use of an alternative record system and should consider this for implementation across all nursing groups in the area. Training should be provided in the light of the new system.

3.1.2 Given the leadership roles of the nurses involved in the 1998-99 incidents. It was considered important for the Trust to feel confident that they recognised and reflected on the seriousness of the situation as it had occurred.
Action: Mrs Cameron with Mrs Parvin would meet the three nurses concerned. The purpose of this was to formally interview the nurses regarding their omissions in recording, and subject to their understanding of the seriousness and their responsibilities under the Nurses Code of Conduct, Mrs Cameron and Mrs Parvin would determine the next steps, to be taken. These meetings were arranged for 19 April, 2002.

3.1.3 While the nurses had undergone training over the intervening years, much of this was technical in nature and would not assist their leadership function. This includes; ensuring standards on the wards, modelling effective nursing practice and record keeping.
Recommendation: a relevant and evaluated training and development programme would be instigated for the individual nurses. The RCN Gerontological Programme Team should also be involved in addressing the general issue of culture and attitude.

3.1.4 The statements from managers and supervisors regarding the three nurses were positive, although only one nurse remained in the same post since 1998.
Recommendation: Regular supervision of all nursing staff and their clinical practice should be ensured in the PCT, in order to prevent poor practice in the future. It should consider implementing the Department of health's "Essence of Care", Clinical Benchmarks for this purpose.

3.1.5 Since 1998, there had been increases in the numbers of staff on the wards and the creation of a Clinical "H" post, which has 50% of time spent in clinical practice.
Recommendation: As part of the PCT's Clinical Governance arrangements, staffing and workload evaluations should be undertaken at agreed, regular intervals.

4. Summary

The investigation demonstrated that the record keeping of three nursing staff, during 1998-1999 had been sub-optimal, especially relating to the recording of patient care activities. There was no evidence that this continued or that the nurses were not competent to safely undertake their duties at the present time. In order to be certain that the nurses understood the important nature of care documentation and the potential seriousness of the situation they would be interviewed by Mrs Cameron and Mrs Parvin. Action subsequent to this would be determined as a result of these meetings.

While there were individual omissions on the part of the nurses concerned. Trust systems errors also contributed to the events referred to in the Expert Witness Reports. Many of these have been addressed through a number of Trust initiatives but the continued supervision of staff and evaluation of practice is essential to ensure best practice in the future.

NURSING MIDWIFERY COUNCIL

Protecting the public through professional standards

Private and confidential
Kathryn Rowles
Director of Public Health
Fareham & Gosport NHS Primary Care Trust
Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

03 October 2002
BlankAddress Code A 12053
Direct Line : Code A
Fax : 0207 636 2903
Email : conduct@nmc-uk.org

Dear Ms Rowles

Nurses at Gosport War Memorial Hospital

Thank you for your letter of 16 September 2002.

This matter was placed before the Preliminary Proceedings Committee of the Council at its recent meeting.

After careful consideration of the papers before it, the Committee members came to the following decision:-

That the matter should be adjourned in order to await the outcome of investigations by the Crown Prosecution Service.

The case will be considered by the Preliminary Proceedings Committee in due course after which time you will be informed of the outcome.

The names of the nurses reported are:

Code A

Code A

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Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 OFH

Tel: 01329 233447
Fax: 01329 234984

15 OCT 2002

Code A

Nursing Midwifery Council
23 Portland Place
London
W1B 1PZ

FC/MT

11 October 2002

Dear Code A

Thank you for your letter to Kathryn Rowles, Director of Public Health at Fareham & Gosport Primary Care Trust, dated 3 October 2002.

The list of names you provided me with is most helpful. However, I should point out that, whilst I have previously received correspondence from yourself in relation to Phillip Beed and been asked to provide information regarding specific issues, I have received no communication from you in relation to Code A Code A

In addition, in two previous communications with me, you have asked for information regarding particular issues relevant to nurses whose names do not now appear on your list, those of Code A I would be grateful if you could clarify for me which, if any, of the names I have mentioned are still the subject of consideration at the NMC.

In relation to Code A I would be grateful to understand the context in which these individuals have been referred to you, as these nurses are currently employed and practising within the PCT.

Thank you for your help with this matter.

Yours sincerely

Code A

Fiona Cameron
Operational Director

IN THE MATTER OF:

NURSING AND MIDWIFERY COUNCIL ("NMC")

GOSPORT WAR MEMORIAL HOSPITAL

GUIDANCE TO THE PELIMINARY PROCEEDINGS COMMITTEEOF THE NURSING AND MIDWIFERY COUNCIL OPERATING UNDER THE NURSES MIDWIVES AND HEALTH VISITORS (PROFESSIONAL CONDUCT) RULES 1993

In relation to these cases of alleged misconduct (cases relating to patients Page, Carby, Middleton, Wilkie and Devine) which are to be determined in accordance with the 1993 Rules, the Preliminary Proceedings Committee ("PPC") should follow the guidelines set out below.

1. Where there is more than one practitioner facing allegations, each practitioner must be considered separately.

2. The PPC must consider separately each allegation made against a practitioner.

3. In relation to each allegation the PPC must:

    a. Review the allegation which is made.

    b. Review the evidence which is available in relation to the allegation and any response to the allegation which has been submitted by or on behalf of the practitioner concerned.

    c. Bear in mind that:

        i. The PPC has a limited filtering role and is considering the case in private on documents alone.

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ii. Public confidence and the legitimate expectation of complainants require that allegations will be publicly investigated by the Conduct Committee in the absence of some special and sufficient reason.

iii. It is rarely if ever the PPC's role to resolve conflicts of evidence, issues of admissibility, weight or inference, or to anticipate potential defences that might be run – that is the function of the Conduct Committee.

iv. Any doubt as to whether a complaint should go forward is to be resolved in favour of the investigation proceeding.

v. The PPC should be particularly slow in halting a complaint against a practitioner who continues to practise.

vi. The PPC should exercise the utmost caution before declining to forward a complaint based on a finding made by another medically qualified body, for example, another regulator, or a coroner or a judicial inquiry after it has heard oral evidence in public.

vii. The PPC may at any stage:

- require further investigation to be conducted;
- adjourn consideration of the matter;
- refer the matter to the professional screeners;
- take the advice of the NMC's solicitor and may instruct him to obtain such documents, proofs of evidence and other evidence in respect of the allegations as he considers necessary; and/or
- require, in the case of a complainant who is not acting in a public capacity, that the complaint be verified by way of a statutory declaration.

d. With the factors set out in paragraph (iii) above in mind, the PPC must decide the main matter: whether there is any question raised which is capable of resulting in a finding of misconduct bearing in mind that an allegation must be proved on the balance of probabilities, that is so the Conduct Committee is of the view that it is more probable than not that the allegation is correct.

e. In order for the PPC to answer this question they must consider whether there is a real (as opposed to fanciful) prospect of the factual element of the allegation being established. In this regard the PPC should have regard to the delay in these cases coming before it and effect of that delay on the real prospect of each allegation being established. If there is such a prospect, the PPC must consider whether there is a real (as opposed to fanciful) prospect the Conduct Committee might decide to

remove her name from the register as a result.

f. In deciding the main matter, it is not for the PPC to attempt to answer any question which is raised by the complaint: that is for the Conduct Committee, if the complaint otherwise passes muster. This means the PPC should not decide conflicts in the evidence whether factual or expert.

g. With the factors set out in paragraph (iii) above in mind, the PPC may decide whether in these cases to take into account the effects of the delay upon them and whether the delay is such that the proceedings in relation to any allegation should be stayed for abuse of process.

h. Whether proceedings are an abuse of process is generally a question for the Conduct Committee. The PPC should only refuse to refer a case on the basis of delay in highly exceptional cases where it is very clear that a fair hearing cannot take place. If it is not clear the PPC should, if satisfied of the criteria set out in 3(d) above, refer the case to the Conduct Committee and allow it to consider whether a fair hearing can take place and whether steps can be taken to enable the registrant to have a fair hearing.

i. When determining whether a case should be stayed on the ground of delay the PPC should bear in mind the following principles:

   i. even where delay is unjustifiable, a permanent stay should be the exception rather than the rule;

   ii. where there is no fault on the part of the complainant or the NMC it will be very rare for a stay to be granted;

   iii. no stay should be granted in the absence of serious prejudice to the registrant so that no fair hearing can be held;

   iv. on the issue of serious possible prejudice there is a power to regulate the admissibility of evidence and the trial process itself should ensure that all relevant factual issues arising from the delay will be placed before the Conduct Committee which can take all into account in deciding the case.

If having considered all of these factors the PCC's assessment is that a fair hearing may
be possible, a stay should not be granted.

4. If the PPC decides that it is very clear in any case that no fair hearing can be held it should refuse to refer the case to the Conduct Committee and stay the proceedings for abuse of process.

5. If the PPC decides:

   a. there **is** a real prospect that the factual element of the allegation could be established and that there is a genuine possibility that the Conduct Committee might find misconduct established and removal from the register to be satisfied

   and

   b. has not concluded that this is an exceptional case in which it is very clear that no fair hearing can be held

   then:

      i. it must direct the Registrar to send to the practitioner a Notice of Proceedings together with the documents referred to in Rule 9(1)(b) & (c) of the 1993 Rules, and then consider any written response and re-determine the matters set out in paragraph 3(d) above; and

      ii. if the Notice of Proceedings stage has already been completed, it must forward the allegation for hearing before the Conduct Committee.

6. If the PPC decides there is no real prospect that the factual element of the allegation could be established on the basis of the available evidence, it must consider what further investigations could (and bearing in mind the factors set out above) should be conducted before a final decision is made on the case by the PPC, and must order those investigations to be made. Subject only to this obligation, if the PPC decides at any point, that no question capable of resulting in a finding of misconduct and removal from the register arises, it may decline to proceed with the allegation.

7. If the PPC decides that there is a real prospect that the factual element of the allegation could be established before the Conduct Committee and that the Conduct Committee could consider it to amount to misconduct, but that there is no genuine possibility the Conduct Committee could consider that misconduct to justify removal from the register then:

   a. if the PPC considers that the practitioner's fitness to practice may be seriously impaired by reason of her physical or mental condition, it must refer the case to the professional screeners; and

   b. if the case is not to be referred to the professional screeners and if the practitioner has admitted the facts alleged in the Notice of Proceedings, the PPC may determine whether the practitioner has been guilty of misconduct and, if so, whether it is appropriate to issue a caution as to the practitioner's future conduct (and if so it shall direct the Registrar to issue a caution.)

8. The PPC must record brief reasons for each decision it makes.

Code of Professional Conduct

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

23 Portland Place, London W1N 4JT
Telephone 0171 637 7181 Facsimile 0171 436 2924

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

June 1992

Code of Professional Conduct for the Nurse, Midwife and Health Visitor

Third Edition
June 1992

Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to:

- **safeguard and promote the interests of individual patients and clients;**
- **serve the interests of society;**
- **justify public trust and confidence and**
- **uphold and enhance the good standing and reputation of the professions.**

As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must:

1 act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;

2 ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients;

3 maintain and improve your professional knowledge and competence;

4 acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner;

5 work in an open and co-operative manner with patients, clients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care;

6 work in a collaborative and co-operative manner with health care professionals and others involved in providing care, and recognise and respect their particular contributions within the care team;

7 recognise and respect the uniqueness and dignity of each patient and client, and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor;

8 report to an appropriate person or authority, at the earliest possible time, any conscientious objection which may be relevant to your professional practice;

9 avoid any abuse of your privileged relationship with patients and clients and of the privileged access allowed to their person, property, residence or workplace;

10 protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by the order of a court or where you can justify disclosure in the wider public interest;

11 report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice;

12 report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided;

13 report to an appropriate person or authority where it appears that the health or safety of colleagues is at risk, as such circumstances may compromise standards of practice and care;

14 assist professional colleagues, in the context of your own knowledge, experience and sphere of responsibility, to develop their professional competence

and assist others in the care team, including informal carers, to contribute safely and to a degree appropriate to their roles;

15 refuse any gift, favour or hospitality from patients or clients currently in your care which might be interpreted as seeking to exert influence to obtain preferential consideration and

16 ensure that your registration status is not used in the promotion of commercial products or services, declare any financial or other interests in relevant organisations providing such goods or services and ensure that your professional judgement is not influenced by any commercial considerations.

Notice to all Registered Nurses, Midwives and Health Visitors

This Code of Professional Conduct for the Nurse, Midwife and Health Visitor is issued to all registered nurses, midwives and health visitors by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. The Council is the regulatory body responsible for the standards of these professions and it requires members of the professions to practise and conduct themselves within the standards and framework provided by the Code.

The Council's Code is kept under review and any recommendations for change and improvement would be welcomed and should be addressed to the:

Chief Executive/Registrar
United Kingdom Central Council
for Nursing, Midwifery and Health Visiting
23 Portland Place
London
W1N 4JT

Rose Butcher
Clinical Manager Multi Disciplinary Response Team,
Night Nursing and Twilight
Unit 120 Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

Code A

PRIVATE AND CONFIDENTIAL

12 March 2010

Dear Code A

Reference request for Code A

Thank you for your request for an employment reference for Code A
I can confirm that he has worked as a Senior Staff Nurse with the Multi Disciplinary Response Team, Fareham and Gosport, since January 2006. The team is primarily involved in the prevention of hospital admission of patients in crisis.

I have been his direct line manager for this period, and have worked closely with him, having daily meetings, and frequently accompanying him on patient assessments and follow up visits.

His duties in this role include the in depth assessment of complex needs, subsequent care planning, care delivery, and on going monitoring of patients' conditions. He also supervises more junior members of the team, participating in induction of new staff, and teaching clinical skills.

He has regularly delivered presentational sessions to other agencies/organisations, explaining the role of the Multi Disciplinary Response Team.

I have always found Code A of good character, and patients and relatives find him to be patient and able to communicate health issues in a way that is appropriate to their understanding. He is a supportive member of a busy team, and can take the lead when necessary.

I find Code A more than able to practice as a Registered Nurse, and I believe his clinical competencies are of an exceptionally high standard. His record keeping is accurate, contemporaneous and precise.

Code A wishes to apply for the Extended Independent Non Medical Prescriber's course, and I will have no hesitation in recommending him for this. He has completed the History Taking and Physical Examination course whilst in my employ, and this has greatly enhanced his clinical practice.

Overall, I find Code A an invaluable member of the team, and would be greatly missed. Currently he is standing in for me in leading the team whilst I am temporarily assisting my Service Manager.

Code A .

Rose Butcher RGN. Dip DN. BACS Hons.

Dr. Stuart R. E. Morgan

Brune Medical Centre
10 Rowner Road
Gosport, Hampshire
PO13 0EW
Tel: Code A
Fax: 023 9279 4189

Code A
Centrium House 1st Floor
Nursing and Midwifery Council
61 Aldwych
London
WC2B 4AE

03.03.2010

Our Ref: SREM/ICS

Your Ref: PRE/RP/GP/12053/JB

NHS N°: Code A

Dear Code A

Re: Gillian HAMBLIN dob - 08.02.1949
3 The Glen, Gosport, PO13 0ZR. Tel: 02392 359221

Thank you for requesting a report on this patient. She developed an anal carcinoma which was diagnosed in 2006. She had chemotherapy and radiotherapy. Her last anal biopsy showed anal intraepithelial neoplasia grade I/II. Her last CT scan in July/August 2009 showed no sign of tumour recurrence. Unfortunately, she has lots of ano/rectal pain and discomfort. Her bowels are unpredictable with urgency and she has to have ready access to a toilet. She has significant fatigue related to all this.

I understand that she does part-time work in a local nursing home, and she is therefore physically fit to remain on the council's register. I don't think that she is fit to work on a busy hospital ward however.

Yours sincerely

Code A

Code A

Code A

Code A

From: Woodward Claire - PA to Chief Nurse [mailto:claire.woodward@porthosp.nhs.uk]
Sent: 02 March 2010 09:48
To: Code A
Subject: TRIM: RE: Matter with the NMC (12053) - outstanding references
Dear Code A
Please find reference for Freda Shaw attached.
I will need to speak to Julie Dawes about the other reference, as I am not sure who was doing this.

Kind regards.

Claire Woodward
Personal Assistant to Julie Dawes, Chief Nurse

Portsmouth Hospitals NHS Trust
Trust Headquarters
Room F307, F Level
Queen Alexandra Hospital
Cosham
PO6 3LY
Tel: 02392 28(6801)
Work mobile: 07535686987
Fax: 02392 286073
Email: Claire.Woodward@porthosp.nhs.uk

From: Code A
Sent: 01 March 2010 14:53
To: Woodward Claire - PA to Chief Nurse
Subject: Matter with the NMC (12053) - outstanding references
Dear Claire
You will recall that we requested employment references for four members of staff
We are awaiting references for

- Code A

I take this opportunity to thank you for the references we have received for Janet Neville and Elizabeth Bell.
If our request is presenting difficulties, please let me know. Otherwise, an early response would be appreciated.
Kind regards

Code A

Click here to report this email as spam.

Code A

Code A

Code A