GEOFFREY PACKMAN

Police officer witness statements
Transcript suspect interviews

SUMMARY OF EVIDENCE

CASE OF GEOFFREY PACKMAN

Background/Family Observations

Geoffrey PACKMAN was born in Derbyshire Code A He was known as Mick, he had three sisters and always worked in office jobs. He met his future wife Betty whilst working in local government in Derbyshire and they married in July 1956.

In 1964 Mick and Betty adopted their son Mark and in 1967 they adopted their daughter Victoria (known as Vicky). At this time Mick was working in insurance in London and in 1969 the family moved to Emsworth in Hampshire.

At this time Mick was fit and healthy; he was on the Committee of the Sea Cadets and would attend the annual camp. He would also 'run the line' for his son's football team. Whilst on an annual camp he injured his knee and his mobility decreased. Due to this his legs started to swell and he began to put on weight.

In 1983 Mick had a falling out at work and became a taxi driver for a local company. In order to do so he had a medical and was found to have high blood pressure and weighed 17/18 stone. In 1985 he started his own business with a friend but after a couple of years the business collapsed and Mick retired, he was 57 years old. During his time as a taxi driver he put on a considerable amount of weight.

By 1998 Mick was virtually housebound. He did not drink alcohol but drank fizzy drinks and liked sweets and crisps. He would sit in his chair in the lounge and listen to classical music. He even started up a music club and friends would visit and listen to music with him. He continued to put on weight and his legs would constantly weep fluid, he couldn't walk properly and had to lean on the furniture and walls to get around the house. For the last 2 or 3 years of his life he had a health visitor who came in and changed the dressings on his legs three times a week.

On 6th August 1999 Mick got stuck on the toilet at home. Four people were needed to get him off the toilet and downstairs. He was admitted via the A & E Department at Queen Alexandra Hospital to Ann Ward. He made good progress his legs dried up and he looked the best he had for years. He was happy, chatty, eating and drinking properly and keen to get home. After two to three weeks he was transferred to Dryad Ward at Gosport War Memorial Hospital for recuperation and rehabilitation.

The family visited on a daily basis and initially he was fine. He was eating and drinking properly, never complained of any pain and was in good spirits.

After a couple of days Mrs PACKMAN whilst visiting Mick was taken to one side by a lady doctor who said in a very abrupt manner, "Your husband is going to die and you have to look after yourself now". It wasn't explained to her why or when this would happen.

At about this time Mrs PACKMAN also received a call from the hospital telling her that Mick had had a heart attack. On visiting him he told her that he hadn't had a heart attack just that he had a bout of indigestion that he always suffered from.

Two or three days after this conversation Mick deteriorated and became 'spaced out'. His eyes were glazed, his head would nod and he had to be propped up in bed. When awake he could still talk but had to be fed. He then became unconscious, he was on diamorphine but no one explained why.

On 3rd September 1999 Mr PACKMAN died. The cause of death on the death certificate was given as heart attack.

Medical history of Geoffrey PACKMAN.

Geoffrey Packman was a sixty eight year old gentleman who was admitted as an emergency on the 6th August 1999 to Portsmouth Hospitals NHS Trust following an attendance at A&E.

He had suffered from gross (morbid) obesity for many years, he had also had venous leg ulceration for at least five years, he was hypertensive and had a raised prostatic specific antigen, suggesting prostatic pathology.

Following a fall at home he was completely immobile on the floor and two ambulance crews were needed to bring him to accident and emergency. He was currently receiving District Nursing three times a week for leg ulcer management. He had become increasingly immobile complicated by the fact that his wife who lived with him and provided care was being investigated for breast cancer. The admission clerking showed that he not only had leg ulcers but he had marked cellulitis, was pyrexial and in atrial fibrillation. Cellulitis was both in his groin and the left lower limb. He was totally dependent needing all help with a Barthel of 0. His white cell count was significantly raised at 25.7, his liver function tests were abnormal with an AST of 196 and his renal function was impaired with a urea of 14.9 and a creatinine of 173. These had all been normal earlier in the year. He was treated with intravenous antibiotics in a special bed.

He appeared to make some progress and on 9th August his cellulitis was settling. A Haemolytic Streptococcus sensitive to the penicillin he had been prescribed was identified. On 11th August the nursing cardex stated that there appeared to have been a deterioration of his heel ulcers with a "large necrotic blister on the left heel". His haemoglobin on 12th August was 13.5.

On 13th August white count was improved at 12.4, his U's and E's were normal and the notes recorded a planned transfer to the Gosport War Memorial Hospital on 16th August.

Later on the 13th black bowel motion is noted but the doctor who examines him records a brown stool only. It is not clear whether he has had a gastro intestinal bleed. On 16th August no comment is made on the possible gastrointestinal (G.I) bleed, but on 20th August his

haemoglobin is noted to be 12.9 no further black stools have been reported so he is planned for transfer on 23rd August. Albumin at this stage is now reduced at 29.

On 17th August sacral sores are now noted in the nursing cardex which by the 20th are now recorded as "deep and malodorous".

He is transferred to the Gosport War Memorial Hospital on 23rd August. A reasonable history and examination is undertaken which notes that there was a history of possible melaena, the clinical examination recorded suggests that he is stable. Blood tests are requested for the next day. The drug chart suggests that his weight is 148 kgs but it is not clear if this is an estimate or a measurement. He is very dependent with a Barthel of 6 and a Waterlow score of 18, putting him in high risk. His haemoglobin on 24th is 12. The nursing cardex on the 24th notes the multiple complex pressure sores on Code A Code A (96-100).

23¼ St

On 25th August the nursing cardex reports that he is Code A

On 26th August a doctor (Dr Barton) is asked to see him and records that he is clammy and unwell. The notes suggest that he might have had a myocardial infarction and suggests treating him with Diamorphine and Oramorphine overnight. It records that as an alternative there might be a G.I. bleed but this is recorded as unlikely because he has not had haematemesis. It also notes that he is not well enough to transfer to an acute unit and he should be kept comfortable, including "I am happy for the nursing staff to confirm death". His Clexane (an anticoagulant given to prevent pulmonary embolus) is now stopped. The nursing cardex on the same day records further deterioration throughout the day with pain in his throat and records a verbal request for Diamorphine. A full blood count is taken (this fact is not recorded in the notes) but the result is filed in the notes recording a haemoglobin markedly reduced at 7.7. It also states "many attempts were made to phone Gosport War Memorial Hospital but no response from switchboard". These significant results are not commented on at any stage in the nursing or clinical notes.

On 27th August the nursing notes record some improvement in the morning but discomfort in the afternoon especially with dressings. On 28th August both the medical and the nursing records are noted to be very poorly with no appetite. Opiates are to continue over the weekend. 29th August he is sleeping for long periods and on 30th he is still in a very poor clinical condition but eating very small amounts of diet. He is re-catheterised the same day.

On 31st he is recorded as passing a large amount of blood rectally and on the 9th September he is reviewed by a consultant Dr Reid who notes that he is continuing to pass melaena stool, there are pressure sores across the Code A, he is now significantly confused. Dr Reid records that he should be for TLC only and that his wife is now aware of the poor prognosis. Nursing notes note that the dose of drugs in the syringe driver should be increased; the previous doses were not controlling his symptoms. The nursing notes of the 2nd September record the fact the Diamorphine is again increased on the 2nd to 90mgs and on 3rd September he dies at 13.50 in the afternoon.

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Geoffrey PACKMAN was a Clinical Assistant Dr Jane BARTON. The medical care provided by Dr

BARTON to Mr PACKMAN following his transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (Good Medical Practice, General Medical Council, October 1995, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination.
- in providing care you must 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
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs
- in providing care you must be willing to consult colleagues.

The medical records were examined by two independent experts. Dr Robert BLACK in his review of Dr BARTON's care reported specifically:-

Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

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

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

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

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

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

- a difficult clinical decision is made without appropriate involvement, of senior medical opinion.

- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.

- a higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

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

Dr Andrew WILCOCK reports:-

There was insufficient assessment and documentation of Mr Packman's clinical condition when he became less well on the afternoon of the 26th August 1999.

There was insufficient assessment and documentation of Mr Packman's clinical condition when he became acutely ill on the evening of the 26th August 1999.

Mr Packman was considered to have experienced either a myocardial infarction or a gastrointestinal haemorrhage, yet advice was not sought from other colleagues nor was he transferred to an appropriate place of care.

Mr Packman received regular oral morphine that may have been excessive to his needs and prescribed a syringe driver, as required, with upper dose ranges of diamorphine and midazolam likely to be excessive to his needs.

Over the days that followed, there was a continued lack of an appropriate medical assessment of Mr Packman's condition; the results of blood tests that would have indicated a gastrointestinal bleed were either not obtained or acted upon.

Mr Packman received increasing doses of diamorphine and midazolam that were likely to be excessive to his needs.

Dr BLACK further states

Both Dr Barton and Dr Reid had a duty to provide a good standard of medical practice and care. In this regard, Dr Barton and Dr Reid fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient, providing treatment that could be excessive to the patients' needs and willingness to consult colleagues.

Mr Packman was admitted for rehabilitation and it was not anticipated that he was likely to die. Although Dr Barton considered a myocardial infarction more likely than a gastrointestinal haemorrhage, the latter would have been confirmed as the more likely if the haemoglobin result was obtained that evening or the following day. A gastrointestinal haemorrhage (or a myocardial infarction) is a serious medical emergency and requires appropriate and prompt medical attention. The cause of Mr Packman's gastrointestinal bleed is unknown. However, as the most common cause is a peptic ulcer which can be cured with appropriate treatment, it is possible that Mr Packman's deterioration was due to a potentially reversible cause that could have been managed by transfer to the acute hospital for appropriate resuscitation with intravenous fluids, blood transfusion and further investigation. This view is in keeping with the opinion of a gastroenterologist, Dr Jonathan Marshall (report of 1st April 2005).

Dr Barton considered Mr Packman too unwell to move. In this regard it seems odd that a patient becoming acutely unwell at Gosport War Memorial Hospital would be at a disadvantage compared to if they had become acutely unwell at home. I see no reason that a patient could not be transferred by emergency ambulance if this was in their best interests. When possible they should be medically stabilised beforehand, but the lack of ability to do this should not be the reason not to attempt transfer at all. Even if one accepted the view that Mr Packman was too unwell to move, advice should have been sought on his management from the on-call physicians/geriatricians or cardiologists.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mr Packman by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Packman by failing to adequately assess his condition and taking suitable and prompt action. Mr Packman could have had a potentially treatable and reversible medical condition, which presented with a serious complication (i.e. bleeding). He should have been urgently and appropriately assessed and transferred to an acute medical unit. He was not appropriately assessed, resuscitated with fluids, transferred or discussed with the on-call medical team. In my view, there was no obvious reason why it was not appropriate to provide Mr Packman with this usual course of action.

Morphine and diamorphine are safe drugs when used correctly. The key issue is whether the use and the dose of diamorphine and other sedatives are *appropriate* to the patients' needs. Although some might invoke the principle of double effect (see technical issues), it remains that a doctor has a duty to apply effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose of strong opioid that was *appropriate* and not excessive for a patient's needs. The stat doses of diamorphine could be seen as appropriate for the relief of severe pain. However, in my opinion, the ongoing use of regular morphine and subsequent use of diamorphine and midazolam were inappropriate; their use was not obviously justified and the doses were likely to be excessive to Mr Packman's needs. In my opinion, it is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Dr Jonathan Marshall a specialist Gastroenterologist specifically reports that :-

Mr PACKMAN was likely to have experienced a significant GI bleed approximately 3 days after transfer to GWMH. He was assessed as being unwell and was managed with escalating doses of opiate analgesia until he died on 3-9-99.

He further states that transfer for endoscopic therapy should have been considered in Mr PACKMAN's case, although this can only take place after resuscitative measures have been taken such as I/V fluids, oxygen etc. Endoscopic therapy allows accurate diagnosis of the site and cause of bleeding. It also allows further procedures to try and stop the bleeding and is 'bread and butter' emergency gastroenterology available in any endoscopic unit.

The critical determinant would be how fit Mr Packman was after resuscitative measures for the ambulance transfer to endoscopy.

'Do not resuscitate' orders refer specifically to not commencing cardiopulmonary resuscitation if the heart stops. Mr Packman was in this 'DNR' category reasonably (high chance of technical futility) but not in a group in whom no resuscitation is attempted if they simply becomes *unwell.*

Interview of Dr Jane BARTON.

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified as a registered medical practitioner in 1972. In addition to her GP duties she took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 17th November 2005 Dr BARTON in company with her solicitor Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Geoffrey PACKMAN at the Gosport War Memorial Hospital. The interviewing officers were DC Code A and DC Code A

The interview commenced at 0914hrs and lasted for 27 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/11. This statement dealt with the specific issues surrounding the care and treatment of Geoffrey PACKMAN.

On Thursday 6th April 2006 Dr Barton was interviewed a further nine times throughout the course of the day where a series of questions were put to her in essence challenging her medical management of Mr PACKMAN. Dr BARTON made 'no comment' to any of the questions.

Operation ROCHESTER.

Key points June 2006.

Geoffrey PACKMAN born **Code A**

Geoffrey PACKMAN was born in Derbyshire. He married his wife Betty in 1956 and they adopted two children Mark and Victoria.

Mr PACKMAN and family moved to Emsworth Hampshire in 1969 whilst working in London in the insurance business.

Following a knee injury and decreasing mobility Mr PACKMAN began to put on weight, as a consequence he suffered gross morbid obesity for many years thereafter.

By 1983 he had become a taxi driver and was weighing 17/18stone, he retired in 1989 aged 57yrs.

He continued to put on weight causing his legs to weep fluid. By 1998 Mr PACKMAN was virtually housebound being visited by a health visitor 3 times a week to change leg dressings. He was suffering leg ulcers and severe cellulitis.

In April 1999 Mr PACKMANS GP noted his weight at 146kg, in excess of 23stone.

On 6th August 1999 Mr PACKMAN suffered a fall at his home address and was unable to mobilise himself. He was admitted to the Queen Alexandra Hospital COSHAM with leg ulcers, marked cellulitis in the groin and left lower limb, at this point he was 68 years of age.

Mr PACKMAN was assessed as being totally dependent with abnormal liver function and impaired renal function. He was treated by way of intravenous antibiotics, variously between 6th and 23rd August 1999 penicillin, flucloxacillin and an anticoagulant clexane.

Mr PACKMAN was reviewed by the specialist registrar the following day the 7th August 1999 who noted that he should not be resuscitated in the event of

arrest the same assessment also being made on 11th 13th and 20th August whilst at Queen Alexandra hospital.

On 8th August he was noted to have 'grade 3 sores' on the sacrum suggesting full thickness skin loss involving damage of subcutaneous tissue.

By the 9th August 1999 Mr PACKMAN seemed to be making some progress with his cellulitis settling. On 11th August 1999 there was reported a deterioration of his heel ulcers with a large necrotic ulcer on his left heel.

On the 13th August 1999 a possible melaena (black bowel motion) was noted, it was not clear whether Mr PACKMAN had a gastro intestinal bleed at that time.

By 17th August Mr PACKMAN is recorded as having deep and malodorous sacral sores.

Mr PACKMAN was transferred to Dryad Ward, Gosport War memorial hospital on 23rd August 1999 for recuperation and rehabilitation.

The clinical examination by Dr RAVINDRANE on admission shows Mr PACKMAN as stable but very dependent and high risk with a declining ability to look after himself over the previous 8 days and little prospect of active rehabilitation.

The transfer for continuing care to Gosport War memorial according to Dr RAVINDRANE did not mean that his condition had improved, but that it had stabilised.

Dr RAVINDRANE recorded that Mr PACKMANS problems were obesity, arthritis to the knees, immobility, suffering pressure sores and constipation. He had a good mental test score and was not in pain. His respiratory system was normal. His legs were slightly oedematous, chronic skin changes were noted. He noted the presence of a meleama on 13th August 1999 also noting the patient's stable heamoglobin.

Dr RAVINDRANE asked for his blood to be re-checked and his condition to be reviewed later in the week.

Medication was prescribed, Doxazosin 4mgs daily for hypertension, Frusemide 80mgs a day a diuretic for Mt PACKMANS oedema, Clexane 40mgs a day for DVT prophylaxis and atrial fibrillation, Parecetomal 1gm 4 times a day for pain relief, Magnesium Hydroxide 10mls twice daily for constipation, Gaviscon for indigestion and cream for pressure sores.

On 24th August it is noted that Mr PACKMAN was suffering complex pressure sores on Code A, and that pain needed to be controlled (at odds with admission report of 23rd August).

Dr BARTON prescribed Temazapam for Mr PACKMAN on an as required basis at the dose range of 10 – 20mgs. 10 mgs were administered to Mr PACCKMAN that night the nursing record indicating that he had slept for long periods.

On 25th August Mr PACKMAN was passing blood rectally and also vomiting, he had seven to eight loose bowel actions throughout the afternoon and evening and fresh blood was observed. As a consequence locum GP Dr BEASLEY took the decision to withhold Mr PACKMAN'S administration of enoxaparin, a drug designed to interfere with the clotting ability of blood.

The following day the locum consultant geriatrician Dr RAVI was contacted he agreed the discontinuation of enoxaparin and asked that his haemaglobin be checked on 26th and 27th August.

During the morning of 26th August Mr PACKMAN is recorded as having had a fairly good morning with no further vomiting. By lunchtime he was feeling unwell and had a poor colour.

About 1800hrs on 26th August Mr PACKMAN complained of indigestion like pain in his throat and vomiting. A verbal order was taken from Dr BARTON for a start dose of 10mg diamorphine, an anti-emetic was also given.

About 1900hrs on 26th August 1999 Mr PACKMAN was reviewed by Dr BARTON who recorded that he was clammy and unwell and might be suffering myocardial infarction. He was treated with diamorphine and oramorphine overnight. It is recorded as an alternative that he might be suffering a gastro-intestinal bleed although this was unlikely due to the absence of haematemesis. Dr BARTON concluded that Mr PACKMAN was not well enough to be transferred to an acute unit and that he should be kept comfortable adding that she was 'happy for nursing staff to confirm death'.

A blood count was taken recording marked reduction in haemagloblin, these results are said to be significant (by Dr BLACK) but not commented on at any stage within nursing or clinical notes.

The drug chart for 26th August indicated that Mr PACKMAN could be administered 10mgs diamorphine (verbal message 1800hrs) this is signed by Dr BARTON 2 days later.

40mgs of diamorphine and was administered to Mr PACKMAN on the 28th 29th and 30th August.

20mgs of midazolam were administered on 28th and 29th August and this dose was increased to 40mgs on 30th August.

Oramorph is written up at 20mgs per night and administered on 26th, 27th, 28th and 29th August.

On 27th August there was some improvement noted but discomfort with dressings.

On 28th August Mr PACKMAN is recorded as being poorly with no appetite. Opiates are prescribed to continue over the weekend.

By 29th August Mr PACKMAN was sleeping for long periods.

By 30th August 1999 he remained in a very poor clinical condition but was eating small amounts. Mr PACKMAN complained of left sided abdominal pain and a syringe driver was commenced at 1445hrs containing 40mgs diamorphine and 20mg midazolam.

Code A

On 1st September 1999 Mr PACKMAN was reviewed by consultant Dr REID who noted that he was continuing to pass a melaena stool (blood leaking from upper gastro-intestinal tract). There were pressure sores across the Code A Code A and Mr PACKMAN was significantly confused. Dr REID recorded that Mr PACKMAN should be for TLC only and that his wife was aware of the poor prognosis. Nursing notes indicate that the syringe driver drugs should be increased given that the previous doses were not controlling his symptoms, 60mgs of diamorphine is administered that day.

On the 2nd September diamorphine was increased to 90mgs and midazolam to 80mg. Hydrobromide was prescribed but not administered.

An entry in the night time nursing reports describes Mr PACKMAN as having a peaceful night.

Mr PACKMAN died at 1350hrs on 3rd September 1999 the cause of death being given as 'myocardial infarction with an approximate interval between onset and death of five days.'

Account Dr Jane BARTON from interview with police 17th November 2005.

Within a prepared statement Dr BARTON detailed the patient history prior to his admission at Gosport War memorial hospital on 23rd August 1999.

Dr BARTON anticipates that she reviewed Mr PACKMAN the following day the 24th August 1999 although she did not have an opportunity to make any entry in his medical records. The prescription chart indicates that she prescribed Temazepam on an as required basis within a dose range of 10-20mgs.

Dr BARTON commented that Mr PACKMAN was seen by Dr BEASLEY on 25th August 1999 and Dr RAVI on the morning of 26th August.

The nursing notes of 26th August indicate that he deteriorated about lunchtime and Dr BARTON was called to see him.

She made an entry on the medical records on 26th August 1999 which indicated that she was concerned that Mr PACKMAN might have suffered a Myocardial infarction and accordingly she decided to immediately administer opiates in the form of diamorphine for consequent pain and distress at a dose of 10mg intramuscularly, recorded on the drug chart as a verbal instruction. In addition Dr BARTON would have been conscious of the large pressure sores on the patient's sacrum and thighs which would have caused significant pain and discomfort.

Dr BARTON additionally recorded that Mr PACKMAN had a gastro intestinal bleed.

Dr BARTON assessed that Mr PACKMAN was very ill and that transfer to an acute unit was quite inappropriate being very likely to have a further deleterious effect on his health.

A blood count taken on the 26th August showed that the patient's heamoglobin had dropped substantially from 2 days earlier.

At 1900hrs on 26th August Dr BARTON again attended the patient prescribing Oramorph 10-20mgs 4 times a day with 20mgs at night, Diamorphine 40-200 mgs subcutaneously over 24hrs together with Midazolam 20-80mgs via the same route on an anticipatory basis concerned that further medication might be required in due course to relieve Mr PACKMANS pain and distress.

Dr BARTON reviewed Mr PACKMAN the following morning and again on 28th August when she made a note in the records reading 'remains poorly but comfortable, please continue opiates over the weekend'.

By 30th August Dr BARTON considered Mr PACKMAN terminally ill and would have been concerned to ensure that he did nor suffer pain and distress as he was dying. Increases in opiates would have been commenced in accordance with Dr BARTON'S instructions.

Dr BARTON anticipates that she would have seen Mr PACKAM during the mornings of 31st August and 1st September 1999 although not having the opportunity to make notes in his records.

Mr PACKMAN was reviewed by consultant geriatrician Dr REID on 1st September who wrote on the notes that he should receive TL, Dr BARTON felt that this was an indication that Dr REID had also considered Mr PACKMAN to be terminally ill.

Sister HAMLIN recorded alter that the syringe driver was renewed at 1915hrs with 60 mgs of Diamorphine and 60 mgs of Midazolam subcutaneously as previous doses were not controlling his symptoms. Dr BARTON anticipates

that she was contacted to authorise this moderate increase in order to alleviate pain and distress.

That night Mr PACKMAN was noted to be incontinent Code A but otherwise had a peaceful night.

Dr BARTON believes she reviewed Mr PACKMAN the following day the 2nd September 1999 and that she and the nursing staff increased the medication Diamorphine 90mgs and Midazolam 80mgs to ensure that Mr PACKMAN did not suffer pain and distress as he died.

Mr PACKMAN died the following day. Dr BARTON believed the cause of death to be myocardial infarction. At no time was any medication provided with the intention of hastening Mr PACKMAN'S demise.

Dr BARTON was further interviewed under caution by police on 6th April 2006 making no comment to questions asked.

Clinical team member assessment (Geriatrician.)

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

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

Quality assurance comment.

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

Following admission to Gosport War memorial Hospital on 23rd August 1999 Mr PACKMAN was noted as remaining very poorly with no appetite. Code A

Code A

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

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

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

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

Expert Gastroentorologist Dr Jonathon MARSHALL comments:-

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

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

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

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

Transfer for endoscopic surgery should have been considered in Mr PACKMANS case when the possibility of a G/I bleed was first seriously considered when he deteriorated (26.8.1999) allowing accurate diagnosis of the site and cause of bleeding. Endoscopy can only occur after resuscitative measures have been taken such as intravenous fluids, oxygen etc. It also allows further procedures to try and stop the bleeding and is 'bread and butter' emergency gastroenterology available in any endoscopic unit.

The critical determinant would be how fit Mr PACKMAN was after resuscitative measures.

Mr PACKMAN would represent a high risk for surgery, it would be difficult to justify the potential mortality of elective surgery in a morbidly obese patient. However each situation is judged on its own merits. A failure of endoscopic surgery to stop bleeding is an indication for emergency surgery. In these situations it has to be put to the patient and family that death during or soon after surgery is a high probability but it is essential to proceed with this high risk option as the only possible way to save life.

Expert witness Dr Andrew WILCOCK (Palliative medicine and medical oncology) comments:-

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

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

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

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mr Packman by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Packman by failing to adequately assess his condition and taking suitable and prompt action when he became unwell with a gastrointestinal bleed. He was not appropriately assessed, resuscitated with fluids, transferred or discussed with the on-call medical team. The use of regular morphine and subsequent use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs were inappropriate.

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

Expert Witness Dr David BLACK (Geriatrics) comments:-

Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in

hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

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

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

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

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

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

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

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

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

Evidence of other key witnesses:-

Victoria PACKMAN. Daughter of the deceased, describes father as not very tall but very big he drank and ate to excess. Background re employment and describes how father became virtually housebound during the last few years of his life. Describes admission to Queen Alexandra hospital and general improvement in health. Father declined at Gosport War Memorial hospital. The change was dramatic and became progressively worse until death.

Betty PACKMAN. Widow of deceased. Background re deceased who came from a plump family. Medical history in respect of increasing weight and warnings for high blood pressure. Husband did not drink alcohol but huge

amounts of fizzy drinks. His legs were a constant problem would weep fluid and were never dry. It reached the stage that he could not walk properly around the house. The district nurse visited regularly to change leg dressings. Describes how she had left her husband in the bathroom on 5th August 1999 and his subsequent admission to Queen Alexandra hospital.
Describes how husband made a good recovery and was cheerful and transfer to Gosport War Memorial Hospital for recuperation and rehabilitation. Remained cheerful, but after one visit she was told that her husband was going to die. Husband then became progressively worse, it was explained that her husband was on diamorphine but she was not told why.

Elliot BERESFORD Friend of deceased .. Background information re lifestyle of deceased, and concerns regarding the attitude of Dr BARTON.

Dorothy BERESFORD As above.

Mark PACKMAN Son of deceased. Background information and lifestyle.

Ruth Elizabeth TOPPING Daughter in law of deceased. Lifestyle and background.

David LATHAM Brother in Law of deceased. Lifestyle and background.

Margaret SHERWIN Retired local priest. Administered the last rites to Mr PACKMAN. + background information.

Richard CHINN General practitioner Havant Health Centre and GP to Mr PACKMAN. Last saw deceased in July 1999 visited surgery and checked blood pressure. Patient suffered, hypertension, obesity, immobility, cellulitis of legs and atrial fibrillation. Referred to a Dermatology Consultant Dr KEOHANE re leg ulcers.

Stephen CHIVERTON Consultant Urologist. Refers to letter from Dr CHINN referring Mr PACKMAN for urology problems. Has no record of any examination.

Stephen KEOHANE Consultant Dermaologist. Mentions referral by Dr CHINN but comments that Mr PACKMAN in fact examined by Dr CLARKE on 30.6.99.

Wendy BEADLES Specialist Registrar. Comment re admission of Mr PACKAM to Queen Alexandra Hospital on 6th August 1999 and detailed examination.

Claire DAVIES GP Examined Mr PACKMAN 11th August 1999 regarding the underlying cause of Mr PACKMANS cellulitis.

Claire DOWSE Doctor. Made entry on medical notes 6th August 1999 'In view of pre-morbid state + multiple medical problems not for CPR in event of arrest' Explains that CPR is a treatment and at that time it was decided that if Mr

PACKMAN had an arrest then the chances of treatment being successful were very slim.

Arumugan RAVINDRANE (2 statements) Consultant Physician in elderly medicine. August 1999 employed as registrar under Dr REID. Examined Mr PACKMAN 23rd August 1999 (on admission to Gosport war memorial hospital) and explains medical notes detailing condition of patient. Describes as a high or very high risk patient. States that Mr PACKMAN died of internal bleeding, cannot say whether it could have been prevented. Had the hospital acted when black stools were noted at Q.A.H and clexane had been stopped then it may have been prevented if done in conjunction with administration of anti-ulcer drugs.
It was too late for this action by 26.8.1999.
In second statement discusses the decision to stop clexane and monitor haemoglobin on 26.8.1999.

Gillian HAMBLIN Senior Sister Dryad Ward. Detailed background re - working practices at Gosport War Memorial Hospital. Explains hers and other entries on medical and nursing notes particularly her report of 26th August 1999. Discussed patients condition with Dr RAVANDRANE and Dr BEASLEY. Wrote up prescriptions for Diamorphine and Midazolam on verbal instructions of Dr BARTON and would have agreed levels with her over the telephone.

Code A Staff Nurse Dryad Ward. Explains nursing notes and medical terminology. Recorded Mr PACKMANS Barthel scores on 23/8 30/8 and 1/9/1999 indicating his worstening condition. Wrote Nursing care plan on admission. Explains her detailed entries on nursing notes.

Code A Staff Nurse Dryad Ward. Concerns re patient care general around alternative analgesia. Questioned Nurse HAMBLIN about the issue who commented 'I hope when you die you die in pain' Verified Mr PACKMANS death at 1350hrs on 1st September 1999. Also explains her nursing entries of 23, 26th August 1999 and her administration of Oramorph between 27th and 30th August 1999.

Jeanette FLORIO Staff Nurse Dryad Ward. Describes ward practices and wrote nursing note 2.9.1999 to the effect that Diamorphine and Midazolam levels had been increased to 90mgs and 80mgs respectively. Witnessed these drugs being administered by Shirley HALLMAN on 2.9.1999.

Beverly TURNBULL Staff Nurse Dryad Ward. Background re use of syringe drivers and opiate drugs, and voices her concerns in use for patients not in pain. Explains her nursing entries in respect of care to Mr PACKMAN Code A Code A Administered Oramorph between 27th and 29th August 1999.

Anita TUBRITT Staff Nurse Dryad Ward. Articulates concerns re lack of Opiate drug/syringe driver training. Witnessed various administration of Oramorph to Mr PACKMAN between 26th and 29th August 1999.

Irene DORRINGTON Staff nurse Dryad Ward (retired). Details limited I/V drug and syringe driver training during her 38years nursing. Worked nights only. Administered Oramorph to Mr PACKMAN between 26th and 30th August 1999 and nursing note entries with reference to black faeces and abdominal pain.

Mary FIELDS Ward Aide Dryad Ward. Witnessed Oramorph administration.

Code A Medical Secretary. Produces medical records Mr PACKAMN from archives.

Code A Produces GP records Mr PACKMAN.

Detective Constables Code A and Code A Conduct caution interviews Dr BARTON on 17th November 2005.

D.M.WILLIAMS
Detective Superintendent 7227
27th June 2006.

Operation ROCHESTER.

Additional Evidence Summary.

Relating to the death of Geoffrey PACKMAN.

Series of tape recorded interviews with Dr. REID in the presence of legal representative Will CHILDS, under caution between 0907hrs – 1627hrs 08 08 2006 in respect of Geoffrey PACKMAN

Key points:-

Interview 1.

- Geoffrey PACKMAN was admitted to Queen Alexandra Hospital suffering from leg ulcers and following an incident at his home where he had become immobile.
  He had subsequently been transferred to Gosport War Memorial Hospital for nursing care
- He was described as being clinically obese, suffering from pressure sores and arthritis. His life expectancy was described as being poor, but there is nothing recorded to the effect that he was in a terminal phase of life.
- Dr. REID states that, in his position he was personally responsible for the care of Geoffrey PACKMAN whilst this patient was in Gosport War Memorial Hospital.

Interview 2.

- Dr. REID commented to the effect that when a patient was admitted to the hospital then that person would be asses by a doctor and nursing staff.
- Geoffrey PACKMAN was transferred to Gosport War Memorial Hospital from Queen Alexandra hospital because his major need was for nursing care, at that time he would appear to have been medically stable.
- On his transfer to Gosport War Memorial Hospital Geoffrey PACKMAN was prescribed DOXAZIN – 4 milligrams for high blood pressure
  FRUSEMIDE (a diuretic) – 80 milligrams per day
  CLEXANE – a blood thinning treatment
  PARACETAMOL – one gram qds this was his only pain relief
- Mr PACKMAN needed a special bed (large) due to his size

- Dr. REID commented that on a ward round, he would make an overall assessment of what he felt the main issues or patients problems were together with what could be done.
- A patient's care plan would change if there was a change in the patient's condition.
- Dr. BARTON was responsible for the treatment of Geoffrey PACKMAN on a day to day basis
- The need arose for Geoffrey Packman's condition to be investigated by means of tests etc. Haemoglobin urea electrolytes and liver function tests, the Haemoglobin tests were to detect any possible bleeding in the bowel.
- Dr. REID commented to the effect that any decision making involving a patient should be recorded.
- If a doctor was to see a patient then Dr. REID would expect to see recorded in that patients notes, any interaction, symptoms which the patient may be experiencing together with a record of the results of any examination and treatment.
- If a doctor had been called to see a patient for any reason and there had been any significant change in the patient's condition, then Dr. REID would expect to see this noted in the patient's records.
- Dr. REID commented that initiating any new treatment is significant and should, therefore be recorded
- Dr. REID had found nothing in the records of Geoffrey PACKMAN to indicate that this patient was suffering pain.
- Dr. REID was aware of the 'analgesic ladder' and stated "you have to make a judgement about what steps of the ladder you take".
- Dr. REID when asked, why with a patient (Geoffrey PACKMAN) who had been on nothing more than one gram of paracetamol 4 times daily and who had no record of documented pain, why there was no record of the reasons for prescribing morphine or other strong opiod to that patient, replied that he was only able to speculate that Dr. BARTON had felt hat this patient was in sufficient distress caused by a condition which could be relieved by diamorphine.
- Dr. REID did not have any concerns about the care/treatment of Geoffrey PACKMAN.

Interview 3

- Dr. REID made comment with regards to keeping up to date with pharmaceutical issues prescribing matters and the fact that he kept himself up to date. The BNF book was described as the 'Bible of Prescribing' and there was usually one on each ward. It was a constant source of information with regards to the possible side effects of drugs and a patient's reaction to new ones.
- Dr. REID had never seen either of the books, Palliative care Formulary or the Nurses Prescribing Formulary.
- Geoffrey PACKMAN had not been prescribed any drugs which were new or seldom used that Dr. REID was aware of; he was only ever given drugs which would be used regularly for a patient in Mr. Packman's condition.

- Dr. REID explained the layout of a prescription sheet and that one part is for the actual prescribing by a qualified person whilst the other part was for use by nurses etc. for administration of the drugs / medicines.
- Dr. REID referred to the notes of Geoffrey PACKMAN and listed the drugs prescribed to him as: - Aloperimide for Diarrhoea. On 26th August 1999 at 1800 hours. 10 milligrams of Diamorphine is muscularly prescribed on the basis of a verbal message from Dr. BARTON, with a similar dose on 27th or 28th. Alvine and mepitol dressings for skin wounds, Gaviscon for indigestion, Tempazepam 10 – 20 milligrams orally on 24th and 25th August. Doxazosin was given for high blood pressure, Frusemide 80 milligrams administered from 24th through to 31st Clexane (subcutaneous injection) twice daily on 25th and 25th August. Paracetamol 1 gram four times daily, a topical cream and Magnesium Hydroxide 10 mills twice daily.
- Dr. REID was unable to explain the discrepancies in the administration, times and dates as shown on Geoffrey Packman's drugs chart, but said that the range of 40 – 200 milligrams of diamorphine allowed nursing staff discretion to increase the dose in the event of non availability of medical staff.
- Dr. REID commented that the range of 40 – 200 milligrams was too large a range at the time when the prescription was written,
- Dr. REID spoke of the side effects of Diamorphine with one of them possibly being confusion and that a patient being drowsy may be an indication that the dose is too high.
- Proactive prescribing was discussed together with variable dosage which allowed nursing staff flexibility in administering a drug to ease a patient's pain etc.
- Dr. REID agreed that The reason for prescribing should always be recorded in the medical notes
- Telephone prescribing and verbal orders were discussed, where a nurse might telephone a doctor to explain a patient's current problem and the doctor would give an authority to administer a different drug or an increased dosage.
- Dr. REID stated that nursing staff would prefer to have a written prescription rather than to rely of verbal orders, particularly diamorphine.
- Geoffrey PACKMAN was seen by Dr. REID on 1st September and at that time Mr. PACKMAN was on a dose of 40 milligrams of diamorphine, but within hours the dose had been increased, possibly by a nurse (Jill HAMBLIN) when the patient had already been noted as being drowsy on the smaller dose.

Interview 4

- On 1st September it is recorded that sister HAMBLIN increased the diamorphine dose of Geoffrey PACKMAN from 40 milligrams to 60 milligrams supposedly to control the patients symptoms, DR. REID was unable to say what these symptoms were because they had not been recorded, even though the patient had been seen by a doctor only hours

previously and was noted to have been drowsy but comfortable, the diamorphine dose had been increased by half without explanation.

- Dr. REID relied upon Dr. Barton's knowledge and experience , he trusted her and the nursing staff to care for the patients
- Dr. REID acknowledged the fact that Dr. BARTON and Sister HAMBLIN were more experienced than himself in the actual care of this particular type of patient, such as Geoffrey PACKMAN, and for whatever reason Sister HAMBLIN had seen fit to increase this dose, possibly because the patients condition had changed in the few hours since being seen by the doctor, but once again he accepted that the reason for the increase had not been recorded.
- Dr. REID described Dr. BARTON and Sister HAMBLIN as a formidable pair, who knew what they were doing and that hey had an established practice of running the ward etc.
- Dr. REID was unable to say with any certainty that his clinical opinion was being ignored in this case, but admitted that on a previous occasion he had spoken to medical staff about the range of Diamorphine being too high for a patient.
- There was a discussion on the administration and prescribing of drugs and the need for syringe drivers.
- With regards to the use of a syringe driver in the case of Geoffrey PACKMAN, Dr. REID said the he could only presume that it had taken that level of administration to control the patients symptoms, and because the patient was drowsy and possibly unable to take the drug orally. Dr. REID was not able to explain why Geoffrey PACKMAN had not been given the drug orally even though this patient had accepted it orally in the recent past.
- Three was no explanation from Dr. REID as to why, when Mr. PACKMAN had been started on a syringe driver, that the matter had not been recorded or why it had been deemed necessary, even though he accepted that such a matter is a significant change in the patient's condition.
- Dr. REID commented that it was Dr. BARTON who had prescribed the syringe driver, but it would appear, from the relevant notes to have been prescribed on 26th when Geoffrey PACKMAN was seen and noted to be unwell, Dr. BARTON had finished the notes with 'keep Comfortable, I am happy for nursing staff to confirm death' but there was no mention at that stage of a syringe driver being commenced. There was a further visit by Dr. BARTON to Mr. PACKMAN but, again there is no note of the syringe driver commencing. It would then appear that on 30 08 a syringe driver was commenced with 40 milligrams of Diamorphine and 20 milligrams of Midazolam and this entry would appear to have been signed by sister HAMBLIN.
- Dr. REID agreed that Sister HAMBLIN would appear to have commenced the syringe driver, in respect of Geoffrey PACKMAN, without discussing the matter with a doctor, and when Mr. PACKMAN was apparently able to eat and drink a little i.e. he was able to swallow.
- Dr. REID commented that it was a 'big decision' to commence a syringe driver' but he was unable to say why sister HAMBLIN had apparently

taken this decision herself, or why she had written in the clinical notes, as opposed to nursing notes.

- Dr. REID said that Geoffrey PACKMAN had been seen by Dr. BARTON on 26th August, he was noted to be possibly suffering a heart attack and was sufficiently distressed that administration of Oramorph was necessary, therefore Oramorph had been prescribed in two dose strengths of 10 milligrams and up to 20 milligrams.
- Dr. REID commented that Geoffrey PACKMAN may have needed MIDAZOLAM because he had been stressed or agitated, and that this drug was mostly for mental agitation rather that physical pain.
- There was a discussion about the range of doses of Midazolam and the lack of information available for nurses regarding the dosage.

Interview 5

- This interview commenced with a discussion about painkillers and opiates.
- Dr. REID stated that Diamorphine is an analgesic and included in a group of drugs called opiates which are strong painkillers.
- Prior to taking Diamorphine, Dr. REID stated that, by referring to the 'analgesic ladder' one would start with Paracetamol and then move up to Coedine and then to extra Coedine and Paracetamol before arriving at drugs which are Opiate related, such as Tramadol. Finally there are the strong Opiates which are known as Morphine and Diamorphine.
- Within the analgesic ladder, Dr. REID stated that Diamorphine fits into stage three, which is at the top of the ladder, being the strongest level of painkiller.

- Dr. REID stated that Mr. PACKMAN had been prescribed Diamorphine in a range of 40 – 200, and this gap / range had been to allow for nursing staff to use their discretion if the starting dose had not been able to control the patient's symptoms.
- Dr. REID commented that the drug Midazolam could be used in conjunction with Diamorphine to be administered via a syringe driver and the same range of dosage would be applied in accordance with the analgesic ladder.
- Dr. REID was emphatic in stating that he would not expect a nurse to administer the highest range of a drug from the outset, he said that the lower range would be the starting point.
- There was a comment regarding the prescription for Diamorphine being prescribed to Geoffrey PACKMAN on 26th August but it had not been actually administered until 30th August, a gap of four days, and Dr. REID agreed that this was pro-active prescribing.
- Dr. REID commented that Geoffrey PACKMAN had originally been prescribed Oramorph as a regular prescription, and the Diamorphine prescription was pro-active in the sense that if the patient was no longer able to take medication orally or that the pain was not controlled then this situation would allow the Diamorphine to be introduced.

- Dr. REID was not able to comment with regards to what circumstances had arisen whereby this patient had been administered the Diamorphine i.e. whether the patient was unable to take oral medication or that the pain was not controlled.
- The interviewing officer made comment to the effect that Geoffrey PACKMAN was eating at that particular time, and Dr. REID himself said that the patient was eating small quantities.
- In these circumstances Dr. REID made comment that a pro-active prescribing policy was not required if a doctor was going to see the patient once a day or was available.
- Dr. REID stated that there was nothing in place at that time, as a guide to nursing staff regarding what increase should be made within the prescribed range of 40-200 milligrams. There were no checks or safeguards on this issue other than it was a requirement for two nurses to carry out the procedure of administration of controlled drugs such as diamorphine.
- When asked as to whether or not Geoffrey PACKMAN was in the terminal phase of his life by the time he was receiving Diamorphine, Dr. REID said that it was difficult to say, because Dr. BARTON had written on the notes, 'remains poorly but comfortable, continue with opiates over the weekend' which implied to Dr. REID that this patient was seriously ill.
- It was put to Dr. REID that there was a difference between being seriously ill and terminally ill, and he agreed that a person could be seriously ill but treatable.
- In the case of Geoffrey PACKMAN, Dr. REID said that it was difficult to say from the notes that he was terminally ill at that stage.
- Dr. REID said that he would expect to see written justification for the use of Diamorphine because it was a switch from oral medication to Diamorphine.
- Dr. REID was asked what he would consider to be an excessive dose of Diamorphine, he stated that it would vary from patient to patient. Also the fact that a patient may be opiate-naïve but the best answer to this lay with an expert in Pharmacology.
- There was a discussion regarding the conversion dosage from Oramorph to Diamorphine and the associated guidelines and Dr. REID agreed that a dose of 60 milligrams of oramorph converted to a dose of 20 Milligrams of Diamorphine.
- Dr. REID stated that he had not advised Dr. BARTON about her Prescribing regime because he had never been asked to. He had not noticed the variance of doses in this case, but said that if he had noticed the variable dosage the he should have said something.
- When Dr. REID saw Mr. PACKMAN on 1st, he noted that he was drowsy but did not feel that he had been overdosed with Diamorphine.
- Dr. REID confirmed that there was no justification in Geoffrey PACKMAN'S notes regarding the use of Midazolam.
- Dr. REID made an observation to the effect that when he saw Mr. PACKMAN on 01 09 the he was in the terminal phase of his life, because he (Geoffrey PACKMAN was taking a fair amount of opiate for pain control, he was passing 'melina stool' and bleeding from the gut, the

overall picture was one in a terminal phase of life. Therefore, despite the apparent symptoms of the patient, he was not referred to another consultant.

- Dr. REID commented on the fact that Geoffrey PACKMAN was unlikely to have suffered a heart attack and that the main cause of his deterioration was due to the internal bleeding.
- There was discussion about the requirements for a doctor to certify death and the notes of Dr. BARTON being happy for nursing staff to confirm death. Also comment was made regarding Dr. BARTON expectation of death in respect of Mr. PACKMAN because of what she had written in the notes on 26th, 'am happy for nursing staff to confirm death'.
- Dr. REID explained the policy of 'not for 555' (not for resuscitation in the case of heart attack etc.) which was the case for Geoffrey PACKMAN but he went on further to state that this did not mean that he patient was not to diagnosed, treated and possibly cured of the presenting complaints.

Interview 6

- The interviewing officer made comment to Dr. REID that Dr. BARTON had made an entry in Geoffrey PACKMAN'S notes on 26th August of two possible matters, the MI (Myocardial Infarction) and the G I bleed.
- There then followed a discussion on the matter of a death certificate and the responsibilities of the medical staff and legal requirements.
- Dr. REID agreed that Geoffrey PACKMAN is recorded as having died of Myocardial Infarction, and that there is no reference to a heart problem when seen by Dr. REID two days earlier.
- There was a discussion about the availability of supervision, guidance and study leave for staff, including Dr. BARTON if ever that person thought it useful.
- It was put to Dr. REID that, in 1999 Dr. BARTON had felt obliged to adopt the policy of pro-active prescribing due to work pressures at the hospital, but Dr. REID himself said that it didn't take long to write out patient notes and that to the best of his recollection, there had not been a time when Dr. BARTON had complained to him about the her work load being too great.
- Dr. REID made comment, saying that if there was sufficient interaction with a patient then it should be noted.
- Dr. REID stated that if there had been any adverse reports with regards to Dr. BARTON then he would have tackled her on any relevant issues, but from his understandings, she was regularly on the wards in accordance with her contract and more, sometimes two or three times a day. It was pointed out to him that there would appear to have been a gap of some six days between notes for Geoffrey PACKMAN when Dr. BARTON would have been visiting the ward where this patient was in poor prognosis.
- Dr. REID explained his personal method of ward rounds and days it was carried out etc.
- Dr. REID stated that when he saw Geoffrey PACKMAN on 1st September, that the patient was dying, he was suffering a GI bleed and he would not

be treated for it. The patient was to be made comfortable and allowed to pass away peacefully.

- Dr. REID re iterated that, in his opinion Mr. PACKMAN was suffering a GI BLEED as opposed to MI because of the huge drop in haemoglobin in a short time. Also the patient was passing black stools caused by bleeding in the upper gut.

Interview 7

- On 23rd August, the day Mr. PACKMAN arrives at Gosport War Memorial Hospital, he is seen by Dr. RAVINDRANE and assessed. It is noted that, as on previous occasions, Geoffrey PACKMAN may be suffering a GI bleed. Dr. REID stated that a GI bleed is a life threatening medical emergency, which is treatable but with difficulty, and he explained some treatments.
- Dr. REID said that the symptoms of being pale, clammy and unwell are very consistent with GI bleeding, and he was, himself sure of this by 1st September following the results of the check. Nothing further was done because a decision had to be made as to whether or not it was in the patient's best interest to transfer to another hospital for the necessary treatment / blood transfusion etc. and whether or not a patient in this condition would even survive the transfer.
- There was no evidence, other than Dr. BARTON'S note entry to support the fact that Geoffrey PACKMAN was not fit for transfer, but Dr. REID stated that it was a judgement which had to be made at the time.
- Dr. REID said that when GEOFFREY PACKMAN arrived at Gosport War Memorial Hospital, he was not in immediate expectation of death, despite his obesity and presenting complaints. He may well have been 'on the slippery slope' but Dr. REID said that he could not tell at that time if Mr. PACKMAN would survive one week or six months.
- It was discussed that there would not appear to be anything in the medical notes where Mr. PACKMAN'S wife was made aware of his condition and the decision not to transfer him for further treatment blood transfusion.
- There was then a discussion about the very poor note keeping in respect of Geoffrey PACKMAN, in particular the administration of drugs and who had actually signed the administration /authorisation. Also it was mentioned that persons charged with looking after MR. PACKMAN had a duty of care to him and his wife, but on looking at the notes, it would seem that little was done in respect of either.
- Dr. REID said that he did speak with Dr. BARTON about variable dose prescribing but he was unable to recall as to what particular patient it was regarding.
- Further discussion on note keeping, Dr. REID said that there were no set safeguards to prevent a patient being administered an unintentional dose other than the expectation of nursing staff to start with the lowest dose.

Interview 8

- Dr. REID was referred to Geoffrey PACKMAN'S nursing notes, and he agreed that on 27th August the patient's condition would appear to have stabilised, and that there should have been sufficient time to obtain the haemoglobin results from the check on the previous day.
- Dr. REID was unable to give an explanation as to why Mr. PACKMAN had not been transferred for treatment to another hospital when his condition would appear to have improved.
- Dr. REID said that Geoffrey PACKMAN'S condition was not discussed with a gastroenterologist or the on-call medical team.
- The interviewing officer pointed out to Dr. REID that Geoffrey PACKMAN had complained of left sided abdominal pain on 29th August. Dr. REID said that it would be unusual for the cause of such pain to be M I.
- Dr. REID agreed that the Geoffrey PACKMAN was started on a syringe driver on 30th, when he is noted to have slept for long periods the previous night. He would appear to have complained of left abdominal pain and there is a 'query' indigestion' but Dr. REID was not able to give an explanation as to why Sister HAMBLIN started this patient on a syringe driver at that time.
- Dr. REID stated that he was not certain if the syringe driver was appropriate at that time, because there is no record of it being required for use at that particular time.
- Dr. REID agreed that it would appear to be the case, where a nurse had made a decision to start Geoffrey PACKMAN on a syringe driver, but there is no record of that nurse having discussed it with Dr. BARTON, so he was not able to say as to whether or not it was a satisfactory situation.
- There was some discussion regarding the haemoglobin test and the fact that the result, although available, was not received for some time, and whether or not there would have been an alternative route for the treatment of Geoffrey PACKMAN, either through his verbal wishes or the requirements of his wife and the ethics of it all.
- Dr. REID was asked if Dr. BARTON had, at any stage, made the correct diagnosis of Geoffrey PACKMAN, and he replied "I don't know"
- Dr. REID was not able to say as to whether or not Dr. BARTON had ever acted on the results of the haemoglobin check results, even though she had seen them.
- Dr. REID said that as far as he was concerned he had fulfilled his duty of care in respect of Geoffrey PACKMAN, he was aware that discussion had taken place between medical staff and Mrs. PACKMAN about her husbands condition and the management of it, he had to take some things on trust, such as what others had recorded, and these factors would influence him in his decision with regards to the treatment of this patient.
- Dr. REID said that, in hindsight, there should have been better documentation in the case of Geoffrey PACKMAN. In his opinion, Mr. PACKMAN died from a Gastro-Intestinal bleed, and if Dr. REID was to certify Geoffrey PACKMAN'S death today, then he would put the cause of death as being a Gastro-Intestinal bleed.

Code A

D.M.Williams.
Detective Superintendent.
12th September 2006

PLEASE ATTACH WITH TAPE

GLOUCESTERSHIRE CONSTABULARY

Station.

J1 No. Item No.

O.I.C.

Identification Ref No.

Court Exhibit No. GL/112

R-v-

Description
A CERTIFIED COPY OF A DEATH CERTIFICATE FOR GEOFFREY MICHAEL JOHN PACKMAN

Time / Date Seized / Produced

Where seized / Produced
SMEDNEY HYDRO
SOUTHPORT

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Major incident item No. X 687

Laboratory Ref

P27B (Rev 2/02)

Code A

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STATEMENT OF DR JANE BARTON

RE: GEOFFREY PACKMAN

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Geoffrey Packman. Unfortunately, at this remove of time I have no recollection at all of Mr Packman. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mr Packman.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998.

I confirm that these comments are indeed a fair and accurate summary of the position then, though if anything, it had become even more difficult by 1999 when I was involved in the care of Mr Packman.

4. Mr Geoffrey Packman was a 67 year old man who lived at home with his wife and daughter in Emsworth. It appears that he was visited regularly at home by the District Nurse who in February of 1999 noted that he had a large red weeping area on the shin of his right leg. A Doppler's test was performed, being an ultrasound measurement of the pressure in the veins of the legs. Mr Packman's GP appears to have referred him to Consultant Urologist Mr Chiverton at some point after April 1999. The GP referred in his letter to symptoms of prostatism and a raised PSA. He said that Mr Packman had had a negative mid-stream urine test, but rectal examination, presumably to assess the size of the prostate, had been virtually impossible because of Mr Packman's huge size and inability to lie properly on his side. The GP noted that Mr Packman was grossly obese, and indeed a subsequent measurement of his weight was recorded at 146 kg - in excess of 23 stone.

5. Mr Packman was noted to have a raised random blood sugar and was also due to have a glucose tolerance test to exclude diabetes mellitus.

6. At the end of June his GP then made a further referral, this time to Consultant Dermatologist Dr Keohane in relation to Mr Packman's leg ulceration. Mr Packman had apparently been attending the District Nurse's leg ulcer clinic for many months, and had hugely oedematous legs. The District Nurse had drawn the GP's attention to a large granulomatous raised area on the back of his right calf, and Dr Keohane's advice was requested. At this stage it seems that Mr Packman was being visited by the District Nurse 3 times a week in order

to dress the leg ulceration, that he had recently become immobile and his condition had worsened. Mr Packman was seen in the dermatology clinic on 30th June 1999, the Senior House Officer reporting back that Mr Packman had bi-lateral severe oedema with some leg ulceration secondary to venous hypertension. Mr Packman was to be brought in for further Doppler's testing.

7. On 6th August 1999 Mr Packman was then admitted to the Queen Alexandra Hospital having suffered a fall. He was unable to mobilise and 2 Ambulance crews were called to assist. It was noted on admission that the GP and the District Nurse were unable to cope with Mr Packman at home. The diagnoses at that stage were bi-lateral leg oedema, with ulcers on the left leg, obesity, and it was noted that he was simply not coping.

8. In the course of clerking-in on 6th August, it appears that Mr Packman was suspected to be in atrial fibrillation. An ECG was arranged which showed atrial fibrillation at a rate of 85. Blood tests revealed that he has a white cell count of 25,000, an ESR of 31, and a CRP of 194. He was felt to have cellulitis in the groin and left lower leg, he was commenced on antibiotics, and his diuretic medication was changed to Frusemide. His past medical history was noted to consist of the bi-lateral leg oedema, which he had apparently had for 5 years, hypertension which had been treated since 1985, and arthritis.

9. It appears that about the time of admission Mr Packman was recorded as having a large black blistered area on his left heel in addition to the leg ulceration.

10. Following assessment his problems were recorded as cellulitis of the left leg, chronic leg oedema, poor mobility, morbid obesity, raised blood pressure and possible atrial fibrillation. In relation to the latter, and prior to the performance of the ECG, anticoagulants were suggested if atrial fibrillation was confirmed, and the possibility of left ventricular dysfunction was also raised. Shortly thereafter Mr Packman was commenced on Clexane 40mgs twice daily.

11. At this stage Mr Packman's creatinine level was noted at 173, with urea at 14.9, suggesting that the insult due to the infection in his legs was resulting in compromise of his renal function.

12. It was also noted on 6th August that "in view of pre-morbid state + multiple medical problems [Mr Packman was] not for CPR in event of arrest". A Barthel score stated to have been assessed on 5th August (presumably 6th August in error) was recorded as zero, indicating that Mr Packman was completely dependant.

13. Mr Packman was reviewed by the Specialist Registrar the following day, 7th August, who agreed, presumably on the basis of what was felt to be Mr Packman's poor condition at that stage, that he was not be resuscitated in the event of arrest. It was suggested that his anti-hypertensive medication should be changed to an ACE inhibitor in view of the oedema, and he was considered for a beta-blocker in view of his atrial fibrillation. His diuretic was changed lest it cause dehydration. Mr Packman was given Flucloxacillin 500 mgs 4 times daily, supplemented by Penicillin V 500 mgs 4 times a day to combat the cellulitis.

14. Although steps were apparently taken to prevent the development of pressure sores, on 8th August Mr Packman was noted to have sores to the sacrum, being described as "Grade 3". I believe this would have been a reference to a wound classification system, Grade 3 suggesting that there was full thickness skin loss involving damage of subcutaneous tissue.

15. Over the next few days it appears that Mr Packman's cellulitis improved, but the overall assessment of his suitability of resuscitation did not change - on 11th and again on 13th August it was again specifically noted that he was not for resuscitation - recorded as "Not for 555".

16. On 13th August Mr Packman was reviewed by a Consultant Geriatrician Dr Jane Tandy. She noted that he had had black stools overnight. The following day a nursing note records that when the dressings on the pressure sores were renewed, the wounds to the Code A Code A were very sloughy and necrotic in places, and very offensive smelling. Clearly by that time, Mr Packman had developed significant pressure sores.

17. A Barthel score measured on 14th August again recorded a score of zero indicating his complete dependence.

18. It appears that by 15th August a decision had been made that Mr Packman should be transferred to the Dryad Ward at the GWMH. A note in the nursing records indicates that Staff Nurse Hallman at GWMH had indicted that we were not in a position to take Mr Packman at that time. This is likely to have been an indication that there were no beds available, and that we would have been under considerable pressure in consequence of the high bed occupancy.

19. An entry in Mr Packman's records for 20th August by the Specialist Registrar indicates that Mr Packman was due for transfer to the GWMH on 23rd August. The Specialist Registrar also noted that Mr Packman remained not for resuscitation. A Barthel score measured on 21st August again recorded a score of zero indicating his complete dependence.

20. Mr Packman was then admitted to the GWMH on 23rd August 1999. There is a clerking-in noted contained within his records, but I do not recognise the handwriting or signature of the doctor who assessed him on this occasion. His problems were noted to be obesity, arthritis, immobility and pressure sores. The episode of melaena on 13th August was noted, with his haemoglobin being stable. At that stage he was said to be in no pain. Cardiovascular and respiratory systems were thought to be normal. The clinician admitting Mr Packman also prescribed medication in the form of Doxazosin 4 mgs daily for hypertension, Frusemide 80 mgs once a day as a diuretic for Mr Packman's oedema, Clexane 40 mgs twice a day for DVT prophylaxis and atrial fibrillation. Paracetamol 1gm 4 times daily for pain relief, Magnesium Hydroxide 10 mls twice daily for constipation, together with Gaviscon for indigestion and cream for his pressure sores.

21. On this occasion, a Barthel score of 6 was recorded for 23rd August, suggesting that, although Mr Packman might have improved to a degree, he was still significantly dependent.

22. I anticipate that I would have reviewed Mr Packman the following day as part of my assessment of all the patients on the ward, though it appears that I did not have an opportunity to make any entry in his medical

records on this occasion. The prescription chart shows that I prescribed Temazepam for Mr Packman on a PRN basis - as required - at a dose range of 10-20 mgs. 10 mgs of Temazepam was then given on the night of 24th August, with a night nursing record then indicating that he slept for long periods.

23. I anticipate that I would have reviewed Mr Packman the following day, 25th August, though again I did not have an opportunity to make an entry in his records. It appears that Mr Packman then was noted to have passed blood per rectum, and Dr Beasley was contacted, Dr Beasley presumably being on duty out-of-hours. He advised that the Clexane should be discontinued. Dr Beasley also appears to have prescribed Metoclopramide by way of verbal order, which I later endorsed, together with Loperamide. The Metoclopromide was apparently given at 5.55 pm with good effect. The dressings on the pressure sores were removed on 25th August and were noted to be contaminated with faeces.

24. I do not know if I reviewed Mr Packman on the morning of 26th August. He was noted by the nurses to have had a fairly good morning. Sister Hamblin has recorded that Dr Ravi, locum Consultant Geriatrician, was contacted and he confirmed that the Clexane should be discontinued and the haemoglobin repeated. Again, Mr Packman was noted to be "not for resuscitation". Sister Hamblin may have contacted Dr Ravi if I was unavailable that morning. The nursing record goes on to indicate that Mr Packman then deteriorated at about lunchtime, that his colour was poor and that he complained of feeling unwell. I was called to see him, my entry in his records on this occasion reading as follows.

"26-8-99 Called to see pale clammy unwell
suggest ? MI. treat stat diamorph

and oramorph overnight
Alternative possibility GI bleed but no
haematemisis
not well enough to transfer to acute unit
keep comfortable
I am happy for nursing staff to confirm death."

As my note indicates, I was concerned that Mr Packman might have suffered a myocardial infarction, and accordingly I decided to administer opiates in the form of Diamorphine for pain and distress consequent on the possible myocardial infarction, at a dose of 10 mgs intramuscularly. In addition, I would have been conscious that he had large pressure sore areas on his sacrum and thighs which would have been causing him significant pain and discomfort. I prescribed 10 mgs Diamorphine intramuscularly to be given immediately, which is recorded on the drug chart as a verbal instruction. An alternative diagnosis which I recorded was that Mr Packman had had a gastro intestinal bleed.

25. My impression when I assessed Mr Packman on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to an acute unit was quite inappropriate. Any such transfer was very likely to have had a further deleterious affect on his health.

26. The nursing note for 26th August indicates that we were to await blood test results. There was then a further deterioration later in the day, with Mr Packman complaining of indigestion and a pain in his throat, which was not radiating.

27. The blood count taken on 26th August subsequently showed that Mr Packman's haemoglobin had dropped to 7.7 grams, a substantial drop from the 12 grams which had been recorded 2 days earlier.

28. It appears that I re-attended to see Mr Packman at 7.00 pm on 26th August. Concerned that he should have further appropriate medication to relieve his pain and distress, I prescribed Oramorph 10-20 mgs 4 times a day together with 20 mgs at night. 20 mgs of Oramorph was later given at 10.00 pm.

29. I also wrote up prescriptions for Diamorphine 40-200 mgs subcutaneously over 24 hours, together with 20-80 mgs of Midazalam via the same route on an anticipatory basis, concerned that further medication might be required in due course to relieve Mr Packman's pain and distress. It was not my intention that this subcutaneous medication should be administered at that time. The nursing record also indicates that I saw Mr Packman's wife, explaining her husband's condition and the medication we were using. I anticipate I would have indicated to Mrs Packman that her husband was very ill indeed, and in all probability that he was likely to die.

30. I would have reviewed Mr Packman again the following morning, and indeed the nursing record confirms that I attended to see him then. Sister Hamblin has recorded that there had been some marked improvement since the previous day and that the Oramorph was tolerated well and should continue to be given, though Mr Packman apparently still had some discomfort later that afternoon especially when the dressings were being changed. In spite of the earlier improvement, Mr Packman was said to remain poorly. 10 mgs of Oramorph were administered 4 hourly, together with a further 20 mgs

at night as prescribed, so that Mr Packman received a total of 60 mgs that day, though this was seemingly not enough to remove his pain and discomfort when his dressings were being changed. The nursing records indicate that he appeared to have a comfortable night.

31. I reviewed Mr Packman again the following morning, and on this occasion I made a note in his records which reads as follows:

"28-8-99 Remains poorly but comfortable
please continue opiates over weekend."

32. The nursing record indicates that Mr Packman remained very poorly with no appetite. However, the Oramorph again appears to have been successful in keeping Mr Packman comfortable at night.

33. I do not believe I would have seen Mr Packman on Sunday 29th August. The nursing record indicates that he slept for long periods, but that he also complained of pain in his abdomen. Code A

Code A

34. I do not know if I would have seen Mr Packman again the following morning, Monday 30th August, that being a Bank Holiday. I have no way of knowing now if I was on duty then. If I did see him as part of my review of all the patients on the two wards, I did not have an opportunity to make a specific entry in his records on this occasion. A Barthel score was recorded as 4. The nursing record indicates that Mr Packman's condition remained poor, and later that day - at 2.45 pm the syringe driver was set up to deliver 40 mgs of Diamorphine and 20 mgs Midazalam subcutaneously. I anticipate that Mr Packman would have continued to experience pain, and clearly in view of the significant sacral

sores, it was highly likely that he would have been experiencing further significant discomfort.

35. In view of his poor condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying. Mr Packman had received 60 mgs of Oramorph daily over the preceding 3 days, and the administration of 40 mgs of Diamorphine subcutaneously over 24 hours did not represent a significant increase. Mr Packman would have started to have become inured to the opiate medication, and an increase of this nature was in my view entirely appropriate to ensure that his pain was well controlled. Indeed, the nursing record goes on to state that there were no further complaints of abdominal pain and Mr Packman was able to take a small amount of food.

36. I anticipate that the nursing staff would have liaised with me prior to the commencement of the Diamorphine and Midazalam and that this would have been set up on my instruction, directly if I had been at the Hospital, or otherwise by phone.

37. On the morning of 31st August Mr Packman was recorded as having had a peaceful and comfortable night, though he then passed a large amount of black faeces that morning.

38. I believe I would have seen Mr Packman again that morning, though again I did not have an opportunity to make an entry in his records. I anticipate his condition would have been essentially unaltered, and that he would have remained comfortable. Similarly, I would probably have seen Mr Packman again on the morning of 1st September but would have been unable to record this. I anticipate that his condition was again

unchanged. 5 separate pressure sore areas were noted by the nurses. A Barthel score of only 1 was recorded.

39. Mr Packman was reviewed the same day by Consultant Geriatrician Dr Reid. Dr Reid noted that Mr Packman was rather drowsy but comfortable. He had been passing melaena stools. His abdomen was noted to be huge but quite soft, and Dr Reid also recorded the presence of the pressure sores Code A Code A He noted that Mr Packman remained confused and was for "TLC". The Frusemide and Doxazosin were to be discontinued, and Mr Packman's wife was said to be aware of his poor prognosis.

40. The entry by Dr Reid that Mr Packman was to have "TLC" - tender loving care - was clearly an indication that Dr Reid also considered Mr Packman to be terminally ill. Dr Reid had the opportunity to review the medication which Mr Packman was receiving at the time, and clearly felt it appropriate.

41. Sister Hamblin recorded later in the nursing records that the syringe driver was renewed at 7.15 pm with 60 mgs of Diamorphine and 60 mgs of Midazalam subcutaneously as the previous dose was not controlling Mr Packman's symptoms. It appears therefore that Mr Packman was experiencing yet further pain and discomfort. I anticipate that the nursing staff would have contacted me and that I authorised this moderate increase in his medication in order to alleviate the pain and distress.

42. That night, Mr Packman was noted to be incontinent of black tarry faeces, but otherwise he had a peaceful night and the syringe driver was said to be satisfactory.

43. I believe I would have reviewed Mr Packman again the following day, 2nd September. The nursing records show that his medication was again increased, the Diamorphine to 90 mgs and the Midazalam to 80 mgs subcutaneously. I anticipate again that Mr Packman would have been experiencing pain and distress, and that I and the nursing staff were concerned that the medication should be increased accordingly to ensure that he did not suffer pain and distress as he died. That night, Mr Packman was said to remain ill, but was comfortable and the syringe driver was satisfactory.

44. Sadly, Mr Packman passed away on 3rd September 1999 at 1.50 pm. My belief was that death would have been consequent on the myocardial infarction.

45. The Oramorph, Diamorphine and Midazalam were prescribed and in my view administered solely with the aim of relieving Mr Packman's pain and distress, ensuring that he was free from such pain and distress as he died. At no time was any medication provided with the intention of hastening Mr Packman's demise.