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Client: Private

Matter: Gosport War Memorial -v- Gosport War Memorial Hospital

Matter No: 516130/000001/JCW/GOSPORT

Author: Gemma Bailey

Date: 06/04/2009

Units: 1

Attendance on Client

1 Units (Gemma Bailey) - Unknown - Gosport War Memorial

GWMH Day 13 – 06/04/09

Coroner – Today dealing with Dr Wilcock.

AW – Andrew Wilcock. Currently clinical reader in palliative medicine.

Coroner – clarify coroners court so not like normal court dealing with blame. Coroner's act says cant do that so looking at facts surrounding death not fault. Will stop questions re culpability. Start with Pittock. All looked at paperwork only, didn't see any bodies. Paperwork supplied by police. Opinions formed from these notes.

AW – Pittock. Frail 82 year old man, admitted due to depression. Withdrawn, agitated and irritable. Despite admission low mood continued. Developed chest infection and retention. Developed pressure sores. Transferred to Dr Lord. Felt medication appropriate at that time. During Dryad stay condition continued to deteriorate, lack of adequate note keeping and documented assessment. Drugs difficult to justify particularly amounts. Pain not recorded. As deteriorated doses exceeded those considered appropriate considering his previous opiate usage. Comment in notes that respiratory rate was 6 – low. Indication that diamorphine may have been excessive. Naturally coming to end of life, bronchopneumonia terminal event but diamorphine excessive to requirements.

Coroner – excessive or having negative effect?

AW – no doubt coming to end of life and dying from bronchopneumonia. Doses of diamorphine excessive to requirements. Negative effect – indications difficult to judge. May have reduced life by hours/days. Not appropriate dosage, not good palliative care. If given too much opiod they become drowsy nauseated and confused. Respiratory rate becomes depressed, this leads to death.

Coroner – what order going in?

AJ – man coming to end of life. Seen records not as full as typically expect. Understand medical input limited at GWMH.

AW – yes.

AJ – drs had more time with patients, would hope to see full explanation but not case here.

AW – time = elastic phenomenon. If acting and working in accordance with GMC guidelines then attempt should be made to document treatment and reasons.

AJ – will be things that could be done but wont be done because not enough time.

AW – circular argument.

AJ – please explain

AW – lots of people complain being busy but doesn't stop you doing good job, this is part of work.

AJ – notes don't give full explanation for decisions.

AW – lack of documentation...coroner in Nottingham will say if not documented it didn't happen.

AJ – no way of judging if happened or not.

AW – difficult to unpick what happened. Difficult to defend and justify what happened here.

AJ – not here to justify or defend, here to see how deaths came about. Not here to make judgements

Coroner – here to make judgements but not of people.

AJ – administration, has to be consideration o prescribe drug and someone to give it to patient. Evidence jury heard is nursing staff wouldn't give medication if thought not appropriate.

AW – as doctor prescribing you retain overall responsibility for that drug. Ensure prescribe properly. Difficult to understand how prescription as written gives clear guidance to nursing staff as for many is in wide range with no explicit instruction anywhere on chart as to how should be used, what dosage to start, what combination and on whose decision.

AJ – heard good understanding between dr and nursing staff. If to be any change in administration it would be discussed between doctor and nursing staff. Doctor would receive feedback on patient and if felt appropriate to change medication it would be changed. Used to dr prescribing medication at time.

AW – used to seeing use of medication as required. Where unclear what needs of patient are it is safer to prescribe smaller doses. Allows them to be readily available, needs of patient drive their use. Allows you to judge needs and likely requirement. That opportunity never afforded to patients, usually given syringe driver with combination of drugs.

AJ – heard consultants content with what happening, and for drugs via syringe driver may be wide range of prescription. Clinical assistant knew about this.

Coroner – AJ telling you it comes from evidence we heard.

AJ – unusual?

AW – yes from my experience.

AJ – know Dr Reid, medical director was one of consultants. Content with practice to continue. No issue whether followed. Heard circumstances in which resources allocated such as felt to be appropriate way of dealing with prescribing. Nursing staff if going to administer should refrain if thought medication inappropriate.

AW – nurses have own responsibilities.

AJ – nursing staff mindful of those responsibilities, and if had concerns wouldn't have given medication and would have made note why didn't give it. Fact patients receiving medication noted, follows that nursing staff

thought appropriate. Follows prescribing doctor considered it appropriate for patient and symptoms. Where ward rounds consultant would also have thought appropriate. AW said if not documented didn't happen.

AW – view of another coroner.

AJ – hundreds of miles away. If drug administered for pain relief, fact no one wrote patient in pain doesn't mean they weren't in pain.

AW – may also mean had a pain for which opiods were not appropriate. Need to know what cause of pain is, only by knowing that do you know what treatment is appropriate.

AJ – agreed if not recorded in pain, doesn't mean they weren't.

Coroner – does mean impossible to make judgement of that in absence of note. Difficulty = taking view when not there.

AJ – all seen are records for patients. Not seen patients themselves or spoken to any staff, trying to piece together incomplete/inadequate notes. Come in with mindset if not recorded it didn't happen.

AW -commented on that as AJ mentioned documentation. Attempted to provide fair overview from situation as understand it. Looked at all pieces of evidence available in coming to conclusions.

AJ – said evidence limited. Formed view records inaccurate.

Coroner – seen everything there is. Would have been more available with full medical notes.

JT – decision as to where to prescribe and what level is medical not a nursing position, i.e. decision for doctor

AW – in terms of prescribing yes.

AJ – doctor would discuss with nurses in deciding what level to administer.

AW – prescription should be clear and not open to misinterpretation.

JT – final decision re dose to give rests with doctor.

AW – yes.

TL – act for number of families but not Pittock. Evidence re common themes for these cases. Mention prescription of amounts of diamorphine and absence of analysis as to how affecting patients.

AW – common theme = lack of ability to give intermittently the drugs which could be prescribed proactively. Good practice to prescribe small doses so if no doctor available patient can receive small doses. About using a safe dose and assess what patient needs and dose appropriate and required and need to commence drugs on regular basis. Identify patient needs drugs and likely dosage required, and review regularly. In many of these cases go straight to syringe driver or dose given which is difficult to justify. Intermittent doses allows you to control and reassess patient and adjust dose accordingly. One of reasons here is has been missing piece of jigsaw. Don't know if patients required the doses given.

TL – not dependent on absence of notes but matter of good practice what should have happened. Should start with small dose and see if effective for patients needs.

AW – if dealing with elderly frail patient, not sure what will happen, not unusual to be uncertain. Not unreasonable to prescribe small doses of drugs to be used if necessary. One element of good practice = pre emptive prescribing but always small doses not syringe driver with wide range of doses.

TL – notwithstanding absence of records comment on drugs given?

AW – without intermittent doses cant say with certainty that doses were appropriate. If patient had extra doses as symptoms not controlled then would justify increasing dose next time. Lack of any guide here.

TL – danger of that?

AW – doses used not informed. Not based on patients needs. If giving more opiods than required can lead to nausea, confusion, respiratory depression and death. All recognised.

TL - If don't follow may run risk of death?

AW – opiods seen as dangerous drug. Morphine if used appropriately is very safe. If not used safely there are side effects. Draw analogy with diabetic i.e. more insulin, the better for the diabetic. Have to track dose carefully to ensure correct outcome without excessive side effects. Similar with morphine, good drug, used for number of reasons but cant give as much as like and more the better. Must suit dose to patients needs without getting risk of negative side effects by giving too much. Should minimise side effects.

TL – told Dr Reid approved some of practice of anticipatory prescribing. Change view?

Coroner – not what AW critical of?

AW – pre emptive prescribing for syringe driver in wide range not experienced before. Small doses is good practice.

TL – range of 20-200 = outside acceptable experience.

AW – never seen that before, not acceptable practice.

TL – fact that supervisors may have approved doesn't alter view?

AW – no.

TL – fact nursing staff didn't raise concerns doesn't alter view?

AW – no

Coroner – nursing staff not giving view of proactive prescription. Nobody criticised prescription. Not within their remit. Said if told to go straight to 200 then would have said something.

TL – nursing staff when administering raised no concerns. In absence of concerns of nursing staff acting in accordance with doctors instructions, lead AW to change view?

AW – no.

Coroner – final point with Pittock, cause of death = bronchopneumonia. PB gave alternatives too. AW goes for bronchopneumonia.

AW – yes

Lavender

AW – frail 83 year old, admitted to Haslar following fall down stairs. Pain to shoulder and arms. Seen by Dr Tandy, some improvement in mobility. Concluded suffered brain stem stroke. Transferred to GWMH for rehab. Failure to keep accurate records and no documented assessment of condition and pain. Found increased white cell count, blood sugars going up, increasing back pain, retention, all indicate damage to nerves. Prescribed morphine despite lack of assessment. Dose increased, may well have been excessive. Diamorphine and medazolan excessive for needs.

Coroner – PB took issue re cervical cord imaging. AW view on that? No assessment done but pain.

AW – not expert in this but looks as though examined after fall. If significant trauma to neck would expect some sort of symptoms. Should have had xray of neck. Over time anticipate pain should have improved, seemed consistent or getting worse. Doctor should have questioned why. Xray of neck reasonable and documented neurological examination should have been done.

Coroner- jury will have to decide on cause of death. Will either accept what given or chose another cause of death. PB said spinal cord injury likely because of nature of pain.

AW – if high cord injury would cause immobility and contribute to death. White count going up, insulin need going up, indicator of infection. Suspect infection underlying deterioration.

Coroner – CVA from dr, cervical injury from PB and sepsis from AW. Any questions?

AJ – Mrs Lavender seriously ill when arrived?

AW – not seriously ill on transfer but became seriously ill.

AJ – PB said entering terminal phase of life. Likely had several serious illnesses.

AW – depends if potential infection.

AJ – giving regular injections as required could be done and dose changed even if doctor not to hand.

AW – if doctor prescribed small doses prescription would be as required. Nurses can then administer in accordance with drug chart.

AJ – image of GWMH and two wards concerned. Formed view doctor on hand most of time?

AW – seen job description and Dr Barton's comments on this, can understand doctor not readily to hand but if patient required medical attention then had to provide 24/7 care to patients.

AJ – heard doctor might be on ward – ward round ever second week on Monday pm, but apart from that would do ward round every weekday taking 30mins, would admit new patients at lunch time, and speak to relatives in evening if necessary. 6 hours on ward every second week, 2-3 hours a week. For 168 hours every week would be doctor to hand for 5-6 hours a week. Not very much

AW – no but if read job description. It is clear. Understand not entirely limited post, remunerated as number of sessions.

AJ – evidence heard = JB very busy when there. Eager to be informed of how patients getting on and changes in condition. Know came back frequently to deal with patients there for some time. Grappling with real situation or hypothetical one?

AW – clarify?

AJ – suggest may have approached without full understanding of what actually happening in hospital and time constraints etc.

AW – 2 issues. Job description clinical assistants worked with previously paid per session. Not come across GP working as GP and clinical assistant at same time. Understand time constraints but not seen previously. Should be present for sessions paid to work, but job description says nominal payment for 24/7 care.

AJ – JB can resolve this in giving her evidence.

AW – job description clear, if issues re lack of time then other opportunities available rather than trying to do both jobs. By not having doctor available doesn't limit ability to give doses subcutaneously. Wouldn't be here if obvious need demonstrated for drugs.

AJ – those there at time felt appropriate administration otherwise wouldn't have been given.

AW – lack of documented justification.

TL – expand on last question. JB not there 24/7. Difficult to give dose.

AW – left with situation where patients could be given what needed when needed. If only needing doses twice a day then symptoms reasonably well controlled. Maintain ability to access drugs. If needing more then reasonable justification for syringe driver as would receive regular dose then and could have extra doses if required. Still able to give regular dose and give top up as required. Review extra doses as needed.

TL – mention importance of monitoring condition.

AW – trying to ensure patient as comfortable as possible and no undesirable side effects. If become more agitated or confused then ask why. In some situations impossible to say why. Still go through exercise of making sure not missing something simple to correct. Drug may be increasing agitation or confusion.

TL – where patients in continuing care environment same principles apply?

AW – where people on syringe driver check to ensure running to time. Reasonable as general check to ensure driver ok. By checking driver you will also check patient.

TL – any untoward effects should be apparent then?

AW – yes. Will know if patient settled and comfortable or agitated and distressed.

TL – described possible adverse effects. Where doctor not present 24/7 would that serve to increase importance of initial prescriptions being in low range?

AW – comes back to say using drug at dose required to treat symptoms. Ensure drug appropriate for patients needs. Use drug in appropriate dose.

Jury – job description – how many sessions per week?

AW – not in front of AW, but understand initially 4 then increased to 5. 4 hours per session? Understand nominal payment. Job description says care 24/7, remuneration based on shorter time. Not being paid for 24/7 care, but nominal sessions.

Jury – paid for 20 hours whether worked 10 or 40 hours.

Coroner – payment for cover for the hospital.

Helena Service

AW – 99 when admitted to QA. Confused and disorientated, chest infection. Condition improved relatively quickly. Did remain confused at times. Likely experienced stroke affecting left side of body and became more dependent on nursing staff. Couldn't return to rest home to sent to GWMH for continuing care. Behaviour challenging at night. Day of transfer noted to be well. On Dryad medication mostly unchanged. Pre emptively prescribed diamorphine, hyoceine and medazolam 20mg. 20mg medazolam given as failed to settle on first night.

Coroner – blood tests showed potassium. Confusion?

AW – can do.

Coroner – confused medically well on transfer. Change in physical condition at GWMH?

AW – difficult to say. Not sure why unsettled at night. Of interest to note thyridozine (to help settle at night) was stopped at GWMH. Expect may be unsettled for first night especially as drug stopped.

Coroner- explored effect of moving elderly patients.

AW – can aggravate the situation, unfamiliar surroundings. May have been appropriate to give her something to settle. If agitated and required medazolam then pre emptive prescription of small dose would have been appropriate. Didn't give chance for her to be assessed.

Coroner – death certificate and PB say congestive cardiac failure. AW view?

AW – death didn't strike as CCF, but not area of speciality.

AJ – see what Dr Petch gave by way of comments re prescription of diamorphine.

AW – disagree with them.

AJ – remind what he says. Dr Petch re diamorphine by syringe driver says doses appropriate. AW disagree. Para 7.0 says prescription appropriate. Come to administration in due course. Disagree – why?

AW – outlined reasons why.

AJ – view of administration of 20mg diamorphine and 40mg medazolam – Petch says appropriate and desirable. Agree?

AW – in context of this situation difficult to agree fully. If someone dying of terminal heart failure and breathless then opiods used to relieve breathlessness. Drug should be used accordingly and given in way to relieve symptoms whilst avoiding excessive side effects.

AJ – Petch opiates standard drugs used for relieving these symptoms. Diamorphine = standard practice for many decades and remains so. Right man for job doing as expert?

Coroner – can talk about diamorphine.

AJ – presenting what might be the ideal? Not in position to give real world view as no recent experience,

AW – look after geriatric cases with cancer, aware of needs re caution with drugs in elderly. Renal function often impaired. No need if approaching safely and appropriately to say there is a difference.

AJ – only asking as expressed concern in an email to coroner.

AW – if wanted geriatrician view. In terms of use of drugs can give view. In palliative care have wider experience re use of opiods.

Coroner – AW here as drug man not getiatrician.

AJ – geriatrician could give better view. Invite AW to defer to views of PB.

AW – in terms of what appropriate in terms of geriatrician then yes.

TL – here because considering appropriate use of opiate analgesia. Substantial experience of this. Presume some patients geriatrics.

AW – majority yes. Average age = 70.

AJ – what is geriatric?

AW – means different things to different people. 65 plus.

TL – looking after these patients for many years. Concerned to ensure don't suffer pain unnecessarily. Administered diamorphine to stop pain. Used syringe driver. Heard PB not used syringe driver. If asked to give opinion re appropriateness of drugs used in syringe driver any doubts re ability to do this?

AW – no. Looked at doses likely to be required. People with severe pain given medium dose of 40mg in syringe driver.

TL – starting dose?

AW – no dose at end of life, achieved in step by step fashion. Based on 100 patients. This is extreme end of spectrum. Deaths in general hospital setting mean dose for oral morphine equivalent = 30mg, - 10mg diamorphine. This was for whole range of causes of death, not just cancer.

TL – have better view than someone who wouldn't use diamorphine – PB hadn't used syringe driver.

AW – yes.

TL – 40mg diamorphine used for very severe symptoms at end of life. Dose required in last 24 hours. What category appropriate to administer 30mg oral morphine/10mg diamorphine?

AW – 2/3 didnt have cancer, 1/3 had cancer. These were people being cared for in general hospital setting.

TL – symptoms?

AW – given for pain, breathlessness,

Coroner – PB said anxiety and distress too?

AW – differing view of that. Ask why agitated. By giving opiod wont relieve agitation.

TL – medazolam drug of choice for agitation and anxiety?

AW – depends on school of thought but not unreasonable to use if agitated. If delirious then can make it harder to orientate themselves. Then anti psychotic may be better or use in combination with medazolam. But medazolam on its own not uncommon.

TL – appropriateness of medazolam where anxiety and agitation. Appropriate having given that to see if successful in reducing agitation and anxiety before introducing another drug e.g. diamorphine?

AW – depend on context. If someone likely to have agitation no assessed and unsure of reason/cause, safest to have single dose of medazolam. Don't want unnecessary distress but need to understand why distressed so can provide appropriate treatment. Answer not always drugs. Wherever possible try to determine likely cause.

TL – if go straight to diamorphine/medazolam risk obscuring cause of problem.

AW – could do. Wouldn't use opiods just for agitation. If agitated relieve symptoms, but don't give continuing dose of that drug unless attempt to identify source of agitation.

TL – in context of elderly confused patient in new ward have to factor new surroundings.

AW – Lavender – hadn't been having problems in Haslar. Aware change of surroundings could aggravate confusion. Try to determine proportional approach. Down to nurses. If drugs were required, any reason not to use orally or give a drug already on? Why not continue thyridozine?

TL – if given thyridozine and then that stopped what is likely effect on patient?

AW – hard to say but if what needed then may be less sedated at night and more agitated.

Jury – average of diamorphine dose for last day of life. How many patients?

AW – looked at last 100 deaths. 50% of those going into hospice go home so not just terminal care. Data for hospice based on 72 deaths. Hospital similar number.

Jury – average 40mg on last day.

AW – in hospice. Different opiods by different routes so express in common way – oral morphine equivalent. 120mg oral morphine = 4omg diamorphine.

Jury – maximum in those patients?

AW – min 17, max 1950mg.

Ruby Lake

AW – 84 , admitted after falling and fracturing left hip. Repaired under operation, but problems with heart and kidneys and chest infection. Confusion and agitation. Given IV fluids. Seen by Dr Lord, uncertain if would improve. Appeared to be making progress prior to GWMH. Day prior to transfer noted to be confused and temperature. Transfer reported well, comfortable and happy with normal temperature. Lack of notes for GWMH. Chest pain so syringe driver started. Became drowsy. Died 21/08 – bronchopneumonia.

Coroner – said MI ischemic heart disease, would also expect to see fractured hip.

AW – temperature and confusion prior to transfer may suggest infection, possibly chest infection. Feel immediate cause of death bronchopneumonia.

No questions

Cunningham

AW – frail 79 year old widower. Heart disease, abnormal blood count. Long standing back pain, behaviour could be difficult, thought combination of depression and dementia. Improvement of mood after anti depressants. Followed up in day hospital but sacral sore worsened. Refused to swallow medication and expressed wish to die. Admitted for high protein diet and treatment of sore. Prognosis noted as poor. Lack of

notes making progress difficult to monitor. Diamorphine dose excessive to needs. Increases difficult to justify. Ill and frail man whose deterioration documented. Death of bronchopneumonia was terminal event.

Coroner – seen mention of sacral ulcer and parkinsons.

AW – yes all mentioned.

Coroner – drug regime

AW – were doses reached in understandable way? Because of lack of extra doses as needed, hard to know how justify increases in driver.

TL – instructed on behalf of CF. 3 principle concerns re AC's treatment at GWMH. Confirmed at GWMH 21/09-26/09/98. Concerns administered palliative care too early when not enough done to heal sore; doses excessive; as result of excessive doses he died. BNF at time – palliative care is active total care of patients whose disease is not responsive to active treatment.

AW – yes reasonable definition

TL – dr expected to provide care until decide condition unlikely to be responsive to curative treatment.

AW – separate to palliative care

TL – yes relates to duty of doctor where possibility curative treatment will work

AW – correctible approach – i.e. anything causing problems or distress which can be treated?

TL – if condition can be cured doctor should take steps to cure it.

AW – yes in general terms

TL – pg 457 medical records – letter by Dr Lord on day of admission. Dr Lord examined AC, and subsequently went to GWMH. Letter explains reasons for admission. Says more aggressive treatment on sacral ulcer. Social worker will keep bed at home open for 3 weeks. Also 643 – care plan set out by Dr Lord. Dr Lord recommending treatment of ulcer, high protein diet, oromorph to be given as required, 2.5-10mg oral morphine. CF concerned doesn't appear that Dr Lord anticipated he was dying. Admitted for treatment to ulcer. Recommended high protein diet, possibility might benefit from diet. Heard in some cases time lag between referral and admission to GWMH. Here referral and arrival happened on same day. First entry at GWMH pg 645.

AW – transferred to GWMH, make comfortable, give analgesia, happy for staff to confirm death.

TL – CF attended that day was told AC wouldn't survive. On 23/09 CF spoke to JB and told dying. No evidence he was given high protein diet as recommended.

Coroner - AW aware of that?

AW – not documented.

TL – 21/09 commenced on diamorphine and medazolam. Appears commenced on regime of palliative care from admission.

AW – difficulty = insinuating palliative care = negative. Feel strongly against that as palliative care not always negative.

TL – no attempts made to comply with high protein diet and different view taken re chances of survival to that of Dr Lord.

AW – would get more out of Dr Lord.

TL – doesn't appear from admission letter or care plan that Dr Lord thought he was dying.

AJ – statement at pg 25.

AW – patient where certain signs recorded in notes – drowsiness, difficulty swallowing tablets, sore worsening, may be scope for some improvement but overall his prognosis is poor. Impression of what Dr Lord is saying is give it a try but wouldn't be surprised if deteriorates and dies. Never know, may have been realistic chance of doing something to cure sore.

TL – given may have been realistic chance of improvement, appropriate to progress treatment suggested by Dr Lord re diet and others?

AW – given constraints of condition, very poorly, if nothing could be done wouldn't have admitted him. Admitted probably to see if anything could be done.

Coroner – if terminal wouldn't admit him?

AW – if thought no chance wouldn't have written a plan. Give benefit of doubt.

TL – asked JB questions re her approach. Suggested only reason for not following care plan was she took different view re survival prospects. Said yes on personal assessment and as result of personal examination. No material change in circumstances when Dr Lord assessed AC and admitted and assessed by JB that afternoon.

AW – no no material change.

TL – given absence of change, expect decision not to progress care plan should only be taken following thorough assessment of condition?

AW – difficulty = patient constraints in terms of following plan. Main issue = high protein diet. Difficulty swallowing tablets so wont be able to take diet. Treatment for ulcer progressed as per the plan.

TL – whilst CF visited on 21/09 AC asked him for chocolate. Suggests no difficulty in swallowing?

Coroner – not supportable. Asking for and eating are different matters. Minor point. Not an indicator he can swallow.

AW – where poor prognosis consider whether appropriate for nutrition. Balance against harm benefit analysis.

TL – bronchopneumonia = cause of death. Heard can occur as complication from respiratory depression following overdose of opiods. Aware of that?

AW – all can increase risk.

TL – can develop as result of depression though?

AW – if depression to extent you are concerned depression would be more obvious.

TL – accept can be result?

AW – an association I am familiar with.

TL – opiate doses given. Dr Lord recommended oromorph as required 2.5-10mg. When AC arrived he was fully conscious. Initially given oromorph at 2.50pm. Pg 753, at 6pm took co-proximol, would have been administered orally. Subsequently received 10mg oromorph at 8.15. AW say clarify why 10mg given. No justification?

AW – if 5mg helped then usual to repeat that amount.

TL – AC due to take medication at 10pm. Pg 754. Reason given for not taking it is sedated. Suggests 10mg too much?

AW – may have been.

TL – dose excessive to needs.

AW – possibility. When people first start strong opiods can induce drowsiness. Can be present for 3-7 days. Use 5mg and assess doses of that to see if relieving pain. Would disagree with 20-200mg dose range but 2.5-

5 or 5-10mg range = ok, sufficient leeway to change dose if not sufficient. 10mg may have been more than needed.

TL – should have crossed minds of those responsible for his care?

AW – need to evaluate effects of drug given.

TL – should have reassessed need for opiate analgesic treatment?

AW – had several doses, needed additional doses. Agree adequacy of weaker opiod should be ascertained. Not unreasonble to consider use of stronger opiods.

TL – sedated may mean too much. Should have reassessed amount receiving afterwards.

AW – potentially. 5-10mg dose range seen as usual dose. Difficult to say outside what would be considered normal or usual practice.

TL – at 11.10 given diamorphine subcutaneously. Given appears able to take oral medication when not sedated, concern about diamorphine too early legitimate?

AW – use of diamorphine not unreasonable on basis required additional doses of strong opiod despite regular use of coproximol. Not an injectable form of that. Suggest ability to swallow likely to deteriorate. Would rather avoid distress of making patient swallow if could use syringe driver.

TL – agitated behaviour , pg 867, episode of aggression. CF told following day given something on 21/09 to quieten him down. What happened was indication of agitated unusual behaviour.

AW – yes

TL – told jury new ward and surroundings can cause agitation. May resolve itself without need for medication.

AW – in this situation given biological prospects likelihood of him deteriorating was high. Drugs in those doses not considered abnormal.

TL – had been on number of drugs recommended by psychiatry team. Appears those weren't administered. CF concerned appropriate response would have been to resume administration of those drugs recommended.

AW – cant say why stopped but seems odd medication prescribed by others was discontinued. May be discontinuation contributed to agitated state. Everything coming to head at same time. Bronchopneumonia resulted in likely to become unable to take medication anyway. Condition not stable, was rapidly changing.

TL – where someone in pain, important to review pain. Here doesn't seem any analysis done of site of pain. Aware detailed analysis not done?

AW – difficult trying to remember details. Obvious existing physical cause of pain, i.e. sore. Not detailed pain assessment as would expect but approach to relief of pain.

TL - AC had Parkinsons, immobile and problems with joints. Had those symptoms for some time?

AW – aware of patient when moving them. Turning patient to preserve pressure areas may cause pain. Once in new position likely to settle down. Pain assessment would allow to see if that was causing problem. Increasing opiod doesn't stop being uncomfortable when turning. If short lived on turning then just get it over and done with. If severe distress on turning which doesn't settle quickly (often give dose upfront). By prescribing small doses as required could cover these sorts of incidents. Better than giving increased doses. Lot of others would probably have followed similar approach. Most is lack of understanding and knowledge about pain.

TL -Admitted 21/09. On 23/09 medazolam trebled to 60mg. Suggestion may be result of agitation. Shouldnt consideration have been given to possibility of agitation resulting from diamorphine?

AW – difficulty being clear. Could be in keeping with pneumonia. Doses used still within range that people consider ok.

TL – also concerned agitation result of hypoxia as result of respiratory depression.

AW – if bronchopneumonia could result in hypoxia but cant be sure.

TL – justification for increasing to diamorphine 80mg and medazolan 100mg was that he didn't like being moved. If reason was discomfort when being turned shouldn't he have been given breakthrough dose approach suggested.

AW – suggest minimising turning and giving pain killers prior to turning. Try to suggest relieve symptoms. Ask how can improve symptoms.

TL – CF concerned when visited on 23/09 he appeared unconscious. Suggests opiod excessive to needs.

AW – don't think can be unpicked from deterioration due to condition. Regular analgesics not sufficient. Staged approach to analgesia. May have done things differently but seems in keeping with what others would have done.

TL – CF concerned no consideration given to possibility AC respiratory symptoms and deterioration due to opiate induced respiratory depression. Should have been given.

AW – to cause depression usually at end of other stages. If turned and no response then may be concerned but during opiods turning is what he reacts to. Bronchopneumonia.

Coroner – believe IW should be next but PS not here.

TL – PS attending tomorrow so deal tomorrow instead.

AJ – PS has requested this. May be want to hear from JB tomorrow on Wilson as well time permitting.

Coroner – minded to look to narrative verdict to questions re opiates. Draft anything of help. Have some ideas re the appropriateness of medication and dosage.

Enid Spurgeon

AW – relatively fit 92 year old. Fell whilst walking dog, broke right hip. Fixed by surgery. Within hours of surgery thigh swelled to twice the size. Most probably developed a haematoma. Pain continued to be a problem. No changes made to analgesia. 26/03 transferred to GWMH. During stay lack of documentary evidence. Syringe driver doses likely to be excessive. Unresponsive when reviewed by Dr Reid. Diamorphine dose doubled.

Coroner- what basis doses too high?

AW – my assessment and Dr Reid. Unresponsive since syringe driver commenced indicates this. Dose of diamorphine halved but don't understand why medazolam dose doubled.

Coroner – doses given more than expected?

AW – initial dose of oral morphine not unreasonable – 5mg daily and 10mg at night. Syringe driver 80mg was excessive based on that.

Coroner – expected starting dose?

AW – add up previous 24 hour requirement = 30mg oral morphine = 10mg diamorphine.

Coroner – no explanation for this prescription.

AW – no.

Coroner – effect of medication on ES?

AW – believe that made her unresponsive. In comparison to other situation with AC, he reacted to pain. ES on dose such that pain free. Indicates depth to which unresponsive.

Coroner – achieving desired result?

AW – not at expense of side effects. Rendering unresponsive = serious side effect.

Coroner – achieve at minimum risk, balancing act.

TL – report concludes that inappropriate doses would have contributed to death more than minimally. What meant?

AW – had she got something correctable? Was cause of pain something that should have been addressed? Anyone reading notes would realise something wrong with leg. Why is there that problem? Expect after surgery it would improve but it didn't here. Should something more have been done? Could have adjusted analgesia. Something not right with hip. Want to improve pain relief but to give so much that renders her unresponsive is not reasonable.

TL – say use of inappropriate doses which would have contributed to death.

AW – rendered unresponsive. Then wont be taking fluids, will dehydrate, can only survive so long without fluids.

TL – excess opiods can result in loss of consciousness, coma and cause death.

AW – ultimately wont be drinking, will dehydrate. Even moving her painful leg didn't trigger response which suggests excessive opiates.

TL – respiratory depression, coma causing death

AW – view that that is what happened here. More appropriate way of managing pain? Obvious evidence in notes that dose excessive.

TL – as consequence of that she died when she did.

Coroner – careful.

AJ – jury heard from JB about day before ES died. Died 13/04. On 12/04 notes say remained ill, syringe driver satisfactory but some discomfort when attended to. Previous day – tenderness around wound site.

AW – nursing summary says very drowsy on 11/03.

AJ – if complaining of tenderness doesn't suggest being overmedicated?

AW – syringe driver satisfactory, also says breathing very shallow.

AJ – if dying may drift in and out of consciousness.

AW – if correct then logic wouldn't have been to halve dose as Dr Reid did.

AJ – PB said patients may drift in and out of consciousness.

AW – may do.

AJ – part of dose received before death.

AW – at an increased rate. Not sure what mean

AJ – don't get whole dose if on syringe driver.

AW – dose would have gone up so bigger dose over same time period.

AJ – cause of death? Said CVA, stroke

AW – don't feel mode of death in keeping with that

AJ – trying to interpret with notes which are incomplete

AW – suggest something wrong with hip, tender red and hot which suggests infection. May be sepsis from that. Medical staff considered that likely and reduced diamorphine. Must have been reason for this.

Coroner – PB said fractured hip.

AW – agree.

Geoffrey Packman

AW – GP an obese man, swelling of legs, cellulitis and pressure sores. Improved with antibiotics. Passed loose blood stools. Haemoglobin checked which was stable – excluded GI bleed. Lack of records and assessment. Diamorphine excessive to needs. 26/08 – unwell. Haemoglobin checked reduced significantly. Deterioration put down to myocardial infarction. Considered too poorly to transfer to acute hospital. Next day improved but not transferred. Haemoglobin not rechecked. Cause of death = GI bleed but certified cause of death = MI.

Coroner – dosages excessive

AW – taking step back and asking cause of problems. If having MI could say give opiate to relieve that pain but not seen before where given regular doses to treat this. For GI bleed, don't know cause so emphasis to determine cause. May be impractical or impossible but here such a key decision it should have been taken in consultation with others and should have been recorded.

Coroner- JB said transfer not practicable and not capable of endoscopy being done due to size.

AW – patient not known to be terminally ill and then develops acute condition, if making decision not to pursue that decision then should be documented why not pursued. Result of blood test which would have confirmed GI bleed would have been available that night or next day. Not obtained or not acted on. Is signed but not dated.

AJ – PB said doses used were required to control symptoms and didn't contribute to his death.

AW – depends what you consider appropriate.

AJ – range of opinions.

AW – whether reasonable to evaluate someone and determine whether can treat underlying cause. Was he likely to be bleeding from ulcer? Second day he had settled down, so another chance. Blood test results would also have been available so would have known GI bleed.

AJ – jury know discussions with Mrs Packman. PB said within reasonable ground to provide symptomatic care only.

AW - only if clear that only appropriate cause of action.

AJ – Dr Reid involved. After his involvement diamorphine increased.

AW – not sure why increased as says drowsy and confused but comfortable.

TL – 4 concerns of family of GP. Omission to adequately assess condition on 26/08, omission to obtain and act upon blood test results, omission to transfer to acute hospital, and drugs given excessive. Justified?

AW – deal one at a time.

TL – say inappropriate management of haemorrhage and excessive doses which caused death.

AW – yes.

Coroner – expressions read out not helpful to jury in being judgemental. Dont think AW read that.

TL – that is his evidence in cause of death in his report

Coroner – jury don't have that.

TL – dealing with cause of death.

Coroner – misheard.

TL – coroner confirmed entitled to provide opinion on care and treatment. In providing jury with your opinion, standard applied should be guided by what you consider reasonably competent clinician would have done. Consider responsible body of opinion which would arrive at different opinion would say so.

AW – yes

TL – GP not terminally ill when arrived at GWMH

AW – yes from looking at notes no sign of that.

TL – history of swelling of legs. No factors which made him terminally ill. Before going to GWMH was at QA for 2 weeks. During stay appeared condition improved. Pg 48 entry 10/08/99.

AW – temperature 36.5, patient well, cellulitis improving.

TL – entry 5 days later pg 51 18/08

AW – stable, wounds look better, recheck blood supply. Monitor blood pressure. Stop antibiotics

TL – what would that indicate?

AW – wounds getting better

TL – pg 163 bartel index. What is bartel?

AW – overall score takes into account patient's abilities.

TL – by 23/08 bartel index improved?

AW – yes, remains low but has improved.

TL – jury heard from VP, said GP made good progress. Looked best he had for years. Everyone seemed positive.

AW – accords with view from records – getting better.

TL – pg 54 when admitted, 23/08. Clerking doctor notes pre existing problems with obesity, arthritis, mobility, pressure sores and constipation. Episode of possible mylena. What is this?

AW – black or dark stool containing blood.

TL – high protein diet, better in himself. Good mental test score. Reference to no pain. No indication terminally ill. Admitted for rehab.

AW – specified?

TL – yes Pg 68. Entry 26/08, expectation of physiotherapy.

AW – my report mentions transfer to GWMH for rehabilitation.

TL – pg 108 confirms admitted for rehab. Physio indicates what?

Coroner – did he get any?

VP – no.

TL – during stay evidence of internal bleeding. Pg 133 – 13.45 11/08. Reference to loose black stools. Pg 52, 13/08/99, reference to black stools overnight. Dr Tandy who assessed him then. Then proceeded to do rectal examination.

AW – yes.

TL – as far as Dr Tandy concerned appropriate to do full blood count and he was stable. Exclude bleed at that stage. 5 days later on 19/08 reference to black stools. Entries suggest may have been GI bleed?

AW – possibility of it yes.

Coroner – more than that. Isn't that the diagnosis would draw?

AW – if blood in stools then yes. Further blood count 20/08. Although 2 episodes of Melina, no significant drop in haemoglobin. Not sufficient for him to have lost large amount of blood.

TL – at least possibility of GI bleed. Doctors responsible at GWMH should have read previous records and been alert of possible GI bleed.

AW – yes

TL – 2 days after arriving at GWMH reference to fresh bleed. In light of conclusion that appropriate cause of death was GI bleed, is that entry linked to it having happened?

AW – suspect not. If fresh blood bright red blood would be local cause of bleeding e.g. haemorrhoids. May be 2 separate things.

TL – seen 26/08 by JB.

Coroner- repeat blood count

TL – Dr Ravi contacted. Advice recorded is to get blood tests done that day and next. Know JB aware of that. Blood test referred to pg 205.

AW – print out of haematology report.

TL – dated 26/08. Comment in box saying many attempts to phone results to GWMH. Apparent why attempted to phone result through?

AW – clinical details on request forms said bleeding PR, haemoglobin low so suspect thats why.

TL – what should haemoglobin be?

AW – result = 7. Normal = 11 or so. What is more relevant is how much it has changed compared to his normal levels. Anyone should be able to say something not right. Overall outcome = lost blood most likely to be from GI bleed.

TL – said significant results not commented on at any stage in records. Expect this?

AW – medical assessment made and diagnosis reached. Given blood count been checked that day (blood test taken) would seem reasonable to phone labs and ask for results. Would help with diagnosis.

TL – pg 55 – note recording diagnosis. Alternative GI bleed.

AW – call to see, pale clammy. Oromorph overnight, possible MI, alternative GI bleed. Not well enough for transfer. Keep comfortable, happy for nursing staff to confirm death.

TL – had JB reviewed the results would she have arrived at diagnosis of GI bleed?

AW – should come top of list of possible diagnoses.

TL – given circumstances in which in hospital, expected thorough medical assessment to be performed to ascertain cause of condition?

AW – yes as acute change in clinical condition. Unexpected. Called to see patient as had become unwell.

TL – part of reason for assessment to ascertain if condition reversible?

AW – medical assessment is to come up with working diagnosis. Trying to come up with cause of problem.

TL – if reversible then treat it.

AW – assessment which should have been undertaken include temperature, pulse rate, blood pressure, especially as clammy and unwell, listen to heart, chest and check abdomen. Reasonable minimum examination.

TL – was this done?

AW – no record of being done.

TL – if undertaken would they have provided indicator as to appropriate diagnosis?

AW – heart attack or bleeding. Because of history bleeding would be top of list. Check results of blood test that day. Working diagnosis that he lost significant amount of blood by GI bleed. Reasonable conclusion based on history and blood count.

TL – most likely explanation for GI bleed = ulcer.

AW – commonest causes but range of other causes too.

TL – when patient has GI haemorrhage is it an emergency? What would happen?

AW – yes. Not gastro enterologist

Coroner – this report isn't admitted)

AW – if someone lost enough blood to suggest shock would have to resuscitate i.e. restore blood pressure, give IV fluids, oxygen, blood transfusion. Establish cause of bleeding so treatment could be given effectively.

TL – likely to have treatable reversible condition?

AW – on paper yes. Don't know what ultimate diagnosis would have been but working diagnosis yes. Ulcer top of list.

TL – given emergency could he have been dealt with at GWMH?

AW – from limited understanding of GWMH no. Whether having GI bleed or MI decision needed to be made what was best cause of action. Have to weigh up pros and cons. May not have been appropriate to treat but where patient not known to be terminally ill, should have been point for discussion with senior member of team to see if should have been transferred. Not in best interests to take less active approach. No notes of any discussion ever happening.

TL – told by PB risks of transfer itself low.

AW – impossible to quantify. Catch 22. If people poorly at home he would be transferred. Reasonable to transfer him to somewhere he can be treated. Absence of ability to stabilise condition before treating not a reason not to transfer him.

TL – expected to have been transferred in circumstances?

AW – if decision that could be successfully treated then yes.

TL – had he been transferred what would have happened?

AW – would have been stabilised, IV fluids, blood transfusion, try to make diagnosis, endoscopy.

TL – had he been suffering an ulcer could this have been reversed?

AW – yes usually treatable. GI bleed = medical emergency. Has to be treated rapidly. Cant say would definitely have survived as chance he may not have done but on basis of potential good that could have been done he should have had that chance.

TL – likely he would have survived?

Coroner – cant say that. Should he have received treatment, answer = yes.

AW – on basis of what read cant see reason not to treat.

TL – one of suggestions made = mark on records NFR. May have contributed to lack of transfer.

AW – specific issue. When drs write NFR that relates to circumstances if hear or breathing stops unexpectedly. Doesn't relate to other aspect of care. Because of obesity wouldn't be appropriate to administer cardiac treatment as unlikely to get him back. Not unusual to weigh up likelihood of success. For some not appropriate to give this treatment but doesn't mean they are not treated appropriately. NFR does not mean not for any treatment. Reasonable NFR but not reason not to treat him appropriately.

TL – in light of what said, decision not to treat condition meant no prospect of recovery?

AW – had GI bleed, blood pressure will drop when bleed. Pressure causing bleeding will reduce so bleeding may stop. Could be period where levels out. Don't know what underlying cause was so don't know if that would have happened. Suspect once crossed this threshold it would probably be likely to cause his death if untreated.

TL – PB said because of complexity it should have been discussed with patient, consultant and family.

AW – yes. Not obviously known to have terminal illness. Good practice to lay that and involve family in discussion. Need to include patient views, take note of patient.

Coroner – no consultation with gastro enterologist. Didn't happen.

TL – 27/08 condition had improved.

AW – nursing entry said some improvements.

TL – if appropriate to transfer on 26 would it have been appropriate to do so on 27 given marked improvement?

AW – depends what decision made. Even if blood count not obtained on 26th, should have been something making doctors chase test results. Wouldn't wait for results, would call if concerned about results.

TL – changing condition not discussed with consultant. Should have been?

AW – not documented. As consultant in charge of patient would want to know about their condition as in charge of their care.

TL – Dr Ravi suggested blood test be done on 26 and 27th. Doesn't appear to have been done.

AW – if not looked at previous result, by doing second test would have given second chance. Nothing documented to say why not done. Expect it should have been done

TL – JB saw GP on 28/08 and 31/08. Pg 79 nursing entry dated 30/08.

AW – peaceful night, black tarry faeces +++, nil by mouth, remains hot. Peaceful and comfortable night, large amount of black faeces passed.

TL – 2 other entries referring to black faeces on 31/08. What would those entries indicate?

AW – indicate most likely cause of problems to be GI bleed.

TL – report says should not have been any doubt about diagnosis now. Heard RR reviewed him on 01/09. PB said given time between GI bleed on 26/08 and what happened since, had reached point of no return by now.

AW – plan based on assessment of consultant for TLC. Documented plan and decision involving clinician.

TL – agree with PB?

AW – issue = has reasonable decision been made about how best to manage his condition? Critical period whether to treat. By now accept days passed and likelihood of getting him back diminished. Clear plan stated but no reasons but still clear stated plan. When TLC focus = relieving symptoms.

TL – given evidence of GI bleed after 26/08 expect diagnosis to be GI bleed?

AW – yes.

TL – Did omission to identify and treat this amount to conduct which fails to meet expectations?

AW – may be situation where GI bleed and not appropriate to pursue usual management plan. Decision comes back to date of decision when blood tests were available. Anything after that goes back to date of decision.

TL – first 3 of concerns that omission to assess, omission to act on results, and omission to transfer those justified?

AW – owed an appropriate explanation why the treatment plan not to do those was considered appropriate.

Coroner – blood test was an omission – no one picked up on results

AJ – blood test results signed but don't know when.

TL – given was signed by JB more or less in accordance with expectations fact she was aware?

AW – not sure. Ask JB. No documentation within notes suggesting result looked at or acted on. No date. Even if at time reasonable to say may be heart attack or bleed, melena stool should put GI bleed at top of list. Don't

know how long printed results take to get from lab to doctor. Results may have been signed after death. Odd not recorded in notes about likely cause of acute deterioration.

TL – opiates 26/08 oromorph given. Diamorphine 40mg, then 60mg, then 90mg commenced after and medazolam 20mg – 80mg. Not a case of terminal agitation. Only justification is for relief of severe pain.

AW – being able to justify dose given. No evidence why didn't use small dose when needs it to gauge likely requirements, response and decide whether regular dose needs to be given. If understand cause of pain better it will allow correct drug to be used. Was abdominal pain constant? Ensure clear assessment of pain and cause is made. Morphine and diamorphine not best treatment for all types of pain.

TL – said at pg 46 report that ongoing use inappropriate.

AW – not usual to give regular morphine treatment after. Reasonable to allow access to those if pain, but different to giving regular dose. If acute event which settles there wont be a need for ongoing pain relief. Pain from GI bleed ask what caused it. If written up for things as required, and needed several doses a day and syringe driver went up then documented reasons why necessary. Crucial decision = how best to manage.

TL – anticipate would have continued pain given sacral sores. Significant discomfort = justification for drugs used?

AW – pain due to pressure sores not flagged up as an issue particularly. May have been an entry mentioning some discomfort.

TL – pg 54, sacral sores. 23/08 – no pain.

AW – receiving paracetamol but thats it. May have been for temperature though.

TL – reviewed by Dr Reid 01/09. Pg 171. Diamorphine commenced that afternoon.

AW – thought 30/08 started.

TL – recorded that had peaceful night 02/09,– pg 63, dies 03/09. AW view that inappropriate management of GI bleed and exposure to unjustified and inappropriate doses that contributed to death.

AW – yes.

AJ – disagree with PB on last points. He said doses used required to control symptoms and didn't contribute to death. As far as decision not to transfer within reasonable decision.

Coroner – said decision not documented.

AJ – 26/08 – day of significant change JB says not well enough for transfer. Issue of whether to transfer is in her mind.

AW – that is her view.

AJ – asked about NFR. View that Dr Ravi took prior to bleed. Further deterioration. Mrs Packman informed. 7pm that evening wife seen by JB, explained condition. Would expect questions about transfer asked in that meeting.

AW – may have been but may have been based on MI not GI bleed.

AJ – would have involved general state of health.

AW – would expect general discussion. If not familiar with patient would require further input from JB.

VP – no discussion about medication or transfer, just told father dying.

Coroner – aware JB said it did take place.

Jury – normally consider weight when deciding dose?

AW – generally start with small dose and work up. Range within that dose. 2.5-10mg diamorphine depending on size of patient.

Gregory

AW – 91 year old, confused, significant history of asthma and heart failure. Asthma medication discontinued at Haslar. Transferred to GWMH. Experienced possible mini stroke. Became more disturbed at night. Increasing sedation, chest infection. No comprehensive medical assessment to consider cause of breathlessness. Considered may have been stroke. 19/11 short of breath. No documented medical assessment. Syringe driver given. Died 2 days later, bronchonpenumonia.

Coroner – reason for infusion not documented. What would it have been?

AW – ask what is symptom that needs treating. More specific treatment to relieve breathlessness? Heart failure must have been considered. In absence of documented medical assessment hard to know why given.

AJ – PB's view says by 18/11 very rapidly deteriorated. JB makes record oral opiates to be started in small dose given deterioration. Appropriate response. No significant progress after 3 months in hospital. Agree?

AW – opiods used for relief of breathlessness. Acceptable for this but doubt because of lack of documentation is whether breathlessness caused by something that could have been treated. Only heart failure treatment discontinued. What is causing breathlessness. If new symptom or symptom worsening would hope they receive assessment to come to cause of that. In absence of thorough assessment unclear if use appropriate. Breathlessness causing distress. May be appropriate to treat but need to look at cause of it. Could be opportunity to treat it. In absence of treatment will deteriorate.

AJ – PB - received 5mg 6 hourly or oral morphine. Believe appropriate. Started 20mg diamorphine. Decision to start this nursing one but reasonable given she is dying.

AW – if distressed and considered dying the use of opiods acceptable but has she got underlying problem which can be treated. Cant be sure.

AJ – increase within range of acceptable doses.

AW – comes back to cause of breathlessness. If considered underlying medical condition and other therapies considered not appropriate then yes, but potentially treatable causes may have existed.

AJ – now very ill. Consider blood clot may have caused death. Not surprising after poor mobilisation after fractured hip.

AW – is a possibility.

Coroner – which would you go with? PE or bronchopneumonia?

AW – difficult to diagnose. Can see why PB says what he does re PE, but in terms of being able to say with certainty it is hard. Don't know extent to which patient examined.

BB – conclusions at end of report – decline noted over number of weeks. Natural decline over terminal phase.

TL – no questions.