Dr Reid

Clinical Observations - Statement from 26/11/2004

Monday 25th October
You saw my Mother and recorded:
Washes with supervision and dresses herself; continent; mildly confused
Blood pressure 110/70
No pulse rate taken
Cannot answer for Barton's attendance
Normo chronic anaemia

1. You state that you **may** have done a physical examination. But this is not recorded on the clinical notes. However if you had done so you would surely have recorded this or is this normal practice? Mention did you have discussions with Barton/ regarding Multiple Myeloma and palliative care as you don't mention this in your statement? Where did Barton get this? This is the first time you would have seen my Mother?
   How do you justify 'mildly confused', **you do not mention that she was deaf in any of your reports she had no hearing aid dropped in the bath on arrival at the GWH and was with only 30% hearing in one ear.**

   See psychiatric report where the mini-mental test is null and void since it states that;

Not sure if she heard or understood a lot of what I was saying as she is very DEAF

2. Trying to get out of windows after one week in hospital after haloperidol
3. States she has a history of Multiple myeloma not true, Dr Cooper states to Dr Luznat that my Mother has no myeloma, why was this then diagnosed by Taylor?
4. At the time of seeing her calm, co-operative, friendly, no evidence of delusions or hallucinations.
5. Sure that this lady has a diagnois of dementia but do not know how much is related to her underlying myeloma.
6. Cannot return home for short period.
7. If behaviour deteriorates while in hospital will Transfer to Mulberry for further assessment? what will that be?
8. Blood pressure 110/70
9. **Why did you cease to request my mother's biochemistry report to include T. Protein, Albumin, Calcium etc? Levels, which were taken frequently prior to her admittance to GWMH?**
10. Why did you allow on admission **Oral morph** to be written up when my Mother was in no pain and was not admitted for any care requiring **opioids**? Then **Temazapan** was added. We have no proof that this drug was given or not given because the nursing notes are appalling and you state that you were using these notes or verbally to evaluate my Mother condition. Based on the medical chart alone, you would think that you were treating a terminally ill lady who was in severe pain.

Her regular drugs, **Thyroxine, frusemide were written up on the 21st and started on the 22nd, however Amiloride was not written up or administered until the 1st November.** Why would this have been why did you not note on the drug chart that this was not being taken together as it should have been Dr Stevens who changed her drug to this combination also stated to me she must take them together? **Both frusemide and Amiloride were to be taken together to ensure that the potassium levels in the blood remained stable.**

Monday 1st November

Quite confused and disorientated e.g. undresses during the day. I would have to see the circumstances on this as most days she changed her clothes if she knew she was having visitors she would dress up or going shopping. The 11th Nov when we arrived she had all her clothes on the bed neatly folded. I spoke to my Mother about it when she returned from her bath.. she thought she was going home. (Request nursing note that states this)

1. Where is this in the nursing/clinical notes that you would have referred to?

Physically independent, needs supervision, continent. Quite confused and disorientated. (request original notes) Yet also walking short distances unaided by staff or aid.

2. Why state **'appeared'** to be suffering from Dementia? So your not sure also? (check brain scan)
3. What happened to the home visit? You clearly thought from your physical examination that she was capable of living at home. You also state that her confusion could have been due to her being in the hospital and you find her to be stable.
4. Amiloride commenced late – why? (talk about potassium in the blood)

Monday 15th November

Pulse rate - 100

Very aggressive at times. –

1. Did you witness this aggression and why did you not question as to why the 'very' aggressive manner was not recorded or check the nursing notes? (check nursing notes for record)
2. Thiorizadine started on the 11th.
3. The urine had blood and protein and yet when it returned from the lab there was none – how is this possible? Why was this test administered after 4weeks in hospital? Knowin My mother had kidney problems? It is not in the nursing/clinical notes? (request a copy of the notes where this test recorded?)

4. Why do you take the pulse rate this time (for the first time) and no blood pressure? What were your reasoning for recording these 2 readings so sporadically.? You did

not see my Mother for 2 weeks and you don't bother to give a physical examination?

5. You state Oedema in the thighs – previously you didn't not record, why was this never previously mentioned? So we do not know how long the odema was in the thighs and it certainy had not stopped her movement.Why wasn't she given fluids and her diuretic dosages adjusted?
6. All of your comments are 'may'; you are not clear or cannot confirm her behaviour.

7. Why start the antibiotic before the tests have returned from the lab? (check dates of test results returned and Barton statement)
8. Why use Trimethoprim? which you state should be used carefully with those suffering from Kidney disorders – Are you aware that this drug causes artifical increase of creatinine? (look up Trimethroprim and Cefaclor on kidneys)
9. Why when you saw confusion on the 15th, did you not associate this with the drugs since they both can have this as a side-effect?
10. Thioridazine and other drugs are compatible
11. Are you aware that Thioridazine causes NMS?
12. I saw my Mother on the 11th, when I visited with my Daughter. My mother had just had a bath, selected her food from the Menu and we chatted about my Husband and the hope that we would be home all together again for Christmas. She was not aggressive, or confused. If there was an issue, one that required an anti-psychotic drug, why did no-one speak to us that day and explain that she was putting herself and others risk?
13. On the 17th, My mother slept well and went to the toilet twice and did not require thioridazine. On the 18th C. Evans signed that my Mother has no issues on that evening, yet you state that she had a marked deterioration in my Mothers condition overnight with confusion and aggression and a marked decline in her kidney function. (according to Barton)
14. Why does the psychiatrist that visited on the 18th not mention her hearing? She states that she was confused? But about what? There is not one note which states what this was based on. She had signed her pension book in the afternoon when my ex-sister-in-law visited. And was well aware what was happening; infact she asked if she could go out for a tea but was refused.
15. You mention not once about her hearing being a factor in her unable to understand what was being said.
16. Not one of your staff mentions it.
17. You state that my mother was administered the fentanyl at 9.15 because she refused her other medication. Her drug chart shows she took Amiloride at 0600 hours and your statement clearly shows she did.. The Frusemide and Thyroxine is crossed out at 0800hrs. This drug should be given together, as you state in your statement the reason for Barton to start it on the 2nov was correct to do so because of the Potassium levels.
18. Oral Morph was inappropriate then why leave it on my Mothers file to use at will we have no prove that it was given or not as drugs were left on trolleys to use as will.
19. My Mother being more restless is a total myth waith no prove what so ever.
20. On the 18th November At 0915am Jill Hamblin/Jane Barton concluded she was dying! As a 25mg fentanyl was placed on her body the equivelent to 135mg

Morphine in 24hours. Which would not have reach optimal levels for 17/23 hours. The drug is a serious opioid and should not be given to patients that are not opioid tolerant are you aware of this? There was never any need to sedate my Mother what so ever. Later in the day her ex daughter in law visited, dried her hair as she had just been given a bath. My Mother signed her pension book chatted and had tea with her. Evening her son visited stay for an hour or so None of them had concerns! My brother was not informed he would have called me and everyone else in the family. As least we could have been with our Mother. (Tell story she woke)

You state that to keep my mother out of distress you had to keep her sedated. You state that otherwise she would have had to receive several injections daily to keep her sedated. Fentanyl was the best option. Sedation is overdose of opioid (see facts)

21. You state you were happy for Barton to prescribe the fentanyl so are you saying that you would treat a patient to receive this form of opioid without any previous knowledge of her being opioid tolerant?
22. My frail Mother 50kg, who was unable to lift herself out of a bath woke on the 19th - dressed herself which according to the medical file was previously had been unable to do. Then allegedly tried to get a patient out of bed, threw one nurse across the room and another against a bookcase. 4 nurses then held her down on the floor and gave her an injection of 50mg chlorpromazine an extremely painful injection and on the upper level. After now receiving approx 135mg morphine it is no wonder she woke confused. Why did it take 18months for this to come to light? From the day she died to June 2001 I've been asking what happened that day, what made the nurses administer such a cocktail of drugs? Finally this story appeared in the I.R. After some 3months and many requests to the Portsmouth Healthcare Trust to view the medical accident book where this alledged incident should have been recorded, I finally was informed nothing was recorded. So why was it not.

23. Remember according to the notes that on the 18th PM she had a bath and her hair washed. Although Jane Barton had already decided my Mother was dying as she had applied the Fentanly Patch equivalent to 135mg Diamorpine. (the same goes for the 16th bath and hair wash, 15th bath given, which seems excessive for her needs.
24. You state that Dr Barton is a very experienced doctor, so she would know the effects of these drugs?
25. You state that on the 19th there was a marked deterioration over night with confusion and aggression and a marked decline in her kidney function and a further deterioration that morning. An injection of 50mg chlorpromazine was given an antipsychotic drug to sedation and the dosage at the upper range bearing in mind the previous drugs administered. Do you think that the morning my Mother woke etc. and in her confused state had nothing to do with the concoction of drugs that she had been given.
26. When you saw my Mother on the 15th and state that she was swollen and renal failure was taking hold. Why did you not prepare a palliative care plan with Dr Barton? You would have known the pain that she was expected to be in over the future days/weeks? Although I understand that Renal failure you become tired CHECK

27. Why did you not set up a fluid chart or transfer my Mother back to the QA when you saw her decline?
28. You state that Dr Barton should have made clinical notes of the fentanyl and the chlorpromazine – both powerful drugs and also represent a important change in Mrs Devine's condition and treatment.
29. Why was my mother not weaned onto diamorphine after the fentanyl patch? Which is correct palliative care. Instead she was given in 24hour
    Chlorpromazine – 50mg Injection
    Diamorphine – IV – 40-80mg (they state 40)
    Midazolam – 20-80mg (they state 40mg)
    Fentanyl of 25microgram equilivent 135mg morphine was still in my Mother's system

30. After the removal of a fentanyl patch is it not correct palliative care to give a patient a subcutaneous breakthrough dose. Which for a fentanyl patch of 25 micrograms would be 5-10mg diamorphine ever 4 hours, instead of injecting a dose of 40mg straight into the driver. On top of this, you state that infact the diamorphine was given before the patch was removed, which exposed my Mother to an overdose/increased dose, likely to be that of 80 mg
31. Further to this over prescription, which lies outside of normal palliative practice Dr Barton saw it necessary to administer midazolam, which was also given over the normal starting dose, which you state was 10-20 and Barton administered 40mg. Do you consider this necessary?
32. Is it correct for a patient to be unconscious during palliative care?
33. Is is true that these drugs should not be administered together as they cause respiratory depression.
34. You state the diamorphine was appropriate for the fentanyl patch, but infact under palliative guidelines 25mg Fentanyl transposes to 20-40mg Diamorphine. 40-70mg Diamorphine is equivalent to 50mg Fentanyl. And 70-100mg Diamorphine is equivalent to 75mg Fentanyl.
35. You state that it would have been better not to use the fentanyl but smaller doses under injection so that my mother's reaction to the drug could be monitored. But the injections would have been more distressing. Why not give oral morph it was written up on the file 4weeks earlier ready for use!
36. Can I clarify that the 50mg of Chlopromazine which you state was at the upper limit; is that exclusive of the fentanyl patch or are you taking into account the drugs already in the system?
37. You state that you would expect to see a reaction to the drug after 30minutes to 1 hour. However my Mother reactive adversely to this drug and was sat holding two nurses life after 4 nurses held her down to administer the drug. Then those nurses walked her for several hours until lunch time when they transferred her to a bed. Why might that have been?
38. You state that drug should last 3-6 hours, but you have limited expertise. Why would you use such a powerful drug outside of our own medical knowledge and how often have you used this drug at the GWH?This drug was used in the GWMH and as the consultant shouldn't you be aware?
39. You state that it was a concern that when my Mother was administered the Midazolam that the chlorpromazine was not at full effect. Why do you only

mention the midazolam? Should you not be concerned that it was the Midazolam and the Diamorphine?

40. You agree yourself that there was no reason given for the administering of Midazolam and alone could have lead to over-sedation– and that the diamorphine dosage ALONE without midazolam would have lead to over-sedation. So what of them together?
41. You state that used of these analgesics is well recognised to hasted death; in the course of relieving suffering and making a patient comfortable. By whom is it well recognised? The Wessex guidelines do not state this. My mother was signing her pension book one minute and the next she was terminally ill and unconscious. I state that her kidney impairment did not cause this. The drugs she was given 100% did. You speak of the drugs she was given broken down individually, but what of it when all the drugs are taken into account as a whole. What woman of any age with a week kidney could have possibly survived? You can show me no proof that my Mother was in pain or 3 days from her death, when you started what you consider to be palliative care.
42. You state that the drugs were written up so that the nurses could have increased the dosage should it have been required. You state that no increase was ever given. However I put it to you, that why would it have been? My mother was started on such a high dosage at the start that she was left unconscious and with respiratory depression through the last 2 days of her life. She was unconscious 4 hours after this cocktail was administered and remained so until she died. Unable to speak with her family. Is this acceptable palliative care?
43. My Mother wasn't the only patient started on these high dosages (as found in the CHI report) you agree that the dosage was high. Did you not ever look at patients palliative care prescription and remark to Barton on her oversubscription?
44. You state that the turnover in the Dryad ward was relatively low? What does this mean?