Mr Black

Chronology/Case Abstract

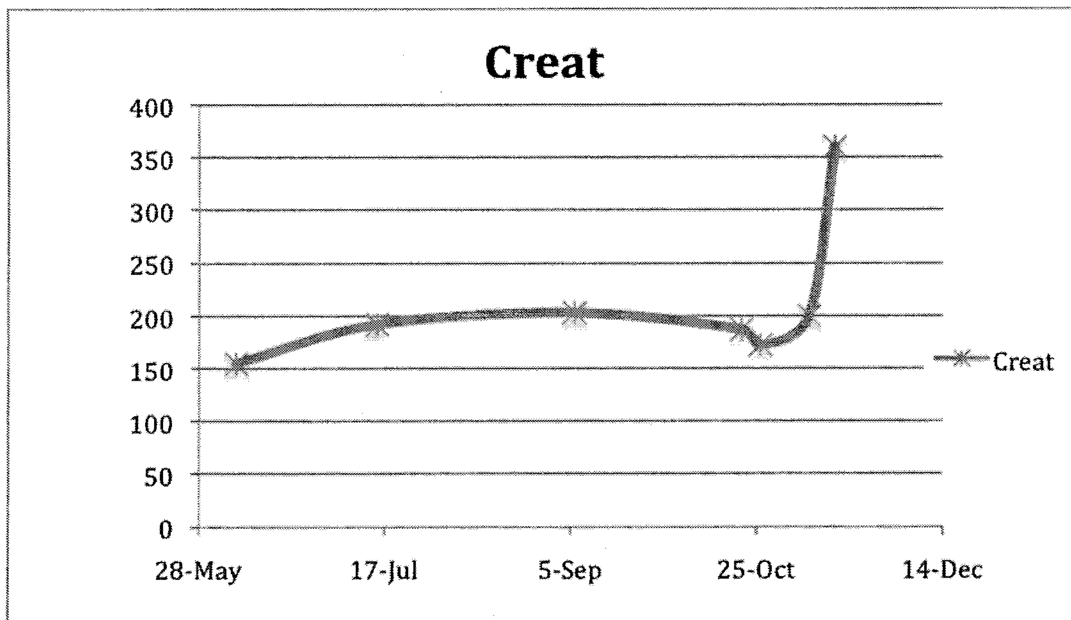
My mother was 88 not 89

1. (S)(5.5)You state that in July 1991 my Mother's haematologist found 6% Plasma and albumen of 22% and suggested a watch and wait - this was July 1999 not 1991.
2. (S) (Q) (5.6)9th October my mother was admitted to the QAH following a crisis . My Mother had a bladder infection, which was causing confusion. She would have come home from the QA had I not been in Hammersmith with my Husband. You comment that I could not cope and that there was a 'story' of confusion and aggression is completely incorrect. Where do you pull this from? Where in her file does it show that she was aggressive or confused prior to her urinary infection?
3. (S)(5.6)You state that my Mother's blood showed no infection – but this test was taken after the antibiotics were given; and her consultant felt that the antibiotics could have been the reason why the urine came back clear.
4. (S)(5.7) You state that on the 12th October my Mother was distressed and agitated and undergoes a CT Scan. This is incorrect. Her medical file states that her CT scan was on the 18th October; but this scan is not on her file nor can it be retrieved by the Trust from the QA.
5. (S)(5.8) On the 14th of October my Mother was noted to be wandering and on the same day she is accessed by DR Taylor who noted the history of confusion and disorientation and a 10 month history of mental deterioration. This comes from no basis. As her consultant describes in April (5.5) my Mother was very bright. This is the first time my Mother ever saw a psychiatrist, so I fail to see the 10 month history. As for disorientation – I would like to see anyone get around the QA without getting lost. My Mother was left to find her own way to the toilet and even I found myself disorientated when having to do so. The toilet was 12metres down the corridor with mirrored doors all the way down.
6. (S)(5.8)I raise the point that Dr Taylor mentions at the end of their statement that after his/her assessment she might not have infact even heard the questions asks, because she only had 30% hearing in one ear. In the other she was completely deaf. I push that the mini mental test which you classify to put her with moderate to severe dementia cannot possible be upheld. (present cards from GWMH to family)
7. (S)(5.8)On the 20th October my Mother was discharged with the assessment from her Consultant was that she can stand and 'may' have had a urinary infection (because of the quick antibiotic start) on top of her chronic renal failure and that she was quite alert.
8. (Q)(5.10)Who did the 3/10 mental abbreviated test?
9. (S)(5.11) 21st October you state my Mother was transferred for continual care - this is incorrect because it was already in discussion where my Mother would go for the interim period that I was in London. A nursing home, family, GWMH? This is why her Consultant put on her transfer letter that she was discharge for rehabilitation. You note her Bartel to be 8 but infact when she left the QA it was 12. Jane Barton's test dropped it by 4.
10. (S)(5.11) You state that Barton incorrectly writes that my Mother has 'Myeloma'. You fail to mention that she writes up her usual drugs, frusemide and Thyroxine but takes my Mother off of Amiloride.
11. (S)(5.12)25th October my Mother is reported to be washing with supervision, but remains confused. Dr Reid states from his visit that day that my Mother was MILDLY confused – this is not explained and it is made clear that this diagnosis was made from verbal comments made by the Nursing staff.

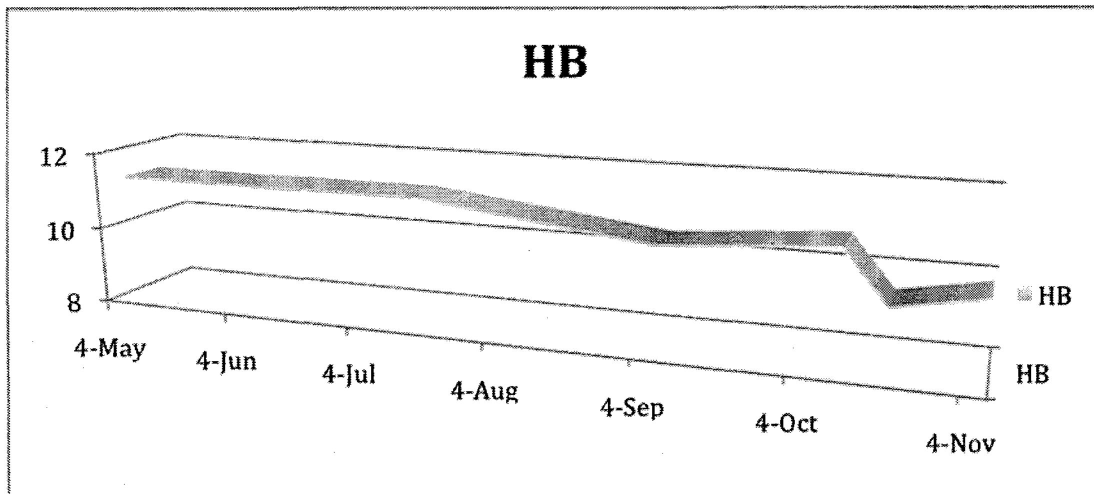
12. (Q)(5.13)1st November, you report that she was quite confused and wandering; where did you see this in the nursing notes?
13. (S)(5.13) 11th November you state my Mother had an MSU, which report no growth. This is quite misleading. My Mother was given and MSU and started on Trimethoprim because of an alleged dip stick report, which showed protein and blood in her urine. The result, which you talk of, was not available until the 15th and returned with no blood or infection? 15th November my Mother was noted to be very aggressive and restless and having Trimethoprim.
14. (S)(5.15)18th November you state that she was rapidly declining and refusing medication. Did you not see from her prescription sheet that she took her amiloride at 6am. So from refusing her frusemide and the thyroxine it took 1.5hours to then administer a fentanyl. (25milligrams, which is upto 135mg Morphine)
15. (S)She had a bath, her hair washed, dressed herself and visited with her ex daughter-in-law (Sandra Briggs) Signed her pension book, Sandra asked if she could take my Mother to the coffee shop which was refused, so they ended up sitting in the lounge having a cup of tea. My Mother also had a visit from her son in the evening and again sat in the lounge; she was apparently in her terminal stage and yet quite able to sit up in the lounge.
16. (S)(5.16)The team noted that 'in their view' there was no NEW physical problem and she should be put on the waiting list for the Mulberry Ward, yet there is no time on the visit record and no record of any mental/physical examination. (Later Black states that the fentanyl patch was for terminal restlessness. The Mental Health team clearly did not agree). At this turning point there is still no notification given to any of the family – even though my Brother and his ex-wife both visited this day. Dr Taylor reports that my Mother states "tablets make her mouth sore". Why then does Dr Taylor witness the critical pain that required the fentanyl patch?
17. (S)(5.16)16th Potassium is 5.6 and Creatinine is 360. Both of these could be attributed to the drugs given and dehydration. Her haemoglobin also increased which is a mark for dehydration
18. (Q)(5.16)19th November you speak of a marked deterioration of night. Where did you see this on the nursing/clinical notes? What proof was there of this deterioration. My mother was not opioid tolerant and her alleged behaviour of getting dressed, getting someone out of bed and throwing two nurses up against a bookcase. This sort of behaviour could be seen as an overdose.
19. (S)(5.16)Your paragraph 5.16 is completely incorrectly recorded. Can I just correct you, or at least highlight to facts.
    a. Fentanyl patch 25mg had now been on over 24 hours. Administered at 0915 the day before. Your statement of 'yesterday' gives way to confusion (you fail to mention this)
    b. Chlorpromazine was administered at 0830 – this was 50mg (you failed to mention this)
    c. 0945 Syringe driver given with 40mg of Diamorphine & 40mg Midazolam (5.19 you state that all other drugs have been stopped but they have not! The Fentanyl patch is still being administered and even after removing the half-life period lasts in the body for 17 hours or more.
    d. 12.30 the Fentanyl patch is removed
    e. Barton states happy for Staff for confirm death
    f. 1300 Barton informs the family via Harry – for the first time. (Your opinion reads that he was informed prior to Barton stating she was happy for staff to confirm death, this is an appalling recording of the events)

Technical background/examination of the facts in issue

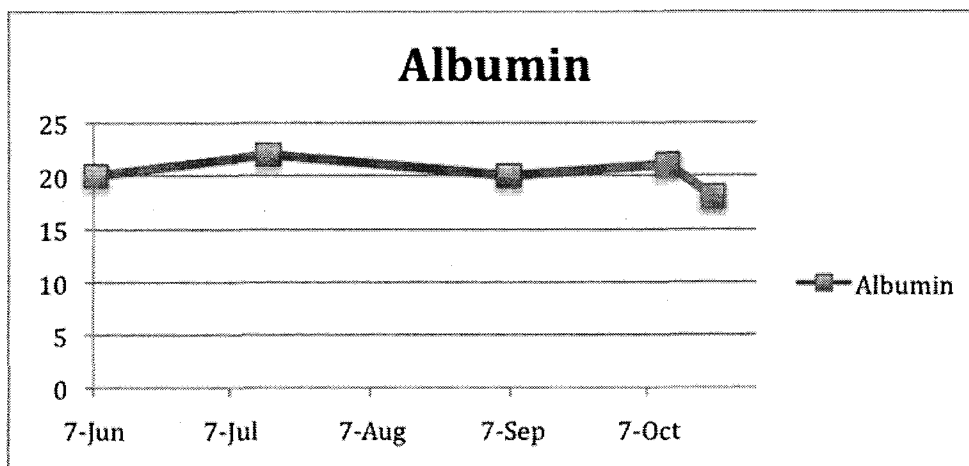
20. (Q)(6.2) You state that you have been asked if it was correct to state that My Mother was terminally ill on the 19th. Why this date and not the 18th? When the fentanyl patch was administered?
21. (Q)(6.3)You state that my Mother had a physical and mental deterioration illness starting in 1999 - this is incorrect. What evidence do you have for this statement?
22. (S)(6.23) You state that the prediction of how long a terminally ill patient will live is virtually impossible and palliative care experts show variation, yet in (7.3) you state that my Mother had no more than hours to days to live.
23. (S)(6.4)You state that my Mother's creatinine rose through the year. But in fact it fluctuated and this was generally due to hydration and drugs. Dr Stevens who saw my Mother was not concerned with her creatinine at 200 and stated that she would see her in 2 months time. My Mother Creatinine fluctuated between 155 and 203 from May 99 and the only significant increase was from the 9th to the 15th November after the administration of Trimethoprim and Thioridazine.



24. (S)(6.4) You state that her haemoglobin also fell, but again this fluctuated and was increasing again by the 9th November.



25. (S)(6.4) You state her albumin also falls, but again this fluctuated from 20 in June to 22 in July to 20 in Sept to 21 in Oct , and then fell to 18 on the 22nd October. There were no further Albumin scores measured, so we cannot say that My Mother's albumin fell over the year. There was only this 1 reading and based on previous patterns the levels would have risen again.



26. (S)(6.4) You state that her renal physician and haematologist all conclude that she had a progressive problem with no easily treatable or remedial cause. The small kidneys shown on the ultrasound usually suggest irreversible kidney pathology. There is no doubt that my Mother had weak kidneys and that they were small. But for her age her kidneys were only slightly small. The kidney begins to get smaller at about age 35. By age 80, most people have lost about 30% of their kidney mass. These specialists whom you speak of were not concerned about the size of her kidneys or her blood results, which regards to imminent renal failure.
27. (S)(6.5)You state that the history taken from by the Mental Health team also described mental decline. Could you please show me the report? I would like to know who this is? If we are talking about Dr Luznat and myself having a telephone call regarding my Mother's temporary placement in a nursing home then there was no such discussion about a mental decline. She lived alone in August whilst the family went to Spain and cared for herself. My

ex-sister in law visited in the evenings to check that she was cooking her dinner ok, but she did all her other meals and washed/dressed herself without concern.

28. (S)(6.5) You state that my Mother missed appointments. To clarify this was on Tuesday the 31st August, an appointment which I cancelled and rescheduled for the following week.
29. (S)(6.5) You state my Mother did not know the tablets she was taking. To clarify, she knew she took 2 tablets each morning. She may not have known the names, but she knew how to describe them. Most of us have difficulty with the pronunciation of some medication. She wouldn't have told you the name 2 years ago; this is not a sign of dementia. I was with my Mother for the September appointment; I would like to see where this information came from? I do not recall anyone asking about the drug names.
30. (Q)(6.5)You state that in September the notes fail to make a diagnosis of Alzheimer's or Multi-infarct dementia. What are the notes that you are referring to? (I cannot see a consideration of Alzheimers versus MID)
31. (S)(6.6)You state that the hospital stay would have exacerbated and already underlying dementing illness. My Mother was not demented, as I have already stated, her confusion was an isolated incident, which her consultant believed to be due to a urinary tract infection.
32. (S)(6.7)15th October - Dr Taylor (not the mental health team) assesses and give 9/30 mini mental; **however she does state that my Mother might not of heard. – you don't seem to wish to mention this; for the record, my Mother had 0% hearing in one ear and 30% in the other?** This test should be thrown out. Taylor on the 15th states in her letter that my mother is diagnosed with Multiple Myeloma (INCORRECT as confirmed to Dr Luznat by her Dr Taylor in my Mother's notes – NO MYELOMA) Hyper-thyroidism (CORRECT) but where was her renal impairment? Taylor misses this completely.
33. (S)(6.7)You state again that her mental decline was rapid over the year. Where do you get this information?
34. (S)(6.7)You state that her physical decline was rapid over the year, but where do you see this information in her file. Her blood results were stable up until the last week of her life when the drugs commenced.
35. (Q)(6.8) You state that on admission to Gosport Dr Barton write in the notes that my Mother has Myeloma (a malignant disease). How can a doctor of so many years experience make and incorrect diagnosis of a malignant disease? You state that this is common in non-specialists? I am not aware of any reports which suggest this trend – can you share your backing for this opinion?
36. (Q)(6.11)You state that my Mother **had** a number of markers suggesting a very high risk of in-hospital death.
    a. That she had been in hospital over 2 weeks (this was not for any illness, but due to her being unable to return home at that time) Where do you pull this data, Medical Publication shows that Length of stay proved not to be significant in the rate of Mortality. (http://www.bmj.com/cgi/content/full/318/7197/1515?ref=ARKADASBUL.NET) I can appreciate this correlation should a person be in hospital for a terminal illness
    b. She had a possibility of delirium on top of a rapidly progressive dementing illness. The delirium was never diagnosed and any symptoms were only realised in full after the administration of the Psychoactive drugs which directly affect nerve cells in the brain causing delirium.
    c. She had extremely low albumin at 18., but again this fluctuated from 20 in June to 22 in July to 20 in Sept to 21 in Oct, and then fell to 18 on the 22nd October. There were no further Albumin scores measured, so we cannot say that My Mother's albumin fell

over the year. There was only this 1 reading and based on previous patterns the levels would have risen again.

i. You state that low albumin increases susceptibility to infection (which my Mother didn't have) to pressure sores (which my Mother didn't have) and in coping to the psychological stresses – can you quantify those, because my Mother wrote a card and letter to the family about her daily routine which didn't' outline remarked stress; if anything my Mother may have been suffering depression from bullying.

37. (S)(Q)(6.10)You state that upon admission Hyoscine (please state where you saw this? We could not find it as written up on admission) and a small dose of Diamorphine were written up prn. Can I state here that the 5mg of Oramorph had no 24 hour dosage guidelines, therefore it cannot be gauged as either a low or high dosage. The Hyoscine was written up with a dose of 200mg – 800mg to be given by SC. You state that writing up of diamorphine and hyoscine is unusual in a patient who has no known causes for severe pain or underlying cardiac condition, however it can be seen as pragmatic practice. Could you please explain what you mean by pragmatic? (How can it be pragmatic to write up drugs that are not necessary?)
38. (S)(6.10.2) You state that one interpretation of this pragmatic approach is that this ward although seen to be for continual care or slow stream rehabilitation, was in fact where patients were unlikely to leave hospital? Where the patients are not immediately dying but who are too ill to be put through the trauma of moving to a nursing home only to die shortly after. (Q)To clarify are you saying that because a number of patients died at the GWMH that it became their culture to write up drugs for the terminal phase with the intention/prediction that the patient would die under their care?
39. (S)(6.1)You state that the MSU was sent on the 9th, but this is incorrect. My mother's blood tests were sent on the 9th and came back with no significant change from her reading in July

    Creatinine – July – 192, 9th Nov 200

    Where is the clinical deterioration that you speak of? On the nursing records there is nothing reported about my mother from the 21st October where they state she slept well, right up until the 10th. It is signed daily without any issues recorded.
40. (S)(6.11)On the 11th my Mother had a random dipstick, which lead to an MSU. The dipstick apparently had blood and protein, however the results showed this to be false.
41. (S)(6.11)You state that the tests wouldn't have been done unless there was a decline in her condition. But she had the blood tests done on the 22nd, 27th, 9th, 16th, (check the pathology reports) The only extra test that was administered was a dip stick which is not on the nursing records. It was verbally mentioned to Dr Reid that this was administered and found blood and protein. My mother was prescribed Trimethoprim (which causes an artificial increase in creatinine) and this was administered twice daily from the 11th through to the 15th; Barton alleges this was never given.
42. (S)(6.11)You state that new medication started (thioridazine) and the antibiotics subscribed (trimethoprim) and the blood and urine test all suggest a major change in condition.
    a. The thioridazine was started on the 11th, I visited my Mother this day with my Daughter and witnessed no signs of psychotic behaviour. As you state this drug is for significantly disturbed behaviour. My Mother had just been given a bath and had her hair washed. There was no mention that my Mother had been 'difficult' or 'agitated'.
    b. The antibiotics were subscribed and administered on the basis of a dipstick, a test that can present false positives and could have easily been contaminated. I find this to be poor clinical practice.

c. The blood test was regular and normal clinical practice; it was not part of any new investigation.
d. Finally the urine test was done on the basis of a dipstick test, which was never recorded.

43. (S)(Q)(6.13)You state that by the 18th the pragmatic treatment my Mother was given didn't work and she had declined and was now refusing medication. This is incorrect my Mother took her amiloride on the morning of the 18th – so where was she refusing oral medication? And what of the pragmatic treatment? The effects of Trimethoprim and Thioridazine on Creatinine and the side effects shouldn't be taken into account?
    a. Trimethoprim –
        i. alone can cause an important but reversible increase in creatinine concentration in chronic renal failure. (Renal Failure in Practice, by Paul Glynne, Andrew Allen, Charles Puse)
        ii. Hyperkalaemia and non-oliguric renal failure is associated with trimethoprim
        iii. Potassium-sparing diuretics (amiloride) increased risk of hyperkalemia
    b. Thioridazine
        i. Can cause drowsiness, dizziness, confusion, headaches, shakiness, trouble sleeping, dry mouth, blurred vision, difficulty passing water, unintentional movements, feeling slow, agitation.
        ii. Is contraindicated in patient with Dementia (as stated by the MHRA)
        iii. Thioridazine is not more effective than placebo or other neuroleptic drugs for improving the behavioral, global clinical, or cognitive states of elderly patients with dementia. Thioridazine reduced anxiety only when compared with placebo or diazepam and led to worsened behavioral scores and increased dizziness.
        iv. Before commencing treatment with thioridazine, baseline ECG should be performed and serum calcium, magnesium and potassium levels measured and corrected in all patients.

44. (S)(Q)(6.12)You state that a patient that is already frail and running with a creatinine of 200 can have rapid decline. I disagree, those with CRF will have a slow decline before entering the end-stage renal failure, suffering symptoms which my Mother did not have.
    a. My Mother had creatinine of 200 since June, which did not lead to serious intervention, and the renal consultant was not concerned of any rapid decline.
    b. If she was frail why was she referred to go home on the 1st November and moreover why was she administered high end dosages of opioids and neuroleptics.

45. (S)(6.12) You state that blood tests are carried out on the 16th and my Mother's creatinine is at 360. These results were not available until the 18th. You state that due to this reading and her increased potassium, which is now at 5.6 showing her to be Hyperkalaemic (both a side effect of the drugs she was administered for the previous 5 days) that she is now in established **acute** on chronic renal failure.
    a. What is the acute part of her CRF and how do you diagnose this? Clinical assessment should include identification of acute exacerbation, e.g. drug history, assessment of blood pressure and cardio status for evidence of possible hyperkalaemia.
        i. Acute renal failure can be present on top of chronic renal failure. The acute part of AoCRF may be reversible and the aim of treatment, as with ARF, is to return the patient to their baseline renal function, which is typically measured by serum creatinine. Acute kidney failure usually occurs as the result of a sudden interruption in the blood supply to the kidney, or as a result of a toxic overload of the kidneys. **Drug overdoses, whether accidental or from chemical overloads of drugs such as antibiotics or chemotherapy, may also cause the onset of acute kidney failure**. Unlike in chronic kidney disease, however, the kidneys can often recover from acute failure, allowing the patient to resume a normal life.

46. (S)(6.13) You state that on the 19th she was now seriously ill, but you do not include any effects that could have been related to the 25miligrams of Fentanyl which was now in her blood stream from the transdermal patch administered 24 hours prior.
    a. Do you know what fentanyl is?
    b. Should it be administered to non-opioid tolerant patients?
    c. Is 25 milligram an appropriate dosage for a frail elderly lady?
47. (S)(6.13)You state that the question would have to be answered by the doctors on the 15th and 19th if this was a further acute event that could be easily reversed?
    a. What is the acute event from the 15th?
    b. How can a decision to reverse my Mother's state have been made on the 19th when by this time the Fentanyl patch had already been administered. Surely a decision was made on the 18th that my Mother was in the terminal phase? You yourself state that it is likely as she was not recorded as in pain that this was administered for terminal restlessness.
        i. Fentanyl is the strongest opioid (approximately 80 to 100 times the potency of morphine) Because its peak delivery does not occur until 12 hours, an alternate analgesic must also be given initially.
        ii. if my Mother **was** in pain – why then was she not given as much as a parcetamol prior to this?
        iii. Fentanyl can cause restlessness as one of its side-effects.
48. (S)(6.16)You state that fentanyl could have been given for severe restlessness in a terminally ill patient. But in 1999 Fentanyl transdermal patches were only licensed for the relief of chronic intractable pain due to cancer.
    a. To be clear, on the 18th, after the Fentanyl had been, keeping in mind that the patch takes upto 23 hours to take effect my mother was sat drinking tea with her ex daughter in Law (Sandra Briggs) Sandra was so unaware of any terminal restlessness or pain that they asked if they could take their chat to the hospital coffee shop – this request was denied. Later that same day my Brother (Henry Devine) visited his mother and recorded no behavioural concerns.
        i. During both of these visits neither were notified of my Mother entering the terminal phase, experiencing pain – or even the fact that a strong opioid had been initiated. (for whatever purpose)
        ii. My Mother was not given as much as a paracetamol to relieve this pain whilst the fentanyl was taking affect. Do you consider this normal practice? Remembering that you believe the writing up of oralmorph on admission was pragmatic – why then would you not consider that this should have been given prior to the fentanyl?
49. (S)(Q)(6.15)You believe that most clinicians would conclude that because of the increased creatinine my Mother was terminally ill and they opinion would also be influenced by her 1 month stay in hospital. Would these clinicians not look at her drug intake and other influential factors in this increase?
50. (S)(6.16)You state that it would have been inappropriate for Dr Barton and her team on the 19th not to have offered
    a. High quality palliative care – High quality does not mean high dosage.
51. (S)(6.16)You state that my Mother was confused and aggressive on the 19th and was given SC Midazolam and Diamorphine.
    a. You fail to mention that prior to this she was injected with 50mg of Chlorpromazine; a dosage of less that 25mg is more appropriate for an elderly patient.
        i. How can you give any assessment to my Mother's care when you clearly do not have the facts?

b. Do you think it appropriate to administer 50mg Chlorpromazine, 40mg Diamorphine, 40mg Midazolam all within an hour whilst the 25milligram of Fentanyl is now at full effect; equivalent of 135mg of Diamorphine over the previous 24hours.

52. (S)(6.17)You state that this overlap is unlikely to have a major clinical effect.
    a. Why then are the dosages set out under the Wessex guidelines to be administered in much lower dosages?
    b. (6.20)You then contradict yourself stating that these dosages were two times higher than the u – although there is no exact science to judging the dose of diamorphine to give. Although it is normal clinical practice to start low and increase the dosage rapidly! Should it not be slowing and in small increments after 24hrs. (as per the Wessex guidelines)
53. (S)(6.17Can you explain paragraph 6.17. You state that there is also a discussion regarding her status with a member of the family; and there appears to be no dissent as to the appropriateness of her proposed care.
    a. Where do you see this in the file? Gill Hamblin called my Sister-in-law at 8.30 to ask for my Brother to come in and see the doctor. She asked if it was an emergency and was told it was not. My brother then visited at 1pm as usual. At that time he was informed that my Mother was terminally ill. We were never informed of her previous or current medication.
54. (S)(6.18) You state that a pharmacists opinion should be obtained on the actual way the drug was subscribed; that you are not certain that the prescription of diamorphine follows national guidance, in writing dosages in words and figures as well as total dosages. That it is written in a way that leaves some discretion to the dosage to be used.
    a. Could you please explain this?

55. (S)(6.23)You state that 360 creatinine would have meant that she would have been dead by the 21st anyway. I am interested to understand how you quantify this as people are not usually put on dialysis until levels are between 400-800? And some CRF patients have creatinine levels much higher than this. Her sudden creatinine rise is reflective of the acute renal failure, which is reversible.
56. (S)(6.24) You finalise by stating that you are not able to say that the use of Fentanyl, Diamorphine and Midazolam were prescribed with the **intention of deliberately** shortening my Mother life.
        i. You omit the Chlorpromazine
        ii. You omit the 5 previous days of Trimethoprim
        iii. You omit the 5 previous days of Thioridazine
    b. More importantly it is not your place to decide the criminal intent. Only to state if the medication was appropriate and if at any point put my Mother's health in danger. For this you summarise that they were high dosages and it is possible that her life was shortened. (this opinion – only bases upon some of the drugs administered)

57. (Q)Have you been previously employed by the Portsmouth Health care trust?