DAY 6

Blake Lapthorn

# File Note

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Code A

Client: Private

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

Matter No: 516130/000001/JCW/GOSPORT

Author: Gemma Bailey

Date: 25/03/2009

Units: 1

**Attendance on Client**
**1 Units (Gemma Bailey) - Unknown - Gosport War Memorial**

GWMH Day 6 – 25/03/09

Coroner – Miss Ballard, found document very useful.

TL – not had opportunity to take final instructions but will do so over lunch.

Coroner – would be useful for jury to have copy. Has drug chart been amended for AC?

TL – not yet.

Coroner – happy for it to be distributed provided factually correct. Plan to do Packman, Devine, Spurgeon, Gregory.

(jury bought in)

Coroner – PB still here. Geoffrey Packman, 68.

PB – 67 in 1999, admitted as emergency. Morbidly obese for many years, suffered consequences e.g. leg ulcer disease. Increasingly immobile, wife also ill. Admitted as emergency, found cellulitis (infection of skin) – difficult to treat, can be serious. High white blood count, abnormal heart rate and impairment of kidney function. Streptococus so antibiotics given. Deteriorated, developed blisters on heals and then sacral sores. 13th black bowel motion mentioned – if bleed from gastric tract at top of stomach it oxidises as it passes through. Examined and doctor says no black stool. Doctor said wait and see. Important to note that don't start him on treatment so continued on injections of Heprin (appropriate for obese patients) but side effect makes you more likely to bleed. No notes whether this was discussed. If did have ulcer drug makes it more likely to bleed again.

Coroner – reasonable to look at endoscopy?

PB – would have been difficult to do on large man but not impossible. Would be normal next step in otherwise fit patient. Could have been done. Problem = managing the person and giving them sedation. Problems not insurmountable. Then transferred on 23/08 to GWMH. Haemoglobin 12, normal range but had deep complex pressure sores. Poor prognosis for someone with this but not necessarily terminal. Chances of getting out of hospital are small but cant say that they wont. Nurses record passing blood from rectum and vomiting but no

evidence seen by dr. On 26th seen by Doctor – suggested may have had heart attack overnight. Not well enough to transfer to acute unit. Heprin stopped. Full blood count done – now 7 so lost 4/5 pints of blood. No doubt he had second massive haemorrhage.

Coroner – follow up for blood should have been ordered by Dr Barton either by ringing or by result arriving following day. She would then pick it up on ward round next day.

PB – yes. Nobody followed this up. By 27th is time to make crucial decision. Some treatments can be done simply with endoscopy or where rebleed may need surgery. Risk of surgery huge for someone like this. Doing nothing also high risk, likely would die if nothing done. Important and serious decision to decide whether to do surgery or not. Should have involved consultant, patient and relatives as they would all have an opinion.

Coroner – Dr Barton said too sick to move at that point.

PB – that is part of decision making process. Assess risks of moving v risks of doing nothing where may die anyway. Important all parties involved in decision. No black and white answer. Remains where he is, continued to bleed as other mentions in notes. Will become frailer, breathless, may feel unwell and heading towards death. Want to relieve symptoms which then becomes terminal care. Receives oromorph. Difficult tell exact dose but seems to receive regular doses from 27, 28 and 29th, then put on diamorphine 60mg on 30th. Judging starting dose difficult in relatively young person who is very obese, variable absorption. Assess patient in front of you. Expect pressure sores to be painful.

Coroner – if someone obese with sores turning them difficult and dressing difficult?

PB – use a hoist. Would give regular analgesia injection before dressing.

Coroner – would then be put back down to sores?

PB – may have managed to nurse him on one side. Would have to check with nurse. Huge management problem. Then seen by consultant on 01/09, consultant clear dying. Dies on 02/09.

VP – 03/09.

Coroner – was 03/09.

PB – report given said inaccurate death certificate – should have read gastric haemorrhage, and pressure sores.

Coroner – bleed is documented and unresolved and not necessarily going to stop of own accord.

PB – unlikely. People bleeding early on may stop but where rebleed have to do something to make it stop.

Coroner – options at that stage?

PB – 25/09 nursing staff first noted bleed. Seen by doctor on 26th. If decided for active treatment then would have had to be transferred back to QA, had blood transfusion, taken to ICU, had endoscopy to look into stomach to see ulcer, also can be injected with adrenalin to stop blood. In number of cases would stop it but if not then would require surgery. 20% mortality for normal person but risk much higher for Mr Packman. All part of balance.

Coroner – terminal event = GI Bleed, and pressure sores and morbid obesity.

TL – GP in late 60's at time of admission. Substantially younger than other patients. Falls into slightly different category?

PB – one of factors to take into account but don't make decision based on age.

TL – geriatric care doesn't necessarily apply here.

PB – older you get less reserve you have.

Coroner – health section cannot be ageist? Treat people to best of ability regardless of age.

PB – yes long time ago there was a rule about this. Now no longer any rules – cannot use age as pure determinant of care.

TL – in GWMH for 11 days. On 3rd day became acutely unwell – 26th.

PB – *nurses said vomiting on 25th.*

TL – acutely unwell either second or third day. PB says because of GI bleed. That he ultimately died from. Not the cause of death attributed at time of death. Appears those responsible for care didn't know cause of problem?

PB – seen by consultant who was clear GP bleed two days before death. Clear consultant was aware.

TL – any evidence that Dr Barton knew what was going on? Will have seen Dr Wilcock's report.

PB – seen some.

Coroner- sent report to PB.

PB – not received any report from coroner.

TL – Wilcock reaches a number of similar conclusions. Says omission to adequately assess GP's condition. Omission to obtain blood test results, not discussed with on call medical team, and lack of discussion with colleagues.

PB – no records no.

TL – GP also put on excessive doses of drugs.

PB – doses would need to be justified. Struggled to find what dose was. 60mg would be very much at top end of dose, but was younger man very obese.

TL – is justification recorded in notes.

PB – cant sanction decision until heard from Dr Barton. Has to explain to jury and coroner why she gave those amounts.

TL – Wilcock says peptic ulcer most likely cause of bleed. Something which can be reversible.

PB – yes, discussed that.

TL – instead of problem being addressed he was commenced on palliative regime of pain relief.

PB – yes.

TL – instead of rehab care we move to palliative care.

PB – doesn't follow. Issue about assessing all problems at that time. Feel important to have had review of all issues and involve everyone.

TL – 11 days before death when admitted was admitted for rehab.

PB – yes to treat acute medical problem.

TL – rehab treatment recorded in notes as reason.

PB – yes. Became immobile because of infection. Expect to resolve that and get him back home.

TL – jury will in due course hear from VP, daughter who will say GP made good progress and keen to go home. Everyone seemed positive and he was happy. Pg 54, assessed at GWMH. Included in findings – little to find on examination bar pressure sores and obesity.

PB – bartel and waterlow score also recorded.

TL – nothing in that entry to record terminally ill.

PB – agree with that.

TL – during first two days sat up in bed, cheerful, eating and drinking properly, never complained of pain or showed signs of pain. Never saw him out of bed despite being there for rehab. Notes then mention passing

blood rectally. Seen by Dr Barton 26th, believes nature of problem may be heart attack, treat diomorphine and oromorph. Alternative = GI bleed, not well enough to transfer, keep comfortable, happy for staff to confirm death. No observations re heart rate, temperature etc. Those should be in medical notes?

PB – yes would expect that.

TL – when condition changes for worse, medical examination should be carried out and recorded in notes.

PB – yes.

TL – not appropriate to rule out GI bleed.

PB – if ulcer in stomach blood will accumulate in stomach, may vomit. Some just feel unwell and blood passes through.

TL – Dr Barton decides not to transfer. Doing nothing here where evidence of earlier bleed would mean likelihood of death.

PB – yes.

TL – consequence of her decision not to transfer that he died.

Coroner – no consequence of his condition that he died. Decision of management is a different matter. Doing nothing was one of options PB mentioned. May have observations on that.

TL – decision making process required balancing act of risks involved.

PB – risks of transfer very low. Lot of discomfort but transfer risks low. What then happens is crucial. Would expect input from senior consultant then, and expect them to be involved.

TL – Dr Barton couldn't make that decision?

Coroner – consultant only did fortnightly ward round. Dr Barton there making the clinical decisions. Difficulty in saying consultant should have been there. Should Dr Barton have expanded decision making process at that point?

TL – clear not consultant there at all times, but consultant was contactable. Had GP been moved then would have been a consultant available.

PB – in difficult situation appropriate for clinical assistant to ring consultant.

TL – process of transfer itself low risk.

PB – yes. Not necessarily easy or without discomfort but low risk during actual transfer.

TL – in event of Dr Barton not being able to reach consultant she could have had him transferred to hospital where appropriate care could have been given.

PB – yes.

TL – blood tests arrived when?

PB – possible results arrived a week later. Had to be something proactive by doctor to ensure blood report available.

TL – as result of not transferring and not receiving treatment he died.

PB – he died from haemorrhage yes.

TL – starting dose of 40mg diamorphine higher than most would given.

PB – may have original version of report?

TL – statement given to police.

PB – re reviewed notes last year to try to fully understand drug chart. Still not certain but think started morphine 60-100mg a day then received 40mg diamorphine. If started on 100mg oral morphine that is higher

than normal starting dose. No justification for this. If no problems with this dose though then no problems with 30-40mg diamorphine as starting dose. No explanation for high doses.

TL – will hear from VP that within 3-4 days very sleepy but could talk. Not able to hold cup. Change very dramatic, became progressively worse. Family believe due to excessive dose of analgesia.

PB – possible. Could also be because continuing to bleed and becoming more anaemic.

TL – given surprising decision probable that decision to hasten his death?

Coroner- not why we are here.

TL – here to establish cause of death.

AJ – cause of death was natural causes.

PB – GI haemorrhage.

AJ – report says GP died of natural causes.

PB – just said died of haemorrhage.

AJ – pg 16 of PB's report, para 6.8. on 26th Dr Barton makes decision too ill to transfer. Decision is complex and serious decision should be discussed with patient and consultant and families. No evidence in notes. Mention of discussion with Dr Barton in notes.

PB – didn't find that. Would be a number of opinions on this matter. Difficult to say must do one thing or the other.

AJ – clinicians may take different approaches in treatment.

PB – should not be case that doctor knows best, doctor should provide information and help come to a decision.

AJ – as far as opiates concerned, diamorphine required to control symptoms.

PB – apparently. No side effects noted.

AJ – if talking to daughter wasn't overdosed.

PB – obviously wasn't unconscious.

AJ – Dr Reid happy with management. Later that day diamorphine increased as previous dose not controlling symptoms.

PB – nursing notes note syringe driver should be increased to deal with pain. Thats why assume dose increased.

AJ – in relation to decision whether to transfer chance of surviving surgery very small. Within boundaries of reasonable clinical decision to treat symptoms only. Decision taken in previous hospital not to resuscitate.

PB – not necessarily linked. Doesn't mean shouldn't give all other medical treatment. Wouldn't influence decision about operation.

AJ – means family spoken to and knew bad condition.

PB – might imply that.

Miss Bannard – decision to do anything else well past by 01/09. 01/09 first time Dr Reid saw patient. By that stage death inevitable. In report PB considers prognosis. Notes gross obesity, pressure sores and catheterised.

PB – at that stage simply possible GI bleed.

TL – moved away from that?

PB – every version of report uses same words. Complex pressure sores terrible, patients often deteriorate despite care in hospital.

AJ – used to say invariably deteriorate.

PS – nothing to ask.

Jury – likelihood he would have died anyway. Would you have given him the chance of surgery?

PB – up to surgeon to make that decision. Would be long, drawn out and distressing for everyone if surgery done. Give options and chances where possible.

Coroner – obesity and prospects of surgery in face of that are major factors. Hopefully Dr Barton can help with this.

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Devine

PB – ED 88 years old on final admission. Been doing well. In march 98 seen as outpatient as infection of leg, heart trouble but managing and ok. Also seen orthopaedic clinic and found to be fit for knee replacement. Key point. Something started going wrong early 99. Notes say renal function significantly deteriorated. Now significantly abnormal. Seen by geriatrician – moderately frail. Difficult to define. Referred to renal specialist and haematologist. Found irreversible progressive renal failure with problems including loss of protein causing swelling in legs, nothing reversible. Small kidneys shown up on ultrasound. If younger patient then consider transplant or dialysis. Can see rapid change in short period. Also found to be blood abnormality – plasma cells in bone marrow produce lot of protein. Probably doesn't have big impact on its own, may result in more infection, or may show other infection going on. 5-10% would eventually develop cancer of those cells but no evidence here. Progressive problem which will eventually end in death at some stage. 09/10 admitted to QA with confusion and aggression recently got worse. UTI infection? Common in elderly people. No evidence found for this. Remains distressed and agitated. CT scan of brain shows changes, patchy low density consistent with small vessel disease. Happens where small strokes take out parts of brain. Don't know its happening, silent condition. Causes irreversible brain damage. Can be related to kidney problems. Would appear disease of small vessels in brain and kidney. Psychiatrist notes underlying dementing illness. Doesn't really settle, cooperative and friendly but tends to get lost. Would almost certainly need care in care home when left hospital. Can take time to organise so transferred to GWMH. Functions relatively well – can wash, mobile but remains constantly confused. Started going wrong between 01-18th November. Starts wondering, aggressive, restless at night. ? UTI infection, no evidence of infection. Keep looking for reversible causes for increased confusion. By 19th confused and aggressive, blood test done. Shows kidney function got much worse. No doubt it is progression of renal disease that is cause of death. Trouble on ward managing restlessness and aggression. Given Fentynyl – not sure why started. Would need to check with Dr Barton. Unusual drug to start as takes several days to have effect. Not what would use for instant relief. Subsequently started on syringe driver with 40mg diamorphine and 40mg medazolan on 19th.

Coroner- one of points raised was cross over of fentynyl and diamorphine. Residual effects?

PB – problem is difficult to know what effect fentynyl has as takes 3 days to get to steady state. If patch removed immediately then levels would start dropping but if left on when driver started would increase levels.

BR – takes 1 day to reach maximum effect and lasts for 3 days.

PB – not an expert on this. Further deterioration overnight on 19th. By now terminally ill as result of renal failure. Written up for diamorphine and medazolan. No pain documented so query why used diamorphine, and starts on 40mg. After starting this is comfortable, dies 58 hours after diamorphine started.

Coroner – uses of diamorphine. Stressed for pain relief but also to solve problems with agitation and anxiety. Here ED distressed.

TL – asked PB be provided with copy of records for ED.

Coroner – cause of death?

PB – would say renal failure and multiple infarch disease and IGA.

TL – short table similar to AC.

Coroner – check accuracy and give to jury if ok.

TL – ED 88 years old with history of kidney problems. Described as frail.

Coroner –important to remember PB Not seen any of patients.

TL –prior to 18/11 no previous analgesia. When originally admitted oromorph written up on admission. PB described this as unusual. Whatever justification poor clinical practice. ED's introduction to opiate analgesia was at 9.15 on 18/11 when given fentynyl patch. Are circumstances where may be appropriate to give patch, outlined in Wessex guidelines. Useful where difficulty swallowing or vomiting, or constipation. Pg 9 headed use of morphine. Suggests minimum patch to be applied is 25micrograms. That is what was given to ED. Beneath that conversion table giving indication of morphine equivalent for this = less than 135mg morphine. If recommended starting dose is 30mg for elderly patient then patch is equivalent to more than 4 times starting dose.

PB – outside area of expertise as don't use fentynyl.

Coroner- asking wrong person.

PB -would guess divide it by 3.

TL – patient information leaflet on fentynyl. Slow release patches. Might take up to 24 hours before full effect.

PB – strong opiod, can cause serious side effects including breathing problems which can be fatal. Only started if using other opiods. Not use unless opiod tolerant, tolerant if taking at least 60mg oral morphine daily or 8mg oral hydromorphone daily for week or longer.

TL – don't get it unless opiod tolerant.

Coroner – PB doesn't use fentynyl.

TL – pg 2 – only for patients with chronic pain round the clock expected to last 3 weeks or longer.

PB – should not be the first opiod medication prescribed. Do not use if not already using other opiod medication.

TL – pg 6.

PB – do not take other medicines including prescriptions and non prescriptions. Be careful about other medicines which make you sleepy.

TL – include diamorphine?

PB – yes. Serious side effects including troubled breathing which can be fatal. Should seek urgent help if feel faint, dizzy and confused. Can be symptoms of overdose or dose too high. May lead to death or serious problems if not treated right away.

TL – ED did not meet the criteria for opiod tolerant.

PB – agree that.

TL – no record of her being in chronic pain.

PB – correct.

TL – leaflet makes it clear fentynyl should only be given where chronic pain.

PB – made it clear no reason given for using fentynyl.

TL – patch applied at 9.15 on 18/11, not removed until 12.30 next day. If not fully effective for 24 hours after administration it would have become fully effective at 9.15 that day.

Coroner – PB doesn't know.

TL – will hear from Dr Reid about that. Before patch removed ED given diamorphine at 9.25 on 19/11. When diamorphine began it was at 40mg over 24 hours. Equivalent to 120mg morphine.

PB – between 80-120mg. Fair assumption 120mg.

TL – if conversion table is accurate and 25microgram patch is equivalent to 130mg morphine add the two together (assume 130mg kicks in at 9.30 on 19/11) giving total 250mg morphine.

PB – twice intended dose. Or maybe deliberate. From 9-11 there would be evidence as twice the dose before or after then. Problem = complex.

Coroner – substantial increase in dose for that period. Maths may not be accurate but substantial overdose.

PB – accept that.

TL – may be appropriate to seek guidance elsewhere. If patch becomes fully effective at 9.30 on 19th you have 255mg.

PB – disagree, not mathematically correct. Would suggest get further expertise.

TL – if correct would mean received 8.5 times recommended starting dose on 19/11.

PB – presume removed so not received that. Don't accept argument. Accept received for 3 hours received twice dose.

TL – accept 40mg of diamorphine = 4 times recommended starting point.

PB – yes accept higher.

TL – in light of what must be seen as massive overdose.

Coroner – substantial on any interpretation.

TL – in light of excessive risks with morphine, no surprise death thought likely.

PB – cant necessarily relate those two events. Depends why put on high doses. Underlying problem = renal disease.

TL – para 6.17 PB says overlap between patch and diamorphine unlikely to have major clinical effect. Materially inaccurate statement.

PB – not aware of evidence in notes that it had major effect for 3 hours.

TL – not just 3 hours. If have overdose on one day it may result in death days later.

PB – would expect if patient received too much then should see evidence then of unconsciousness or breathing problems. Would expect death to be quicker. Patient apparently ok later.

TL – does this fall outside expertise?

PB – which bit?

TL – whether overdose on 19/11 may have caused death?

PB – interpreting notes can do.

Coroner- if effect of overdose then effect would be there and then? Doesnt happen 3 days later.

TL – death happens if effect on level of consciousness.

Coroner – chain of events. Over 3 days?

TL – thats what we say happens here.

PB – nothing in notes to support this.

TL – justification for giving amount made on basis that not decided terminally ill. Decide whether or not to offer palliative care. Analgesia given done on basis of appropriate decision that ED terminally ill.

PB – yes accept that.

TL – given in 99 fentynyl licensed for chronic pain would expect appropriate if in that pain.

PB – no evidence of justification for using this.

TL – reference to sore mouth on 18th (pg 405). Reviewed on ward. No comment about chronic pain. Pg 156 entry by psychiatrist – deteriorated, aggressive and restless again. Not eating well, physical condition stable. No reference to chronic pain. If chronic pain on 18th would expect it to be obvious to relatives.

PB – yes. But she was confused.

TL – jury will hear from Sandra Briggs who saw her on 18th, not aware of chronic pain.

Coroner- PB says no reference of chronic pain in notes.

TL – given strength of patch, decision she was terminally ill would have been taken before applying patch.

PB – would need to clarify why patch used. Cant tell that from notes.

Coroner- difficulty = notes signed. PB can only go on what is in notes.

TL – when admitted, admitted for rehab.

PB – admitted for assessment. Moving to rest home but yes happy to call it rehab.

TL – at 18th and 19th ED terminally ill.

PB – physical status deteriorated. Evidence in notes of increasing confusion.

TL – mental state at time admitted to GWMH. Pg 154 Dr Reid – entry 25/10. Records mobile, unaided, washes with supervision, continent, records blood pressure. Refers to chronic renal failure. Dr Reid sees her again on 01/11. Confused and disorientated. Dr Reid says element of confusion may be alleviated by going home. Doesnt go home. By 11/11 deteriorated, further drug prescribed for treatment of agitation, restlessness and confusion. On that between 11-15 20mg per day, 16th 10mg and 17th 10mg. Notes then say that drug no longer required. Assessed by psychiatrist on 18/11. Psychiatrist says appropriate for waiting list at mulberry ward. 18th was when patch administered. No indication here that terminally ill.

PB – no but concerned. Deteriorated and not eating well.

TL – number of elderly patients get aggressive or confused but doesn't mean terminally ill. Dr Reid says no marked change in condition between 25/10 and 1/11. On 1/11 sees her again, main focus was confusion. Nothing about physical condition causing concern. Then concern may have developed infection, on 11th given antibiotic for 5 days. Blood tests show no evidence of infection. Nursing records on 15-16th no indication physical state such she is likely to die. Psychiatric review on 18th records physical condition stable. Seen by relatives on 18th, no indication in terminal state of decline. On 19th jury heard incident involving ED where in confused state suggested she threw staff into book case and had been pulling patients out of bed. Seems unlikely from physical state she was in state of terminal illness on 19th.

PB – disagree. Certain medical condition dies of = renal failure. Clear evidence of rapid deterioration of renal condition. Goes along with deterioration in mental condition.

Coroner – PB suggested may be similarity between renal and brain problems.

TL – give other reasons why may be in terminal decline.

PB – marker of severity.

TL – jury need to understand what caused her to die. Length of time in hospital not relevant.

Coroner – worthy of note but will direct jury on this.

PB – in terms of managing symptoms overwhelming problems easier to manage on psychiatric ward.

TL – had been having blood tests throughout the year.

PB – unusual for blood tests to be done by community hospital.

TL – was suspected infection.

PB – would be a reason then. Someone obviously saw her and was worried about something.

TL – was having regular blood tests. None of blood tests noted terminally ill.

PB – no but noted progression of renal failure.

TL – between 9/11 and 16/11 marked increase in cretatine level. Marked decline over 6 weeks resulting in death. Based on blood tests.

PB – yes.

TL – look at blood tests for 6 weeks prior. Pg 355. Rather than indication of progressive kidney failure, recording on 9/11 was lower than September level.

PB – accept little difference.

TL – speculation. Any justification? Told jury marked deterioration over 6 weeks before death. Cretanine level on 06/09 203, on 18/10 201, on 21/10 161. Would suggest kidney function improving.

PB – on 09/11 201, 16/11 360.

Coroner – from 21/10 onwards marked deterioration?

TL – want to understand changes.

PB – started with cretanine of 90, increased eventually to 360. Accept over that period was a big change.

TL – not pattern of progressive deterioration. Increase between 200-360 coincides with time when ED receiving antibiotic.

PB – yes it does.

TL – aware where someone receiving that it may cause significant reversible increase in cretanine.

PB – rare side effect.

TL – product information sheet for althrin. Pg 3

PB – should not be given in severe impairment unless blood can be monitored.

TL – suggests should not be given in cases of severe renal impairment. On 09/11 when ED commenced on antibiotic wasn't in severe impairment.

PB – not sure. Was blood test done on 09/11?

TL – yes cretanine 200. If given appropriately would suggest not in severe impairment. On 16/11 get raised cretanine level.

PB – yes accept that.

TL – could be due to drug.

PB – yes.

TL – cannot infer severe renal impairment from raised level on 16/11.

PB – no clearly had severe renal impairment. Drug may have raised that. Was stopped though.

TL – increase was reversible though.

PB – if caused some of that deterioration then yes should have been reversible.

TL – if acute renal failure could have been treated by stopping diuretics and other antibiotics?

PB – depends on cause of deterioration. No evidence that due to acute dehydration. If due to drug then it was stopped.

TL – PB assumes there was a deterioration based on cretanine results. Cretanine levels may be related to drug. If is then would not indicate case of irreversible kidney failure.

PB – would have been dip with chronic irreversible condition.

TL – state patient already frail with cretanine level of 200 can have rapid decline. No evidence of rapid decline.

PB – disagree.

TL – if dying of kidney failure would be lying down and feeling unwell.

PB – can be symptoms yes but here systemic illness affecting brain too. Can die suddenly of kidney failure.

TL – here told jury progressive condition.

Coroner – progressive condition surely.

TL – if dying from kidney failure then would manifest itself in lying down and feeling ill.

PB – complex question. May get anaemic, breathless, tired. Both issues happening together here – physical and mental.

TL – also refer to falling haemoglobin. Recorded as 9.9 on 09/11. Increased since previous reading.

PB – both low. Take evidence of haematologist. Progressive renal disease will result in chronic anaemia.

TL – Will hear from Wilcock in future who says symptoms not consistent with progressive renal decline. He says would expect to see more graduated approach.

PB – not seen his report.

TL – accept opiates in excess of what would be expected.

PB – agree as no justification.

TL – in patients agitated or confused can be appropriate to give medazolan – max dose 20mg (ordinary dose) or corpromazine – max dose 12.5mg - 25mg. BNF said reduction in dose for elderly people. When treating patient for agitation use one of above, not both?

PB – start with one or other. If difficult problem may have to add drugs.

TL – to assess whether one had worked would have to wait 2-3 hours to see if any effect. Unsafe to administer both together.

PB – wouldn't start that. Would wait 3 hours before doing anything.

TL – on 19/11 at 8.30am ED administered 50mg corpromoazine. Received 2-4 times recommended dose.

PB – would have to be good justficaition.

TL – less than an hour later given 40mg medazolan.

AJ – in syringe driver.

PB – yes in syringe driver.

TL – say this is 2 times recommended dose.

PB – for most older people use lower dose, BNF says 40-80mg.

TL – effects cumulative? If too much diamorphine and corpromazine and medazolan would increase risk of death?

PB – would increase side effect and death depending on amount.

TL – if 2 times dose then at least 4 times drugs to deal with agitation.

Coroner – accept substantial overdose.

PB – 2 drugs simultaneously on high starting dose.

TL – at time when fentynyl likely to be reaching maximum effect.

PB – yes 3 hour overlap.

TL – 40mg diamorphine 4 x recommended dose. As far as fentynyl concerned get expert evidence.

PB – yes.

TL – 20/11 ED visited by daughter at 9am. Will hear from daughter that at 9am appeared to stop breathing for long periods and would then take a deep breath. As explained yesterday = classic example of respiratory depression following overdose.

PB – accept it could be.

TL – result of that that ED died.

AJ – trimethaprin given at QA?

PB – don't know.

AJ – if given overdose would be a respiratory death. May affect breathing centre in brain. Message to lungs wouldn't get through. Don't stop breathing today and die two days later.

PB – no.

AJ – asking PB to look at drug chart. Prescription written at beginning of November for trimethaprin. Ever given?

PB – copy in his notes imply trimethaprin given from 11-15th. Could be page missing. Was given from 11th.

AJ – also suggest given in QA in octobre.

PB – given an antibiotic but not sure what

AJ – reach the conclusion that ED had physical and mental problems. Deal with various aspects of treatment including decision to start her on patch on 18/11. Clinical entry for that date from psychiatrist. Dr Taylor writes deteriorated, restless and aggressive, not eating. On occasion aggressive and confused.

PB – giving medication to people in that situation difficult. Getting their consent is difficult too.

AJ – fentynyl can be used as patch giving slow release over period of time.

PB – yes.

AJ – not written in records why fentynyl used. What would you have done?

PB – need expert mental health nursing. People very confused better nursing in that environment. Would probably have given injection. Needed to deal with underlying problems.

AJ – given manufacturing document for fentynyl. Would normally look at BNF. Manufacturers document may have number of cautions to prevent manufacturer being sued. Will look at BNF instead. BNF does contemplate giving it to patients who haven't previously received medication.

PB – says mentions cancer patients already receiving other opiates. Would have to follow audit trail through. Patients not previously received opiate patch should be replaced after 72 hours. Previous analgesic therapy should be phased out.

AJ – patients not previously receiving opiate suggest 25microgram patch. Provided here.

PB – what patient received.

AJ – appropriate. Evaluation of effect shouldn't be made until patch worn for 24 hours. Happened here. Patch worn here for 27 hours. If another form of medication started then would anticipate doctor considering effect of patch. Fentynyl will remain in system for 22 hours.

PB – replacement therapy should be started on low dose and raise as fentynyl leaves body.

AJ – concentration of drugs. If produce chart showing concentration, could chart concentration of drug in body.

PB – yes sure an expert could.

AJ – what is relevant is how drug gets into blood stream. If intra muscular drug available fairly quickly but not as quick as IV. Another route = subcutaneous. Slower again. Less effective in elderly patients.

PB – yes possibly.

AJ – also other routes – swallowing, available through blood stream at more gradual rate. With patch drug released at gradual rate over time. Also consider half life, i.e how long drug stays effective in system, some quick others longer acting. TL suggested if patient received higher dose they may die several days later. Nonsense.

PB – 3 hours where peak dose would have been highest risk.

AJ – at time of death drug would have been out of system.

PB – yes understand that from BNF.

AJ – any concerns re risk from excessive opiates long passed at time of death.

PB – peak time of risk is that 3 hour period.

AJ – said ED received good palliative care for symptoms in relation to medication provided. #PB – comfortable and without distress.

AJ – report of Dr Dudley?

PB – no.

AJ – specialises in kidneys. Jury will hear this in due course. Treated appropriately in terminal phase of illness with strong opiods to deal with pain and ensure calm to enable nursing care and to maintain dignity. Agree?

PB – remain concerned about dosage levels given. Would want to see or hear justification. Cannot tell from notes.

AJ – would acute confusional state be common? Death from renal failure can be characterised by acute confusion.

PB – agree.

AJ – asked to comment on use of strong opiods. Commented strong opiods commonly used in terminal care for those in renal failure to ensure comfort and calm. Para 6.15 PB report – report 2005, may have been updated. Said PB's opinion by 19/11 terminally ill and reasonable decision to come to this conclusion. 18/11 day when seen by psychiatrist, deteriorated etc. Not all clinicians would come to same conclusion.

PB – added that more rapid deterioration possibly due to use of fentynyl on top of everything else.

AJ – having decided terminally ill, next decision to offer terminal care or not. Now inappropriate not to provide high quality palliative care.

PB – now said appropriate to provide it.

AJ – emphasise earlier report. Overlap unlikely to have major clinical effect. Also discussion with member of family. Son involved heavily, daughter to become involved on 19th.

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Gregory

PB – 91 years old when admitted. History of damage to lungs over years. In 95 clearly documented to have severe heart failure. Episode of double vision, may have been due to small stroke. Seen by psychiatrist thought may be early dementure but nothing more came of it. Severely ill when admitted. Extremely lucky to survive. Nothing else in notes until august 99 with acute fractures necofemur. Never recovers after op. Complications after this operation. Swollen leg, constantly confused, delirium, early dementure, diarrhoea, doubly incontinent. Increasingly unlikely to return home. Seen by consultant who queries whether will leave

hospital. Transferred 03/09, highly dependent – bartel 3-4. Another neurological event – small stroke. 2 months when reviewed regularly and makes no progress. Confusion, remains catheterised, remains incontinent.

Coroner – difficulty with healing of femur?

PB – not on this case. Not going to recover now. Left with severe disability. Episode of vomiting. 15th examined, unwell but no real conclusion. Distressed and breathless. Decide to start oral opiates to deal with breathlessness. Cardex reports her as poorly. Further decline. Fast heart rate. Relevant examination says chest is clear. Receiving 20mg oral morphine a day from 15th, then started on syringe driver. Continues to deteriorate and dies on 22nd. Had long standing severe illness, didn't recover from operation. Pulmonary embolism likely to be cause of death – side effect of stroke, swollen leg etc side effect of that. Would also cause breathlessness etc. Also cardiac failure, and , ischemic vascular cerebral disease, fractured necofemur also likely to contribute.

Coroner – progress in her nothing remarkable.

PB – slow decline following fall and operation. Not uncommon picture.

Coroner – opiates administered latterly any comments?

PB – clearly breathless and distressed. Started 20mg oral morphine. When converted to syringe driver given 20mg a day could be at upper limit of normal. Not exceptional but could require justification.

TL – nothing to ask.

AJ – nothing to ask

PS – nothing to ask.

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Mr Wilson

Coroner - 74 year old.

PB – admitted 23/09/98 with fracture of left upper arm. Very painful fracture. Unless able to pin it will continue to break. A & E decided to operate and pin. Well documented severe alcoholic liver disease documented back to 94 but in 97 admission to hospital showed damage to liver and other complications. If take alcohol to excess over long period of time you get liver damage –inflammation, and scarring. Liver begins to fail. It produces a number of important proteins. May start to accumulate fluid, stop producing vital proteins, get expansion of blood vessels, enlarged spleen, likely to result in fluid in abdomen, may get toxins building up, confusion, coma, restlessness, can lead to death as chemicals not being removed. In 97 scan of liver shows problems, jaundiced, fluid in abdomen. At A & E he refuses operation but kept in. Next day vomiting. Now decided too ill to operate. Do other tests which show problem with platelet count, haemoglobin falls – may be bleed somewhere. Impaired renal function. Given morphine for pain in arm – appropriate. Could be cause of vomiting. Alcohol also withdrawn, could be another reason for vomiting. Deteriorates over 2-3 days. Not eating, in pain, restless, arm becomes swollen. View then that wont be fit to go home even if arm can be sorted. Catheterised, incontinent. Then improved and becomes more alert. Reviewed – may be dementure, alcoholism, notes speech slurred and sleepy. Social services then say too fit for nursing home but still pain in arm. Weight 103kg on admission, by 14/10 was 114kg. Not food – is salt and water. Mental state improves but severe liver disease and fluid retention. 12 or more litres being retained. Severely restrict recovery. No doubt that pain after morphine better (5 doses in total throughout stay 2.5mg or 5mg) also given paracetamol and codine. Think on admission had change in mental state associated with liver failure. In pain, received morphine, may have had small internal bleed, alcohol withdrawal, started on sedative drug. Went downhill but started to improve again. Any or all could have changed to allow functional state to improve. If at this state

critical issue = improve overall medical condition and stabilise liver disease, deal with fluid, weigh him daily. Hope improve over time so he could have an anaesthetic. Pain in arm wont go away until deal with pain in arm. QA managing this with paracetamol and codine prior to admission to GWMH. When arrives at GWMH not written up for paracetamol or codine. Is written up for oromorph 10mg 4 hourly. 10mg 2.45 and 10mg 23.45. don't understand why written up for analgesia received in QA, and no evidence for why given strong opiates without other pain killers. Then starts on 15th 10mg oromorph x 5, 10am 10mg, 2pm 10mg, 6pm 10mg, 10pm 20mg. On 16th declined overnight, shortness of breath, weak pulse, query silent heart attack and liver function. Suggest increase diuretic to deal with gross fluid problems. On 16th 10mg at 6am, 10mg at 10am and 10mg at 2pm, then diamorphine pump started 4.10pm with 20mg diamorphine and 20mg medazolan. 19th – comfortable at night, rapidly deteriorating. Cardex notes bubbly chest, hyoceine added 17th. Fluid suctioned 17th, deteriorated 18th.

AJ – died on 18th.

PB – to check notes.

PS – reference quoted is to 17th. Pg 179 – easy mistake to make as entry poorly written.

PB – 17th, comfortable night, rapid deterioration between 16th and 17th. Died 18th. Concern = understanding rapid deterioration after admission. He gets rapid complications from liver disease, in severe fluid overload, begins to affect chest. Dies of complications from alcoholic liver disease. Problem = well documented in notes that morphine can be precipitant. In using it on 15th has to be very clear justification that use of it outweigh potential side effects. Liver disease makes side effects more likely. Books advise clinicians to take greater care in this case. Were all risks and potential downsides understood? Could have been developing chest infection due to fluid on lungs. Confident died from liver disease, but not able to decide whether treatment received made that more likely or not.

Coroner – alcoholic liver disease = cause of death?

PB – yes complications from this caused death.

Coroner – more comfortable with alcoholic liver disease. Don't need to specify complications.

PS – cant exclude Mr Wilson may well have died as result of coma induced by prescription for oromorph. Coma a result of physical state already existing, i.e. serious alcoholic liver disease.

PB – said cant exclude that.

PS – refer to fact there has to be clear justification for use of oromorph.

PB – agree.

PS – find that in notes?

PB – no.

PS – in context would have sought or should have sought advice on that?

PB – normal expected practice would be to put justification in notes.

PS – look at state of Mr Wilson's health on transfer. Best description provided in pg 21 of notes.

Coroner – nursing home placement on discharge.

PS – concerned with entry for 13/10 from social worker summarising review of medical team. Continues to require special medical care. Right foot already about to break down, oedema. 24 hour hospital care until healed arm. Pg 26 – 12/10/98 – until 08/10 Mr Wilson reluctant to eat. Concern about nutritional intake, nutritionist involved.

PB – happy with that statement.

PS – good breakfast taken, pain when being cared for, refused to be weighed. Arms hands and feet remain swollen. On 13th weight increased. For discharge to dryad ward, no complaints of pain. On morning of discharge slept well, no pain. Sense of well being improved.

PB – cerebral status improved.

PS - Pg 179. Needs help in all daily needs, continent. Bartel score of 7. Plan gentle mobilisation. Complaints of pain in arm – assumed in pain, his complaints were fewer.

PB – yes according to cardex notes.

PS – aware of Hamblin?

PB - Read Gillian Kimberly. Aware nurse Hamblin.

PS – clinical sister on Dryad. Provided series of statements. 11/06/05 statement – pg 4. Refers to checking in procedure at Dryad. Would ring transferring ward to get more info on patient. Notes implied multi organ failure, assumed admitted for terminal care. Is that conclusion justified?

PB – couldn't justify that conclusion.

PS – does that inform treatment he did receive?

Coroner- recognised pattern of treatment.

PB – would expect someone ill to be assessed by doctor who would make clinical decisions. Would discuss with nursing staff. Medical staff would be in charge.

PS – appreciate not a patient of PB but on view not transferred for terminal care.

PB – no not for terminal care.

PS – on 14/10 drug chart starts page 258. Confused about an entry on 15/10.

PB – on regular paracetamol. On admission written up as required but never given.

PS – was written but not given. Any reason why?

PB – don't know.

PS – On 14th prescribed oromorph at 14.45 10mg.

PB - Cardex crossed out regular and put PRM. Inappropriate way of dealing.

PS – any justification for change in regime?

PB no nothing in records.

PS – change clinically justified?

PB – nothing in notes to explain why decision made.

PS – although now familiar with introduction for ormorph, in context of problems here what would you have expected to find to justify oromorph?

Coroner- any reason at this point to introduced oromorph?

PB – may have been reason but not justified. Nothing in notes.

PS – step 1 – step 3 change on Wessex protocol/ ladder.

PB- important to conduct full examination on admission.

PS – pg 278 – nursing care plan on transfer. 14/10 – had to change mattress, restless at times, used urinal with assistance. Oromorph 10mg given for pain control. 15/10 settled and slept well. On 14th conscious – wants to stand and is assisted to do so. Any reference on 14th or 15th to pain control?

PB – no.

PS – in terms of contrasting physical state anything to suggest physical pain had worsened?

PB – no.

PS – are we entitled to conclude from nursing care plan that Mr Wilson was conscious?

PB – yes. He wanted to get up so yes.

PS – looking at clinical records (pg 179) entry covering 15th at all?

PB – no.

PS – is this record used by clinicians?

PB – yes, no other medical notes.

PS – turn to 15th. Prescription regime then introduced on 15th – settled and slept well, oromotph given at midnight 20mg, good effect, 10mg given 0600 hours. Prescription details on pg 261 no entry for 15th.

Coroner- 15th was given at midnight so would be recorded on 16th.

PS – just read note from 15th.

PB – notes difficult to get chronology.

Coroner – just misunderstanding.

PS – anything from note in 15th (nursing care plan) relating to pain or restlessness?

PB – bits showed earlier didn't mention pain.

PS – anything on 15th or 16th indicating whether or not Mr Wilson is conscious? (pg 278)

PB – says difficulty in swallowing medication. If unconscious couldn't even attempt this.

PS – assume conscious then. Night of 15th-16th has declined with shortness of breath (pg 179). Can you exclude possibility overnight that he went into coma as result of medication?

PB – no cannot exclude it.

PS – given what known about Mr Wilson's condition and assume that prescription was justified on basis of pain, was prescription at that level justified?

PB – in presence of severe liver disease would be normal to start with lowest dose possible and work up. Previous doses at 2.5 and 1 dose at 5.

PS – feasible to start oromorph at those levels?

PB – yes. Might have been proper to do so.

AJ – clarify how oromorph given? Oral or injection?

PB- records show given intra muscular for last 2 doses but previously IV and subcutaneously.

PS – on 16th syringe driver introduced at 4pm. Diamorphine 20mg and hyoceine 400mg. Little bubbly when repositioned. More secretions during night, not distressed, appears comfortable. Understand use of syringe driver and increase in drugs?

PB – cannot find from notes a justification for those changes?

PS – if Mr Wilson in coma then what would effect of increase be?

Coroner- can we ask that?

PB – might or might not.

PS – trying to establish whether would have meant come would have been deepened.

PB – might have done but don't see how can say that.

PS – on 17th hyoceine increased 600mg as secretions increased. Then increased 800mg, diamorphine 40mg, medazolan added. Appears comfortable, hot at times. Any justification for increases?

PB – no.

PS – Nurse Hamblin's statement – pg 7 and 8 (11/06/05) recounts involvement in his care. 17th hyoceine increased to cope with increased secretions on chest. Diamorphine increased because of increased pain. Any reference to increased pain?

PB – no not found any.

PS – condition continued to deteriorate. No staff recorded reason for increase in notes. Re coma on 15th-16th, on what basis could you justify increasing dose on 17th if remains in coma?

PB – nothing in notes to explain that. Could be an explanation but cannot see it.

PS – nursing care plan – one reason to increase morphine = if apparent distress. Note on 16th says no distress appears comfortable, 17th not distressed, appears comfortable, hot at times. Contraindicate need to increase dosages?

PB – would not give indication of need to increase dosages.

PS – pg 11. Practice for administering diamorphine to control pain was to double dosage. Here trebled in 48 hour period.

PB – conventional process increase 50% over 24 hours but may in certain circumstances feel justified to double.

Coroner – would look for justification. That is what is missing. Should be something in records.

PS – conclusion of PB's report, v2, 95 report. Para para 7.3 – prescription of 50mg oromorph following 20mg give on 14th was not appropriate. Formed major contribution towards decline and deterioration. More than minimally contributed to his death. Still hold that view?

PB – in view of evidence would add 'likely' to form major contribution.

AJ – had fall in sept 98, admitted to hospital. Offered operation on admission but refused. Significant history of chronic drinking led to advanced liver disease. Poor nutritional intake. Poor nutrition increases chance of pressure sores and skin breakdown. Notes say taking half of required amount. Naso gastric feeding considered. Were improvements. Psychiatrist involved. Suggests anti depressant treatment so started on that. Notes mention hope he tolerates it in light of liver and kidney problems. Maybe early dementure as result of alcoholism. Transferred to GWMH. Significant fluid overload. Cardiac insufficiency?

PB – no. Nothing wrong with heart but may give similar symptoms. Liver disease gives fluid all over body.

AJ – psychiatrist suggests dementure.

PB – common with alcoholic liver disease.

AJ – know from prescriptions once admitted written up for paracetamol but never given. Written as required prescription. Also variety of other drugs. Anti depressant, multi vitamins, diuretic, etc. (pg 260). Diamorphine 20-200mg, medazolan and hyoceine also written up. Oromorph given, complaints of pain noted in records but not regularly. 15/10 – commenced on oromorph for pain in left arm. Wife told condition poor. Deteriorated overnight. Oromorph given to good effect. What does this mean?

PB – not sure can be certain. One inference might be if started for pain in left arm that pain no longer there.

AJ – nurses should ask if still in pain.

PB – assumption that have to be able to ask patient. Can assess if unconscious.

AJ – know he declined overnight. Queries silent heart attack and possible liver function for deterioration. Assume doctor prescribing drugs would be aware of what was being given.

PB – yes fair assumption.

AJ – after his visit he is started on syringe driver. Dr Barton not involved here. On 17th (pg 265) slow deterioration, in already poor condition. Dr Peters added to prescription chart – added hyoceine. If r Peters or Dr Natman had concerned would expect them to put line through inappropriate medication?

PB – yes would have opportunity to do that.

AJ – every nurse involved had own obligation re care given to patients. May have a view on medication.

PB – true. Importance of multi disciplinary approach.

AJ – if diamorphine written up as required, nursing staff must be giving information to doctors.

PB – have difficulty with way diamorphine written up.

Jury – ideally stabilise condition and give operation. Anything in notes they were trying to stabilise condition?

PB – when admitted all drugs written up. If intention had been there for terminal care it is usual to stop medication not needed and give minimum needed. Written up for all here.

PS – in light of question, pg 260 prescription sheet see reference to frusamide at top, then multi vitamins etc. After 9pm on 16th frusamide not given.

PB – re written by Dr Natman on pg 261. Says given.

PS – given on 17th?

PB – no. Not sure if could have taken tablets then.

PS – if in coma, what of drugs listed could he have been given?

PB – if in coma then difficult to take all medication.

AJ – any evidence from nursing records in coma?

Coroner – no

AJ – expect nurses to write this down?

PB – would need to check notes.

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Enid Spurgeon

PB – 92 when admitted March 99. Previous problems, heart attack some years before, depression, early dementure. Previously fractured hip – no op needed, and chronic bone disease. Not been provided with Haslar notes so just have hand written summary of transfer. Hip screw – can be mobilised. Incontinent at night, small pressure sore, leg swollen, only on paracetamol as required. Not weight bearing when arrives at GWMH and not incontinent – discrepancy between notes. Nursing plan to sort analgesia. From point admitted continual comments re pain in hip. Difficult to reconcile with Haslar notes. May have been continual pain which wasn't noted, or may have been accident in transfer. Possibilities for discrepancies. Continual pain from nursing notes, doesn't settle, interfering with attempts at rehab. Given 10mg morphine slow release, vomiting. Morphine stopped and given oral codrydamol. Vomiting stops but pain continues. Morphine started again increased on 06/04 to 20mg. On 7th seen by consultant doesn't know why pain. Arranges xray – no evidence ever done or looked at. Starts on antibiotics. Pain must continue despite oral morphine. On 12th syringe driver started instead. At time was on 20mg morphine, 40mg in total. 15-20mg diamorphine appropriate converted dose. Started on 80mg, no reason why this was case. Dr Reid reviews her, believes dose excessive and reduces to 40mg. Same day medazolan increased from 20mg – 40mg. Not sure why. Subsequently dies on 13th. Very elderly – infected wound likely on balance of probabilities, secondary to fractured necofemur. No doubt not mobilising, not doing well and in continual pain.

Coroner – which hip?

PS – right hip.

Coroner – date for operation?

PB – 20/03 from notes.

Coroner – incomplete. Unsatisfactory. Any idea what happened to Haslar notes?

Police – believe we have them, cant understand why PB didn't see them.

Coroner – sad no one here. No questions. Tomorrow – Mr Wilson – first. Dr Barton after that.

AJ – Dr Barton – Lavender, Service, Pittock and Lake.

Coroner- see how far we get with them.

AJ – usual for witness not to discuss evidence given.

Coroner – may be week or so between the matters so make exception here.