DAY 5

Blake Lapthorn

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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: 24/03/2009

Units: 1

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

GWMH Day 5

Dr Black – 'delerium' and 'dementure'. Delerium = acute confusional state. Patient because of illness becomes acutely confused, becomes disorientated. Dementure = impairment of faculties. Can range from very confused to slightly confused. Permanent

Coroner – reports from notes provided, no knowledge of patients?

PB – no. Geriatric medicine = complex. Often a number of problems.

Coroner – Pittock.

PB – Pittock had severe depression. Recurrent admissions to hospital, deteriorated over the years. 2 years before death more frail, drug induced Parkinsons. Losing weight. In bed all time. Beyond care of psychiatric ward. Physical status that needs care. Catheterised, pressure sores, arranges for transfer to long term care. 'wife aware' means doctor thinks patient very frail, coming to end of their life. 11/01 – regular oromorph. Reasonable clinical decision. Terminally ill, no criticism. 35mg oromorph per day. 15/01 – oromorph stopped and syringe driver started. Often reasonable when people stop eating. More pleasant for relatives, better pain control. Some difficulty when converting 35mg oromorph to diamorphine (ratio 1:3) but Wessex protocol may have suggested 1:2. People often get tolerant to drugs so sometimes necessary to increase.

Coroner – starting dose for Mr Pittock more than expected.

PB – Yes more than conventionally expected. Not able to find reason for this in notes. Then started 80mg per day of diamorphine, then increased to 120mg on 18th. Died on 24th. Side effects of morphine = stopping breathing and death. From notes good palliative care.

Coroner- how would you assess level of analgesia that is appropriate?

PB – have to be clear what you are treating. Not just using to treat pain but agitation, distress, breathlessness etc. Good drug for doing that. Decide what symptoms are and then adjust dose to treat those symptoms. Dont want them to be unconscious as may want time with relatives still. Balancing act so conventional approach is go low for first 24 hours. But NB been on drugs for days before switch so assume relatively well controlled. Not clear why change in dose. On death certificate would have put pressure sore, chest infection and drug induced parkinsons, and also severe depression.

Coroner – what would mechanism of death be for pressure sore?

PB – usually sepsis and poor nutrition.

Coroner –from notes seen would that deterioration be a well recognised pattern? Anything exceptional?

PB – no nothing exceptional. Nothing else re Mr Pittock.

TL – Nothing

Miss Bannard – Nothing

JT – Nothing

AJ – Process of Mr Pittock's death – dying man, family appropriately involved. Not untypical pattern of decline.

PB – yes.

Coroner – no family members for Mr Pittock but any generic questions?

CF – Increases in diamorphine which are normally 50% at most. What spacing would expect to find?

PB – have to treat patient in front of you. Patient needs regular assessment. Someone on syringe driver should be seen daily and if not then nurses there to review. Difficulties in hospital when doctors not there every day.

CF – starting dose assessed on idea that patient be kept conscious. Start low dose and then increase as necessary. What sort of dosages?

PB – BNF gives a range. Conventional starting dose talks about 30-60mg morphine orally per day but have to treat patients individually. For diamorphine BMF says normal conversion 3:1 but some books talk about 2:1. 10-20mg diamorphine normal starting range. Could start higher if good reason but reason should be documented in notes. If challenged could then show why.

CF- increase?

PB – increase by 50% each time. But if no relief then possible to double.

TL – in light of CF's issues have couple of questions. Will ask in due course about individuals but now just want general principles. Here to assist members of jury to decide whether acts or omissions in death.

Coroner – here to explain how people came by their deaths.

TL – when considering care given important to differentiate between rehabilitative care and palliative care.

PB – with any patient be clear what goals are. They may and often do change. Passage of time will help. See where are now, start with assumption cure it, make it better, alleviate symptoms, and at worst reduce pain. Deal with pain at same time as treating them. In general two extremes – if admitted with stroke expectation would be care until independent enough to go home. If admitted with terminal cancer or heart disease then going for nursing care as most appropriate.

TL – cancer interesting as if caught early enough then admitted for rehabilitative purposes. Have to be clear why patients admitted.

PB – may do both simultaneously.

TL –once decided no hope for an individual goal of palliative care = prevention and relief of suffering.

PB – agreed.

TL – in offering palliative care should not be intention of carer to hasten death.

PB – agreed but may happen as side effect of relieving distress. Should not be primary aim.

TL – if intention of treatment given is to hasten death then unlawful.

Coroner – significant comment.

TL – intention should be relief of suffering in palliative care. Not intending patient should die. Focus should be on relief of suffering. Before deciding to change focus of care regime from rehab to palliative, doctor must decide whether patient will be responsive to treatment.

PB – may pursue 2 paths and relieve symptoms and try again to cure. Can pursue both. Remember cases when unexpected change. Can be going down palliative care when gets better. Multi disciplinary decision, discuss with nursing team and family.

TL – before giving up on rehab care doctor must be satisfied patient unlikely to respond to further curative treatment.

PB – yes.

TL – because of obvious change in focus from rehab to palliative care this decision must be made with utmost care.

PB – yes. Important decision.

TL – council provides guidance – doctor obliged to perform examination and become familiar with notes. Good clinical care = adequate assessment from notes and clinical examination. Without this unable to form valid decision. Should record decision.

PB – yes. Should be recorded. Rehabilitative care may not be to cure it may be stabilising or slowing process, maximise functional state.

TL – when providing rehabilitative care doctor has duty to apply effective measures which give least risk to life. Number of drugs which can be used to manage care. Risks associated with stronger opiods.

PB – risk with any drugs if used and not managed properly.

TL – strong opiods can be fatal risks.

PB – can also be fatal risks with paracetamol.

TL – one of risks associated = risk of aggravated confusion. Signs of confusion can result in patient getting lost, scared or aggressive.

PB – unusual side effects, most common = sedation. Common in a younger person.

TL – confusion can result in patient becoming aggressive or scared.

PB – not common symptoms but do happen, but cannot remember personal experience of these side effects. Cannot remember someone getting aggressive but is within list of side effects in text book.

TL – one effect = drowsiness. Can result in coma in extreme. When providing palliative care aim = not result in patient sustaining lack of consciousness.

PB – aim = relieve symptoms, not make them unconscious.

TL – if patient = unconscious indicates excessive pain relief?

PB – not necessarily. As people become older and frailer they will spend less time in conscious state whether on opiods or not.

TL – loss of consciousness may result from excessive opiates though.

Coroner – part of balancing exercise between pain relief and consciousness? If patients remaining conscious is there a point where more pain relief required? Concerned as one case where patient lapsing into unconsciousness as pain relief not effective.

PB – job = relieve suffering. If did lead to unconsciousness then ok.

TL – would have to be excessive pain, extreme to justify to state of unconsciousness.

PB – would also include mental distress.

TL – other associated risk = respiratory depression. Chesty symptoms.

PB – can be complication but not related directly.

TL – respiratory depression can flow from excess opiod?

PB – yes, can result in breathing difficulties.

TL – if breathing appears laboured then could be indication that patient suffering respiratory distress?

Coroner – define laboured breathing.

TL – slow and shallow = one example.

PB – if respiratory depression you are not breathless. Patient may take big breaths. Can occur in people very near death from any cause, or death by itself.

TL – possible indication of excessive dose?

PB – accept it is possible.

TL – if opiates excessive they may stop breathing for long periods then take deep breath.

PB – yes could be but could be that they are near death.

Coroner – Mr Pittock – 6 breaths per minute. Not said to be laboured. Is this the kind of pattern?

PB – would be sort of thing expected in someone near death.

Coroner – keen take respiratory pattern that is just decreasing. Point is he isn't reacting but just decreased respiratory effort.

TL – could also manifest itself in slow breathing followed by deep breath. When patient with respiratory depression can be secondary complications eg bronchopneumonia.

PB – yes.

TL – if left untreated can result in death.

PB – yes.

Coroner – saying treatment causing the condition.

TL – if someone loses consciousness as result of excessive dose, on diamorphine syringe driver, may be possible to redress situation by reducing diamorphine or administering antidote.

PB – last resort. Cruel to reverse dramatically pain relief, would be unpleasant for patient. Depends on pain and symptoms.

TL – hyoceine

PB = reduces secretions in the airways. As coming near to death will stop bringing secretions, will have rattle. Hyoceine helps dry up secretions.

TL – opiods aim to relieve pain without losing consciousness. If lose consciousness then suggest opiates may be excessive.

Coroner – not right is it? May be indicative. Question of assessing needs and treating appropriately.

TL – not suggesting one necessarily follows the other but if patient loses consciousness dose MAY be excessive. Given risk to life associated with respiratory distress doctor has duty to apply effective pain relief measures. Patient should be reviewed.

PB – suggested should be regular reassessment.

TL – if adverse symptoms become apparent would necessitate a review of medication.

PB – once this ill will continue on opiods but may move dose up or down.

TL – where patient lost consciousness, diamorphine and medazolan should not be increased?

PB – once unconscious and near death no obvious reason why need to increase. If calm then no need to change things.

TL – hasten death = unethical and unlawful.

Coroner – how do you assess consciousness? Patient demonstrates signs.

PB – every patient will demonstrate different signs. Nurses there 24 hours a day, key to care. Doctors may only be there an hour a day.

TL – consistent with duty to administer care appropriate to administer fluid?

PB – controversial area. Current standard practice = if someone ill and near end of life whether or not unconscious, not normal practice to use drip and neogastric tube. Many studies done here. Seen as invasive.

TL – to not put IV drip would be appropriate to make where treating clinician certain patient going to die?

PB – would have to look at cases but in general right. Clinical decision taken with patient in front of doctor.

TL – still substantial guidance of analgesia.

PB – BNF and Wessex protocol give guidance for this.

TL – version of BNF (jury not seen this). What is this?

PB – booklet produced quarterly by independent body for government which lists every drug which can be prescribed. Gives guidance re where should use and dose ranges and specific areas e.g. prescribing in children and old age. Mentions common side effects. Standard book clinicians use when prescribing.

TL - important to comply?

PB – should be aware of its contents.

Coroner – if don't comply should be reasons in notes why don't comply.

PB – yes.

TL - other document = Wessex Guidelines. Pg 7 deals with pain. Doctor under obligation to identify symptoms and how to deal with it. If don't know what problem is cant treat it.

PB – absolutely. Must assess problem.

TL – pg 11, management of specific pains. Reference to bone pain, muscle pain, etc etc. Important to identify nature of problem. Wessex guidelines suggest manage pain without reference to medication if possible. If not possible then move to medication and analgesic ladder.

PB – yes.

TL – guidelines suggest substandard clinical practice to go straight to strong opiods.

PB – may be exceptions. Cases where know severe pain which requires morphine.

Coroner – not talking about that extreme situation here. Looking at older people with chronic pain generally.

PB – what would expect to have been followed.

TL – appropriate standard would require graduated approach. If then doctor decides only strong opiods suitable there is morphine, diamorphine and fentyl. Because of risks involve there is guidance re dosage in Wessex and BNF. Difficult to predict individuals reaction to opiod. Important to start low and work up gradually, if don't do that then run risk of injury and possibly death. Re amount appropriate to start with, BNF pg 12 suggests starting dose 10-20mg every 12 hours if no other analgesia or only paracetamol taken previously. This equates to 20-40 every 24 hours. Mid point = 15mg average starting dose over 12 hours and 30mg over 24 hours.

PB – yes for morphine slow release. But few patients put on this. Many on oral morphine.

TL – how go from 30mg every 24 hours.

PB – 30-60mg oral morphine, get to faster pain relief by using oral morphine. Always risk of giving low dose and giving another dose before first dose works.

TL – BNF contains passage re prescribing for elderly. If standard between 30-60mg then for elderly patient wouldn't be more than 30 if follow BNF.

PB – yes but comes to individual judgement. Difference between patients. Huge variation.

TL – if 30-60 = normal dose for healthy individual. Half will be 15-30 for elderly patients. Dealing here with elderly patients so first dose should be no higher than 30mg.

PB – yes unless good reason otherwise.

TL – wouldn't want to start more than 30mg.

PB - would need good reason.

TL – some circumstances when syringe driver used. Wessex guidelines suggest appropriate where patient unable to swallow, or vomiting or weakness. Where moving from oral morphine to syringe driver preferred opiod = diamorphine because more concentrated?

PB – yes and also water soluable.

TL – following page = opiod equivalents. 30mg = upper limit. Diamorphine equivalent for this 30mg = 10mg.

PB – yes on 3:1 basis but does vary from 2:1.

TL – BNF pg 12, parental route, diamorphine preferred for injection, can be given in smaller volumes. Difference between ratios – anything from ¼ to ½ or 1/3. Wessex guidelines use 1/3 mid point. Same starting dose of diamorphine = 10mg.

PB – if reason why needed to give more then give higher dose but if stable then yes do direct conversion of 30-10mg.

TL – yesterday put it to witness that starting dose of 40mg of diamorphine was substantially in excess. Witness agreed.

PB – without further information not sure. In general yes excessive but would need more information. Would be in excess of the norm but may be reason why. Not normal.

TL – 4 x usual starting dose pretty unusual.

PB – yes if not had any oral morphine before.

TL – substandard to do so?

Coroner- not going to answer that.

TL – as far as elderly concerned, start on bottom rung of ladder. Older you are less sufficient kidneys are or for different reason?

PB – multiple reasons. Metabolism of morphine metabolised in liver then excreted. Liver disease and function likely to be more important than kidney function. About sensitivity and ageing brain, may be poor absorption. Difficult to predict what will happen. May need more or less.

TL - If elderly person with history of kidney problems added reason for being cautious?

PB – don't normally worry about kidney problems.

TL – active metabolites of morphine are excreted by kidneys.

PB – mostly degradation products. More concerned about liver function.

TL – Mr Wilcock says caution in patients with kidney problems.

PB – don't agree or disagree.

TL – excessive dosage runs risk of adverse injury to health. Greater dose greater risk to individual.

PB – yes.

Coroner – not rocket science. If overdose will die, until then side effects are increased depression and effect on nervous system.

TL – not acceptable to run such a risk in absence of clear evidence it is needed.

PB – no. Doctor shouldn't run unnecessary risks.

TL – anything above 3x recommended dose would be grossly incompetent practice.

Coroner – cant ask that. Need to be careful. If not in accordance with guidelines then ok but don't want judgemental view. Would expect to see reason in notes and in absence of reason would query it.

TL – in ordinary circumstances shouldn't be given then?

Coroner- follow guidelines unless reason.

TL – diamorphine used for relief of pain?

PB – no used for any symptom of elderly care.

TL – no guidance in Wessex protocol here but says medazolan should be choice of drug for irritation. If elderly patient receiving medazolan for agitation and restlessness, addition of diamorphine could be for relief of pain?

PB – yes or relief of other symptoms.

TL – agitation would fall under terminal restlessness. Is a symptom of it.

PB – might be.

TL – if diamorphine too then pain problem?

PB – no not purely for pain relief. If patient had no distress and controlled by medazolan then no need to add diamorphine.

TL – pg 15 BNF.

PB – rare to give less than 2.5mg diamorphine.

TL – issue of agitation, BNF pg 13 restlessness and confusion may require additional drugs. Co-promazine alternative to medazolan?

PB – yes. Widely used.

TL – would need reason to use both together. Appropriate dose – pg 165, initially 25mg 3 x daily or 75mg at night, adjusting depending on response. Elderly 1/3 – ½ of adult dose. Copromazine reduce by 1/3 or ½ for elderly patient.

PB – written for oral treatment of psychotic conditions.

TL – injection of copromazine would be less than 25mg as starting dose.

PB – yes.

TL - If 25-50 for normal adult then max 25, min 12.5. unless reason otherwise. Risks associated with medazolan – respiratory depression.

PB – any sedative can lead to respiratory depression.

Coroner – now under time pressure. Need to move forward.

CF – said not necessarily issue that pain factor in use of diamorphine. Why is it necessary at all?

PB – used widely for all symptoms of elderly care. Single best drug to help people at end of life. 56% of patients did receive it at end of life.

Coroner – don't want comment from CF.

AJ – study quoted was published in 87 – 56% of terminally ill patients on long stay wards received opiates. Opiates used commonly in these circumstances, diamorphine common for syringe drivers. Syringe drivers recommended in BNF. Where long stay beds in district hospital would expect consultant doctor to be on site and other lower doctors there at all times. In community hospital doctor wouldn't be there very much.

PB – nurses there all the time but doctors not. In community hospital don't have 24 hour doctor cover.

AJ – make a difference to opinion of doctor prescribing? If breakthrough pain and further dose necessary need doctor there to prescribe.

PB – yes unless written up small dose to be prescribed.

AJ – wont be too much of a problem? If community hospital and no doctor there all weekend and more drugs required, cant get it prescribed quickly.

PB – doctor should have 24 hour cover in hospital. Should expect same level of responsiveness.

AJ – jury heard reluctance on part of out of hours doctors to prescribe.

PB – different issue, expect 24 hour cover.

AJ – did you know position of Dr Barton?

PB – provided information after first reports. Didn't know position of Dr Reid. Understand now Dr Reid was consultant. Seen contract of Dr Barton which confirmed employed for half a week. If medical manager would expect 5 mornings/afternoons a week but should be arrangements for 24 hour care.

AJ – there were.

Coroner – different issue. PB saying everyone should have access to care.

AJ – prescribing and administering drugs. Interesting answer in that have to treat patient in front of you. Guidelines are guidelines but may not necessarily help deal with patient in front of you. Doctor will need to factor in info from medical records and own observations. Nursing staff key as can provide information to doctor as there 24 hours a day. Adjusting dose depending on response.

PB – yes.

AJ – in community hospital where no doctor all time, doctor would get info from nurses.

PB – yes.

AJ – if still experiencing pain then doctor should be aware. Possibility of patient receiving overdose. One effect of opiate = affects breathing centre and brain. Messages don't get through to brain.

PB – if get large dose intravenously then stop breathing. Will be respiratory death.

AJ – loss of consciousness not uncommon in patients who are dying. Can happen with those on no medication at all. Shouldn't interpret loss of consciousness as result of overdose. Bronchopneumonia – common in bed bound patients.

PB – yes common and very common in lungs of everyone who has died. Whatever you are dying of will also have some infection in lungs.

Coroner – jury.

Jury – raising dosage from oromorph to diamorphine. Assume jump in dose was because marked downturn in Mr Pittock?

PB – Cant explain, nothing in notes to say why increased.

Coroner – keep for Dr Barton.

Jury – doesn't appear some of patients on other analgesia. Wouldn't expect them to go on syringe driver without other painkillers first.

PB – trying to control symptoms. Possible for it to be used even if no previous painkillers.

AJ – every patient on something. Start dose for syringe driver – will affect where start on ladder if been on drugs previously.

PB – would increase conventionally by 50% if pain. Could be occasions where increase by 100% but would have to be clear on occasions when this is case.

PB -Elsie Lavender – previous long standing diabetes, stroke. Problems with notes as weakness on both sides, constant pain. Not typical of a stroke. Stroke very rarely gives you pain. Think she broke her neck, weakness of all 4 limbs due to damage to cervical spine, also causing incontinence. Xray would have shown this. Notes say it was done but no record of this and nobody in notes records having seen it. Doesn't show picture of stroke. Not making progress, not surprising as don't make diagnosis and stabilise spine then no reason why will improve. Transferred to GWMH. Second problem = blood test, very low platelet count puts her at risk of life threatening bleed at any time. Various possibilities but investigations never done. Could have been infection, bone marrow problem, rare conditions. Remains frail, cant get out of bed, pressure sores, doubly incontinent. No explanation in notes as to why in pain still and blood test results. Underlying condition not treated so doesn't get better. By 24/02 – decision needed to be made. Important she received adequate pain relief. Documented she was in pain. Started slow release morphine 10mg x 2 per day. Upped then to 20mg x 2 per day. Worried notes don't document why things continuing to deteriorate.

Coroner- part of problem is there is a diagnosis but possibly a misdiagnosis? Diagnosis made preconditions everyone who reads the notes.

PB – yes. Even if was diagnosed options either are long term bed rest (pneumonia, bed sores, clots etc all risks – high mortality rate) or neurosurgery which also has high risks. Even if diagnosed prognosis still likely to have been poor. No progress at all. 05/03 – oral morphine stopped and diamorphine started. Given 100mg in 24hours having been on 40mg in total week before plus medazolan. Cant explain dosage. Significantly higher than conventional starting dose. No evidence documented to show significant side effects. Notes refer to her being comfortable. Until 05/03 lots of comments re pain. Died 06/03.

Coroner – 05/03 – pain uncontrolled. Son informed.

PB – yes uncontrolled despite oral morphine. Likely diagnosis which led to death was cervical spine injury.

Coroner – anything arising from Lavender?

AJ – how confident are you diagnosis was cervical spine?

PB – confident enough if seen her clinically would have put her in neck brace and given ct scan. Consultant at Haslar says assumes cervical spine xray normal so must have crossed his mind too.

AJ – provides example of complex and challenging problem. Multiple medical problems and increasing physical disability. After arriving at Gosport seems likely several serious illnesses unlikely to be reversed, entering terminal phase at admission to GWMH. During GWMH prescribed various pain reliefs by Dr Barton.

At later stage given syringe driver. 05/03 – not eaten or drunk for days. Start syringe driver. Dr Barton on 06/03 notes further deterioration

Coroner – does that relate to 06/03 or is it historical?

AJ – nurse couchman described pain as uncontrolled.

Coroner – Ruby Lake. 84 year old.

PB – 84, previous problems include heart failure and swelling of legs, renal failure. Fractured necofemur. 30% of men and 50% of women die in a year of having this. Mark of frailty and other diseases. Became breathless, renal function impaired, chest pain, may have had small heart attack during admission. Cardex repeatedly says unsettled, calling out, short of breath, needed oxygen night before transfer. Not sure condition stable enough for transfer to GWMH. Problems most evenings. Not prescribed opiates in Haslar. Arrives on 18th, notes some pain. Distressed anxious and confused. State of delirium as not well. On 19th 11.50am marked chest pain, grey around mouth. Could have been heart attack or clot. Doesn't appear to have had investigations but does get oral morphine and later that day started on syringe driver. Reasonable to give strong opiate but no more investigations done. Syringe driver 20mg medazolan and diamorphine. Nursing notes say pain relieved for short period. If have heart attack normally given pain relief as required but if doesn't manage it then review.

Coroner – agitated.

PB – not seen syringe driver in someone who had a heart attack. Need justification for use of that. Then dies peacefully next day. Struggled to think what would write on death certificate. May have had heart attack, pulmonary embolism, or may be fractured necofemur. Date of repair was 5th or 6th august.

DM – 5th August.

Coroner- significant that lots of documentation missing for RL.

PB – not one of cases where thought missing documentation but little in medical notes made it difficult to assess what happened.

DM – surprised no ECG done and no ECG machine in GWMH. Stated doubtful of what would put on death certificate why?

PB – if ECG showed heart attack would have been clear but not enough info in notes to allow opinion. If don't know cause then have discussion with coroner.

Coroner- more likely than not that heart attack?

AJ – after oromorph given RL still in pain. also breathlessness, good reason to give diamorphine.

PB – yes good reason. Lack of ECG could have been good reason to send back to Haslar.

Coroner – order = Packman,

TL – request do Packman tomorrow.

Coroner – difficult as Wilson tomorrow.

TL – ready to deal with Cunningham and Devine.

Coroner – Devine, Gregory, Spurgeon, Cunningham.

Miss Bannard – what about Helena Service?

Coroner – Service first after lunch, then Cunningham.

Coroner - Helena Service first

PB – very elderly, 99 at last admission. Number of problems. 2 strokes documented, severe heart disease, high blood sugars, had been in nursing home for 2 years, decreasing frailty. Becomes bed bound, admitted with acute confusion and delirium. Very little progress at first. Appears to have another stroke. Transferred to GWMH. Signs of ongoing confusion, breathlessness. Unresolved heart failure. Cannot do anything herself. On 04/06 medazolan started in syringe driver. Deteriorates overnight, diamorphine 40mg, deteriorates and dies on 05/06. Very frail elderly lady, makes no progress in hospital. Becomes restless and agitated. Reasonable to have used diamorphine from start. Confident cause of death heart disease and multiple strokes.

Coroner – move caused concern. Survives 36 hours after move. Moving elderly people can cause concern.

PB – not good practice to move patients who are clinically unwell, but not significantly changed outcome here.

Coroner – any significance from medication?

PB – was frail, would have used lower starting dose 5-10mg in first 24 hours. May be reason why started on high dose.

Coroner – agitated and short of breath.

PB – difficult as didn't see her. Suspect would use lower dose but difficult to criticise 20mg without having examined her. Would have started on 10mg.

Coroner – 99 and really unwell, but demonstrating conditions which could be treated.

PB – can usually improve those with heart failure but not everyone. Had heart failure for several years. Those with heart failure often have worse prognosis than cancer. Many people would just say old age.

Coroner- acceptable. Any questions?

AJ – report read yesterday from Michael Petch.

PB – not read report.

AJ – asked to deal with no of questions re HS. Asked opinion of prescription for diamorphine and medazolan by syringe driver – said treatment appropriate.

PB – feel muddling various things. Ideally would give IV dose of morphine whilst try to do other investigations. Wouldnt normally use syringe driver for it. Using that when believe get to situation where you cant reverse what is going on.

AJ – asked view on subsequent diamorphine 20mg and medazolan 40mg over 24 hours. Said appropriate and desirable.

PB – will get body of opinion. Might have started on 10 and if didn't deal then increase to 15 or 20, about judgement. Very frail and elderly lady. Want to ensure dealing with symptoms but have to be careful.

AJ – para 8.2. talks about HS remaining unwell despite various treatments.

PB – diamorphine would have been drug of choice but query dosage.

AJ – second sentence in 8.2 – opiates helpful at night. Difference between PB and Petch = dose.

PB – agree but that is down to judgement.

Coroner – any questions?

PB – Mr Cunningham 79. War injury and also Parkinsons. Parkinsons degenerative disease of parts of brain controlling movement and balance. Starts with tremor, gets worse, stiffness. In early days responded well to drugs but brain getting more and more damaged, harder to treat, drugs become less effective, need higher doses and drugs have side effects. Situation where on too few drugs or too much. Increasingly difficult to manage. 1980's good response but by 97 difficulties. Diabetes by then too. Serious problems with mobility. Starts to lose weight – was 102kg, but progressive decline. When admitted lost 40kg, massive amount. Suggests serious problems. Noted abnormalities in blood count. Doesn't see haematologist. Suggest may be type of leukaemia, reduced blood and platelet count. Starts to get depressed – not uncommon. Thought early dementure. Then behavioural problems. Already in home, not getting on well. Admitted to psychiatric ward, delirium. Chronically ill. During admission had to be catheterised. Assessed on psych ward. On 11 psych nurse saw him. Day hospital on 14/09 – bit brighter, low blood pressure. Pressure sore swabbed and antibiotics given. 17/09 – pressure sore discharging. Acutely confused. On 21/09 – not taking tablets, pressure sore described as large necrotic sacral ulcer. Given oromorph and admitted for nursing care. Keep nursing home bed open but prognosis poor. (usually very likely will die in near future.) Appropriate to admit at that stage and observe and provide pain relief. Patients like this almost inevitably die in hospital. Pattern of illness.

Coroner – not cooperating so difficult to treat pressure sore.

PB – early dementure. More ill he got problems become harder to manage and more confused. Given oromorph 5mg and 10mg on 1st day. Then next day very confused and delirious, decision to put on 20mg diamorphine and 20mg medazolan. Agitated at night but not so bad. Diamorphine increased to 40mg and medazolan 80mg. Nothing in notes to explain fourfold increase in medazolan. No further notes referring to distress in notes so symptomatically controlled. Sepsis would be main cause of death, also parkinsons, diabetes.

Coroner – had post mortem. Dr Hamid gives cause of death as bronchopneumonia. Died 26/09/98. Death certificate issued by Sarah Brook. Step son didn't agree with cause of death hence post mortem. Both lungs solid and congested.

PB – infection led to death, bed sore and parkinsons.

Coroner- interesting that only one out of 10 had post mortem.

CF – what requested was different to what happened.

Coroner- would like to talk about that before said.

TL – asked for medical records to be looked out. Copy to go to PB. Prepared small table setting out dates and dosages of drugs given. CF Mr Cunningham's step son. Difficult for jury to identify so CF bought picture.

Coroner – no. Easy for jury to dispassionately exercise duty without becoming detached. Cant adjudicate objectively if sharing grief of families. No disrespect but difficult issue.

Miss Bannard – one error on table produced.

TL – 2 bundles of medical records. Pg 457 – letter from Dr Lord, 21/09/98 day AC admitted. Dr Lord responsible for his care. Appears from letter that Dr Lord admitted AC with a view to more aggressive treatment of sacral ulcer. Reason admitted to GWMH was for rehab care.

PB – pg 643 – different impression from notes.

TL – sets out care plan Dr Lord felt appropriate. Cream for ulcer, high protein diet to improve nutrition and help healing. Request nursing home bed open for next 3 weeks to establish whether he would be able to return. Recommendation re oromorph. Correct prognosis poor at that stage. Dr Lord says this. Poor but not completely hopeless.

Coroner – what does prognosis poor mean?

PB – shorthand for don't expect patient to improve and go home. Bought in to do 2 things – see if he would improve, and also treat symptomatically. No problem treating both. Not sure what will happen in next 24-48 hours. They may have expected decline. If genuinely thought someone going back to nursing home then say keep bed. 3 week – standard thing.

TL – letter encapsulates Dr Lord's view why admitted. Said due to sacral ulcer.

PB – cant give 24 hour nursing care and give high protein diet etc in nursing home. Had to be done on ward.

TL – Dr Lord would have been aware of medical history and had option if appropriate to admit for terminal care.

PB – no assess someone. Can see ill, want to get assessment. Prognosis poor means not optimistic about future.

TL – had decision on 21/09 to admit for rehab care or terminal care.

PB – don't accept that. Accepts black and white. Can admit for both. Giving appropriate symptom relief.

Miss Bannard – refer to Dr Lord's statement itself for clarification.

Coroner- prognosis poor, felt unlikely to recover.

TL – Prognosis poor but not completely hopeless hence mentioning intensive therapy to ulcer, recommended high protein diet indicating may live, and asked for nursing home to be kept open.

Coroner – being obtuse? Phrase is prognosis poor. Difficulty with how being interpreted. Understand what prognosis poor means.

TL – next entry at pg 645 21/09, day of admission. Dr Lord recommended staged approach to future care. Dr Barton says transfer to Dryad, make comfortable, happy for nursing staff to confirm death. CF will give evidence in due course. He visited 21/09 and was informed in light of bed sore would not survive. No evidence of receiving high protein diet.

PB – didn't find evidence of that no. But think would have had difficulty taking it as hadn't been eating in nursing home.

TL – where people lose ability to eat possible for people to provide liquid replacement.

PB – difficult practically.

TL – if could have done it would you expect it?

PB – would assess for 24 hours. If unconscious then terminally ill and wouldn't. But depends on cause of unconsciousness. If due to excessive opioids then couldn't tell.

TL – would expect medical records to record clear conversation re not being given fluids or nutrition.

PB – not necessarily. Would be good practice to have discussed with family.

TL - Day after admission commenced on diamorphine?

PB – what is says in notes. My mistake, was in fact 21/09 at 23.10.

Coroner – 26/10 cant make out first word.

TL – diamorphine and medazolan started 21/09. Between that and death 5fold increase in medazolan (20-100) and 4 fold in diamorphine (20-80). Your view is diamorphine on 25-26th excessive.

PB – have later report and earlier one. Notes don't say whether increase was medical one. Increases appear excessive without explanation in notes.

TL – report to police says may have slightly shortened life but cant find evidence to satisfy beyond reasonable doubt.

Coroner – if had been in records then may have been reasonable.

PB – just don't know as not in records.

TL – in light of syringe driver being started on evening of admission, appears palliative care regime in place from outset.

PB – doctor would have to find out why giving oromorph not dealing with symptoms. Syringe driver started to deal with symptoms.

TL – given CF told father would die when he attended on 21/09, and not provided with nutrition recommended, and no attempt to provide IV fluids, from 21/09 AC was being treated with palliative care for illness they didn't think would get better.

PB – not sure if that is what was told to son?

Coroner – not heard his evidence yet.

TL – don't know why syringe driver was administered. Shouldnt speculate why. No detailed analysis of past medical history on admission.

PB – agreed.

TL – usual medical practice to provide relevant history when admitting a patient. If problems occur then something to compare it against.

PB – agree.

TL – not to do this would not be what you would expect.

PB – yes.

TL – been in receipt of other medication – purpose of this?

PB – put on these medications by psychiatrist to control mood.

TL – in view of psychiatrist they thought appropriate to give this medication.

PB – not documented why treatment not continued.

Coroner – speculation to this. Was he able to take medication?

TL – cause of death bronchopneumonia.

PB – cant argue with that.

Coroner – septic deth.

TL – bronchopneumonia can occur as secondary complication of opiates for respiratory depression. Want to explore whether original diamorphine dose excessive. Consequences of this not followed and failed to follow instructions. Re original dose intention of opiods is to relieve pain without patient losing consciousness. Possible can lose consciousness as result of excessive opiods. When AC arrived he was in conscious position. Attended in Dryad ward and found father sitting in bed, had discussion with him.

CF – sent to get chocolates as going to London for couple of days. Capable of eating them

TL – AC there as behind sore.

PB – notes say not complying with requests, refused to eat etc. Would say acute confusion. Can get variable pictures – can be lucid one minute and not the next.

TL – that afternoon 21/09 – commenced on oromorph at 2:50pm 5mg, 6pm took coproximal and 8.15pm received 10mg. 10mg at top end of bracket recommended. Nothing in notes to justify increase from 5mg to 10mg. No note of having had oromorph previously. At 10pm that night (pg 754) due to have coproximol.

PB – note says sedated but could be he was sleeping. If so wouldn't give further sedation.

TL – record consistent with being given too much.

Coroner – little doubt he would be sedated if had oromorph. Depends if suggesting unrousable.

PB – if said over sedated then would take as too much.

TL – record saying sedated consistent with having had that amount? If reason for not having normal medication at 10pm that night was due to oromorph that night then should regime have been reassessed?

PB – could conclude working well and appropriately sedated.

TL – given risk of overdose, appropriate to admit diamorphine?

PB – don't know why diamorphine started or what changed re his condition. Nothing in notes.

TL – pg 867 reference to AC being agitated until 20.30, syringe driver administered as requested.

PB – presumably received oromorph at 20.15 but don't know when follow on note written. Dont know why driver started.

Coroner – says 'as requested'

PB – who requested syringe driver?

TL – suggests request was made for it to be done rather than adverse event in symptoms

Coroner – witness cant answer that but someone should be able to at some point.

TL – little explanation as to why syringe driver commenced rather than repeat administration of oromorph. Told jury that elderly individuals should receive no more than 30mg morphine = 10mg diamorphine and would need very good reason to go above recommended dose. At 11.10 on 21/09 AC given 2 times appropriate amount.

PB – spent time this morning discussing options but would want justification as to why increased.

Coroner – concerns that no reasoning in notes. Taken that on board.

TL – pg 867 of medical records entry dated 22/09/98 reference to son in law telephoning which says told about syringe driver following episode where AC tried to wipe sputum on nurse, tried to remove catheter and removed sacral dressing and then exposed himself. CF told on 21/09 (will give as evidence) by Nurse Hamblin he had been given something to quieten down. What appears to have happened is episode of unusual behaviour, delirium?

PB – yes could be.

TL – sort of behaviour patient may display if not receiving a number of drugs.

PB – consistent with him having confused state. If had received the drugs this may have happened or happened another way. Could have happened though irrespective of drugs.

TL - given agitated state medazolan given.

PB – appropriate.

TL – appropriate to restrict treatment of agitation to medazolan in first instance given appeared sedated at 10pm.

PB – one of number of possibilities. Have to assess patient at time. Was he in pain? If no pain then other drugs could have been given. Have to assess and make decision. No medical assessment in notes.

TL – doesn't appear that any analysis ever done re cause of pain.

PB – would have to take TL's word for that.

TL – number of other problems eg back pain, difficulties with knees, immobile so joint and muscle stiffness when turning and moving.

PB - would accept all of those.

TL – appropriate to analyse what pain is before treating it. In absence of this risk that opiod treatment excessive to needs.

PB – yes or inappropriate.

TL – appears sufficiently sedated to lose consciousness by 23/09. Pg 754 – on 23/09 not given regular medication as not able to take. CF attended on 23/09 and finds AC totally unconscious with syringe driver. Then appears of morning of 23 and 24/09 develops chesty symptoms.

PB – evidence here not totally unconscious as agitated and describe discomfort.

TL – reference to chesty may have signified bronchopneumonia which he died from. No consideration given that due to excess opiate.

PB – nothing in medical notes re chest, only in nursing notes so not clear if doctor aware. Possible that any patient will get bronchopneumonia.

TL – where diamorphine recommenced on double recommended dose consideration should have been given whether chest symptoms as result of excess analgesia.

PB – cant make that assumption from notes

Coroner – but might have been a factor

TL – on 23/09 at 8pm medazolan increased from 20-60mg. No entry prior to that explaining increase. References to agitation. 11pm. Not apparent why increase from 20-60 not 20-40.

PB - No evidence at all.

TL – agitation result of diamorphine?

PB – possible but unusual.

TL – when last contained syringe driver?

PB – never given diamorphine and medazolan together in syringe driver.

TL – why?

PB - use copromozine.

TL – possible that respiratory depression due to morphine leading to shortness of breath?

PB – don't get shortness of breath.

TL – if expert says agitation due to hypoxia would you disagree?

PB – wouldn't disagree. Accept AC had respiratory problems.

TL – likely to result in marked depression of consciousness. Did this affect his death?

PB – yes. Think he would have died whatever. May have slightly shortened his life.

TL – other less risky strategies could have been used such as injections using 1/6 of total 24 hour amount.

Coroner – point of syringe driver = delivering constant slow release.

PB – syringe driver aims to stop having to give regular injections.

TL – confirmed doses excessive. Pg 876 – 25/09/98, peaceful night, position changed, still doesn't like being moved. Principle concern of CF was AC admitted by Dr Lord for rehab and rehab not pursued.

Coroner – diamorphine would have been drug of choice for this condition.

PB – yes for pain relief for pressure sore. Would cope with agitation too. Majority would use strong analgesic.

TL – no further questions.

AJ – pg 87 18/08/98. Different ward, different consultant, lots of medication to be taken orally. Plan to start other medication. Went to bed happy, cooperative and contented. Woke up confused and muddled, verbally abusive and paranoid. Told nurse she was trespassing. Confused state?

PB – yes.

AJ – not on any opiate here. When arrives at Dryad – pg 642 have start of Dr Lords notes. Very frail, tablets in mouth some hours after given. Sacral ulcer with scar. Significance if have tablets in mouth hours after given?

Coroner – indicates not swallowing them.

PB – unusual for tablets not to dissolve in mouth but would indicate not swallowing. Maybe not producing saliva, dehydrated.

AJ – few days later notes say was producing saliva. Dr Lord suggests high protein diet. Dr Barton saw him 21/09 – pg 645. Photograph of ulcer as start of entry. Usual to do this?

PB – can be helpful to document progress. Necrotic ulcer normally much bigger than what is actually seen. Down to bone by post mortem.

AJ – reference to make comfortable and give analgesia. Know patient will require strong medication.

PB – have to assess patient. Likely to have severe pain but cannot assume that.

AJ – pg 867 22/09 – had oromorph, then put on syringe driver previous night. Sound like patient over sedated or unconscious?

PB – clearly not over sedated or unconscious.

AJ – know Dr Lord wanted to stop medication for psychological problems.

PB – people with psychological problems present management problems. Need cooperation to give high protein diet. If given naso gastic tube he would have pulled it straight out.

AJ – know Dr Barton saw him again next day – pg 868. 23/09 – CF asked why unconscious? Told on small dose of opiate. Sheila Hamblin saw CF, very angry driver commenced. Explained driver to control pain. Any criticism?

PB – these are nursing notes, nothing in medical notes. Would expect something in medical notes to justify too.

AJ – Alternatives for pain relief?

PB – regular doses of oromorph.

AJ – CF now fully aware AC dying and should be made comfortable. 24/09 – report from nightstaff AC in pain. Pg 876, peaceful night, position changed. If resisting movement is he unconscious?

PB – may be semi conscious. Doesn't like being moved seen as sign not comfortable.

AJ – pg 21 para 7.1 of PB's report AC example of complex and challenging problem. Multiple chronic diseases, gradually deteriorated. Challenge to clinicians to decide when to stop treating and manage symptoms. Managed appropriately. One concern = increased dose of diamorphine on 25-26th.

PB – also other concerns mentioned earlier as couldn't find justification.

Coroner – 10am tomorrow. Want to finish PB tomorrow.