Prof. Ford

DAY 21

A

THE CHAIRMAN: That is probably very wise, then we definitely have them for the next patients.

MR KARK: I will just ask for that to be done. (Copies distributed)

THE CHAIRMAN: Miss K, the Panel already have the new chronology for. There is a
B replacement Patient A.

MR KARK: We are trying to remember now what we have added, but I know it was something crucial.

MR LANGDALE: 9 January.

C MR KARK: I think L has been transmitted, but it is being produced at the moment.

THE CHAIRMAN: I understand it is with the print room and we hope to have it by the end of today. As far as Patient G is concerned, we have now received both updated chronology and we note that within the file of Dr Barton's statements there is a statement in respect of G.

MR KARK: About 20 minutes/half an hour?

D

THE CHAIRMAN: I think we will take a short break and combine that with some reading efforts. It is coming up to ten to four. If we say quarter past four, that will give everybody a chance for a quick break and give the Panel a chance to dip their toe into the paper.

MR KARK: Thank you.

E (The Panel adjourned for a short while)

THE CHAIRMAN: Welcome back everybody.

MR KARK: The chronology in relation to Mr Cunningham is fairly extensive. I expect you have been reading it again over the last few minutes. I am not going to spend any time going through all the early entries. The Panel have read them all and they reflect this patient's state
F on of health. There is reference to him suffering from Parkinson's and being a difficult man to manage; him losing weight. He was reviewed on occasions by Dr Lord. In July he found himself on Mulberry Ward, which we heard was the elderly psychiatric ward, or the ward for the elderly. Reviewed in September, and this was the first reference to infection, to sores being diagnosed, his weight being mentioned. This is page 7 of the chronology. His weight is recorded as 68.6 kg:

G "Not eating too badly, sleeping reasonably."

On 21 September he is reviewed again by Dr Lord at the Dolphin Day Hospital in respect of a sacral ulcer and he is admitted to Dryad Ward.

Can we look at page 8 of the chronology first. We can see that on 21 September when he is reviewed, he is shown to have a large necrotic sacral ulcer:

H

A "Extremely offensive. Some grazing of the skin around the necrotic area, also reddened area with black centre on left lateral malleolus. Parkinson's no worse. Mentally less depressed but continues to be frail. Admitted to Dryad Ward with a view to more aggressive treatment on the sacral ulcer as I feel this will now need aserbine in the first instance."

Pausing there, this gentleman is being seen at the Dolphin Day Hospital?
B A Yes.

Q It is being suggested he be admitted to Dryad Ward for treatment?
A Yes.

Q What sort of treatment can be applied to this sacral ulcer?
A Essentially it is nursing care which is at a level which you cannot achieve in patients
C in the community. Admitting to a rehabilitation unit allows you to do more intensive nursing care, more regular dressings with staff that may be more experienced and would be more available than would be the case if he stayed in the community. Getting large pressure sores to heal in patients who are in the community is very difficult, so admitting them is an appropriate practice that is done.

Q If there is a necrotic area, with a reddened area with a black centre, would that
D indicate debridement?
A You would often consider debridement and various ways to do that.

Q Is it aserbine?
A Yes, I am not particularly familiar with that. It is a type of dressing to clean ulcers, I believe.

E Q If we go to the top of page 9, the patient is described as:

"Very frail. Tablets found in mouth some hours after they are given. Offensive large necrotic sacral ulcer."

I will not go through the rest of that. Can we look at the diagnosis first.

F "Sacral sore.
PD."

A Parkinson's disease:

Q
"Old back injury. Depression and element of dementia. Diabetes mellitus - diet."
G

In other words it is diet controlled diabetes.

"Catheter for retention",

so he is suffering from urinary retention?
A Yes.
H

A Q "Plan: Stop codanthramer"?

A Which is a laxative, and metronidazole which is an antibiotic which he was probably on because of the inflammation and offensive nature of the pressure sore.

Q

B "Dryad today, aserbine for sacral ulcer, nurse on site, high protein diet."

A Yes, because if you improve nutrition, one of the problems with achieving tissue healing is if you have poor nutrition you do not get good tissue healing, so, again, admission and ensuring patients take a good diet with high protein to help ulcer healing.

Q

C "Oramorph PRN if pain. Nursing home to keep bed open for next 3/52 at least. Patient informed of admission."

So that is admission to the hospital:

"Inform nursing home, Dr Banks + social worker. Prognosis poor."

D What is this gentleman's biggest problem, as it were?
A He obviously has lots of problem, but the main problem at the moment is the sacral sore. If that is not improved, he is likely to get infection and become more unwell and frail from the sacral sore itself.

Q The suggestion of PRN Oramorph, is that a reasonable suggestion at that stage?
A Yes, one would expect this to be painful. I cannot see what other medication he was
E on at this point, but if he has not responded to codeine or paracetamol, it would be an appropriate analgesic, yes.

Q Because he was not at that stage actually in hospital, he was visiting a day hospital, I do not think we know what pain killers he had previously been on.
A I think you should go up the analgesic ladder with someone like this, but if it is very severe some people would consider starting Oramorph. The other rationale for that might
F have been, I think it is mentioned, some of the concerns about swallowing tablets, so slightly easier to swallow syrup, but that in itself is not a strong indication to go to Oramorph.

Q At the bottom of page 9:

"Seen by Dr Lord. Pressure sore looks worse although NH [nursing home] felt it had improved. Plan: Admit Dryad Ward for treatment of pressure area. Ask Thalassa to
G keep bed for 2/3 weeks at least. Plan of care for ward written in med [medical] notes by Dr Lord."

MR LANGDALE: I am sorry. It is my fault, maybe I missed it, did you mention "Prognosis poor".

MR KARK: Yes.
H

MR LANGDALE: I am sorry, my mistake.

MR KARK: That is the plan for this gentleman, to treat his sores and he is being admitted to Dryad for that purpose.
A Hopefully, with the intent that after two or three weeks this sore will have improved enough that he can be discharged back to the nursing home.

Q He is reviewed the same day by Dr Barton and we have her note at page 647. This is the one where we have the note at 644 which is pre-transfer on 21 September and then the note from Dr Barton on page 647 at the time of transfer. We apparently have a photograph which we cannot see, but it is in the notes if anybody wants to look at it. 21 September Dr Barton writes:

> "Transfer to Dryad Ward
> Make comfortable
> Give adequate analgesia
> I am happy for nursing staff to confirm death."

In terms of assessment and plan, how do you regard that note.
A I think it has to be looked in the context that he has already had a detailed assessment by Dr Lord, so one would not expect that to be repeated. I do not think anyone would have any particular problems with any of that. There is a clear instruction about the type of approach to analgesia from Dr Lord. They are happy for the nursing staff to confirm death we have discussed before. In itself, this is a sick, frail man with many problems and he could die suddenly. That is not the issue. It is whether that has connotations around other aspects of his management.

Q I was going to ask you about that note and also the note "make comfortable". We have heard, as you appreciate having read the transcripts, quite a lot of evidence about that being a euphemism for a particular route.
A It can be a euphemism, but it can be exactly what it says. I would not like to speculate about what the specific meaning. I would acknowledge that it can be interpreted in different ways.

Q It is a question of how the nursing staff would interpret the note?
A Yes.

Q Back to the chronology, please. We will find the drug charts, or the chronology dealing with the drug charts, at page 12. On the day of his admission, Dr Lord has prescribed a PRN dose of Oramorph which we looked at earlier from 2.5 up to 10 mg of Oramorph.
A Yes.

Q And you commented on that already. Dr Barton then prescribes 20-200 mg of diamorphine. We are dealing with the prescriptions first before we actually deal with their deployment, and 20-80 mg of midazolam and hyoscine. In terms of this patient, at this stage of his life, how do you regard those prescriptions?
A I will not go through; the prescriptions are too wide and hazardous for that, but, yet again, I do not see a clear indication as to why he needs to be written up for continuous infusions. In previous discussions of this I indicated the benefits in somebody who might have difficulty swallowing, and there were some suggestions that he might well have

A difficulty swallowing, of having an alternate route which could be for PRN. Oramorph itself is subcutaneous or could be written as separate subcutaneous diamorphine. That would be appropriate, but not to put a high starting dose of diamorphine and midazolam when one has not established his response to morphine to begin with.

Q I am sorry. I just wanted to ensure I had not misheard you. Did you say that Oramorph could be given subcutaneously?

B A Sorry. Oramorph cannot. Morphine can be. Sorry. Thank you for correcting me on that. Morphine can be given subcutaneously but diamorphine is generally used, so what I am saying is, it would be appropriate and good practice if one was concerned about his ability to swallow to have alternate PRN opiates to give which would say, "Administer if unable to take Oramorph".

Q Before we come back to the actual administration of those drugs, I think we need to

C go to page 13, which reveals a note from the evening before so the day that that prescription is written out, we then see this note, which is made the following day:

> *"Mr Farthing has telephoned, Explained that syringe driver commenced yesterday evening for pain relief and to allay his anxiety following episode when Arthur tried to wipe sputum on a nurse saying he had HIV and was going to give it to her. Also tried to remove catheter and episiotomy the bag and removed sacral dressing throwing it*

D *across the room, finally he took off his covers and exposed himself."*

That in any setting, I suppose, is challenging – what is nowadays described as challenging behaviour?

A Yes. One does come across older people who are confused and agitated, or can occasionally be difficult, of course. The history suggests there were difficulties with his behaviour in other settings.

E

Q Then, if we now go back to page 12 of the chronology, do we see that night, at ten minutes past eleven, the diamorphine and the midazolam which Dr Barton had prescribed, is started? Sorry – you are nodding?

A Yes. I do apologise.

Q That is all right, but it has to go on the transcript. Unless Dr Barton was attending the

F hospital that time it appears that that was or may have been a nurse-led decision?

A Yes. It appears in my initial report to Hampshire Police; I indicated it might raise concerns that the midazolam and diamorphine infusions were commenced to control his behaviour and sedate him.

Q And how appropriate or inappropriate would that be?

A He is taking Oramorph, so he is getting morphine to control the pain, so there is no

G need to change that unless he is refusing to take medication, which this note does not say. Midazolam is not a treatment for behavioural difficulties and agitation in older people. It is, to remind ourselves of the Wessex protocols, a treatment for terminal restlessness, so it would be quite reasonable if one was going to use pharmacological measures to control his behaviour – one does not always have to resort to that – to look at a dose of haloperidol or thioridazine. One would start with an antipsychotic as a rule for these sorts of symptoms. One might consider a benzodiazepine but for this sort of agitation and behavioural difficulty

H most geriatricians would not choose a short-acting benzodiazepine but you would not choose

Code A

A to give midazolam or some continuous infusion when that is recommended for use with the management of terminal restlessness.

Q This was a patient who, it appears, was able to swallow his Oramorph, at least because we know that was being administered. Is there any other indication as to whether this gentleman needed a syringe driver as opposed to any other form of delivery?
A I am trying to find it. There is a record that he swallowed a drink of milk, if I have it
B correctly.

Q There is. I think he took two glasses of milk. It is page 10, the bottom of page 10.

> "Driver commenced at 23.10 containing diamorphine 20 mg and midazolam 20 mg. Slept soundly following. BS at 23.20. 2 glasses of milk taken when awake. Much calmer this [morning]."

C

Can we look at how this administration went on. First, if the nurses had started diamorphine and midazolam inappropriately and the doctor treating this patient comes across that, what in your view could or should the doctor have done?
A At this point, the first thing is there was a recognition that the patient should have pain treated, so the first thing to assess is are they in pain, and do they have any adverse effects from the diamorphine that they are now receiving, recognising that because you started a
D continuous infusion it is going to be some time before the maximum effects of that infusion will occur. It might be up to 24 hours. That might likely require adjustment or conversion back to oral morphine, in the sense he is able to swallow. I really would be very critical about the continuation of midazolam because this is highly likely at this dose, if one continues it, to produce marked sedation, particularly in the context of giving a large dose, starting dose, of the 20mg or 60 mg of oral morphine equivalent.

Code A

E Q If we go on in our chronology please ---
A Sorry, can I just add a comment to that?

Q Yes.
A Partly that is because behavioural disturbances often are intermittent and people have behavioural problems and agitation for a short period. You treat that and then you withdraw the drugs. The trials which have looked at behavioural disturbances in patients with dementia
F and psychotropics show, for example, a very high response rate in the placebo group, the group in a trial who do not receive any active treatment, about 40 per cent, and 60 per cent with treatment. That is a broad generalisation. You would always review drug management for agitation and behavioural problems unless, obviously, we are now in a position where it has been decided he is dying and for terminal care. This again does not seem to be explicitly articulated. It does not seem to be the reason it was started by the nursing staff. It seems to follow his behavioural problems and it is trying to palliate those symptoms, but it is not clear
G that there was an intent that he was for terminal care.

Code A

Q We can see on page 13 that the driver continues. Over to page 14, at the top, it continues on the 22nd and is administered at twenty past eight in the evening, or re-started at twenty past eight in the evening. Then, on the morning of 23 September, he is reviewed by Dr Barton. This comes from the significant events in the nursing plan. There is no note, I do not think, made on the 23rd of any review by Dr Barton, but we have one on the 24th at page
H

645 of the file notes. Can we just look at the bottom of page 14 before we go to that. In relation to 23 September:

> *"Became a little agitated at 23.00, syringe driver boosted with effect. Seems in some discomfort when moved. Driver boosted prior to position change. Sounds chesty this morning. Catheter draining, urine very concentrated."*

I do not think we have food or fluid charts for this patient?
A No, no.

Q The only entry we have is the two glasses of milk that we have looked at?
A At this point my interpretation of the notes was that he was not receiving any hydration or nutrition.

Q And the comment "syringe driver boosted with effect": can you just help us with this. The syringe driver can be boosted, I think, with a button on the side?
A I interpret this to mean the infusion rate was increased. That is my interpretation.

Q Let us have a look at the top of page 15. We can see that in the morning of 23 September, at 9.25, the 20 mg dose of diamorphine is continued and then re-administered but at the same dose at 8 p.m. The midazolam appears to start at 20 mg and then there appears to be a three-fold increase?
A Yes. And I think that is what the term "boosted" means, so it is a threefold increase in the infusion rate of midazolam. That is a very high dose for this man and a very, very large increase.

Q It may be obvious but what effect is that going to have in terms of sedation?
A This dose would be definitely expected to produce very marked sedation in a man of this age.

Q We heard evidence from Mr Stewart-Farthing – Day 6/8 – that on the 23rd, the day that this boost took place, he found him (he called him Brian) unconscious and unrousable. He says he went berserk, got very angry and he demanded to see the people responsible in the hospital, and he had a row with Sister Hamblin. He asked for the syringe driver to be removed so that he could speak to Brian. Now, obviously one does not have to follow, I suppose – you have indicated yesterday – the wishes of relatives.
A Yes. And that is in the best interests of the patient. One of the problems of using sedation therapy is exactly this. It sedates people and they are unable to communicate at the end of life, and that is why, irrespective of any effects it may have on shortening life, it has to be weighed up very carefully if you introduce sedation therapy because it means you have somebody dying who is no longer alert who might otherwise be. Good quality end of life experience for many people might be to be alert and to be able to hold a loved one's hand. These are the potential problems with using sedation therapy. It is not just the risk of respiratory depression. It is that you are rendered less conscious which, by definition, is what sedation therapy does.

Q If he is described as unconscious and unrousable on 23 September, first of all is that a state that the patient should be in?
A It would be a state that he would be in if he had a clear indication and his symptoms were uncontrollable through any other means except by going to that level of sedation; but

this was a very large dose, a very large increase, and there was no attempt to titrate or adjust it. What could have been done was to reduce the midazolam at this point, and see what happened. He was variable in his agitation and, of course, we had the problem that it possibly was the diamorphine and its metabolites that might be worsening his agitation. It is a very difficult situation. The good palliation at the end of life, you try and adjust and optimise drug therapy, so you minimise side effects. You keep a patient's symptoms in control, but you keep them as alert as possible. The aim is not to render patients unconscious through high doses of sedation therapy. Code A

Q Even if you do not feel that the nursing staff, or the doctor does not feel it appropriate to remove the syringe driver completely the dose could be reduced?
A Yes. If you have somebody who is over-sedated, or has excessive amounts, and that is your judgment, of opiates or sedatives, it is best to initially stop for a few hours and then see what happens to the patient, and then re-start the infusion at a lower rate. That is best practice if someone is clearly overly treated. It is reasonable if they are not in an immediately life-threatening situation to reduce the infusion.

Q If we have a look at Dr Barton's note on 24 September – it is page 645 if anybody wants to turn it up but it is revealed in our chronology at page 15:

> "*Remains unwell. Son has visited again today and is aware of how unwell he is: sc analgesia is controlled pain just. Happy for nursing staff to confirm death.*"

And over the page, at the top of page 16, Sister Hamblin:

> "*Report from night staff that Brian was in pain when being attended to, also in pain with day staff, especially his knees. Syringe driver renewed at 10.55 with diamorphine 50 mg, midazolam 80 mg and hyoscine 800 microgram. ... Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition.*"

Can we just look at the drug charts set out at the bottom of page 16 of the chronology:

> "Diamorphine: 40 mg/24 hrs administered at 10.55"

This is all on 24 September. Then, on the same day:

> "... increased to 60 mg/24 administered...".

A Yes.

Q So within a 24 hour period, unless I am misreading it, just looking back at page 15, on the 23rd he had been on 20 mg diamorphine and by the end of the 24th he was on 60 mg of diamorphine?
A Yes.

Q The midazolam, he had been on 20 mg on the 23rd, and we have already looked at that – there was that threefold increase.
A Can I comment? I find it difficult to know how the nurses could assess the pain was in his knees at this point. He had a very marked depressed conscious level so I find that comment slightly surprising. I would have thought it would be difficult for them to gain an

A idea where his pain was. I can only assume when he was being moved he was making noises which led nursing staff to believe he was in pain.

Q Can we carry on, please, we see at the bottom of page 16 that the syringe driver continues. Over the page, now on 25 September, we can see that the driver is recharged with 60 mg of diamorphine and 80 mg of midazolam. At the bottom of the page, Dr Barton has re-prescribed the diamorphine, this time with a higher starting dose, of 40 – 200 mg.
B Midazolam is prescribed again, as is hyoscine. The diamorphine continues to be given at 60 and the midazolam at 80. Over the page, at page 18, we are on to the 26th, the note is:

> "*Condition appears to be deteriorating slowly. All care given. Sacral sore redressed. ... Driver recharged ...*"

and, again, it has gone up to 80 mg of diamorphine and 100 mg of midazolam. If we go back
C to the notes at page 647, we can see that there is a note on 25 September by, I think, Dr Brook?
A Yes.

Q

> "Remains very poorly on syringe driver
> For TLC."

D

By this stage, what sort of condition is the patient going to be in?
A He is dying. With those doses of midazolam in particular and diamorphine, he is bound to be deeply unconscious. It is a very high dose of a potent sedative drug.

Code A

Q This patient, I think we all understand, is not being hydrated.
A Yes. At this point, the decision has clearly been made that he is dying; he is not for
E hydration or nutrition. He is moved into this at that early period. Once he has a depression of his consciousness level, it would seem he is on at that point an end of life pathway.

Q So from the point on 21 September, after his agitation, he is put on the syringe driver and it is increased either with diamorphine or midazolam on I think a daily basis. By this stage on 26 September, in your view is he going to be saying anything, is he going to be rousable?
F A No, he is not. I just think it is an unusual approach to managing the problem. I think most geriatricians faced with this type of problem would have carried on with intermittent prn morphine at this stage and would have given a prn variable dose of an antipsychotic, such as haloperidol or thioridazine would have been used, and one would have observed the response. One would not have started an infusion at this point.

Q We can see that the patient died at 11.15 p.m. on 26 September. In your view, would
G these drugs have had any significant effect on that event?
A I actually think it would be difficult to conclude that the drugs did not play some part in his death through causing deep sedation and respiratory depression, but equally the literature is unclear about people who are clearly having palliative care – this is often cancer patients – as to whether sedation therapy significantly shortens life. But in this patient, who was not initially in that setting, I think the fact that he became unconscious, it is very likely that drugs contributed to respiratory depression and him getting bronchial pneumonia. But he
H

Code A

was at high risk of getting bronchial pneumonia and dying anyway, so again you cannot conclude that the drugs definitely caused his death.

Q At the time that he was transferred on 21 September, he was supposedly destined by Dr Lord for a high protein diet.
A Yes.

Q Does any of that plan in fact appear to have been put into action once he had got to the GWMH?
A No. The plan appears to have been changed by the behavioural problems and the institution of the diamorphine and midazolam infusions at that point. When he was admitted, Dr Barton's note still indicates there was a plan to try and improve this man's function and his pressure sore.

MR KARK: That is all that I ask about this patient. I suspect that would be a convenient moment to break.

THE CHAIRMAN: Yes, particularly as there will be a need for certainly the Panel and I guess yourselves to be organising those papers which you need to take out of the room tonight, since it will not be available to us tomorrow. Thank you. We will resume on Friday at 9.30.

(The Panel adjourned until 9.30 a.m. on Friday 10 July 2009)