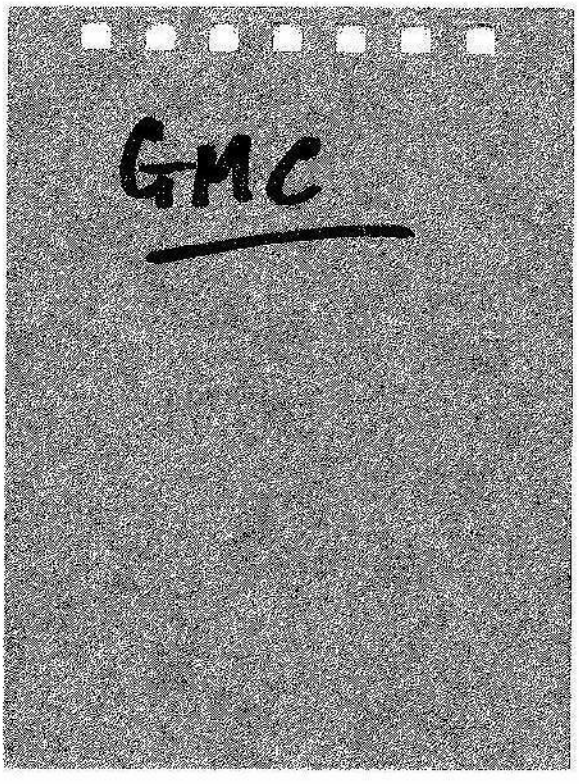

GMC

[redacted]

Barrett / 23 June

LEGAL SEC

(X) Dr ROGERS X X X (X)

(X) WILLIAM PAYNE (LAY)

(X) PAMELA MANSELL (LAY)

Other doctors using same wide prescription — never questioned

Didn't know about 90's complaints

LORD 16/17 July — NDED LINK.

K ? Admitted OK to move around, [black eye
Next day, 3 steps restrained
— Sat rest of morning.
S-D 0925 — 40 D/no pain
— don't know why, there but
cannot remember. Can't say
why. No hydration/rehydration
— cannot comment, possibly dopa-
poking if on/not on S-D !!!

NOT troubled by medication

[redacted]

Dr. Logos THYRIDAZINE (already)
– plan to go to nursing Hom
(SNCR: Taylor (p157) – she
refused medication,
(p407) Reviewed, happy, waiting
for daughter.
p279. prescription: FENTANYL 6
on 18th, off 19th. Agressive
19th – not unusual, often
no reason. Try calm down,
try relax sit down, if not
=) it's help. Try to have
colleagues – uncontrollable –

[redacted]

from CLOPROZERINE. Works quickly, but slowly with Elsie — then started on 5-D with D + M.

[redacted] Oramorphin prescribed by Dr B but none given LADDER

Elsie went from 5ml — to 15mg D (now Oramorphin) = added pain of 5 mg / 4 hourly up to 10mg if heavy person.

chronic pain 5–10 mg / 4 hourly (start at 5mg).

(PL) Elderly — reduce ½ to ⅔

Little lady — said DON'T OVERDOSE

(ATTACKS = SITE LIES).

FENTON yr. - (withdrawn)
Mood change / mental discomfort
10%. Confusion made worse by ↑
(p280) 40 mg D (1974)
CO-PRO earlier in morning
HAVE FENTINOL effects
CO-PROMAZINE
40 mg D, should be
at least 50 mg.
MID with (started 40mg) = SEDATIVE
WE DON'T OVERDOSE = RUBBISH
DID YOU OVERDOSE - no answer
NEVER REDUCE ONCE STARTED 48 hrs later

[redacted]

REASONABLE TO SAY NO CHANCE TO RECOVER / REASONABLE TO SAY CAUSED DEATH - began to begin stopped

Answers could lead to giving answers that change from witness to defendant.

- no part in selling medication or personal responsibility

= warning - To not have to answer by personal liability = [redacted] = REFUSED TO ANSWER (upset).

She had never questioned doctors

[redacted]

Shallow breathing common (evidence)
Ej Barrett Sim, REFUSED TO ANSWER
Assessed as patient grimaced when moved = pain.

NO INDICATION TESSIE WAS OVER IN PAIN – given opiates for agression > increased sedation dose.

Ms Gillian.
(KAM)
(K) – Did agression behaviour dictate level of Opiates? cannot remember – [redacted] agreed be approp to administer outside guidance.

[redacted]

c/man.

(1) Ward Manager (Beds) stated that once on S-D = terminal phase ∴ no i/v hydration

Confirmed Dryad Ward was a final Ward (terminal)

Sounds as though Elsie was already on S-D when brother arrived at mid day – YET SHE SAID PURPOSE WAS TO CONVALESCE before this!

TLC can mean "end of life" care

"Make comfortable" – got everything need, and family involved, towards end of life.

1994 (Elsie) = TLC and put on S-D as order by Dr B.

"Happy for morning staff to confirm death"
– a normal statement
– "always assist – at lowest dose unless told otherwise": Same for everybody,

[redacted]

M
40 from the Else i.e. only
Dr would authorise.
Cannot remember concerns about
excessive drugs. Forgotten 1991
meeting = AMNESIA by Barker
[redacted] confirmed = DEFINITELY

JENKINS 3 GDS? Increases
always discussed with B before.
Other partners less willing to attend.
Full time dr. after Barker
(K) p.155 - att. 21 Oct.
p.184 - "NAILED" BARKER
p. 190 -
p 279B - Overnight pulse = NOT given

[redacted]

FENTONAL : (not recorded when started)
p.223. patch on period. CHLORPROMAZINE
took longer than usual to work
p223/4 : Marked determination, son
seen by Dr B. Attr. late 1960s (p224)
p157: More restless, aggressive = PATCH
general condition deteriorated.
= not eating / drink, loss of mobility, etc
Chronic = long term.
C/Nam stopped JENKINS for diversion
= STOP.
- tried to show RSIE's determination
was due to deterioration of Kidney function

[redacted]

Saline 3 litres

KARK.

vein

Hydration: No intravenous but subcutaneous used (under skin)
(very slow absorbation by body
typical 1L / 24 hours if poss.
Should be recorded.
— STARTED after new Dr arrived (post B)

(K) 21 Oct. Initial food / fluid chart
— but more later.

p203 Barted still good > gets higher
to 16 (23 Oct) 2 INN V 1 = DRUGS

18NOV: Aggressive, wandering, waiting for daughter, wanting transfer to Mulberry. Reason for Fentanyl?

09 – cannot remember.
0915 FENTANYL
Drugs given by Hamblin, witness SHAW. REMOVED 1230 19NOV

OTHER DOCTORS – 20 – 120 D,
(not 20 – 200)

Why so wide – don't know.

after D started

[redacted]

Hamblin trained nod of Steel
Complete trust Barton / Hamblin
Att. 1995 S-D training OJT
Knows analgesic ladder
{ No concerns about prescribing
{ practice although never seen before
Nurses decision to start S-D, B
always consulted before.
Dosage changes - nurses + B Not
necessarily consulted
Not always approp to start at
bottom of analgesic ladder
DIAMORPH used to control
BREATHLESSNESS NOT AGITATION

FAM002319-0016

[redacted]

TINA MARIE DOUGLAS

Sig of wishes of Conscious

Comfort – Subcut fluids, last wishes

Need of dying = none

Sub-cut fluids are sometimes more a comfort to family than of benefit to patient on SD

SDs used to resolve signs/symptoms only

Once on SD in Dygod ⇒ never off

TLC Active treatment, made comfortable in till end deteriorating patient

[redacted]

24 June (pm) SHOW

Chronic amnesia throughout but confused:

(1) Confusion between BALTZER dated 22/9 and admission sheet for 21/9, but dated 22/9, where would eat, drink, etc

(2) During Jenkins session, admitted that Dryad NOT for rehab, and relative down often misled, also Rx patients not suitable (bed shortage issue).

[redacted]

SHIRLEY HALLMAN (24/6)

Fell out with Barton / Humblin
— left on grievance.
98-99. Diagnosed with use of SDF
— shocked to find patients on, although
OK when went off duty.
Start of SDF + clang ^ at destruction
of Nurses.
Wide Range due to reluctance of
BJ Consultants to start S-DF if B not
available — left to nurses to decide
SD started too soon, too high starting
dose, too high increases = Conflict
w. Humblin / B.

[redacted]

Ruby Lake

D+M incr. X2.

Brian

p.861. Smg of Dramorph prior to dressing wound

Telephone conv. re. me – No !!

Dia = secretions = Hyoscine = BPH.

p758. no involvement in drugs

Robert Wilson

TLC – not to treat for prolonged (active) life, but make comfortable.

Make comfortable – relieve symptoms.

[redacted]

Happy to Confirm Death : Only if patient expect to die

Under Xexam - H left in tears. to Most of Time

PM Evidence : EVERY Patient had SD written up

Barton said "you don't understand what We do here" interpretation was SD = death.

Dosages ↑ too large, and not given top up doses where pain cannot remember Wessex Protocol.

Said HARRISON was ↑ by too much

Grievance (early 2000)

Complaint against B+H, harrassed
letter to Mrs Cameron (24/3/00) complaint
– suggested SD's played part in grievance
(no mention about SD).
ENQUIRY – ROSEMARY SAMUEL !!
⇒ meeting ⇒ report ⇒ nothing
said about SD concerns.
Left at end of year.
Victimised (End of letter) became questioning
handling of patients, SD's, unhappy
about treatment of self + patients
– apparent from arrival because of
prev. experiences. SD's were underlying
throughout.

H deeply frustrated at not knowing why patients put on SDS, although OK when on last seen. When gr. told "because" by H.

G

8b/. Info got from night staff

[redacted]

Night duty (98)

Nurse Tunbridge (still working)

1. Fully supported B.
2. Everything OK by 1996 following training.
3. Deterioration due to drugs & [illegible] experience! (Cannot explain)
4. PRN drugs given as judgment.
5. Regular: daily usage unless supply prob. or unable to take.
6. Radcliffe: felt concerns not heard
   - worried about own ability.
   Worried about jobs when authority involved
   - felt nurse not believed / DI wound.

[redacted]

Doesn't know why assumed laboured breathing as natural detect. Prefers over drugs.

REID

Stated OK for nurse to start SD subject to prior agreement of Dr. Reid agreed system in Bryant was acceptable. SDs actually do the setting up, not Dr.

END SPURGIN

Reid asked for X Ray, done, seen?

[redacted]

At QAH, Reid said he sent patients to GWMH for rehab/remob.; and expected approp treatments
When he moved to GWMH, he noted shortage of physio, but did not think it approp to ↑.
Barton started ES on 80mg gp D, Reid reduced to 40mg (still x2 of what should be). Also on slow-release Morphine + Midazolam ↑.
d. of deep-seated wound infection?

Panel

Q (1) in fair, impartial & judicial spirit

(2) Probing / demanding is OK.

(3) Not give impression contrary to (1)

(4) Q must not endorse personal views

(5) Do not "difficulty in accepting"

(6) Panel must Keep open mind

[redacted]

TANDY 2/7

(1) Confirmed B short of time, and more important to see patients than write notes.

(2) Notes were equiv. standard to other similar units.

(3) No concerns about drugs
- similar to other units.
- appropriate arrangement
- no concerns about nurses
- nurses give free range to decide dosages
- pre prescribing standard procedure

[redacted]

Dryad Nurses (Tandy)

(1) Excellent with measurement

(2) V. good bed sores

(3) Dryad – well run, not aware of any problem.

(4) Dryad: one stop. V. unwell / unlikely to make better

(5) Not uncommon [redacted] to be misled = complaints, disappointments, etc

(6) Patients in Dryad unfit for Nursing Home / Rehab.

PITTOCK

Aim of pain relief to reduce pain & agitation

Tagrene B oramorph, but not considered when B prescribed

8 x diamorph. (80mg)

PANEL

Effects of D.

Sick / nausea / coughing / respiratory depressions / conscious ↓ / confusion / hallucs / agitation => even small doses, but worse of higher

If confused => worse.

[redacted]

V reluctant to change from "palliative" to "end of life" treatment unless personal assessment.

Diff = ? 80mg.

High dose of D (in 5-D) started - to relieve symptoms - T said high dose. GWH [redacted] assumed too low dose, ∴ T not concerned. Nobody contacted T!!! Did T blame B + nurses to accept situation, ∴ T trusted them.

[redacted]

Dr Ravindrae (3/7)

(QA Registrar)

Robert Wilson.

23/9 - Admitted A&E - fracture (L) arm

20/9 - exam = high alcoh symp. Pain from fracture. Underactive thyroid.

Sedation to counter alcoh. withdrawal

Co-prodydramol ⇒ 25-30 Sep. Codine ↑

35/9 Paracetamol after, stop

225 or 2

23/9 - 2.5 mg, 24/9, stopped on 25/9

3/10 - Morphine, 5, 6, etc.

28/9 Renal better, low sodium, Hypot thyroid still evident, dehydrated., drowsy

← no liver prob evident

[redacted]

Stopped sedation to avoid aggregating liver condition. Consider TTE for evaluation. Massive bruise at fracture.
Poss. LTC (Long Term Care) Specialist care in NHS. Eating better. Not keen on Rest Home.
8 Oct Eating/Drinking OK.
9 Oct —u— . Referred to SS for placement.
13 Oct Still needs care, esp diet recomm. NHS bed rehab. not rising. NY fit to go home, or bed enough for rehab bed. Liver (cortin) normal.

[redacted]

Transferred 13/14 Oct to Dryad.
– needed to be v. careful re.
Sedation because of liver probs.

PACKMAN (v. large gentleman)
(6 Aug 99 – QA)
Transfer 23/8 : Assessment done
by Dr Rav. at GWMH (visiting –
training day).
Examined with Sister / nurse ! Obese
Arthritis, tinnitus, ↑ press sores,
constip, mental v good no pain,
better in himself no fluid overload
cardio / resp both normal.
– Cont.

Physical Examination
(1) Examine Ned. Notes.
(2) Permission, questions
(3) — " — examine
(4) Kit flat, abdomen.
⇒ note notes.

} STANDARD EXAM =

Cont — legs swelling (poss. fluid, heart prob, etc). BLACK stool 13/8.
= test to monitor internal bleeding
Notes could have more detail

Time: 15–20 mins

[redacted]

Doug Chart

23 Sep. Rev prescribed. Doxocine – blood press / water tablet / anti co-agulant / paracetamol / skin cream / may lig lax = laxative.

HAEMATOLOBIN – blood measure of activated compound, normal 12–16, but W. dif (LOW) thank Mem.

Not in Recuscitation – nurses note implied telephone conv. with Dr Rav. but no memory of this, and warned not assess this way over telephone.

[redacted]

FORD (6 July)

BNF = guidelines, but not apply to every patient. Basis for outside prescribing. Must work within limits for doing = Justification needed - notes vital for recording and ref. by others + self

Many of 12 admitted were not ready for palliative care. F frequently uses opiates for relief of pain. Anticip prescribing not objectionable for analgesia. Opiates > long range

(1)

(2) If expected in future (no dose available)
- depends on risks v benefits A/R
morphine is NARROW range
Not usual for wide prescribing,
esp opiates.

Sometimes go direct to opiates
for severe pain.

Oral > Subcut Unable to swallow
½ oral dose / ¼ - ⅓ for diamorph.

Reasons for shift
(1) Swallow (drowsy, etc)
(2) Avoid repeat injections (dose known)
(3) Smooth drug concentration

[redacted]

Older people - ½ lifes longer.
ITNS ½ lives, dong gone if young. Longer ½ life if older & lower dose & body (Ω) or longer between.
Everybody responds differently, more variable if older
To reach correct level. In pain, know to opiates, typ 5mg, observe, if still pain after 2 hours, repeat, if still pain, increase further.
- normal to titrate in 1mg doses. If depression & stop and give antidote.

[redacted]

Fentanyl | Oral v S-D. = similar to S-D.

If dose too high = left in pain after 12 hrs or excess toxicity

Also poss to get resp depression from Fent.

Lower Dose patch NOW avail

How long:

Diamorph 30-60m.

Diamorph - Iv if vascular, c. 15m if intramuse.

S-D Start w. loading (higher) dose, then low dose continuously.

- normally set up by nurses

[redacted]

Excessive Resp. Secretion: reduced by HYOSCINE. F agreed approp for end of life care.

Hydration Contentious. Lack of evidence what effect is. Reason accepted is better skin / thirst / etc but can worsen secretion

Needed if "NOT end of life" treatment – needs to be prescribed. (but not done of (2 [illegible] GWMH).

RESTLESSNESS & CONFUSION

Common in older patients, worsened by urinary retention, etc (also medication, esp. opiates). Opiates

[redacted]

Not a treatment for this

Opiates are used for pain

CONFUSED + PAIN Treat pain and see if still confused.

Opiates can produce urinary retention = pain = makes worse.

30 mg oral = 15 mg diamorp.
60 mg oral = 20 mg diamorp
Conversion rate = 1/3, except 1st is 1/2

[redacted]

Charlotte Gray – Centre Now3

Midazolam used for agitated pain, but [redacted] NOT other causes (delirium, etc).
Alzheimer's is a form of Dementia
Dementia is usually progressive and fluctuates commonly (good days and bad days).
Guidelines
Always question if needed
Dosage should be no more than 50% of adult dose – relates to opioids, generally known

Charles Stewart-Fairbairn – PATIENT G

[redacted]

Resp. Depress. = Shallow and slower breathing. Effects = [redacted] death

Codeine is an opiate, very weak
Fentanyl has longer ½ life (Thp)
- removal = wait several hours for effects to [redacted] (poss 17 hours or longer for reduce enough = care in intro of other method, Start V. low.
HYOSCINE - Caution ↓ Diff
for end of life and normal treatment
MIDAZOLAM Sedation induced, prior to surgery, etc. Dysgeusia

[redacted]

more sustained (½ life 2-3 hrs)
LOW DIAPHORAP ↑ risk of
Resp Dep. (definitely used on
normal patients).
END OF LIFE: Good Medical Practice
- Adequate assessment = V. important
upon admission. Imp. to document
problems, no change, devise care plan
= drug therapy needed (20-30 mins /
pos. more). If no notes on arrival,
= much more work.
Transfers produce, upset/confusion
diff. due to new event (assmt essential)
↓ dehydration, assess for treatable

[redacted]

Delegation F yes, does but not prescribe drugs. If units, discretion of nurses. If opiate (or more potent) / antipsychotic + nurses have discretion to ↑, commencement of SP diff. only delay. If clear protocol as to when + drug range.

Commencement is medical decision by Dr.

- If end of life (on oral), not unreasonable for nurse to switch, Change of condition = assessment by Dr first. Dr should decide switch from curative to EOL

[redacted]

No logic for nurses to switch, as Dr always available within 4hrs.
- Some adjustment ↕ permissible within narrow limits.

Wessex Protocol (PALLIATIVE CARE H/B)
Principles are OK, but cites drugs F would not have used.
BE CAREFUL that side effects are not worse than problem
Generally expect 50% increase in opiates. Double if severe pain but care / adverse effects.
Resp Dep is unacceptable, and cause for ↑ of opiates

[redacted]

Decisions to Switch (to EOL Pall.)

Culture changed in last 10–15 yrs.
Now, discussion with patient and/or relatives (part of decision making)
Consult with senior Dr. involved
TLC = EOL care.

PATIENT A. ([redacted] Pittock).

Common to give double dose at night
Start of opiates was appropriate; prescription 30mg of ORAMORPH (24hrs)
D 80–120mg PRN (equiv 10, max 15 dose)
– Allowing for increased need, poss start 20–30mg. Cannot understand from notes why so ↑ ⇒ not consistent with any medical practice. Hazard

[redacted]

Significance = Resp Dep + Unconsciousness esp. w. Midazolam (Disc. 40 - 80 mg)
NOT CONSISTENT W Good Med. Practice

No rationale for use, other drugs more approp.

Combined Drugs

Not alert, Resp. Dep. = easy D.
— treatment should be approp to needs,

Suggests MISUSE

S-D started — no clear info
one SD started could not swallow

Agitation continued = post ↑
Mid or Hyprodol or D =
excessive

Further deterioration? cannot tell why or what. Now unresponsive, mild hydration, unconscious, ? drug after stopped eating = dehydrated.

Adequate assessment done? Not adequate, or reasons for S→2

Drug doses not justified, also width not approp.

Addition of Hydration not approp, but OK alternative

Double Effect & Drugs should be to comfort symptoms only.

[redacted]

Couldn't find reason why oramorph prescribed. Coeding OK start for bedsore morphine given, not justified, appears to have been used to treat anxiety. Also prescribed 2v - 2x mg D+M. Reported chest pain, no record of assmt, D+M aborted. Inapprop + excessive. Later distress reported, high listing possibilities. SD would have been having effect by then. Next day D x 2, M x 2 (actually x3 dose of 24 hours). V. marked

[redacted]

Ruby Lake

Overdose suspected. Doses V. likely contributed to death, but may not have been cause due to other probs.

18/8 Happy + comfortable

21/8 ! Dead.

[redacted]

Brian (7/7/09)

Treatment explained. Essentially nursing care, better than NH.
Stop antibiotic / anticonstip /
Oramorph if pain
Big Problem - Sacral sore. PRN
Oramorph is OK,
Expect OK 2-3 weeks
Review B: TF to D, make comfortable, adequate analgesia, happy for steps to confirm death.
Make comfortable = explanation for parties
Drug Chart L - 2.5-10mg OM.
B - 20-200 D / M+H

[redacted]

Cannot see reason why written up for INFUSION. High starting dose unacceptable without reason

Bad behaviour – challenge behaviour occurs in difficult people / confusion etc.

2310 D+M started. Nurse-led decision concerned to control his behaviour. Normally start with anti psychotic drugs, not D+M (= terminal restlessness)

P10 able to drink 2 glasses Milk

What should doctors do on finding:

[redacted]

Assess effect of drugs, cannot
able contemporaneously = Sedation
D+M seems to have been used
to palliate bad behaviour
23/9. Booked driver (agitated) — no
food / drink since 21/9.
23/9 (0925) 25mg D same, X3 IM. ⇒
V. marked sedation
No attempts to titrate or reduce. Likely
D worsened agitation.
COULD HAVE BEEN REDUCED - Should
have stopped sedation and Restraint
Order at lower level.

[redacted]

23/9 20 D
(24/9 D-40 > 60 (within 24hrs)

Md 20 > X3 (23/24),
F cannot understand how nurses to think he was in pain.
D ≥ 60 M ≥ 80
D ≥ 80 M ≥ 100
With these dose he was dying of v. high dose dosage (EOL pathway)
Mods would have continues with intermittent Oramorph

Diff to conclude drugs did not cause resp. dep. = B/pheom.
(but cannot conclude)

[redacted]

Plan (Lord) High prot. diet never used.

---

11 July.

Diana – not approp for euphoria UNLESS also pain → Difficult if cannot communicate. Nursing perspective + Relatives important inputs.

5 Sessions/wk (1½ covered by practice)

1 Session = 4 hrs (plus 3½ hrs)

40+ beds, too much? No, depends on consultant input – too much to document everything, they

but cannot focus on every patient
Cont. Care : no input
Now : ½ hr + comm w. relatives
Cover ~~used~~ was typical
TANDY not avail late 98 -
mat leave (after LORD ?)
— no changes suggested re - notes are
other factors may have resulted
in her method of prescrib.
B may have had inadequate
clinical support.
Oversight of B was also sub optimal
F agreed work load was greater
98 - as than before.

[redacted]

Fluid drugs should NOT be used to compensate for lack of staff. May be OK if ICU care. [redacted] DTs may disappear starting doses? Not in my just specific reason.

Diff between 10 or 20 mg starting dose can/cannot be significant. More important is patients response to any dose: Prob w. many DTs is understanding steady state needed

[redacted]

Opiates are used in 1/4 - 1/3 Opiates on long-stay patients.

[redacted] patients dont do GWTT were mentally unstable. Pain is often undertreated/undertreated Treatment of pain = drowsy/sedation Death is OK if inadvertently killed due to treatment (ie double effect).

Drug levels at death would not help to decide cause of death.

Drug increases 1/4 - 1/3

Anticipatory Prescribe. Opiates (SD) is good practice in some

[redacted]

Cases of already on oral but becoming unable to swallow. SD needs discussion with Dr. The problem is the size of the dose. Dosage monitored as condition changes.

(A) Tardy-TLC. Signif deterioration, depression, functional decline, poss. sores. Dramorph readily, D+M prescribed 40–80 Concerned to use high starts (F worried use 10–15) Problem is lack of info, and too high a start dose.

[redacted]

Lord 16 Jul

later 1900

Ward round 1400-1700 (Monday)
1992-2000 overlap with B,
L briefed by B on each patient
- examine, agree management
plan.
Opinion B good doctor, sensible,
kind and caring. No major
disagreements.
Patients got more complex
over years, the longterm care
moved into nursing homes.
B/W started taking people w
fractures, etc, disabilities

[redacted]

post surgery, etc, although
nausea stayed same.
Prescribing of S-D in advance
was OK, to enable continuous
analgesia, agreed nurses could
could commence if need arose, if
other medication was inefficient.
L has doubts about large dose
range, although S-D option OK.
L not seen as high as 20-200mg ^
started low + wide. Happy dose
titration up in advance.
Understanding: Notes would
show S-D in discharge letter &

[redacted]

Problems with cover for persons who B not avail. Absences nurses would discuss first.
B usually contactable.
Karen Hamblin – excellent ward sister, good rapport. Joins us old school no-nonsense approach – effective
Beade: Good [redacted], encourages patients.
Overall standard of nursing care good – but dropped as patients changed d/t short duration

[redacted]

L. always contactable by phone.
B's notes too brief – never
mentioned to B – why? probably
due to being busy, also no
formal structure of supervision.
– B already in post when L
started, deemed OK, but
in retrospect should have been
corrected. Didn't feel patients
were damaged by regular
absences of B. She feels
due to work becoming tensions.

[redacted]

Leslie Pittock (A) - Age 82
Cannot recall. Prognosis; fell
could not return to RH, completely
dependent, bladder wash, high
prot. diet Outlook not good.
(poor) - means client first could
be made better to go back to
RH. Very unlikely to become
less dependent.
Eva Page (C) -
Confused and agitation, forgetful
no pain. Transfer to CC from QA.
Fentanyl [redacted] used but high dose
Cannot recall 20-200 mg diamo. -

[redacted]

A seen, would have agreed
Fentanol continued. Agreed
diamorphine eppoop. even though
already drowsy. Resp. Depression
always risk with all drugs, diff
is to get right balance, difficult
to give close titration due to
sporadic attendance of B, relied
on nurses.

Alice Wilkie (D) 4 Aug 1998.
Advanced dementia. Prognosis poor
- too dependent to return to NH.
DNR - (Do not resuscitate) not
in pt's best interests.

[redacted]

Age 85.

Ruby Lake (F) Fract. hip
Heart defect. AF. Ulcers. Low potasium. Dehydrated. To Cont. Care at GWMH.

Brian (G) Mar 98. Levodopa for Park – disagreement about level – Sometimes get extra from visiting Drs at weekends (dependising Service for OOH cover)
3M later. Noticeable wt. loss – why? degree of depression, wt. can be lost w. park. Monkey pole. Levodopa ↓, too much before.

[redacted]

Sep 9th. Reviewed - large ulcer - pain. less depressed, v. frail - admitted to Dryad.

Option 1. Return to NH - for treatment but, needed more specialised treatment. Bed vacant

Option 2. Bed in Dryad.

Option 3. Sent to QA (not appropriate due long wait.

Tablets found in mouth - not able to swallow, reason?

Cared in bridge relationship

Exclusion of dementia from poor assessment by Psychiat. team

[redacted]

Stop 3 drugs (lax, blood press, antibiotics).
TCI (to come in). Prognosis poor - ulcer not good (NH indeed) nutrition not good.
Scrotal ulcer to heal ulcer
H pylori. diet
Oramorph (syrup)
Approp. due to distress.

Later S-D, stopped? Did not see after admitted, unusual to stop once started. Balance is pain control v reason

[redacted]

F. Normal to stop 5-7, but occasionally delay start if distant visitor due.

age 73

Jean Stevens (L)

Stroke – Lt weak. Not well enough to travel to GWH (from Hesla) – looked at by L with view to taking her over. Not appropriate for artificial feeding. Later transferred.

[redacted]

KARK (on Lord)
Lord acted as BF friend during CHI enquiry ?
Did not say DJD / W-J-W running
I cannot remember challenging Hamblin about opiates (only actually saw 2 of 8 [redacted] after transfer)
Prescribing Accepted too much. Cannot recall if in use 1992, never challenged, did not register range was inappropr.
Now realise harmful consequences.
Left too much to nurses. Antip prescrib of SD. assumed Dr discussion
- [redacted] I recollection = change

[redacted]

of patient's condition. S-D stage of end of life route.
PRN - agreed should have clear range + clear notation of such.
Over-sedation = risk. BP notes unset. Seen, but not pricked-up. L prob. saw widest of doses but not noticed - did nothing
Proper assessment, important + listen + plan + prescribing } Yes
PITTOCK High Protein, bladder wash Lx week, ulcer dressing, happy to go to LONG STAY at GWMH. Had to be stable for transfer, expected

[redacted]

her care plan would be done.
Not reviewed by L at GWMH

Evalage (c) L still uses Fentanyl
Then known was 25μg, now 12½μg
Fentanyl 24 hrs to get into
system, stays constant for 3A.
Extreme caution about use of
opiates after 24 hrs, but known
dose in 1st 24 hrs of pain.
S-D started when Fentanyl in
place. If known would
have objected. Explored B &
known + serious needs.

[redacted]

(D) Alice Wilkie. Saw 4ds after transfer to GWMH.

(E) Gladys Richards S-D with D + M, cannot remember details. Told police, elderly frail lady D 40mg + 20mM — Lagered V. large amount of opiates but not seen by her.

(F) Ruby Lake.
Seen 5d before transfer, but not at GWMH.

(G) Person L to Admitted by GWMH, Care Need could otherwise be met—

[redacted]

Purpose : agressive treatment
- fdt available on ward, nurses
on Dryad V. good w. pressure
sores + skin conditions.

21 Sep. Prog. poor. Plan : Aseptic
Nurse on side, high prot diet,
oramorph prn. (result of
exam). Not [redacted] ready
for S-D. 2·5-10mg 4 hrly as req'd
(not more freq than 4 hrly).
Not for end of life care when
examined. If ulcer healed OK,
prospect of return to Nursing
Home. [redacted] No

[redacted]

[redacted] ✓ Normal to stop. Found unconscious unresponsive, reasonable to reduced sedation when asked ⇒ reasonable to reduce for conversation by me.

(L) Stevens – no contact after transfer to GWMH.

ROBBLN

Did not agree formidable, although PRO had disagreements.

Expect nurses to start S-Ds lowest, but records after higher. If felt S-Ds too high, would have questioned

FAM002319-0077

Brian (Jenkins)
Nursing docs up C-P.
Next page records admis
873, 874, 875, 876
– poss to t/f to Nursing Home ? Pres.
Sore (top grade) chance of
healing is remote (some months
lying on side).

PANEL

Mansell: Brian Prog poor, NH
Keep bed open. If no chance of
healing, why? Theoretically
could be returned there if

[redacted]

C-P

got a bit better. Indicates treatment although recognises near end of life. H-P Diet - no mention in B C-P (same day). No emphasis on HP diet to improve condition. L+B's Care plans diff. Took into account L? Report that next saw Brian in Worse condition (ie end of life).

L did not review (did sooner than expected). What review of care - not done, no concerns. But would be satisfied best care, up to standard. Did not

[redacted]

follow-up. Answers to Jenkins about quality based on assumptions, not a criteria reveal.

WPANE: B contract 14 hrs/week, prob. did more on occasions. If there every day is it necessary to prescribe as did. Understood to cover time when B not available Partners not happy about S-Ds or opinion - don't know why Verbal orders to alter drugs were spoken to 2 nurses.

[redacted]

Dr (Clare) – Brain
– Sore way horrendous, does
it mean will be painful,
Sometimes not necessarily
painful, pos. When healing
Otherwise if in pain. Agree.
Distressed ?? Assumption re
recollection (vague Recoll.)
Assoc with diff things, could be
unhappiness – yes.
Dyed – Jean – Laptop.
3 worked for you ? probably,
Yes. Under L. direction

Starting S-D W. D+M, surgicals end of life? Yes.
S-D not ~~stopped~~ usually stopped until death.
Decision to start < decision to enter EOL pathway — who?
(L patient) poss joint decision with patient, staff, family —
L. MO - involved with decision
for S-D concerned?
Dr B + nurses competent, sometimes need to make decisions?
//

[redacted]

Distressed at night? What?
no didn't see — understood
agression, throw things, such
episode (expert) do occur
if in distress, agree.
We have B with prospects
for recovery, precise plan, but
to wait for treatment. Acute
episod ⇒ EOL path. How
reconcile? Need detailed
conversation w. staff, not
clear from notes, no mention
of pain. No comment

What makes you feel that S-D could not be reduced ?
Something could be considered — if ask by relative ?? discussed. Review of ~~[illegible]~~ patient, prob. lower the dose. <u>Possible to consider</u>

<u>JENKINS</u> (Brian)

Heard passed away - Reaction. Cannot remember, some sadness due to long knowing — SHAW

<u>Pain</u> Nurse Assmt 22/9: Ticked boxes for pain / confused

[redacted]

22/9

Prescription (p754) Given Oramorph
X2 (21/9). Why wide range
2.5-10mg. Long wait too
large a dose if in pain.
S-D 21/9 (2310)

If severely intolerable
unfortable. Analgesia "just"
controlling pain. Poss. to
Quasher ↓.

Monday 21 July

When realised notes were a prob?

— no thought before 1998 police enquiry

Admitted prev. failings

About 25% of inpatients came without notes = full exam, etc — Yes.

Full exam? — Yes.

Do what? General condition assess / look at injury, blood press, heart, etc

— failing to make clerk-in notes, yes — DJ for full case — full assess + note — yes.

1991 Issues = concern? yes. Minor

1998? Diff issues, diff between night / day
staff / att towards end of life care.

<u>Written concern</u>

Not all patients given dia had pain – Y.
Although sliding scale not used — Y.
Drug regimen used discriminately — No
Opiates used unnecessarily — Y.
Patients d. because unconscious. – Y
2-D al diam, never reduced – Y, except 1
Unconscious / unresponsive due drugs – no.
1991 – aware of night staff concerns.
– thought resolved by mgmt.
– Not aware nurses wanted written policy
Dec 91 – B present at meeting, no memory

[redacted]

Spoke out. Staff concerned about monitoring use of DiaM. Practice did not change — nurses made to understand OK.

HALLMAN — upset B (B said you do not understand what we do here!)
B felt it was misrepresented and had come from diff background.
— she chose to misunderstand!!!

Do you accept some people might prefer to stay alive in some degree of discomfort? — [redacted].
And — do no accept drugs caused death.

[redacted]

A) LITTOCK: Day before admission — hard prognosis — recommend give up Rest Home place — prog poor — OK to transfer to Dryad.

Admission: No mention of LS plan. Will eat/drink for TLC. Seen by B and Tandy — cramorph.

3 in the Diary 40–80 Mid 20–40 (not complaining of pain). Nurses allowed to increase at level they decide. Min D — 40mg (= 120 oram)

— What expect? Hope relief of symptoms.

— expect warning change? Yes pain

FAM002319-0089

Care, entered terminal = needs
suff. analgesia – assessed by
personal knowledge.
Took into account Oramorph prescrip?
– assumed OK if he manages it –
Agreed 4 x step was OK !!
– where ever read ? not in books,
done on assessment. Agreed
never read anything.
Agreed, sedation by adding M.
D 5, 5, 5, 5, 5. Then double min. dose.
Assumes pain had increased.
∴ dose doubled result of assessment of
morning. SD = x 8 increase !!!

[redacted]

Never read anywhere – agree.
Doubted Validity of guidelines and protocols. B said appropr in pall. care not necessarily EOL.
This patient not displaying dementia pain. Would not have consented guidelines.
15 Jan. Cath. bypassing – distress assumed to be general. B instituted SD.
Prev. 30mg oral/day. Precis 5x of normal. Note essentials but None
Titration not considered – dying.
SD not started by nurses over W/E, for B: assumed deterioration DVS/DVS

[redacted]

Pain assessment done to agitation on turning.

Next day D+M ↑ 50%, Pyzadol x4 added ? = greater sedation.

Charge Sheet.

B confirmed doses OK, but accept higher than guidelines.

Do you accept x 8 too high — No

Agreed drugs could have been excessive

∴ Dose Range was too wide - agreed

Do not accept dose administered too high but potentially hazardous.

How can be approp ? B felt stated was approp.

[redacted]

(B) Elsie Lavender.

B designated EOL due to tenatrois pain from fracture. Cause wouldn't not have altered treatment. Screamed when moved. Quiet when left alone.

B. prescrib. 80-120 D + 40-80 M = x8 increase if administered. Increased MST? (x2) — Rx. 30, needs day Rx. 40. Also nurses could have started D&M if wanted to, and informed B later. = massive ↑ (no account of BNF, etc) Then, MST ↑ 60/day. B described deterioration - no mention of evaluation

but said she did assessment. SD started due to cont. pain. Poor, on 60 mg M = 30 DM, but given 100 mg = 3 x. + M
- no teaching or guidelines? Yes, but considered approp, but aware of over-sedation poss. [redacted] FATAL
Border large ↑ after person seen but no note. No surprise to B She passed away next evening.
- Get rid of cat, here to die, but disagreed about bluntness.
Is loss of organs due to opiates? Yes, but also of dying.

[redacted]

Charge Sheet Do not accept dosage too high, or inapprop. — No.
Did not do proper check in — No.
No plan of treatment = EOL care.
B partners relied on nurses, not notes.

(c) EVA Page.
Presents. small oram. later thyridamine, later regular thyridamine. Self care.
2/3 Started Fentahol 25 + SD 3/3 (D+M) agitated
Would have told staff to remove patch after starting SD. Neverthe together, [redacted] recorded patch removed, but S7 already running. Opiate naive — no (she had left Oram), but mostly

[redacted]

+ excessive

CHARGES Admitted 3/3 Pres. too wide.
B concerned she might have had
stroke = drugs approp.

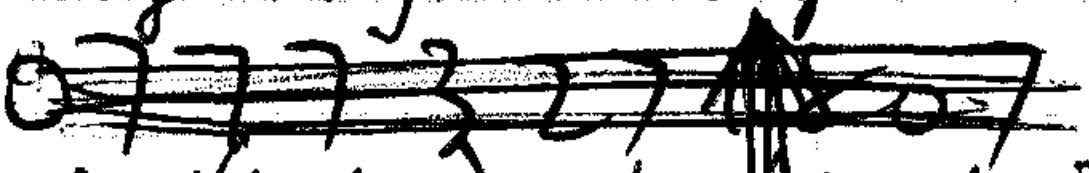
(D) Alice Wilkie Dementia, UTI, 81
- 6 Aug GWMH - opiate naive
10/8: Lord give up Addenbrookes slot
17/8: Deterioration (Mon) - no pain
Ward in chaos because of this Richards

Prescription: Drugs - 20-200 D
(no date) Bede
- assumed to 2018, not sure.
Daughters reported pain - B stated
SD, assumed wrote poss written 17/8
Problem of who did what, when

[redacted]

Bede start on V. high dose (90mg oral) — B agreed. Also higher than prescribed. Relative confusion worsening in evening, d. next day. Can doses be higher if dying?
Yes, to relieve symptoms.
[redacted]e B. would have agreed w. Bede if asked, even though too high
Agreed, situation extremely unsafe.
Does not accept opiate caused d.
CHARGES B agree
Regret can g Wilkie suffered due to Laos — important to review analgesia — not done — not oversedated!!!

(E) Gladys Richards – fall, fracture, operation (+ morp), remobile, eating – 10 Aug ! Fully wt. bearing



Admitted (11 Aug) ! Not seen by B.
– B assessment diff, deterioration assumed due to f. Now operate now? – Yes. Need to mobilise? – Yes.
Prescrib. 5-10 Oramorph PRN + wide ? dose of D + M + H. Regarded terminal ? No.
Why give morphine? Antip dementia + fracture could cause

[redacted]

Needs in future.
Nurse can ORasy pimmed. Next day
Same = drowsy that evening ⇒
12/8 ⇒ no medication given
13/8 - found on floor ⇒ chair ⇒ Oram.
(dislocated hip ?)
14/8 Reviewed by B, pain not controlled
⇒ back to HASU/R ⇒ op.
Recovered eating, drinking
- B unable to commit. Back to
Dryad 17/8 - B knew sensitive
to M + D. (reaction)
Admitted - peaceful, 17/8 Complaining
deep pain / distress. B ordered
x Ray.

[redacted]

18/8 (X-Ray seen – no dislocation
– (large haematoma (Bede assessed) Ford high but OK (pain)
B suggested SD 4OD + M (Ford said no justification) esp. when known of sensitivity (over Bedation).
B said approp.
B probes chest infection (Leslie)
– exactly what happened.
Problem was high haematoma around site of injury.
– B said nothing could be done, not willing to extract blood. B considered time would resolve.

[redacted]

Made unconscious to be free of pain.

RUBY LAKE O = oramorph.

F Opiate naive.

Oram 5-10, M -20-40 D by

SD 20-200 | H

Allowed nurses to end patients life - Yes.

Banked 6 - does not reflect all

Ignored BNF etc - Yes. / Transfer to D

Admission - 5mg O (my patients did not have to suffer pain)

- She "deserved" O. Give 10 labour

though not approp for pain. Assume heart deterioration

[redacted]

She wanted someone to sit. Response was drugs ↑ B. assumed confusion and doze to settle.

Agreed elderly patients can hallucinate with O.

Agreed that if nurse gave only ½ her prescription, could have killed HARMON considered pain not heart

If heart, morphine approp !!! She would have sanctioned SD. Started 2nd day, B thought she would have assessed. Dosage 2mg D+M, no notes at all. Agree not acceptable. Did not agree outcome absent nor

[redacted]

Father

Walking notes – did not see movement
Overnight – deteriorate – ↑ drugs
20/8: D x2 M x2 HT ↑ – 16 hrs later
↑, ↑. All with 3d of "week
comfortable + happy".
Cause of D – bronchopn. B said
condition could have caused this.
B never consider dose, agreed rare
to do so.
Criticisms by Ford do not give cause
to question actions. Diff [redacted] motives
now.

(G) Brian:
Agree better appt to deal with ulcer.
B. Reviewed at DDH (not Mulberry)
with L. "Make comfortable = palli care"
B. decided terminal path. Not
told Brian – not told about SD.
Intervention to cure? Happy to
follow care plan, but 2nd worse
she had seen. More concerned
about sore than diet. Expected
plan of Lord – although considered
in front/end. B [redacted] agreed that
she would have discussed terminal
P/wrong from outset.

[redacted]

B Prescrip. D+M+H. Given O x2,
then HALLMAN describes bad behaviour
- prob due to pain + distress, also
confused, Yes due to stoppage of
antibiotics. Blood toxins not checked.
SD stated "as requested" Who? no
- poss. rang and agreed, but may have
gone ahead anyway.
Next Sun 22/8. Under ↓ pain =
opiate unjustified - No, wanted
to control B's symptoms. Considered
approp, and supported nurses.
Night-staff stated SD awoke not
proper explanation.

[redacted]

23/9 – evening SD boosted with after.
(boost button on SD ?). D same
M×3, why ? Effective for termin
restlessness – B said approp. [redacted]
[redacted] Did not produce excessive
sedation !!

24/8 D×2, then D×3. M ↑80
B reexamined, but not termin
to be sore.

25/9 D ↑ justification ? 0 in notes.
Culture not to make notes ? No

26/9 ↑80 M100 – V high dose.
Review by Brook, considered approp.

[redacted]

B disputes Brian was unrousable
on 23/9!!!
Agreed I was care/loving relative
— dose not reduced because
inhumane to ♀. Did not
take account of my request —
her duty to Brian!!!
SD started — HALLMAN,

B considered justifiable due to
behaviour — she stands by it.
— if
Never been asked to withhold
or stop analgesia in 35 yrs

[redacted]

Did you think about taking advice?

NB.

PATIENT H (Robert Wilson)

Alcoholic liver disease. Fracture, Opiate naive.

Knew opiates were damaging

[redacted]

PACKMAN (J) ~68

10d. after admission still in QA
Feeds himself, poss intestinal bleed,
20/8 Review - No pain or nausea, press. sores
23/8 Admission to Dryad (obese, immobile, HP diet) No apparent pain.
Ford - [redacted] to mob. but Dryad not equpt.
QAH (17d) cont by paracetamol.
24/8 - blood sample (poss Signet ring count)
25/8 - Passed fresh blood - stopped Kleptrate due to poss. pile, not intestine
26/8 B ordered DiaM due to cardio-function. Further drop in blood count, B didn't know when ordered DiaM - but would

[redacted]

not have made diff (not for resuscitation)
B claimed approp. analgesia, not
practical to ttf to QAH. (opiate naive)
B. Set on terminal pathway. Discuss
w. wife, but not offered choice. Did not
discuss w. patient or offer choice.
Dr Ravi aware of limits at Gosport,
although "not for rescue." B. assessed
unfit to travel. Prescribed Om (two
prescriptions) 5-10, 10-20 — why 2?
Dose superceded 1st. B did not refer
to RAH.
27/8 - Improved, still Om (60/d) why?
Relief from anxiety/distress/pain =
discomfort

[redacted]

B said became terminal over W/E 28/9/8
– same Om. (30/8) Abdom pain, SD
started, still eat/drink.
Prescrip: 40–200 D, +M^20. Highest dose
(26/8) because of wt and Om.
(30/8) – would not justify D, pain alone
Concern was underlying condition
Nurses reported deterioration = SD start
Appears to have been set up by Hamblin,
plus X2 of Om dose. Later, further
bleed. 1/9 Reid – drowsy but comfortable
but Hamblin ↑ SD 40↑60, 80↑60
presumed for control of terminal restlessness.
2/9. D↑90, M↑80

[redacted]

B. claims drugs controlled discomfort, did not kill, poss. contrib to drowsy.
d. MI (heart) and/or bleed.

ELSIE DEVINE (K)

21/10 Good barthel & Ongoing kidney prob - not for treatment.
TRIMETHOPRIM for UTI, con ↑
Creatinin level, not always.
Admitted QA. Acute confusion - delirium - Chronic Renal failure.
└ = up/down.
If discharged to GNMH. Stand, walk with help, suitable for rehab.

[redacted]

B. said approp bf. Came to GWMH until future residence sorted out. No pain. NO sig. analgesia 21/10 to GWMH. Rest Hom idc. Pleasant lady, unsteady on feet Prescrib: Drugs for renal. Opt PRN (not administered) even no sign of pain. 8/11 Rand. Confused, etc needed help dressing etc. 10/11 Confused, wandering, pass due to UTI, started on Trimeprim + major tranquilisers to feel less agitated, a reason for nurses to handle.

[redacted]

+ Taylor

Seen by Reid. Now aggressive and restless, refusing medication.
⇒ Alderberry Ward, when poss.

21/10 Same, removing other clothes, happy, no complaints (after Fentinol had started prev.)

[redacted] B - felt entering end-stage of dementia + renal + anxiety
B. agreed Fent + SD use was inapprop. together. F can cause confusion, dizziness, euphoria, etc. but suitable for renal prob.
Clear instructions on use of

[redacted]

other analgesia eg 17hr ½ life.
18th given F ⇒ deteriorates overnight, CrCl ↑
⇒ SD terminal path ⇒ d. 2d later.
B arrived during incident, aware
of F., refusing help. B. prescribed
procosamin (fast quieter)
8.30 / 9.25 SD commenced.
F still full effort, esp from elderly.
B. said needed sedatation due
to behaviour. K improved
danger of over sedation, B agreed.
Chloprozamin also. SD started
at lowest 40mg D, B reckoned
exact match with F. B. knew

[redacted]

40m

and started SD despite Chlorpromazine + Fentinol (removed 123).
Ford described extremely aggressive - B disagreed, approp.. B agreed profoundly sedating
Should have been left priority to remove F, relied on nurses.
1030. 40D + 40M + procyclamine + peak Fent.
B - delighted she was comfortable and under control, saw nothing wrong.
19/11 - Ann reported sedated, no discussion of SD, etc. B said

[redacted]

doubtful about details of discussion
21/ Still D+M, d. evening.
d/ ⇒ chronic renal failure - Does
not accept due to drugs

[redacted]

Winding up.

Starting dosages of DM + M2

A. Pittock 8 X

B. Lavender 5 X

C. Page. Fentanyl (DAY 1) 20 DM (DAY 2) x15 (cancer)

D. Wiltshire 30 DM (naive)

E. Richards (naive). 4x oram In 10HIT x4?

F. Lake (naive) X2

G. Cunningham (naive). SD started when quiet.

Lloyd agreed SD to ensure stayed peaceful

Dosages not reviewed after my specific request.

V. likely drugs limited to RD & B Pram.

[redacted]

H. Wilson (naive) 40 OM - 50 OM - 20 DM - 40 DM - ↑ +M MX2
D1 D2 D3 D4 D5
needed continuous to limit

I. Spurgin

J. Packman V. overwt.

K. Devine: no pain. Rehab. Thyroidamine to calm. Taylor planned Mulberry, tablets made worst sore. Fentinol. Aggressive interlude - propoxamine for disturbance ⇒ SD thr later, Fentinol off later, 40-80 D prescrib (Ford: extremely excessive). B WTOTC DHM prescription while on Fentinol - but not appropriate treatment (Ford) ⇒ vv large opiate dose. No titration, V. high succession dose would have contrib to d.

[redacted]

L. Stevens. (stroke) – rehab. (naive)
DAY 1 DAY 2 – SD.
–OM (5-10) + D + M (no clinical analysis)
– no pain. Ford: opiates <u>totally inapprop.</u>

No-one from outside looked in; even consultants failed

B v criticism of B, not accepted by B. Reveals infallibility of own judgement. Total ignored guidelines, no notes what done or why. Delegating to nurses in best interest of patients?

[redacted]

Start 8/6/09

DETERMINATION 20/8/09

(1) General

(2) Findings

(3) Determination

Inapprop. transfers - bed pressure = transfer = beyond rx wants = diff. notes + assessments

Impression on family - optimistic

Transfer Stress = deterioration

Contradictory handling of families

Straightforward approach not appreciated. By families -
Happy for staff to determine death -
patients expected to determine quickly.
Notes inadequate - no time
Ford - not acceptable.
Care requires notes
Integral part of clinical care
Insulff Drug Recording V. Serious
to all our staff from hand.
Nurses had used own discretion
to start or ↑.

TLC - palliative care, near death
SD = terminal path = dies in days
Ford start slow, go slow (opiates)
CAUTION: Elderly
B Well aware of guidelines
B agreed in consensus continuous
↓ artificial SD.
Experts say OK to go over guidelines
↓ SERIOUS PAIN.
B. routinely prescribed ↓ guidelines
↓ BNF + Wessex Protocol
↓ depart from G/L = Clear notes
with reasons.

[redacted]

Antic. Prescrib / Delegation —
might be required — not uncommon
Intended for swift treatment —
risk — nurses go ahead without
justification, use Digest / Dandies
when on SD. Written instructions
essential.

Panel concerned B assumption that
min dose too high for S/D.
Panel expected matching of D + M
approp to current medication
Panel not happy about level
of D + M, esp bottom (10 pence),

[redacted]

No hydration available = death in days,

Beyond the limited nurses the power to start S-D + drugs leading to death

Ford + Secondapped titration 1 does essential. B and unpos. due to lack of staff, not done

Consultants not properly assessed BS prescribing practices, systematic failure and did not render inappop behaviour approp.

[redacted]

Patient has a right to stay awake and free of pain – usually achievable.

B accepts PCA + sedation to ensure symptom free.

PART 2

Burden of proof on GMC, to criminal standard.

A. a proved
bi proved
2bi proved.
2bi/2a iii – proved
2bii/2aii not proved

[redacted]

2b ii / 2a iii not proved
2b iii admitted
2e not proved.
2d proved
2e i - iii / 2a ii proved.
2e i + iii / 2a iii ✓
2e ii / 2a iii admitted.
2e i + iii / 2a iv not proved
2e ii / 2a iv proved
2e i + iii / 2a v not proved
2e / 2a v proved
2e i - iii / 2a vi ✓
14a i - iii / admitted
14a iv proved

14a v+vi — A.
14b i+ii — ✓
15a+b — ×

(B) 3a i-iv — A.
3b i / 3a iii / D. ✓
3b i / 3a iii / M ✓
3b i / 3a iv / D ×
3b i / 3a iv / M ✓
3b ii / iii — A.
3c i-iii / 3a ii ×
3c 1+iii / 3a iii ✓
3c ii / 3a iii A
3c 1+iii / 3a IV ✓
3c ii / 3a iv A

[redacted]

3d i	X
3d ii	✓
3d iii	X
3d iv	A
3e i + ii	✓
14 i - iii	A
14a iv	✓
14a v, vi	A
14b i + ii	A
15a + b	X

Page (C)

4a + b	A
3 i + m	✓
~	A
14a l – m	A
14a iv	✓
14a v, vi	AN
14b i, n	A
15a, b	X

WILKIE (D)

Va b	A
Va l – m	✓
Vc ii	A

[redacted]

14a i – m A
14a iv ✓
14a v, vi A
14b i, ii ~~A~~
15a, b ✓

Richard (E)

6a, b A
6c i – m / 6a ij ✓
6c i, iii / 6a iii ✓
6c ii / 6a iii A
14a i – iii A
14a iv ✓
14a v, vi A

[redacted]

14b, i + 2 A
15a, b X

LAKE (F)

7a b A.
7c i / 7a ii X
7c ii / 7a ii ✓
7c iii / 7a ii X
7c i, iii / 7a iii ✓
7c ii / 7a iii A
14a i - iii A
14a iv ✓
14a / v vi A
14b / i, ii A

15a b X

G('Brim)

8a, b A.

8c, i + iii / 8a ii ✓

8c, ii / 8a ii A

8c i, iii / 8a iii ✓

8c ii / 8a iii A

Inapp, not in best interest

8d A

14a i - iii A

14a iv ✓

14a v, vi A

14b i, ii A

15a, b. X

WILSON (H)

9a	A
9b i, ii, iv / 9a ii	✓
9b iii / 9a i	X
9c	A
9c i, ii, iii, 9a ii	✓
9b	✓
9b i–iii / 9a iii	✓
9d ii / 9a iii	A
9d i, iii / 9a iv	✓
9d ii / 9a iv	A
9e	A
14a i, ii, iii	A

[redacted]

14a iv ✓
14a v, vi A
14b i, [redacted] A
15a, b X

Spruce (I)

10a A
10b X
10c A
10d i, iii / 10a ii ✓
10 ii / 10a ii A
10e I-iii / a° iii ✓
14a, I-[redacted] A
14a iv ✓
14a v, vi A
14b, i, ii A

15 a b X

Packman J

IIa A

IIb i / IIa, v / D X

IIb i / IIa, v / M ✓

IIb ii, iii A

IIc i-iii / IIa i, ii X

IIc i+iii / IIa, v ✓

IIc ii / IIa, v A

IId i, ii / IIa, iv ✓

FAILED TO GET 2nd opinion.

14a i-iii A

14a iv ✓

14a v, vi A

[redacted]

14b i, ii A
15a, b X

Devon (K)

12a A
12b ✓
12c i / 12a iv ✓
12c ii / 12a iv / D X
12c ii / 12a iv / M ✓
12c iii / 12a iv ✓
12d i - iii / 2a ii ✓
12d i - iii / 12a iii ✓
12d i - iii / 12a iv ✓
12e A
14a i - iii A

[redacted]

14a ? ✓
14a v, vi A
14b, i. ii A
1c a, b X

(4) 13a A
13b i / 13a ii ✓
13b ii / iii / 13a i, ii A
13b iv a–c / 13a, ii ✓
13b iv b, D [redacted] A
13b i / 13a iii ✓
13b ii, iii / 13a iii A
13b iv a–c / 13a iii ✓
14a 1–iii A

14a, iv ✓

14a, v, vi A

14b, i, ii A

15ab X

(3)

Inapp. pr-hazard not in best interest of patients

Insuff evidence for SPM ?


.. SPA7
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