Other Document Form

Number D1222

Title FAX COPY KCT MINUTES TO MATTHEW COWAN.
(Include source and any document number if relevant)

Receivers instructions urgent action Yes/No (No circled)

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

O/M	SIO

Indexer

FAX

CONFIDENTIAL

TO	Mr Matthew Lohn	FROM	Kate Robinson		
OF	Field Fisher Waterhouse	OF	Major Crime Department		
TEL	Code A	FAX	02074880084	DATE	28/10/04
Pages (inc)	6	Acknowledgement required? ☐	TEL 02392892601	FAX	02392 892608

Matthew,
Here are the minutes of the KCT meeting on 10/10/04.

Regards,
Kate Robinson

CONFIDENTIAL

Key Clinical Team Conference.

10 October 2004

Present:	**Professor Robert Forrest**	**(BF)**
	Dr Ann Naysmith	**(AN)**
	Mrs Irene Walters	**(IW)**
	Dr Peter Lawson	**(PL)**
	Dr Robin Ferner	**(RF)**
	Detective Superintendent David Williams	**(DW)**
	Detective Chief Inspector Nigel Niven	**(NN)**
	Code A	**(DG)**
	Mr Matthew Lohn	**(ML)**
	DC Kathryn Robinson	**(KR)**

ML explained the purpose of the meeting, to discuss seven cases which had been individually marked by some KCT members as being more serious and collectively been agreed as a cat.2.
He required the following information, what were the initial instructions given to the KCT, how the process was moved forward and how the final conclusion was reached.

RF: Stated the group were not looking at causation, just the standard of the treatment.

The following cases were then discussed;

Edith AUBREY BJC/04 (2B)

Individual classifications;
ANS= 3C, I W=2B, RF= 1B, PL= 2B,

ML: "Did negligence cause or hasten death, avoiding the issue of intent."

ANS: Noted that the medication given to this patient was not used in the same context within her speciality of palliative care. That the patient had challenging behaviour and was difficult to manage for basic care. That when using opiates for sedation and not pain, could cause hallucinations and paranoia which could account for the symptoms. That giving opiates for sedation was always wrong and that the doses had been escalated. It was noted that the GWMH was not a hospice

PL: Noted that the records did mention pain at the point that the first fentanyl patch was used and then the dose escalated. That it was difficult to know how best to treat this patient.

IW: Noted that pain was first referred to on pages 616/618 of the medical records, that the family didn't want their mother to be prescribed haloperidol and had complained early at the use of morphine.
The patient was unable to swallow.

ML: Was it negligence or sub optimum care from the group?

RF: Noted that the patient was unable to communicate, was clearly distressed and agitated, perhaps due to pain. If the doctor was unable to find the cause, would be criticised for not trying to treat the pain. In considering the time between taking the fentonyl patch off and starting the syringe driver, the patient might have died at any time.

NN: Enquired if the concerns had been addressed?

ML: ANS view balanced against the expertise of the KCT had satisfied him with regards this category

The K.C.T. were content by their grading of 2B

PL: Noted that general practitioners were not experts and this dose would appear to be appropriate over 24hrs

ML: The grading reflected the balance of palliative care expertise with the practicalities of dealing with patients.

KCT were content with their grading

Geoffrey PACKMAN BJC/ 34 (2A)

Individual Classifications,
ANS = 1A. PL = 3A. IW = 2A. RF = 2A.

PL: Explained that the Haslar notes had identified a problem which they couldn't resolve. Code A
The GWMH were to make the patient comfortable not treat him. That non invasive exploration should have been considered at Haslar.

IW: Noted pg 46 Haslar notes stated "Not fit for surgery" – had a lot of pain

NN: Treatment at GWMH was based on information from Haslar. Was the treatment that followed appropriate or otherwise

ML: It seems they allowed him to quietly bleed to death, Why not transfuse?

ANS: Noted that bleed did not stop when blood pressure dropped, transfusion would increase blood pressure and hence increase the bleed. Patient suffered from huge pressure sores, was morbidly obese.

RF: Inappropriate for GWMH to accept view of Surgeon from Haslar. Patient had multiple ailments, If anaemic the M.R. is universal. To ill to move, palliative care was the only option.

DW : Enough concern to seek opinion of surgeon

NN: Clinical team in response to consultation consider we should seek opinion from appropriately identified medic.

Elizabeth ROGERS BJC 44 JR/2 (2B)

Individual Classifications;
ANS=3B. PL= 1A. RF= 1A. IW= 2B

ANS: Noted that patient was highly dependant and suffered a stroke but did not have progressive illness. Was given morphine on a 4 hourly basis, inappropriate for patient's type of pain. Was unable to determine if treatment shortened patient's life.

IW: Noted patient had advanced chest infection and U.T.I on arrival, was catherterised and had MRSA

PL: Noted most practitioners would have used opiates to control patient's pain. The dose was doubled when transferred to syringe driver and increased the following day when patient peaceful.

RF: Disagreed with ANS. Expanded that Parkinson's pain is not in joints and is remorsefully progressive. The patient had suffered from Parkinson's for 15 years was end stage. Had suffered a stroke, was susceptible to infection, had a chest infection, UTI, sacral sore and MRSA. Was of the opinion that patient would not have lived longer if she had received better care
Concluded prescription dose was excessive being 40-200mg

Conclusion of KCT that care suboptimal in view of the prescription.

Henry AUBREY BJC/ 05 (2B)

Individual Classifications;
ANS=3B.IW=2B.RF=2B.PL=1/4B.

ML: Commented that 'this treatment may have accelerated death by days, possibly a week.' That this patient may have died early is a problem. If the concerns were that the treatment was sub optimal how was the final grade arrived at.?

PL: Noted that there were huge doses of diamorphine and the patient was written up initially as 60mg of diamorphine. That there was no pain noted on admission, that there was a fentonyl patch applied on admission and that at 1530hrs on 2/6/99 the patient was given a fentonyl patch and 10mgs of oramorph at the same time.
That he was initially concerned at the size of the doses and that he was not aware of the potency of fentonyl.

ANS: Noted that the Haslar transfer note didn't include morphine. That to offer a patient with lung cancer and a cough an opiate in this format and dose size was inappropriate. This was not good management. Was unable to discover if the fentonyl patch had been removed, or if the patient was allowed to 'wash out' before administering the diamorphine. This could allow a build up of opiates. That fentonyl was sold by the drug company as a lower dose of pain killer and that its potency wasn't realised by many practitioners. 25mg was the lowest dose of patch and the literature stated 4mg per 4hrs which is a modest dose. There was a note of breathlessness.
It is of note that there was no ward pharmacist.

RF : Stated experienced in working in acute wards. Explained the conversion between diamorphine dose to equivalent in fentonyl is to divide by two. That 60mg over 24hrs was not high. Was not clear if the patch had been removed and that the dose of midazolam was large.
Was not best treatment but not clear if negligent?

IW: Noted that in the care plan dated 1/6/ there is no complaint of pain. That the nurses were not experts in palliative care, nor did they work in an acute ward. That the information available would suggest that the dose was appropriate, the patient had just been moved to the ward and people in that situation did not 'move well'

ML: Posed question did this treatment fall below treatment that other practitioners would accept?

KCT Agreed that the doses were unacceptable.

ML: Noted it was helpful to know the conversion of one drug dose in relation to another.

NN: This was not optimum treatment but there are reasons which could explain this treatment.

Code A BJC/13 (2A)

Individual Classifications;
ANS=3B. IW=2A. RF=2A. PL=1A>2A

ML: Queried ANS classification of 3B

ANS: From palliative perspective this patient was vulnerable to number of drugs due to low blood pressure. Midazolam dose of 20mg was equivalent to 80mg of valium. And inappropriate for frail lady with low blood pressure. Unable to take drugs orally but to be given by injection, 20mg is an awful lot. No mention of pain on day of death and diamorphine given.

RF: Noted this was a dying patient, heart failure is as least as deadly as cancer. Diamorphine has a palliative effect on people dying from cardiac heart failure. But the doses were high and midazolam was not an ideal drug to use with a syringe driver.

Sylvia TILLER BJC/48 (2A)

Individual Classifications;
ANS= 2A. PL =n/s. RF= 2A. IW= 2A

ML: Noted that original comments raised concerns regarding the excessive dosage and over sedation.

IW; Noted there was a quiry over the 25mg fentonyl patch.

RF: Noted appropriateness of using high levels of analgesic in patients who are about to die in order to provide solace. To with hold such treatment was unacceptable.

ANS: Commented that dose escalated on the last day of life and therefore the risk benefits shifted. The case was graded a 2 due to the care plan having been written up for analgesia on admission thought not in pain.

Gladys Richards BJC/41 (2A)

Individual Classifications;
ANS= 2A. RF= 2A. PL= 2A. IW=2A.

This case had been raised as one for further consideration by Mathew LOHN upon the basis that ' There had been criticism made that the starting dose of 40mgs of Diamorphine seemed excessive when starting the syringe driver, but it was noted that Mrs RIVCHARDS opiate requirement had increased considerably in the fifteen hours before the driver was started. Dr LAWSON had the considered that the opiates were not considered to be implicated in her death. Dr NAYSMITH had felt the Diamorphine dose too high which had probably shortened her life, but Mrs RICHARDS had seemed unlikely to survive unless she had been left in severe pain'.

However all KCT members had originally assessed this case as a 2A ie sub optimal care but death through natural causes.

AN referred to her notes and commented that she thought that the analgesia had slightly shortened life but that none of the options had been good. She went on to say that the treatment afforded to Mrs RICHARFDS was the least worst option.

Mrs RICHARDS had been admitted from a nursing home with a fractured right neck of the femur. She was placed in a splint in Haslar, and then transferred to Gosport War Memorial hospital for continuing care.

On the 14th August it was reported that Mrs RICHARDS was sensitive to ORAMORPH and that her daughters were unhappy that she was using it.

On the 17th August she was transferred to Daedlus under IV sedation. She was unresponsive for several hours but peaceful.. Haloperoidol

She became very distressed and in pain, she had been four weeks in a splint, the noted show that her daughters agreed to the prescription of 2.5mg of oramorph.

Mrs RICHARDS was X rayed, and given pain control overnight.

On 18th August Mrs RICHARDS was in great pain. Syringe driver analgesia agreed with daughters on the 18th.

20-200mgs of Diamorphine written up. Gladys was started at 40mgs.
20 mgs of Midazolam.
5 mg of Haloperidol.

Mrs RICHARDS was peaceful but reacted to pain when being moved.

On the 21st August she was described as very peaceful bur condition deteriorating.

Nurses failed to query syringe driver drugs at 40mg usually start at 20mg..

A huge barn door of a range of drugs. Page 62 notes..20-200mg diamorphine 12th August.

Page 64 40-200 mg Diamorhine.

On 18th August reported as severely demented.

In the Haslar Notes reported a history of unhappiness at the nursuing home. Had suffered 17 falls, the result resulting in a nursing home complaint.. had been forced to walk on a fractured femur. When treated in hospital drugs were reduced and her condition improved..

Haslar noted pain but never treated with analgesia..

Experts content that all notes have been examined including Haslar notes in respect of readmission ..

The deceased's relatives were better informed in terms of patient care and proposed treatment than other family group members,, this is reflected in the notes..

This case only considered sub optimal at the lower end of the scale ie closer to a category 1 than a category 3.

Originally scored..

IW-2A
RF-2A
PL-2A
AN-2A.

Only sub optimal concerns around the range and levels of drugs although very frail in the last stages of life and in pain..

All KCT content that this remains a 2A case.