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Elsie Devine

Clarifications requested by Detective Sergeant Dave Grocott
10th November 2004

1. As indicated in paragraph 2.11 there are no medical notes between 1st November and 15th November during which she is recorded to have deteriorated in the nursing notes. She is presumably seen by doctors, tests have been ordered but the lack of any medical record makes the medical management impossible to assess and is below an acceptable standard of clinical practice. Also in paragraph 2.13 I have considered whether or not appropriate senior medical advice was obtained from the consultant legally responsible for the care of the patient. Depending on the knowledge, experience and ways of working it may or may not have been deficient clinical practice for further advice to be obtained in this situation.

2. As stated in paragraph 2.20 I would expect professional opinion to differ as to whether the addition of Diamorphine to her Midazolam was appropriate or not. It is my view though, that there is a body of opinion that would find it appropriate. The area of contention was the dose to give. In my view the dose of Diamorphine was higher than standard text book practice and may, but not to the standard of beyond reasonable doubt, have had an effective of shortening her life in a more than minor fashion.

3. The definition of palliative care is: "active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families". Thus palliative care does not only refer to people who are terminally ill, although is commonly used in that sense. It is also possible for people to be terminally ill and not to receive any palliative care at all, possibly because cure is still hoped for up until the last moments. However, when I use the phrase appropriate terminal care, I am meaning the appropriate use of palliative care in someone who is now clearly dying, although the expected time or date of death may be extremely difficult to predict.

4. This is quite a complex question with no black and white answers. Traditionally geriatric medicine divided their wards into acute, rehabilitation and continuing care. Acute was for the immediate assessment, diagnosis and management of the current presenting problem. Rehabilitation would be a ward environment in which you would hope to have controlled the acute problem and you are now assessing the overall needs of the patient, (often in terms of activities of daily living) with an aim of maximisation of mental, social and physical function to(ideally) return back to their place of residence before hospital admission. Continuing care wards, were wards for people who were not going to recover to a point where they could leave

hospital. However in most hospitals, there are no longer continuing care wards as continuing care is provided by residential and nursing homes within the community even if the patients are fully funded by the NHS. Respite care used to be provided in hospital but now is almost entirely provided in social services provision. The aim of respite care is to provide respite for the carers (usually relatives) of highly dependent people in the community. They might be offered two weeks in a nursing home while the carers went on holiday, or perhaps a more regular two weeks break into a nursing home every eight weeks. The aim here is to support the carers, not to provide any particular treatment for the patient.

Slow stream rehabilitation was a further sub-division seen in some geriatric units where they divided their rehabilitation wards into those where they expected the patients to go home soon, where they put the maximum amount of multi disciplinary effort, and those (slow stream) in which they thought it was very unlikely the patient would make a rapid recovery and were almost certainly going to enter continuing care, but they wanted a longer period of assessment to ensure that there was no possibility of discharge home. Possibly 10 - 20% of patients who entered a slow stream rehabilitation environment would eventually go home. In many hospitals the differences between acute rehabilitation, continuing care and slow stream rehabilitation have completely disappeared now. However, most people would now use the community hospital as a rehabilitation environment, or at least an environment in which an assessment for long term nursing home care was made. It would appear that at the time of this enquiry Gosport provided multiple functions. It was a rehabilitation environment and people did go home, it was an assessment unit for long-term care, it did provide some long-term care (I use the terms continuing and long term care as meaning the same). All patients in continuing care eventually die. People were sometimes put into "slow stream" rehabilitation wards because it was expected they would die and therefore they did not want to make a permanent move to a continuing care ward or nursing home. However the pressures are such in the system now, that patients are often labelled as needing continuing care and move to a nursing home, even though they die shortly after. The NHS does not means assess patients for the first three months in a nursing home, as it believes that anyone that dies within three months was actually terminally ill and was therefore the responsibility of the health service. However, few of these patients are actually identified as dying before they enter nursing home care. This emphasises the complexity of assessing people who are coming to the end of their lives in which minor illness may often become agonal event.

5. Paragraph 1.11 I agree should state 21st October.

6. Kidney diseases tends to be either acute or chronic. In acute there will be a single insult, kidney function declines and then as the insult

(possibly an infection, odstruction or dehydration) is resolved the kidney function returns to normal. In chronic kidney disease, there is an underlying pathological process where if it is not possible to reverse that pathological process, will usually leads to a progressive decline in kidney function. Whatever the underlying cause of a chronic kidney condition, if you find small kidneys on an ultrasound, then it is likely that the kidney disease is going to progress at some rate even if you can stop the underlying disease. The kidney specialist who saw her felt that there was no underlying disease that they could successfully treat. I would agree with that assessment.

7. It is very common for General Practitioners and hospital specialist to fail to make the diagnosis of dementia and even more common to fail to make any attempt to differentiate between Alzheimer's disease and Vascular dementia. I do not think this can be particularly criticised.

8. The assumption regarding the urinary tract infection is based on the statement in the letter of the consultant geriatrician (20). As this lady's admission notes are missing it cannot be certain what they actually recorded. It is a very common assumption when admitting older people to hospital with acute confusion (delirium) and no obvious cause, that it has been caused by an asymptomatic urinary tract infection. I would not criticise this care or assumption.

9. Serum albumin is an indirect marker of nutritional status of a patient. It is particularly a marker of protein metabolism. Low albumin in this lady was probably a result of a combination of loosing large amounts of protein through her kidneys, due to her kidney disease and very poor nutritional intake. She is breaking down her muscle and other organs to provide continuing energy and as such will be losing weight. A low albumin and poor nutritional status will make a patient highly susceptible to infections, pressure sores and an inability to cope with other physiological stresses. It is a very strong marker of patients who are seriously ill and likely to die.

10. Do you mean paragraph 2.9 or 2.11? In 2.11 I believe the lack of medical notes over two weeks when there would appear to have been a significant change in her condition is below an acceptable level of clinical practice. In particular as it seems likely doctors had seen her because tests had been ordered.

11. It is my view it is common practice to write up some drugs 'prn' I am afraid I do not know how I could particularly evidence that and whether any study has ever been done. Again I think there are patients when 'prn' Diamorphine would be written up without a specific comment being written in the notes, though I would not condone this as good practice. I am not in a position to prove how unusual it was for the same reason that I have no national data. I think writing up Hyoscine was acceptable practice.

12. I do not think it is good practice but equally I cannot be specific that this is an unacceptable level of good medical practice.

13. Set out in paragraph 2.11. The reason that I believe there was a significant change in her condition is because by the 15th November, she is noted to be aggressive and restless, and that Thioridazine has been started on 11th November suggests that her behaviour was starting to cause significant problems by 11th: (277 and paragraph 1.20). An antibiotic has been prescribed on 11th November (277 and 276 paragraph 1.20) and blood tests have been carried out on 9th November (289) and an MSU on 11th November (363). All of these demonstrate that her condition had changed and people were trying to investigate and treat the cause, what is unacceptable is that there were no medical notes.

14. I am not sure of the exact legal implication of foreseeable harm. I have repeatedly stated that it is an unacceptable level of clinical practice to not make regular entries in the notes, particularly when there has been a change in patients' condition and investigations, drugs and treatment initiated. By itself though this will not lead to definite harm and indeed in retrospect I can find no evidence the lack of note keeping did lead to any significant specific harm.

15. I believe you mean paragraph 2.14 where she is started on Fentanyl. Fentanyl is a strong opioid analgesic (in the same overall class as Morphine and Diamorphine) but has the advantage of being given with a patch on the skin rather than by injection. As I state in 2.14 it is a strong analgesic that is usually used for severe pain but like Diamorphine is sometimes used for the severe restlessness of terminal care on the assumption that it can be very difficult to diagnose exactly what it is that is causing the restlessness. Clinical experience suggests that patients are more comfortable with opiate type analgesia.

    Analgesics are obviously used more often in patients with cancer but are also used in many other non-malignant conditions. Multiple Myeloma is indeed a cancer which occurs in the bone marrow where there is an over production of malignant cells (called plasma cells) which lead to eventual bone marrow failure, kidney failure and death. She has been diagnosed by a haematologist as having an IgA Paraproteinaemia. This can be mistaken at first for malignant multiple myeloma and in five to ten percent of cases progresses to Myeloma, and I agree that there is no evidence that she had progressed to Myeloma at the time of her death. I also agree that Dr Barton has written Myeloma (154) and she may indeed not have understood the difference between an IgA Paraproteinaemia and Myeloma, and this may have coloured her thinking. This would need to be clarified with Dr Barton. The patient's restlessness, confusion and aggression are documented on pages 155 and 156. On the basis that the lady is terminally ill, that palliative care is appropriate and she is already receiving a major tranquilliser (Thioridazine) for her aggression and

restlessness, in my view it would not be inappropriate to use a strong opioid to manage her terminal care palliatively.

Dr David Black 10/11/04