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Report on the Care and Death
Of
Elsie Lavinder
6th March 1996

This report has been provided by Dr David A Black MA MB BChir (Cantab) FRCP, Consultant Physician, Queen Mary's Sidcup NHS Trust. This report is in two parts, a factual summary of the time line including important investigations and in the second part an opinion on the events that occurred. The numbers in brackets refer to the pages of the evidence to support the statements and where the number is followed by an M it refers to the microfilm page numbers.

ORIGINAL

1. Timeline:

1.1. Mrs Lavinder was a insulin dependent diabetes mellitus since the1940's (53). She is referred to the Diabetic Service because of more troublesome hypoglycaemia in 1984 (65). In 1985 she is known to have a mild peripheral neuropathy (73). Her weight in 1988 is 85 kgs (73) and in 1987 her weight is 89 kgs (77). By 1988 she has very poor eyesight (47M). She is also documented to have high blood pressure in 1986 (29).

1.2. In 1989 she has a three-day admission to the Community Hospital (175) after a fall at home. In 1996 she is admitted to the Haslar Hospital on the 5th February (91) following a fall. The Haslar notes are not available, the only information we have is an assessment by a Dr Tandy, consultant in geriatric medicine, documented in the letter of the 16th February 1996 (11).

1.3. Dr Tandy documents that she has pain across her shoulders and down her arms, she has poor mobility, needs two to transfer and has weakness in both hands. She has had long-standing stress incontinence. A mild iron deficiency anaemia is also noted. Previously she lived alone with a bed downstairs but was only able to walk 10 yards. He notes she is in atrial fibrillation and is registered blind. Dr Tandy believes that she had a brain stem stroke causing her fall, and states there was now no reason to do a CT scan. He requests that she is transferred to the Dadalus Ward at the Gosport War Memorial Hospital.

1.4. The medical notes in Gosport (45M) state that she "fell at home from the top to the bottom of the stairs and had lacerations on her head". It also states that she has severe incontinence and leg ulcers. Once in Gosport there is no rigorous clerking of the patient and no examination recorded. In some of the nursing cardex there is a series of assessments confirming that this lady is highly dependent. She has no mobility and bed rest is maintained all through her stay (100 -101). She has leg ulcers

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both legs (107 - 109). She is catheterised throughout, although there is no suggestion that she had a catheter prior to her admission to hospital (111). She has a sacral bed sore noted; "a red and broken sacrum on 21st February" (115) and this progresses to a black and blistered bed sore on the 27th February (115). She is thought to be constipated on a assessment, then continually leaks faeces throughout her admission (119).

1.5. Barthel is documented at 4/20 on 22nd February (165) (i.e. grossly dependent). Her mental test score is normal 10/10 on the same date (165). Lift handling score (171) also confirms high dependency.

1.6. Investigation tests reported on 23rd February 1996 find that she has a normal haemoglobin of 12.9 with a slightly reduced mean cell volume of 75.6 and gross thrombocytopenia (a low platelet count) of 36,000 (57M). The report on the film (58M) shows that this is a highly abnormal full blood count with distorted red blood cells and polychromasia. A repeat blood film is suggested. This is repeated on 27th February (57M) and thrombocytopenia is now even lower at 22,000. The urea is normal at 7.1 on 23rd February but has increased and is abnormal at 14.6 on 27th February (187). Her alkaline phosphatase is 572 (over 5 times the upper limit of normal) her albumin is low at 32 (187). No comment is made on any of these significantly abnormal blood tests in any of the medical notes, though the low platelet count is noted in nursing summary on 23rd February (151).

1.7. An MSU (59M) sent on 5th February showed a heavy growth of strep faecalis there are no other MSU or other blood culture results in the notes.

1.8. Medical progression (documented on pages 45M and 46M) is of catheterisation and treatment for a possible U.T.I on 23rd February. On 26th February, a statement that the patient is not so well and the family were seen regarding progress. Nursing cardex reports (153) a meeting with the son occurred on the 24th February and state "son is happy for us just to make Mrs Lavinder comfortable". "Syringe driver explained".

1.9. The medical notes on 5th March say deteriorated further, in some pain, therefore start subcutaneous analgesia. On 6th March "analgesia commenced, comfortable overnight I am happy for the night staff to confirm death". It is then confirmed at 21.28 hours on 6th March.

1.10. The nursing care plan first mentions significant pain on 27th February (95) and describes pain on most days up until 5th March where the pain is uncontrolled and the patient is

distressed, at which point a syringe driver is commenced (97). On 6th March pain is controlled.

1.11. Drug management. I shall concentrate on the use of analgesia. Throughout the patient received appropriate doses of insulin, Co-amilofruse (a diuretic), Digoxin, Iron and steroid inhalers up unto the last twelve hours. She also received a course of Trimethoprim (an antibiotic) between 23rd and 27th February.

1.12. Morphine slow release (MST) (67M)was started at 10 mgs bd on the 24th February and is given until 26th February when MST 20 mgs bd (145)is started, this continues until the 3rd March. On 4th March Oramorph 30 mgs bd is written up and given during 4th March (139). On 5th March Diamorphine is written up 100 – 200 mgs subcut in 24 hours (137). 100 mgs is prescribed and started at 08.30 in the morning, together with Midazolam 40 mgs (137) (61M). Midazolam had been written up at 40 – 80 mgs subcut in 24 hours. Diamorphine and Midazolam pump is filled at 09.45 hours (61M) on 6th March together with another 40 mgs of Midazolam.

1.13. When admitted into hospital Dihydrocodeine PRN for pain had been written up together Hyoscine. Diamorphine 80 – 160 mgs subcut in 24 hours was written up on 26th February together with Midazolam 40 – 80 mgs in 24 hours subcut, but these drugs were never prescribed (141).

1.14. The notes document (for example page 65M) Dr Lord was the consultant responsible for this patient although the patient only appears to have been seen medically at any stage by Dr Barton, and a different consultant Dr Tandy saw the patient in the Haslar Hospital.

1.15. The Haslar notes and investigations and the reports of her x-ray's from that hospital are not available.

2. Expert opinion:

2.1. This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Elsie Lavinder. Also whether there were any actions or admissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Mrs Lavinder, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

2.2. In particular I have discussed:
a) Her medical conditions

b) Whether she had become terminally ill during her admission
c) Whether the treatment that was then provided was appropriate.

2.3. Mrs Lavinder had a number of serious underlying medical conditions. The most serious of which was her insulin dependent diabetes mellitus going back to the 1940's complicated by hypoglycaemia's, which had led, to falls on previous occasions, peripheral neuropathy which may also contribute to falls and with a combination of diabetes and other processes she had become registered blind. She also had documented frailty prior to admission, for example, already having moved her bed downstairs with an exercise tolerance of 10 yards with a stick. Her son was documented to do her shopping (11). However, she was still living alone, was only documented to have stress incontinence (11) and was cognitively intact (MTS 10/10) (165).

2.4. She was then admitted to Haslar Hospital having had a fall which was from the top to the bottom of the stairs. No explanation is given as to how she was at the top of the stairs, if she was already set up with her bed downstairs at home. Following this she is documented both at the assessment at Haslar Hospital and then on admission to Gosport Hospital as being se.verely dependent. She cannot use her arms properly, her hands and wrists are noted to be weak and she cannot stand and walk, she is so incontinent she needs a catheter and she has continual faecal leakage. Barthel is 4/10. I believe this lady was misdiagnosed and had quadriplegia from a high cervical Spinal cord injury secondary to her fall. If x-rays from Haslar Hospital or Gosport can be found they may provide evidence for this and indeed it might be helpful to get a specialist neurological advice on whether this was the likely diagnosis.

2.5. Other on-going serious medical problems have also not been explained. She has a documented low platelet count on admission to Gosport, which on repeat is extremely low and at a level that makes life threatening bleeding at any time quite probable. The blood film is also highly abnormal which suggests that there is now some systemic illness going on, probably involving this lady's bone marrow. In the absence of infection or a likely drug culprit, then cancer involving the bone marrow would be a high probability. She also has a very significant raised alkaline phosphatase, which suggests either liver, or bone pathology. No other information is now available that would help me clarify this further.

2.6. Other evidence that this lady was frail and ill is provided by the pressure sore which appears to deteriorate during admission and a low albumin documented on admission.

2.7. In my view this lady received a negligent medical assessment as she was not examined on admission to Gosport, or if she was it was not documented in the notes. Thus no medical explanation beyond the "possible brain stem CVA" is made. This would not explain all her physical symptoms, or for her profound neurological deficit. Also no medical diagnosis was made for pain that she continually complained of down her arms, which again would fit with a high cervical Spinal cord fracture or other injury. Also, no attempt was made to determine why this lady had a very low platelet count and raised alkaline phosphatase. Without making an adequate medical assessment it is impossible to plan appropriate management.

2.8. There can be no doubt though that the family, Dr Barton and the nursing staff all recognise this lady was seriously ill although they fail to come to a diagnosis and therefore could not determine whether there was any treatable underlying problem. Evidence for this can be seen that there was already discussion within 2 days of admission with the family about prognosis for recovery and how best to manage her illness. A syringe driver was already being discussed with the family on 24th February. Indeed all the markers of illness I have found, suggest this lady was very seriously ill.

2.9. Even if a high cervical Spinal cord fracture had been diagnosed, the potential for neurosurgical intervention in an elderly lady with diabetes is low and treatment with prolonged immobilisation has a very high mortality rate in itself. The unexplained low platelet count also suggests other significant serious pathology, which was never diagnosed, and on top of this we have somebody who needs all care and has leg ulcers and pressure sores. In my view, there were only two options open at this stage, **a)** to get a further specialist opinion or **b)** treat symptomatically and provide palliative care.

2.10. In view of the complexity of the medical problems, it would have been wise and appropriate to have obtained a further specialist opinion, probably from the consultant in charge of the case before deciding this lady was definitely terminally ill. I can see no evidence in the notes that this was considered. It was appropriate though to provide pain relief for someone who was both apparently in pain and distressed with loss of totally bodily function. To start MST at a normal low dose on the 24th

February was appropriate.

2.11. If the pain was not resolved, increasing the dose to 20 mgs bd on both the 26th February adding the Oramorph 30 mgs bd on 4th March were all appropriate symptomatic responses.

2.12. I have little doubt this lady was moving to a terminal phase of her illness by the 5th March. There had been no improvement in her quadriplegia, she remained faecally incontinent, the nursing cardex documents increasing pain, her platelet count has fallen further and her urea has doubled to 14.6 (187). At this stage a decision to start Diamorphine 100 mgs once a day subcutaneously and 40 mgs once a day Midazolam is made.

2.13. Midazolam is widely used subcutaneously in doses from 5 – 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 40 mgs for 24 hours, which is within current guidance, although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours.

2.14. The Diamorphine was specifically prescribed for pain and is commonly used for pain in terminal care, Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. The dose of Diamorphine actually prescribed was 100 mgs in 24 hours. At that time Mrs Lavinder was receiving 60 mgs a day of Oramorphine. Diamorphine subcutaneously is usually given at a maximum ratio of 1:2 (i.e. up to 30 mgs od Diamorphine in 24 hours for 60 mgs of Oramorphine). However her pain was not controlled and it would be appropriate to give a higher dose of the Diamorphine. Conventionally this would be 50% greater than the previous days; some people might give up to 100%. Thus a starting dose of Diamorphine of 45 – 60 mgs in 24 hours would seem appropriate. Mrs Lavinder actually was prescribed a minimum dose of 100 mgs of Diamorphine, in my view excessive.

2.15. Diamorphine is compatible with Midazolam and can be used in the same syringe driver. It is documented above though that she received a high dose of Midazolam and an excessive, and in my view, inappropriately large dose of Diamorphine. Together these drugs are likely to have caused excessive sedation and respiratory depression. There is no evidence in the notes to prove these complications occurred.

2.16. Mrs Lavinder is documented to be comfortable on the 6th and dies approximately 36 hours after the Midazolam and Diamorphine pumps were started.

2.17. In summary, I am therefore of the view:

a) the medical assessment of Mrs Lavinder was inadequate and in my view, negligently poor, in Gosport Hospital.

b) however, she certainly had serious illnesses which were probably unlikely to be reversible and therefore was entering the terminal phase of her various illnesses around the point of admission to Gosport Hospital.

c) the initial symptomatic management of her terminal illness was appropriate, but in the final 36 hours excessive doses of medication were used that would on the balance of probabilities hasten death by a short period of time.

Code A

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