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Code A

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Report on the Care and Death of
Code A
24th January 1996

This report has been provided by Dr David A Black MA MB BChir (Cantab) FRCP, Consultant Physician at Queen Mary's Sidcup NHS Trust. This report is in two parts, a factual summary of 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 evidence to support the statements, where it is followed by an M this is from the microfilm pages.

1. Timeline

1.1. Code A had a very long history of depression as clearly set out in a summary (13). In 1959 he had reactive depression, it occurred again in 1967. In 1979 he had agitation and in 1988 agitated depression.

1.2. He had a further long admission with agitated depression in 1992 (8) complicated by an episode of cellulitis (30). This culminated in an admission to long stay residential care in January 1993. There were further admissions to hospital under the care of the psychiatric team including June 1993 (37) when some impaired cognition was noted. In 1995 there was a home visit for further psychiatric problems (42).

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1.3. In 1995 (44) there was a change in behaviour, loss of weight and increased frailty was noted. He was falling at the residential home. He was expressing grief, frustrations and aggression. At this time his psychiatric medications included Diazepam, Temazepam, Thioridazine, Sertraline, Lithium, and Codanthrusate for constipation. His other problems were hypothyroidism and Parkinsonism with a tremor. (Note: this was not Parkinson's disease but tremor, rigidity and akinesia which occurs similar in Parkinson's disease but as a result of long-term anti-psychotic medication).

1.4. On 29th November 1995 he was admitted under the psychiatrist Dr Banks (46) to Gosport War Memorial Elderly Mental Health beds. His mental test score was documented at 8/10 (50). He was discharged back to residential home on 24th October (46) with a continued diagnosis of depression (56). However, his very poor mobility and shuffling gate was noted (57).

1.5. On 13th December 1995 he was re-admitted (62) to mental health beds at the Gosport War Memorial under Dr Banks stating "everything is horrible". He was verbally aggressive to the staff and was not mobilising and staying in bed all day. He felt hopeless and suicidal. (62).

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1.6. On 22nd December, diarrhoea started and he also had chest symptoms. It was thought he had a chest infection, and was treated with Erythromycin (64). On 27th December he was "chesty, not himself", and his bowels were causing concern. The physiotherapist noted that he had signs in his chest (65). A second course of a different antibiotic (Cephalosporin) was prescribed (81). The nursing cardex documents that he started becoming faecally incontinent on 20th December and then had further episodes of diarrhoea (140). It is also noted that by 1st January (147) he was drowsy with very poor fluid intake.

1.7. On 2nd January 1996 Dr Lord, consultant geriatrician was asked to see (66) and on 3rd January he was noted to be clinically deteriorating with poor food intake (66), albumin of 27 (67). An abdominal x-ray on 27th December describes possible "pseudo-obstruction" (116). This is a condition when the large bowel fails to work and starts to dilate, usually in patients who have multiple illnesses including Parkinsonism, electrolyte imbalance, infections, antibiotics and other drugs. Prognosis depends on resolving the underlying causes.

1.8. On 4th January 1996 Code A is seen by Dr Lord, Consultant Geriatrician who noted severe depression, total dependency, catheterisation, lateral hip pressure sores and hyperproteinaemia. (67) He states that the patient should be moved to a long-stay bed at the Gosport War Memorial Hospital and that his residential home place should be given up as he was unlikely to return. On 5th January he is transferred to Dryad Ward for "long-term care" (151). Dr Lord also states (5M) "Mrs Code A is aware of the poor prognosis".

1.9. Medical notes after transfer (13M and 15M). On 5th January a basic summary of the transfer is recorded, on the 9th January increasing anxiety and agitation is noted and the possibility of needing opiods is raised. The nurses cardex on 9th said that he is sweaty and has "generalised pain" (25M). On 10th January a medical decision is recorded "for TLC". In the medical discussion (13M) with the wife also apparently agrees "for TLC". I am not sure of the signature of 10th January in the medical notes (13M). The nursing cardex records they commenced Oramorph and that Mrs Pittock is aware of the poor outcome (25M).

1.10. The 15th January the nursing notes document that a syringe drive has been commenced (25M) and by the evening the patient is unresponsive (26M). However on 16th January there is some agitation when being attended to and Haloperidol is added to the driver (26M). On the 17th the patient remains tense and agitated,(27M) the nursing cardex states that Dr Barton attended, reviewed and altered the dosage of

medication. The syringe drive is removed at 15.30 hours and the notes say "two drivers" (27M).

1.11. The next medical note is on 18th January, eight days after previous note on 10th January. This states further deterioration, subcut analgesia continues..... try Nozinan. On 20th January the nursing notes state that Dr Briggs was contacted regarding the drug regime and there was a verbal order to double the Nozinan and omit the Haloperidol (28M). This is confirmed in the medical notes on 20th January (15M). The medical notes on 21st January state "much more settled", respiratory rate of 6 per minute, not distressed and on 24th January the date of death is verified by Staff Nurse Martin in the medical notes (15M).

1.12. Drug Chart Analysis:

Note: Nozinan is a major tranquilliser similar to Chlorpromazine but more sedating. It is usually used for patients with schizophrenia and because of its sedation is not usually used in the elderly, though it is not completely contraindicated. Used subcutaneously in palliative care for nausea and vomiting at a dose of 25 – 200 mgs for 24 hours although British National Formulary, 39 Page 14, states that 5 – 25 mgs for 24 hours can be effective for nausea and vomiting with less sedation.

1.13. On 5th January at transfer (16M), Code A is written up for the standard drugs that he was on in the mental health ward including his Sertraline and Lithium (for his depression) Diazepam (for his agitation) Thyroxine for his hypothyroidism. The drug chart also had Diamorphine 40 – 80 mgs subcut in 24 hours, Hyoscine 200 – 400 micrograms subcut in 24 hours and Midazolam 20 – 40 mgs subcut in 24 hours, written up but not dated and never prescribed. (18M)

1.14. On 10th January, Oramorph 10 mgs per 5 mls is written up for 2.5 mls four hourly and prescribed on the evening of 10th and the morning of the 11th. On the 11th Oramorph 10 mgs per 5 mls is written up to be given 2 mls 4 hourly 4 times a day with 5 mls to be given last thing at night. This is then given regularly between 11th and up to early morning on 15th January. This is a total daily dose of 26 mgs of morphine (19M).

1.15. Diamorphine 80 – 120 mgs subcut in 24 hours is written up on 11th January "as required" as is Hyoscine 200 – 400 micrograms in 24 hours, Midazolam 40 – 80 mgs in 24 hours. 80 mgs of Diamorphine together with 60 mgs of Midazolam are then started on the morning of the 15th January and the pump re-started on both the mornings of the 16th and 17th January. (18M). On 16th January Haloperidol 5 mgs – 10 mgs subcutaneous for 24 hours is written up, prescribed over 24

hours on both 16th and 17th. I am not clear if this was mixed in the other pump or was the second pump referred to in the nursing cardex. (20M and 27M)

1.16. Diamorphine 120 mgs subcut in 24 hours is then prescribed on 18th January, together with Hyoscine 600 mgs subcut in 24 hours. The drug charts (20M) show this starting on the morning of 17th January and at 08.30 hours. If this correct there may have been up to three pumps running, one with Diamorphine 80 mgs, one with Diamorphine 120 mgs in and one with the Haloperidol. It is more likely though that this is a nursing recording error and that actually the pump was started with 120 mgs on 18th January (20M) this would be in line with the nursing cardex notes (27M).

1.17. The subsequent drug charts all appear to be missing for the final 6 days, however the nursing notes (27M, 28M and 29) suggest that there was a fairly constant prescription of 120 mgs of Diamorphine 24 hours, 80 mgs 24 hours, Hyoscine 1200 mgs, Haloperidol 20 mgs and Nozinan 50 mgs. On the 20th there was no Haloperidol and the Nozinan was increased 100 mgs a day. This is still the prescription on 23rd January (27M).

2. **Expert Opinion:**

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

2.2. In particular I will discuss **a)** whether Code A had become terminally ill and if so whether symptomatic treatment was appropriate and **b)** whether the treatment provided was then appropriate.

2.3. Code A has an unfortunate long history of depression which had become more difficult and complex to manage and increasingly distressing in terms of his agitation related to his depressive symptomatology.

2.4. He had many treatments including high level drug treatment over many years and many episodes of electro convulsive treatment (ECT).

2.5. The complex and unresolved psychiatric problem led to a requirement to move to a residential accommodation in 1993.

However he had further relapses and problems in 1995. A change occurred by September 1995 where the residential home was now noticing weight loss, increasing frailty and falls. Although a subsequent admission only came to the conclusion that he was depressed I have no doubt that his terminal decline was starting from that time.

2.6. By October 1995 he had extremely poor mobility and a shuffling gate. When re-admitted in December is aggressive, essentially immobile and extremely mentally distressed alongside his increasing physical frailty.

2.7. It is impossible in retrospect to be absolutely certain what was causing his physical as well as his mental decline. It may be that he was now developing cerebrovascular disease on top of his long standing drug induced Parkinsonism together with his persistent and profound depression agitation. It is not an uncommon situation for people with long standing mental and attendant physical problems, to enter a period of rapid decline without a single new diagnosis becoming apparent.

2.8. His deterioration is complicated by a probable chest infection (64, 81), which does not respond particularly well to appropriate antibiotic and physiotherapy treatment. He also has bowel complications attendant on all his other medical and drug treatment (116).

2.9. Dr Banks, psychiatric service asked Dr Lord, Consultant Geriatrician, to see the patient on 2nd January and he is actually seen on 4th January 1996. Dr Lord describes a very seriously ill gentleman. His comments that a long-stay bed will be found at the Gosport War Memorial and that he is unlike to return to his residential bed, reflect the fact that it was in his mind that this gentleman was probably terminally ill.

2.10. Code A is then transferred to Dryad Ward and is apparently seen by Dr Barton. A short summary of his problems is written in the notes but no physical examination, if undertaken, is documented.

2.11. It remains clear from the nursing record that he remains extremely frail with very little oral intake on 7th January (25M). When seen again by Dr Barton on 9th, there is the first note suggesting that Opiates may be an appropriate response to his physical and mental condition.

2.12. It is my view that this gentleman by this stage had come to the end point of a series of mental and physical conditions and that his problems were now irreversible. He was in considerable mental distress and had physical symptoms partly related to that

and partly related to other medical problems. In my view he was dying and terminal care with a symptomatic approach was appropriate.

2.13. On the 10th Oramorph was started. Oramorph and Diamorph are particularly used for pain in terminal care. The nursing notes document that he had some pain; but most of his problems appeared to be restlessness, agitation and mental distress. However, despite the lack of serious pain, morphine like drugs are widely used and believed to be useful drugs in supporting patients in the terminal phase of the restlessness and distress that surrounds dying. I would not criticise the use of Oramorph in conjunction with his other psychiatric medication at this stage.

2.14. The decision that he was now terminally ill and for symptomatic relief appears to have been made appropriately with both the family and the ward staff and there was no disagreement with this decision.

2.15. A dose of Oramorph given from the early morning of 15th January was 26 mgs of morphine a day (see paragraph 1.14) (19M). On the 15th a syringe driver is started containing 80 mgs Diamorphine and 60 mgs of Midazolam. If a straight conversion is being given from Morphine to Diamorphine then you normally halve the dose i.e. 26 mgs of Oramorphine might be replaced by 13 mgs of Diamorphine. If you are increasing the dose because of breakthrough agitational pain then it would be normal to increase by 50% each day, some clinicians might increase by 100%. This would suggest that the maximum dose of Diamorphine to replace the stopped Oramorphine might be up to a maximum of 30 mgs of Diamorphine in 24 hours. Starting 80 mgs of Diamorphine is approximately three times of the dose that could medically be argued for.

2.16. Midazolam was also started at a dose of 60 mgs per 24 hours. The main reason for using this is terminal restlessness and it is widely used subcutaneously in doses from 5 – 80 mgs per 24 hours for this purpose. Although 60 mgs is within current guidance, many believe that elderly patients need a lower dose of 5 – 20 mgs per 24 hours. This would again suggest that there was the likelihood the patient was being given a much higher dose of Midazolam then would usually be required for symptom relief.

2.17. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Based on the evidence suggesting unusually high dosage of these medications being used I have considered whether there was evidence in the notes of any drug complications. I was only able to find two pieces of evidence.

The first was a statement in the nursing notes (26M) that by the evening that the syringe driver was started, the patient was unresponsive. The aim of palliative care is to provide symptom relief not possible over sedation leading to unconsciousness. However, this did not continue and Code A was noted to be more alert and agitated again on the 16th.

Secondly on the 21st January (15M) a respiratory rate of 6 per minute is noted suggesting possible respiratory depression.

2.18. A further drug, Nozinan, a sedating major tranquilliser is added to the drug regime, 50 mgs a day on the 18th January and increased to 100 mgs a day on the 20th January. Though this is within the therapeutic range in palliative care, 25 – 200 mgs a day when it is used for nausea and vomiting, the BNF advises 5 – 20 mgs a day and that the drug should be used with care in the elderly because of sedation.

2.19. The combination of the high doses of Diamorphine, the high doses of Midazolam and the high doses of Nozinan are in my view likely to have caused excessive sedation beyond the need for symptom control in this dying man. In my view the medication is very likely (on the balance of probabilities) to have shortened life. However I would have expected this to have been by no more than a few days if a lower dose of all (or indeed any) of the drugs that had been used instead.

Code A

11/04