## Other Document Form

Number T217

Title EMAIL DR LAWSON Code A RE FIRST 20 CASES

*(Include source and any document number if relevant)*

Receivers instructions urgent action Yes / No

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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

Indexer

Code C

**From:** Code A
**Sent:** 10 February 2004 09:54
**To:** Grocott, David
**Subject:** FW: first 20 cases

First 20.doc (35 KB)

-----Original Message-----
From: Peter.Lawson@sth Code A
Sent: 21 November 2003
To: Code A
Subject: first 20 cases

Dear Code A
Here are my brief notes on the first 20. As I said to Code A I will have the others ready by this time next week.

Peter

<<First 20.doc>>

Peter Lawson
Consultant Physician and Geriatrician
Code A

BJC/01A
VICTOR ABBATT
Code A
Admitted with bronchopneumonia
Was cyanosed at time of admission
Given temazepam 10mg at 2215
Died at 0005

Bad medicine to prescribe and give temazepam to someone with breathing difficulties
But already very unwell
PL grading A2

BJC/02
DENIS AMEY
Code A
There are no drug cards or relevant nursing notes
Severe PD
Developed gangrenous – decided on conservative treatment

Started on morphine elixir on 11/12/90
On 120mg diamorphine sc per 24 hours by 19/12/90

This is a huge dose but might have been appropriate
There is not enough detail in the notes to be sure of what the opiate requirements were
- probably some medication cards and casenotes missing

He was clearly very unwell and in pain
However the dose of opiate might have contributed to his death
PL grading B but difficult to give a number

BJC/03
LILY ATTREE
Code A

Known to have nasopharyngeal ca invading base of skull

| | | |
|---|---|---|
| Started oromorph prn | 15/8/96 | 25mg total |
| | 16/8/96 | 20mg total |
| | 17/8/96 | 20mg then started 20mg 4 hourly |
| converted to sc infusion on | 20/8/96 | 50mg/24 hours |

slight dose increase from oromorph to driver but probably needed because of pain

increased to 75mg/24 hours on 21/8/96 then kept stable until death on 24/8/96
Terminal disease, dealt with well

PL grading A1

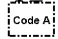
BJC/04
EDITH AUBREY
Code A

Fractured neck of left femur
DHS repair 2/10/94

Previous medical problems eg cerebrovascular disease, dementia and stroke
29/4/96 Fentanyl started, distress when being moved, control of pain
14/5/96 increased to 50mcg
20/5/96 increased to 75mcg
Diazepam continued to help with distress
Reasonable conversion to diamorphine syringe driver
Midazolam also used for agitation

The final cause of death is not entirely clear
Management of pain and distress was reasonable

PL grading B1 or B2

BJC/05
HENRY AUBREY


Unproven but probable diagnosis of lung carcinoma

No records for episode prior to transfer to Dryden except Dr Reid's letter and nursing transfer letter. Neither mention significant pain. Dr Bee Wee mentions opiates for control of cough.

Was on oromorph 10mg BD on 25/5/99
Transferred to Dryden on 1/6/99
Immediately put on fentanyl 25mcg patch and also given oromorph 10mg
Following day at 09.25 given syringe driver with 60mg diamorphine and 40mg midazolam. He died at 18.30

He had a terminal diagnosis and was recognised to have given up.
However the need for such a large dose of diamorphine is unclear (distress is mentioned but not pain).

PL grading B3 because the doses cannot be justified by the available notes.

BJC/06
ELLEN BAKER
Code A

sudden deterioration soon after admission. Consistent with acute myocardial infarction and pulmonary oedema. Treated appropriately with oxygen, frusemide (diuretic) and small dose of diamorphine. There are no concerns about this one.

PL grading A1

BJC/06A
CHARLES BATTY
Code A

History of I Code A , Code A
Lengthy stay in hospital, condition appeared stable with agitation and difficult behaviour. This was initially treated with lorazepam and thioridazine.
Pain mentioned in nursing notes on 28/12/93 not mentioned in available medical notes. Cause of pain not clear. Went from little analgesia to oromorph 60mg in 24 hours. Within 8 hours converted to syringe driver with an increase in dose. Dose kept stable for next 3 days up to his death.

Cause of pain unclear. Large opiate dose without other forms of pain relief and rapid change to driver. Cause of death is unclear.

PL grading B2

BJC/06B
DENNIS BRICKWOOD
Code A

Hip fracture, Code A te, osteoporosis with vertebral fractures, myeloma. Aiming for home but had an unsuccessful home visit.
Developed musculoskeletal chest pain and chest infection. Chest xray suggested anterior rib fracture. Codydramol ineffective. Converted to oromorph then dose increase to MST then large dose increase to syringe driver. Died 24 hours after starting driver. No other analgesics tried ?would have responded to NSAID or heat packs.

Cause of death unclear and use of analgesia was not ideal

PL grading B2

BJC/07
STANLEY CARBY
Code A

Admitted with a severe stroke, rapidly deteriorated and died.
When he deteriorated he was prescribed a large dose of diamorphine via driver. However he died within 45 minutes of it being started ie too soon for it to have a significant effect.

Cause of death was the extension of stroke. The large dose of diamorphine makes care sub-optimal but it no effect on his death.

PL grading A2

BJC/08
EDWIN CARTER
Code A

2 previous strokes
Code A

Was in pain at time of admission. Initially controlled with MST at 20mg twice daily. Increased to 30mg BD on 13/12/93. Deteriorating and report of pain appearing to be uncontrolled when being turned on 22/12/93. Diamorphine and midazolam syringe driver set up. MST 30mg BD changed to diamorphine 80mg via syringe driver ie approx 4-fold increase in dose. Died on 24/12/93.

Likely to have been dying of his c Code A and he started to deteriorate before the syringe driver was set up. But the dose change appears excessive.

PL grading A3

BJC/08A
EDITH CHILVERS
Code A

Dense stroke with severe pain ?thalamic in origin. Only 23 pages of notes and it is difficult to know how the opiates were titrated against the pain. She ended up on a very high dose but it might have been appropriate and I cannot give a grade from the available notes except to say that the description of the stroke suggests it was enough to account for her death.

BJC/09
SIDNEY CHIVERS
Code A

Had a stroke. Initially doing fairly well but it became clear he was not going to make it home. There was a suspicion of Code A for which traditional antipsychotics should be avoided; his dose of risperidone was increased (risperidone is a new antipsychotic which should have been OK). He deteriorated soon after the dose increase with pain in his hands and also abdominal pain. Treated with opioids and then large dose of midazolam.

I am not sure what his pain was caused by although stiffness and pain could have been due to risperidone and abdominal pain due to constipation. After starting with oramorph the opioid dose was escalated through fentanyl 25mcg to diamorphine driver 60mg and 80mg midazolam in 3 days.

Cause of death unclear and opioids escalated without trying other ways of stopping the pains.

PL grading B2

BJC/10
HUBERT CLARKE
Code A

A man with cerebrovascular disease and falls
In his short hospital admission he suffered cardiac chest pain and a pneumonia. He was well looked after with good use of medication via a syringe driver.

PL grading A1

Code A

Code A

Code A

Code A

Code A

Code A

BJC/14
RONALD CRESDEE
Code A

Code A of bronchus with oesophageal obstruction and stent.
Started with prn oramorph then regular oramorph, dose increased and then diamorphine syringe driver. Good dose conversion. Cause of death clear.

PL grading A1

BJC/15
ARTHUR CUNNINGHAM
Code A

Code A
Admitted from a Nursing Home with "difficult" behaviour.
In June 1998 could use a mobile phone and went into Gosport in a taxi.
Admitted from Day Hospital with large necrotic sacral sore.

The sacral sore must have been painful but the reasons quoted for starting the diamorphine/midazolam infusion were related to his behaviour. Even on 23/9/98 when his became more bubbly the change to the infusion was to increase the midazolam ie sedation rather than hyoscine to reduce secretions. Pain mentioned by Dr Barton on 24/9/98 as controlled just. No mention of pain on 25th and 26th September but the dose of diamorphine was increased on both days.

Cause of death probably bronchopneumonia although the medication might have contributed to it. Care sub-optimal

PL grading B2. Different to the majority view but I can see why others would grade worse.

BJC/16
ELSIE DEVINE
Code A

Multi-infarct Code A, moderate chronic renal failure, paraproteinaemia.
Occasionally aggressive and restless. Prescribed thioridazine for this.
When she became more agitated she was started on fentanyl and then converted to large doses of diamorphine and midazolam via a syringe driver. Pain was not raised as an issue.

Cause of death is not clear and the use of opioids questionable especially when considering the doses.

PL grading C2

BJC/17
CYRIL DICKS
Code A

Code A very dependent.
Deteriorating gradually then rapidly over the weekend of 20-21/3/99. One nursing record states sc analgesia and midazolam started on 20/3/99. There is no record of this on the available medication cards or in the medical notes. Elsewhere in GWMH notes the nurses write diamorphine doses given via syringe driver in the notes in red. This is not done here. I do not know if he was given diamorphine.

Cause of death is not clear anyway but if diamorphine was not given it was natural. Care reasonable but he fell on the ward and they were prepared to use diamorphine where it was not clearly indicated.

PL grading A2