Elsie LAVENDER Code A - **6.3.96**

Witnesses

1. **Alan Lavender** her son said that Elsie had been diabetic since 1942.
   She was insulin dependent. She suffered from slight rheumatism, she was partially blind, she had leg ulcers and was incontinent.

Otherwise she was a strong independent woman. However it was noted that she had a nurse twice a day and a home help.

Her GP was Dr Barton.

In February 1996 she had a fall. There was a question as to whether that was a diabetic event or a stroke. It was subsequently diagnosed as a brain stem stroke.

When he saw her she was as well as can be expected.

He considered that Dr Barton was very callous 'you can get rid of the cat' ' you do know that your mother has come here to die'. You may recall his memory of the incident was the same as others that were there.

His mother was admitted to Gosport on 22nd February 1996. She had a syringe driver applied on 5th March 1996 and died on 6th March 1996.
The cause of death given was:
1a Cerebrovascular Accident
II Diabetes Mellitus

2. **Sheelagh Joines** was a Sister employed at Gosport. She had qualified in 1958 and effectively had a lifetime experience.

She worked with Dr Barton and had great respect for her if not affection.

She was concerned with Terminal Care. Some of the patients were for rehabilitation but otherwise the aim was to 'give care, comfort and dignity' and twenty four hour pain relief.

She confirmed that the Dr prescribed and authorised the syringe drivers. These were put up when required by two trained nurses. The matter was discussed with the family and she was able to tell us from the notes that she was at the meeting with Mr & Mrs Lavender when the syringe driver was discussed.

There were occasions when Dr Barton was not there. The prescription had been written up proactively but would not have been used until needed and they would always have consulted Dr Barton.

She certainly felt that they were under pressure from other hospitals because of bed blocking.

She had no concerns about syringe drivers or analgesia.

She has no direct memory of Elsie Lavender but from the notes she is able to say that on 26th February 1996 her son and daughter in law were seen by Dr Barton and the prognosis was discussed. Mr Lavender was happy for the staff just to make Mrs Lavender comfortable and pain free. She says quite specifically that the syringe driver was explained.

It is worthy of note that the syringe driver was not started until the 5th March 1996.

The statement of **Yvonne Astridge** was read. She said that she had been a nurse for 25years and she explained the nursing care plan to relieve pain and make Elsie more comfortable.

By 22nd February 1996 she said that Elsie was unable to care for her hygiene needs unaided. She had bed sores that required to be dressed. She was overweight and unable to get out of bed. By March 1996 she was constipated, she was not eating or drinking and she was in pain.

The care plan on 5th March was for pain relief and on 6th March she had 100mg of diamorphine and 40mg of midazolam by syringe driver.

She had no concerns about patient care at Gosport.

By the 24th February 1996 a decision had to be made as to whether she was to receive treatment actively or palliative care. The pain was well documented in the notes and whilst he believes that was based upon a misdiagnosis the situation under consideration remained the same. The prognosis was poor.

On 5th March some two weeks later the oral mst stops and she is on to 100mgs of diamorphine although she had been on 40mgs of mst. He was unable to say why that dosage had been so much higher. However there no significant side effects from the nursing notes and she appeared comfortable. It is significant that Mrs Couchman had referred in her evidence to Mrs Lavender being in uncontrolled pain.

He would have given the cause of death at:
1a Cervical Chord Injury

In response to Mr Jenkins he said that he may have put Mrs Lavender into a neck brace on admission although she presented a very complex and challenging problem. She had multiple medical problems but felt that there had been a failure to assess her medical condition. He was in no doubt that she was entering the terminal phase of her life.

On 5th March because of the pain it appears that she had been started on the subcutaneous analgesia and on 6th March there was further deterioration and she died at 21.28 hours that day.

Dr Barton gave evidence about her involvement with Mrs Lavender and recounts the medical history. In particular she confirms that Dr Tandy Dr Barton describes as a specialist in stroke care, had suffered a brain stem stroke that had led to the fall. She had been an insulin dependant diabetic for 40years she was registered blind now immobile and had atrial fibrillation. She had pain down her arms and in her shoulders and required two people to transfer her. She had incontinence and anaemia.

Dr Barton admitted Mrs Lavender to Daedalus ward on 22nd February where she records previous medical history fall at home top to bottom of stairs, laceration on head, leg ulcers, severe incontinence, needs a catheter iddm insulin dependent diabetes mellitus, needs mixtard insulin bd, regular series bs transfers with two, incontinent of urine, help to feed and dress, barthel two assess general mobility query suitable rest home and home found for cat and you may recall Mr Lavender's comments on the

same subject. She was highly dependant and was at very high risk of developing pressure sores.

Her prognosis was poor but there was a hope that she may be able to be re-habilitated. She seems to have been prescribed appropriately for her atrial fibrillation, congestive cardiac failure, diabetes and her other difficulties and for pain relief she was prescribed dihydracodeine.

The following day on 23rd February Dr Barton notes cathertised last night 500mls residue blood and protein trimethoprim there was a suggestion that she might have had a urinary tract infection. That was the reason for the antibiotic.

Dr Barton sees her on 24th February which is in fact a Saturday and notes that her pain was not controlled by the dihydracodeine and that she had a red and broken sacrum. That is a bed sore. Dr Barton therefore prescribes morphine sulphate at 10mgs twice a day. That was in addition to the dihydracodeine. Mrs Lavender then has a comfortable night although she appeared to be in more pain the following evening when moved she screamed 'my back'. Otherwise she seemed to be pain free.

The sacral area was now weak and blistered and there were red sore broken areas.

Dr Barton says that she would have seen Mrs Lavender again on 26th February and that the previous morphine sulphate had become insufficient and she therefore increases it to 20mgs twice a day again with the dihydracodeine.

Although Dr Barton has no recollection of the meeting Mr Lavender says that he and his wife saw her at Gosport on 26th February although he describes a fairly brutal exchange Dr Barton says that is highly unlikely.

Dr Barton refers at this point to the detrimental effect on health that a transfer can have on somebody in Mrs Lavender's condition. I did explore that with her and she was quite clear that the move it self can accelerate death.

Dr Barton's evidence at this point is speculative because she has no direct recollection of the meeting but says that she would of discussed with Mr Lavender use of the syringe driver and diamorphine if pain continued. She believes that Mr Lavender would have been concerned that his

mother should have adequate pain relief and that seems to accord with Mr Lavender's recollection.

On 26th February Dr Barton again sees Mrs Lavender and notes not so well over the weekend family seen and well aware of prognosis and treatment plan bottom very sore needs Pegasus mattress institute subcutaneous as analgesia if necessary.

She believes it was as a result of a conversation with Mr Lavender that she wrote up the pro-active prescription for diamorphine 80 to 160mgs together with madazalam 40 to 80mgs and hyoscine 400 to 600mgs. If nursing staff felt that it was appropriate they could obtain Dr Barton's permission over the telephone to administer the medication.

Mrs Lavender is seen effectively daily and her condition is slowly deteriorating. Her blood sugars are elevated on 29th February and she is ordered a quick acting insulin.

After the weekend on Monday 4th March Mrs Lavender is in pain and oramorph is prescribed at 30mgs twice a day. She was probably still taking dihydracodeine at that stage.

On 5th March Mrs Lavender had had a very poor night and was distressed. She was not eating or drinking and had deteriorated quite significantly. Dr Barton says for that reason the syringe driver was set up to administer diamorphine and medazalam at the rate of 100 to 200mgs and 40 to 80mgs respectively and hyacine at 400 to 800 mgs. That syringe driver was set up at 9.30 that morning the dosage was started at 100mgs diamorphine and 40mgs medazalam although the hyacine was not administered at that stage. She is quite clear that the prescription was to relieve pain and distress in a lady who was dieing. Her notes are clear on 5th March has deteriorated over last few days not eating or drinking in some pain therefore start subcutaneous analgesia let family know.

In seeing Mrs Lavender on 6th March Dr Barton notes further deterioration subcutaneous analgesia commenced comfortable and peaceful I am happy for nursing staff to confirm death.

The cause of death is certified as:
1a Cerebrovascular Accident

In response to questions from you if Haslar had picked up the broken neck then Mrs Lavender would have been seen at Accident and

Prof Black

Comments large dose of diamorphine written up 80-160 mg prn 26/2/96

Confirms moving to terminal phase by 5/3/96 + a third stage decision made diamorphine 100mg + midazolam 40mg sub cut + notes dose is double oramorph - but it is not controlling the pain but third dose makes her comfortable & she dies 36 hrs later

He considers the Midazolam & diamorphine were excessively high

He said the symptomatic management of her terminal illness was appropriate but the doses of medication in the last 36hrs were excessive

supervision of staff generally and in relation to opiate prescription and administration in particular.

14. Obviously, each death will raise separate issues and will require individual examination.

15. Given that there are generic issues that appear to apply to all 10 deaths, it is submitted that it would be appropriate for the cases to be heard together. This is likely to result in the best use of resources, including expert evidence, and it is anticipated that a single inquest will allow the generic issues to be considered in appropriate detail. Further, a single hearing is likely to result in closure of the matter for all of those involved – relatives and trust staff alike – and this is less likely to be achieved through a series of separate inquests.

16. Careful consideration will be required as how best to conduct the hearings. At this stage, it is submitted that it would be appropriate for there to be a phase of evidence regarding generic issues, with subsequent consideration of the individual deaths.

17. In terms of the organisation of evidence, it is submitted that it would be appropriate to have a bundle containing generic evidence, then separate bundles in respect of each of the deceased, containing medical records, witness statements and any expert evidence. This would circumvent the problem of disclosing information about each deceased to the relatives of other deceased persons.

Jury

18. It is submitted that it would be appropriate for HM Coroner to sit with a jury, either on a mandatory basis under section 8(3)(d) of the Coroners Act 1988 ("the Act") or on a discretionary basis under section 8(4) of the Act.

19. Section 8(3)(d) of the Coroners Act 1988 provides:

"*If it appears to a coroner, either before he proceeds to hold an inquest or in the course of an inquest begun without a jury...(d) that the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public, he shall proceed to summon a jury in the manner required by subsection (2) above).*"

20. It is submitted that the facts of these cases disclose prima facie evidence that the deaths occurred in circumstances the continuance or possible recurrence of which is prejudicial to the public, in particular elderly hospital patients. The criteria of section 8(3)(d) are made out and the Coroner is obliged to sit with a jury.

Emergency at Haslar. She would have gone into a medical bed there. If she had and unstable fracture Haslar would not have got her to walk. Dr Tandy says that it was a brain stem stroke and she is the expert she was quite clear that she had told Mr Lavender that his mother was going to die.

* Dr Black

Dr Wilcock gave a brief history and was concerned that there was a question about whether Mrs Lavender had entered the terminal phase of her life or whether her conditions were reversible. It was possible that the doses of diamorphine and medazalam could have contributed more than minimally, negligibly or trivially to her death.

He said that there should have been an x-ray and that his concerns were that the pain was getting worse and was not resolving. Again he felt that small doses of analgesics as required should have been used and whether or not the doctor was on the premises was irrelevant. The service agreement required Dr Barton and her practice to provide twenty four hour cover seven days a week. Effectively it was the cover which was being paid for and not a number of sessions. Mr Jenkins suggested that it was the availability of the doctor that was the problem but Dr Wilcock did not accept that.

In response to Mr Leper he said that it was important that patients get what they want when they need it. If patients were distressed of agitated he would hope that the reason for that would be established and he questioned by how much the prescribing doctor could be satisfied that the drugs being administered were being done appropriately.

In response to a question that you asked the job description was for four or five sessions which may be up to twenty hours per week but Dr Wilcock said that that was nominal and that what was being paid for was cover.