Helena SERVICE Code A 5.06.1997

Alexander William Tuffey his statement was read and he said he was the nephew of Helena Service. He told us that his Aunt had gone deaf at an early age. She had always been physically fit and alert and was an intelligent women. After her husband died she continued to live alone and was perfectly able to care for herself.

In the early 1990's she had a stroke but regained all her mental faculties although she had some residual loss of use in her left hand.

She continued to live at home supported by home helps and meals on wheels but in 1993 on the recommendation of her GP she went to Willow Cottage Nursing Home.

In 1997 she became ill and was taken into QA and it was then that the people who ran the Nursing Home said they could no longer cope with her and against that background she was transferred to Gosport War Memorial Hospital. Two days later she died.

The cause of death given was:
1a Congsetive Cardiac Failure

Statement of **Judith Rees** GP for Helena Service. She confirmed that in December 1992 Mrs Service was admitted to QA following a collapse at home. She was then discharged to Willow Cottage Rest home.

She was treated for chest infections and was beginning to suffer shortness of breath and she was treated for heart failure.

In January 1996 she referred her to QA with a swollen hot right wrist and a diagnosis of septic arthritis was confirmed and she was treated.

In March 1997 apparently she started shouting at night and keeping other residents awake. She was prescribed a small dose of sedative which was administered by the care staff in the rest home for night time agitation.

On 12th May 1997 she was becoming increasingly drowsy had ankle swelling and a chest infection appeared to have exacerbated her heart

failure. Dr Rees at that point considers that she is very unwell and is dieing.

Her rest home were unable to cope with her condition and on 17th May she was admitted to QA.

Dr Barton gave evidence and confirmed from the records that she had suffered a cerebrovascular accident in October 1984 from which she made a good recovery.

In August 1987 she was admitted to hospital having sustained rib fractures after a fall at home and she was noted to be in atrial fibrillation.

In December 1992 she was admitted to QA having suffered another CVA but again made a good recovery. From 1995 she seems to be suffering from heart failure and on 17th January 1995 she was admitted to QA where she was not expected to survive. However with the medication recovered and was discharged at the end of January.

In May 1997 her condition deteriorated and her home was unable to cope with her and she was admitted to QA with her condition described as very poorly. It was suggested she had a UTI and whilst that responded to antibiotics she had now become increasingly short of breath, confused and disorientated.

She was in Left Ventricular Failure and was marked at that stage at QA Not For Resuscitation.

On 23rd May 1997 the suspicion was that she had suffered another CVA and her barthel was noted to be 4 which meant that she was highly dependant on others for her care.

Mrs Service was transferred to Gosport War Memorial Hospital on 3rd June and was recorded as being a 99year old with Atrial Fibrillation and confusion. Dr Barton felt that she would have been transferred from QA via the transfer lounge and that would have been a very stressful experience for her.

She carries out an assessment at Gosport and records transferred to Dryad Ward recent admission 17.5.1997 confusion, off legs that she had an upper respiratory tract infection, non insulin dependent diabetes mellitus, congestive cardiac failure, gout, on exertion slightly breathless confirmation that her heart was having great difficulty in coping. Dr

Barton believed that she was very unwell. She believed that she was probably dieing indeed may die very soon.

She had needed diuretics because of her heart failure but they had left her dehydrated. Dr Barton felt quite clearly that she would have been more appropriately treated at QA. The choice at that stage was to consider transferring her back there which of itself may have killed her or leaving her where she was and making her comfortable. On balance it was felt appropriate to leave her at Gosport.

Dr Barton wrote up a prescription for 5 to 10mgs of diamorphine to be administered intramuscularly and she also wrote her up for a diuretic an ace inhibitor, something for her gout, for her atrial fibrillation and aspirin to prevent a further CVA.

In addition she also prepared a prescription for morphine 20 to 100mgs subcutaneously over twenty four hours together with hyacine and midasalam. The reasoning was that if her condition did deteriorate and she developed pulmonary oedema that could leave her with the sensation of drowning which would be profoundly distressing for someone in Mrs Services condition. She says that the diamorphine and medazalam would have the effect of relieving the significant distress and anxiety produced from that sensation.

By 3rd June Mrs Service had a barthel score of 0 and she has a pressure sore on her buttocks from which the skin has broken. Over night she is restless and agitated and she is given 20mgs of medazalam. Notwithstanding she remains restless and the following morning the syringe driver is re-charged 20mg of diamorphine and 20mgs of medazalam and Mr Tuffey the nephew is informed of his aunt's poor condition. She is reviewed by Dr Barton on 4th June and is assessed as being terminally ill with heart failure and she is distressed and agitated. The diamorphine and medazalam continued and she dies at 3.45am on 5th June. At that stage she has been in Gosport two days and has been receipt of diamorphine and medazalam for 24hours.

Professor Black confirmed the medical history and that on 3rd June she is transferred to Gosport being confused, off her legs, having diabetes and heart failure.

He feels that further opinion should have been sort before the diamorphine 20mgs and medazalam 40mgs are started on the syringe driver. He is also critical of QA who he feels carried some responsibility

for the fact that she was transferred in that condition at that age. He noted that she was restless and agitated and that diamorphine may well have been indicated.

He gave probable cause of death as:
1a Congestive Cardiac Failure
1b Ischaemic Heart Disease
II Cerebrovascular Disease

He confirms that the diamorphine may have been started at a lower dose for preference but it is clear that Mrs Service did not settle and that whatever the position Mrs Service had a very poor prognosis.

When questioned by Mr Jenkins he said that in the circumstances diamorphine would have been his drug of choice and the only question her raises is the starting dose.

The Statement of **Dr Peth** cardiologist was read and in response to the various questions that were put to him he confirmed that her treatment for CCF was appropriate and that whatever the position the drug regime was indicative of palliative care and that the drugs would have a role in the relief of breathlessness. His view was that it would be appropriate if curative treatment was no longer possible then the drug regime would have been 2.5mgs intramuscularly or intravenous and 20mgs subcutaneously. However he points out that tolerance would have developed and the doses would have to be increased he confirms that her prognosis was terminal ie: she had a few days to live. He confirms that the prescription for diamorphine was appropriate throughout and concludes that at death the diamorphine and medazalam are appropriate and desirable.

Dr Wilcock gave a brief history and said that he felt there had been inadequate assessment of Mrs Services's symptoms and cardiovascular status. Most of her medication had been continued but the thioridazine was omitted and that seemed to be significant. When she failed to settle she was given medazalam and not the thiroidazine that she had previously been given and he could not understand that.

In response to Mr Jenkins he said that he disagreed with Dr Pech and he could not accept that diamorphine 20 to 100mgs and madazalam 20 to 80mgs was appropriate.

It was queried whether he was the right man for the job and he confirmed that he was principally concerned with the administration of drugs and the majority of his patients were elderly.

In response to Mr Leper he said that seventy per cent of his patients wre geriatric and that he used diamorphine and had used syringe drivers. In his hospice practice the median dose of diamorphine was 40mgs and in the General Hospital the median was 10mgs.

Normally diamorphine would be given for pain, breathlessness and cough. He was concerned that drugs were prescribed without ascertaining the reason for the problem.

All drugs had to be prescribed in context after an assessment particularly to find the cause of agitation. Mrs Services's agitation may have been just because of the change in her surroundings. If that is the case why stop the thiroidazine.

In response to a question from you the sample that had been taken to produce the median doses in the hospice was the last 100 deaths where the highest dose had been 1950mgs and the hospital sample had been worked on 72 patients.