Ruby Lake Code A **21.08.1998**

We heard from **Diane Mussell** about her history. She told us that in July 1998 her mother had a fall at home as a result of which the police were called and broke the door down and her mother was taken to Haslar. She was there for two to three weeks had surgery and her daughter never saw her out of bed. She became very withdrawn and there was a question about whether she had developed fluid on her chest.

When it was suggested that mum was moved to Gosport Mrs Mussell was concerned because she did not believe that her mother was ready for the move. However she was transferred on 17th August 1998 and two days later she appeared very agitated and distressed. The following day there was a notable deterioration and she was unresponsive. She believes her mother was on a syringe driver at that stage but she did not query the medication with anyone and her mother died the following day with the cause of death being given as:
1a Bronchopneumonia

Statement of **Dr Lasrado** was read. He is the Consultant Orthopaedic Surgeon and he confirms that on the 5th August 1998 he performed a left cemented haemiarthroplasty and the mechanics of the operation very much as described by Mr Farqherson-Roberts are described. He says that this was an uneventful procedure from his point of view but did accept that it is always associated with certain risks.

Mr Farqherson-Roberts then gave his evidence and he described his involvement with Ruby Lake and the operation in graphic detail. He confirmed that bronchopneumonia was a well recognised problem in operations of this type. With regard to the transfer he said that Haslar was not under the same pressure as QA to move patients on. He did say that they were very conscious of bed blocking.

Anita Tubritt Senior Staff Nurse at Gosport gave evidence and confirmed that she had been the person to administer drugs to Ruby Lake and that those had been prescribed by Dr Barton. On 18th August 1998 oramorph range 2.5 to 5mgs digoksin slow k bunetanide and allopurinol were prescribed. In addition on 19th August Dr Barton prescribed temazepam 10 to 20mgs and at the same time she prescribed diamorphine

20 to 200mgs hyoscine and medazalam 20 to 80mgs. They were written up sc which would mean subcutaneous and that would be by way of syringe driver.

The nursing notes indicate that the syringe driver was not set up immediately but it was set up the following day by Nurse Hallam.

She confirms that the last oromorph was at 11.15 on 19th August and at 16.00hours that day the syringe driver was commenced. 20mgs of diamorphine was administered together with 20mgs of medazalam.

She was then able to confirm that at 9.15 on 20th August 20mgs of diamorphine was administered together with hyacine and 20mgs of medazalam.

She confirmed that at 16.55 hours on 20th August 40mgs of diamorphine was given together with hyacine and 40mgs of madazalam. At 7.35 on 21st August 60mgs of diamorphine was administered together with hyacine and 60mgs of medazalam. She confirms that those were all in accordance with Dr Barton's prescription.

Dr Barton then gave evidence and recounted the medical history for Ruby Lake and that she had a slightly stormy post operative course in developing chest pain, pulmonary oedema, shortness of breath, diarrhoea and vomiting and she developed a sacral bed sore.

Dr Lord arranged for her admission and she confirmed that the transfer took place on 18th August. She clerked her in and told us 'transfer to Dryad Ward continuing care, fractured neck of left femur, previous medical history angina, congestive cardiac failure, catheterised, transfers with 2 some help with daily living, barthel 6 get to know, gentle rehabilitation, I am happy for nursing staff to confirm death'.

She was looking very much at rehabilitation but accepted that Mrs Lake was in a frail condition. She prescribed dejocsin for her heart failure and other drugs and temazapan to assist with sleeping. All the drugs that were prescribed were those that were received at Haslar.

She also prescribed oramorph for pain relief in view of the recent operation and because of the sacral and leg ulcers from which she was suffering.

She confirms that 5mgs were given at 2.15 after which Mrs Lake seems to have settled.

At around midnight she woke and was distressed and a further 10mgs of oramorph were given but that seemed to have very little effect and she remained anxious and confused.

Dr Barton believes that she would have seen Mrs Lake that morning and would have witnessed her deteriorating condition. In particular she would have been aware of her difficulty overnight. She believed that Mrs Lake was likely to die fairly soon. She prescribed diamorphine on the range from 20 to 200mgs not just for the pain but for the anxiety and distress together with hyoscine and medazalam 20 to 80mgs. Those were all to be administered subcutaneously by means of a syringe driver.

On 19th August Mrs Lake is complaining of chest pains and was noted to be grey around the mouth. She says quite properly she was given a further 10mgs of oramorph and she would have been informed although she has no recollection of that. She did point out that there was no ECG available at the hospital it would have been impossible to say if Mrs Lake had suffered a myocardial infarction.

Because the oromorph was not successful in controlling the pain the nursing entry that day the syringe driver was commenced with 20mgs of diamorphine and 20mgs of medazalam at 4pm that day. She has no memory of being advised of that but believes that would have happened and that the dosage was appropriate.

Mrs Lake had a comfortable night presumably because of the medication but it appears that she was deteriorating and the following morning a further 20mgs of diamorphine and madazalam were administered together with 400mcgs of hyoscine.

Mrs Lake's condition continues to deteriorate and the medication had not completely controlled her distress. Nursing Staff therefore increased the diamorphine to 60mgs the medazalam to 60mgs and 800mgs of hyoscine.

She says that she would have reviewed Mrs Lake on the morning of 21st August although she has no record of that. She confirmed that Mrs Lake died that evening and that she certified the cause of death as:
1a Bronchopneumonia

Professor Black gave evidence and confirmed that Mrs Lake was an 84year old lady with a number of chronic diseases, suffers a fall and a fractured neck of femur. She is admitted to Haslar for her operation but develops post operative complications including chest infection, chest pain and confusion at night.

He is critical of the record keeping at Gosport and told us that it was difficult to interpret what had happened on the information available. However it does say that the swelling of her legs would be and indication of renal failure and that the prognosis after a fractured neck of femur was poor and the figure he gave was that 30% of patients died within a year.

He was concerned that her medical condition was not stable enough for the transfer.

He describes from the records distress, anxiety and confusion and you may remember that he said that for such a condition morphine would be his drug of choice.

He did indicate that you would expect to see some justification in the notes for the use of the syringe driver and he was concerned that there did not appear to be any further medical assessment of Mrs Lake after admission.

He would have given her cause of death as:
1a Myocardial Infarction
1b Ischaemic Heart Disease
II Fractured Neck of Femur (Repaired 5.8.1998)

Dr Wilcock recountered the history briefly and the fractured left hip which was surgically repaired. She had a pre-existing heart and kidney problem and heart failure, atrial fibrillation, renal impairment, with a chest infection and episodic confusion/agitation at night. He pointed out that on transfer to Gosport she was said to be well, comfortable and happy. Again because of the absence of clinical notes he found it impossible to unpick the last three days of her life.

She settles in well but then complains of chest pain is put on a syringe driver containing diamorphine and medazalam and becomes drowsy. Her chest becomes bubbly and the response is to increase diamorphine and medazalam and to start hyoscine.

The diamorphine was 60mgs medazalam 60mgs and hyoscine 800mcgs. He could find no justification for the prescription of morphine or for the use of a syringe driver. He also says that the absence of notes makes it very difficult to understand why Mrs Lake may have deteriorated so rapidly. If there was an underlying medical cause was that investigated?

It may well be that Mrs Lake has entered into the terminal phase of her life but the medication may have contributed to that death.