Text below taken from https://www.gosportpanel.independent.gov.uk/panel-report/part-one/chapter-3/page-10/ on the live website.

Case Study 5 – Elsie Devine summary

Patient story

- In 1999, Elsie Devine was aged 88 and lived with her daughter and her family. Mrs Devine had lost her husband 21 years earlier but had remained independent and self-caring, able to do her own cooking and cleaning. In January 1999, she started to experience some decline in her memory. Mrs Devine had a history of moderate chronic renal failure and in April the possibility of myeloma was considered. A skeletal survey was carried out. Myeloma was not diagnosed. By September, Mrs Devine's oedema had worsened and her kidney function had deteriorated.
- On 9 October, Mrs Devine was admitted to Queen Alexandra Hospital. In the days before admission she had become confused and aggressive and had been found wandering. On 21 October, Mrs Devine was admitted to Gosport War Memorial Hospital ('the hospital') for rehabilitation. On 21 November, Mrs Devine died.

Background, care and treatment

Mrs Devine was admitted to Queen Alexandra Hospital on 9 October 1999. In the days before admission she had become confused and aggressive and had been found wandering. She was treated with antibiotics for a urinary tract infection and was referred to the Mental Health Team.

Between 15 and 20 October, Dr Taylor, a clinical assistant in old age psychiatry, and Dr Jayawardena, a consultant geriatrician, assessed Mrs Devine at Queen Alexandra Hospital. They noted that her behaviour was settled and she was suitable for rehabilitation and transfer to Gosport War Memorial Hospital as a temporary placement until a permanent placement could be found. She was diagnosed with dementia. However, Mrs Devine's condition had improved, her behaviour was settled and she was ready for discharge.

On 21 October, Mrs Devine was transferred to Dryad Ward at the hospital under the care of Dr Richard Ian Reid, pending her return home or to an appropriate residential home. On admission to the hospital, Mrs Devine was assessed by Dr Jane Barton, who noted: *"… Plan: - get to know, assess rehab. potential, probably for rest home in due course."* Dr Barton prescribed morphine oral solution 2.5–5 ml (5–10 mg morphine) four hourly as required.

In relation to the morphine oral solution prescription, Dr Barton stated in an interview with Hampshire Constabulary in November 2004: *"I was concerned that a low dose of pain relieving medication should be available for [Mrs Devine] in case she experienced distress and discomfort and a Doctor was not available to write up a prescription for her."*

During the 2009 General Medical Council (GMC) Fitness to Practise (FtP) hearing, Dr Barton stated:

"At some time in the future, during her admission I imagine that she might suffer from pain from her chronic renal problem or pain and distress at the end stages of her dementia, and I wanted to have it there on the drug chart should we need it in the future. I was not anticipating using the drug at that time."

The Panel has not seen any record of the administration of morphine oral solution.

Between 25 October and 1 November, Dr Reid assessed Mrs Devine and noted that she was *"Mobile unaided, washes with supervision, dresses self, continent, mildly confused"* and was *"physically independent but needs supervision with washing and dressing, help with bathing".*

On 10 November, Mrs Devine was noted to be confused and wandering. The following day Dr Barton prescribed temazepam, trimethroprim and thioridazine *"because [she] thought clinically [Mrs Devine] had a urinary tract infection … Thioridazine is a major tranquiliser … Not a chemical cosh in any way, but just to make her a bit less restless and agitated."*

By 11 November, the plan was to arrange for Mrs Devine to visit her home twice weekly to see her family and to assess if she would function better in her own home.

On 18 November, a locum staff psychiatrist from the Department of Elderly Mental Health assessed Mrs Devine and noted: *"This lady has deteriorated and has become much more restless and aggressive again. She's refusing medication and not eating well."* Her physical condition was noted to be stable and plans were made to transfer her to Mulberry Ward. Dr Barton prescribed a 25 microgram fentanyl patch every three days.

On the same day the staff psychiatrist also wrote, in a separate part of the medical records, that she had reviewed Mrs Devine on the ward. She recorded that Mrs Devine was *"happy, no complaints - waiting for her daughter, not obviously paranoid says tablets make her mouth sore."* The plan to transfer her to Mulberry Ward was not altered.

In relation to the fentanyl prescription, Dr Barton stated during a police interview in November 2004: *"This was in an attempt to calm her, to make her more comfortable, and to enable nursing care."*

During the 2009 FtP hearing, Dr Barton stated: *"In my mind at that point she was becoming end-stage dementia … and I thought that a transdermal patch at that point in time was a kinder way of controlling her symptoms … there were no physical signs of pain."*

On 19 November, Dr Barton assessed Mrs Devine and noted: *"marked deterioration … condition needs subcutaneous analgesia with midazolam. Son seen and aware of condition and diagnosis. Please make comfortable; I'm happy for nursing staff to confirm death."* Dr Barton prescribed a subcutaneous infusion of diamorphine 40–80 mg and midazolam 20–80 mg over 24 hours. The nursing notes recorded: *"chlorpromazine 50mg given [intra muscularly] at 08.30. Taken two staff to special. Syringe driver commenced at 09.25 Diamorphine 40mg and Midazolam 40mg. Fentanyl Patch removed."*

In her police interview in November 2004, Dr Barton stated:

"… on the morning of 19th November I found [Mrs Devine] in an extremely aggressive state, hanging onto the bars in the main corridor of the ward. She was clearly very agitated, anxious, and distressed. She would not allow anyone to approach her or administer any of her usual medication; In due course we were able to administer 50mg of Chlorpromazine … This took some time to be effective … This major tranquilliser had made her quite drowsy and we made the decision to discontinue the transdermal Fentanyl [and] Diamorphine [and] Midazolam ... was prescribed … and was administered with the sole intention of relieving [Mrs Devine's] significant distress, anxiety and agitation, which were clearly very upsetting for her … she was now dying. The Fentanyl patch was removed a little later."

During the 2009 FtP hearing, Dr Barton stated:

"… I suspected, her renal function had deteriorated quite quickly and quite markedly, and was probably contributing to the end stage dementia state that she was in. I did not think that it was related to the fentanyl. I thought that the fentanyl was not doing anything to make it better … [Although no active sign of pain] I wanted the midazolam. I needed the sedation and the anxiolytic properties of the midazolam in order to calm her down once the chlorpromazine wore off, and I was minded to continue an equivalent amount of diamorphine to replace the fentanyl dose that she had been having."

The 'Contact Records' found in the hospital records note: *"social services informed to close the case. Mulberry also informed."*

On 20 and 21 November, the syringe driver was recharged at 07:35 and 07:15 respectively. On 21 November, Mrs Devine died on Dryad Ward at 20:30.

Panel comments

21 October 1999

- The Panel has not seen any document to confirm that Mrs Devine went to Mulberry Ward before being transferred to Dryad Ward.
- There are no medical records to confirm on what basis Dr Barton prescribed morphine oral solution.
- The Panel has not seen any record to confirm that this drug was clinically indicated at any time.
- The Panel notes that Dr Barton did not record her rationale in the clinical notes at the time this decision was made.
- The Panel notes that Dr Barton did not prescribe simple analgesia.

18 November 1999

- The Panel has not seen any record to confirm that fentanyl was clinically indicated.
- The Panel has not seen any record of Mrs Devine experiencing pain.
- The Panel has not seen any fluid charts in the medical records. In the case of a patient with renal failure, fluid management is essential.
- The Panel has not seen any record to confirm that there were adequate attempts to rehydrate Mrs Devine.
- The Panel did not find any document in the medical records to confirm Dr Barton's rationale for prescribing fentanyl. It is clear from later records that the fentanyl patch was administered; however, this is not recorded on the drug chart. The Panel observes that the use of fentanyl might have compounded the deterioration in Mrs Devine's mental state.
- The Panel notes that Dr Barton did not record the rationale provided to the police and during the FtP hearing in the clinical notes at the time this decision was made.

19 November 1999

- The Panel has not seen any record to confirm that diamorphine and midazolam were clinically indicated at this time. In addition, the Panel has not seen any document in the medical records to confirm the rationale for the high starting doses.
- The Panel notes that Mrs Devine was an opioid-naïve patient with renal failure; however, she was commenced on a high dose of diamorphine.

- The Panel also notes that when diamorphine was administered, fentanyl would have been pharmacologically active in Mrs Devine's system despite the patch having been removed.
- There are no medical records to confirm on what basis Dr Barton prescribed diamorphine. There are no medical records to confirm the rationale for the dose of diamorphine. There are no medical records to confirm that diamorphine was clinically indicated. The Panel notes that Dr Barton did not record the rationale provided to the police and during the FtP hearing in the clinical notes at the time she made this decision.

General comments

- A number of clinicians variously and wrongly referred to myeloma as part of Mrs Devine's medical history.
- The acute confusion which led to Mrs Devine's admission and its subsequent improvement would be compatible with a diagnosis of delirium. The records indicate that Mrs Devine also had mild dementia.
- Mrs Devine was tested for a urinary tract infection and the result was reported as negative.
- There are no records to indicate that at any stage when prescribing or administering morphine oral solution, fentanyl or diamorphine, any account was taken of Mrs Devine's severe renal impairment.
- Mrs Devine's renal function had deteriorated but had not been managed. The records do not contain any recent fluid balance chart or any urine output records. The Panel has not seen any nutrition plan among Mrs Devine's hospital medical records. Fluid and nutritional intake is an important part of the clinical picture. Fentanyl, diamorphine and midazolam could impair Mrs Devine's ability to eat and drink.
- The Panel has not seen any document in the clinical records to confirm that nurses engaged in any adequate end of life care discussion with Mrs Devine's family.
- The Panel has not seen any record to confirm that nurses treating Mrs Devine challenged the proactive prescription of morphine oral solution, the prescription of fentanyl or the wide dose range in the prescription of diamorphine and midazolam. The Panel has not seen any document to show that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines;[5] nor did they question any of the consultants, doctors or the pharmacist at the hospital in respect of the prescriptions.
- The Panel has not seen any nursing document in the medical records to show the rationale for the decision to commence and continue the use of fentanyl, diamorphine and midazolam.
- The Panel has not seen any nursing document in the medical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of fentanyl, diamorphine and midazolam. The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on the administration of fentanyl, diamorphine and midazolam.
- The Panel found a lack of detail in Mrs Devine's daily nursing notes. The care plans seen by the Panel were scanty, were not personalised to the patient's needs and contained missing entries for entire days. There was nothing that took account of Mrs Devine's cognitive impairment, capabilities, likes, dislikes and preferences. The Panel found no pain charts or pain management plans in Mrs Devine's medical records. It is not clear to the Panel how Mrs Devine's anticipated pain and the effectiveness of any analgesia was to be adequately monitored.

- The Panel has not seen any document in the medical records to show that the nurses treating Mrs Devine understood or took into account the possible side effects of morphine when noting Mrs Devine's condition.

5.Salisbury Palliative Care Services, 1995. *The Palliative Care Handbook: Guidelines on clinical management*, third edition.