9/4/13 - 12/4/13 RICHARDS

tooks

PORTSMOUTH CORONER

GLADYS RICHARDS

(DECEASED)

2

9/4/13 - 14/4/13

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9/4/13

It's non-committal about whether she is in pain.
Discharged stable & no stabilise
HN weren't involved.

Happy for nurses to confirm death. - 11/8/98
Don't know any of us like.
Idea might have been an administrative thing to i.e. allowed nurses to
Most extraordinary.

It note on 11/8 meant I expect her to die in the night

May have been written in records of every patient.
I saw a lot of these files 10 yrs ago
Many had this phrase in.

Massive haematoma.

I think you would note why you were going to Pall Care - Summary.
GR went for re-habilitation ironically.
Sure
↳ weight

Swallowing
- 2 separate issue
-1- whether a person is in phase of dying → Pall Care
-2- form of pall care. (PC)

Oral morphine is perfectly acceptable for (PC) until such time.
until they can't take it.

Nothing in my drug does diamorph & SC diamorph

Prof Black - diverge with PF on dosage

BNF for Sep 97 - Oral morph 10mg = 30mg diamorphine.

So only from 10mg/4hr 60mg/day oral morph

= 30 mg diamorph.

But she couldn't read 30

That advice was available to Dr B in 98.

Re-assessment

- would expect it to take place.
- difference between dose you need to give benefit & cause unwanted at the time.
- In dying patients you can accept some adverse effects.

You don't know that if you > double the more than necessary in pain clinic.

Mr R wasn't responding

→ you can reduce infusion rate.

Rome would to start w/ low dose & ↑ slowly

20mg in 24 hrs

↑ 30 then 40.

going straight

I would not prescribe it that way

Self-fulfilling prophecy.

she stops eating, drinking, passing urine.

Dose of [illegible] - still w/in range just acceptable.
Prof B - appropriate.

More than illogical to prescribe 40mg [illegible].

when giving diamorphine

Had there been explanations in notes like easier for everyone.
Real decision is whether someone is dying only thing you can do

problem - she gave a high dose

Syringe driver - substantially less acceptable than orally.
- sedation is going to be continuous rather than intermittent
- marks a step toward terminal care.

SWALLOWING
- Q why move to SC diamorphine,
simple note "no longer able to swallow."
taking sips of water.

- generally no need for SD.

Supp cont.
para 12 PRN - pro re nata - as and when.
- nurse gives drugs and when
- range from that is just acceptable -
- allowing people who may not have training

What is sub-optimal?

~~sub-optimal~~ - negligent to give nurse an opportunity to give fatal dose.
anywhere from high initial dose
- why not possible to make a specific dose & increase if it required.

If Dr negligently prescribes something nurse can be negligent.

Co-consultant has ultimate responsibility for actions of Jrs.

Supp report.
- para 11 - no indication
→ why not negligent?
Prof Black & I disagree - no clinical justification present in records
clearly negl if no clinical justification in any event.
D- B may have been conscious of clinical justification
- Indeed to me

Was action around 18 negl?
normal part of prescribing 400 mg not 24 hrs.

She had bad pain
I would - T and morphine
- give small dose of diamorph.

Not considered in terms of med negl.

It is BRD that the opioid increased her chance of dying why she did.
I can't say definitely it led to her death.
BoP it did.

9/4/13

Jw - Is there anything remarkable at

- on first transfer

S62 - written on 11/8/98 - up to 200 mg
S66 - 40 - 200 mg.

200mg - is still a very large dose.
- could be called a 'potentially lethal dose'.

Death Record.
- Over simplification.
- Opioid must a contribution.
- Should be included.

Difficulty in PC one invokes dual effect of morphine

Jw no opioid contributory to bronchopneumonia that occurring.

~~No toxic action~~

secretions otherwise cleared by coughing & deep breaths build up in bottom of lungs & bugs are not cleared by usual sedation.

Lindsey 8-10 - might have died at any time.
- But description was in pain & not close to death.
but after 8 hrs of diamorphine.
impression is, after 8 hrs she was sedated so the condition.

Jw - could rely on temporal relationship between drug regimen & change in GR's condition.

9/4/13

Was it neglectful to Mrs R.
Only if decision to give PC was not made on reasonable grounds
→ was it at all proper to diagnose

JW - Not seen reports from Prof Ford explicitly

Prof - GMC -

JW - Any reference to a haematoma?
Prof - may have been on an X-ray report.
- haematoma - not requiring operation.
- only lethal if they press on something vital - heart etc.
- they contain so much blood there is not enough left to go around.

- Dementia - failed mental test. 4 ↓ 0.
- brain not working.
- had been dosed up w/ Trazodone & haloperidol.
- thought she was brighter after leaving HH (first time).

JW - you may be pressed on dementia - defer to Prof B.
- drugs make difference or a difference?

Prof - GR's life expectancy was short. -
Nothing specific recorded to suggest why she might die in late Aug not early August

JW - anything to say on Trazodone at Nursing home?
- aim to make her quieter.
- would have been criticised now.

4/4/13

IN QUEST

Coroner's examination of GM.

- Falls at GM.
- what injuries - they thought she'd broken her nose.
  - 17 falls in 6 mths - she on Haloperidol & Trazodone at GM.
- 30/7/98 - Fall - I wasn't there.
  - I understand she was raised, assessed & put in a chair.

↳ Fall at lunchtime, picked up - don't know who examined her.
Not sure who examined her.
I didn't know that night. Niece told me.

~~[illegible]~~ Why didn't you think she would survive?
She was 91.
- to have the surgery.
- [illegible] to go to hospital.

Not operable. - I ~~was~~ was amazed in fact she would not give up.

She only had diamorphine on day she had operation.

She was later on co-codamol
no painkillers until discharged to GWMH. (G)

Why did they stop giving her trazodone.
I suggested it to them.
She was more alert than 3-4 mths earlier. [Q4LL]

She enjoyed old conversation etc

I don't believe no one could hear her or see her on floor (Q for PB)

4/4/13

GM- They picked her up & put her in a 'safer' chair? (Q for PB)

C - having heard she'd fallen at G, when did you see her?
GM - she went in HH on 29
I was there til she was discharged.
- I was not aware there was a policy for care homes to sedate them and x-ray them next day.

C - did you see GR at G. - PB was there talking to my sister.
- asked why GR hadn't insisted she be x-rayed.
- I made my views known.
- how did GR progress at HH - came round next morning 0100.
- kept on a drip for a time.
- very dehydrated
- stayed here while she was in HH. - yes.

Returned for transfer to G - I knew she was going back I said I would see her back to G.
- she was already in bed.

- I never saw a patchslide at G.
How did they get the sheet out, when they removed it?
They roll her off sheet. ... it up. then remove

- How did you come to know of SD.
on Tue 18.
SB - should be sent to Dr about to be borne ...
lost her cool.
She is my patient. I will decide. Your mother has been through ..., we will ... tomorrow (Q for SB)

Then we met PB

9/4/13

we saw PB - massive haematoma.

- I was expecting particular nursing.

~~PB said the cord~~.

I knew about SD from Royal Marsden.

C - Why mention Euthanasia?

Because if you give diamorphine to someone before near death, this is it.

GM - Even then I said I would prefer her to go back to HH. unless she is so close to death she is likely to die in ambulance (Q for PB)

- As far as I recall nurses only came in once during 3-4 days
I never thought we had been doing nursing?

- There is a funny noise when people die or are about to die. I said to sister 'this is it'.

- sister called daughter & they laid her out.

- IN MORTUARY - opened a large fridge - bodies on many shelves.
- bodies lying on each other.
- It was packed from bottom to top.

Death Certificate?

- I did not know about it.
- only when we got reply back from Mr NULETT.
Then we could make arrangements for funeral.
- I said it was fiction.
LL said it was something else.
LL - Death cert wasn't it. - just Broncho pneumonia. (bp).
[illegible] - no [illegible] of ..
- should have been [illegible] last.
- then hip first bp. last
Asked why didn't LL query it.

9/4/13

LL said she did

Registrar - If I heard what she said, she would order a post mortem

- LL said she didn't want a post mortem (PM)

GM - It would have been referred to the coroner.

- I said LL had perjured itself.

C - ~~[illegible]~~ GR's funeral/cremat° had happened.

Yes.

got letter on 27/7/98

wanted to allege an unlawful killing.

- GM. told LL - not to make statement on TV.

She wasn't taking it seriously.

- I thought it was a one-off case.

- Is that how you came to give statement you gave.

- I thought - you don't go to GMC w/ a crime - you go to police.

- Cop med is both back separately to make [illegible]

- Police said NCTA.

- GM said you've not seen medical file

P asked them see them.

- P came to see me in April 99

- DCI Burt - said I've been handed dead file on your matter.

- GM asked to have IV taped

-- said it was going back to CPS.

- took early retirement in January.

TC had argued diamorphine leads to pneumonia & → cause death is pneumonia.

Then a letter said it was all a matter of causation.

9/7/13

By April 01 my cue [illegible] all my complaints.

MPs refused to handle complaints.
=> I publicised complaints against police
- 15 other people approached [illegible].
(- referred to GR's dun.
- how did it end?
- by 02 we had a meeting w Dep Chief Constable
- DON called in an expert (Mr Baker)
- by end 02. CHI report.
- 10 Inquests
GMC etc.
1315.

LUNCH - Cannot discuss ev over lunch break.
- 1415

1421.
Ms Boyd - No Q.
Mr Green - ~~[illegible]~~ GX

GX - early days at G - not there 11-14th.
- Made some comments re Oramorph.
- She was showing signs of ~~O~~ Oramorph.
It wasn't [illegible], 'moaning' or wailing
- Nurse would not to relieve that.
Not with Oramorph
- No [illegible] 7-11 @ HH (H)

↳ morphine was prescribed, attempts were made to relieve it.
You start w/ something completely different to diamorphine
last dose of ~~oramorph~~ haloperidol - 615am 12/8/98.

Q for Prof F

My mother was not aggressive.

9/4/13

Gr K both trazodone & haloperidol have side effect.
↳ stopped at H.

- I am not an expert on haloperidol
- I know more about than Dr Banks.
- all Drs who had care of GR were responsible)
No H were NOT less.
- If she was less distressed, less likely to fall.

GR - why considered to put her back in a 'safer' chair.
Gr - not for me
- Nurse Brewer examined her - yy.
- didn't find any abnormality.
- Both Dr B & Lord were on ward

Dr Dr L (Neuro)
Dr IB discharge

have you read Prof Fenwick's rep
Yes.
No evidence of delay/deterioration on admission to H.

-17/8/98 - readmitted to Gr.
- collapse at Cochrane MC - repositioned GR. ½ hr after admitted.
- when we got there she was being fed

- when GR arrived on ward MC was on break.
she came back after break finished.
½ hr later.
- Sister tried to instruct her man to place pillow.
she didn't read discharge letter from H.

Q for MC

- A meal came up which she couldn't swallow?
She was eating normal food.
There was nothing wrong with her

JME000002-0014

4/4/13

Gx - The nurse observes swallowing failure. she can't feed her.
MC sent food to Fulla

- 18/8/98 - diamorphine pump - started. - SD started on 18.
~~- it had been used~~
Diamorphine injected twice ~~24h~~ on 17/8
1 before JB saw her.
1 after . .. ...

- She had oramorph on 17/8.
I don't agree it was only barely enough to relieve her pain.
She was talking to me.
Once she had oramorph she settled.
- She moaned in pain

-- Diamorphine had been written up on 11/8/98.
- She had first oramorph at 1300

~~- Are you saying Oramorph~~
You can't use same prescription after

- An injection of diamorphine given on 17/8/98.

Gx - she was in so much pain
- PO has written his initials for 4 doses during the night.
She was not on.
This would cover up ~~[illegible]~~ diamorphine injection

- we were told she was suffering massive haematoma.
No ev of ..

She was deeply unconscious when SD put on.
From coming out of x-ray she never opened her eyes again

XX of LL

9/4/13

Gx. GM - she was unconscious from drugs the day before

- nursing staff gave her care & she was showing signs of pain.
I was with her from 5D to her death.
Nurses didn't always

Mr Mauley No Q
Mr Jerkby No Q.
Mrs O'Brien ..
Me ..

CX - what was her consciousness on a.m. of 18/8.
She remained unconscious.

Mrs O'Brien LL

Falls in latter part of stay in GH.
I understood nursing staff would need medication to control patients on day to day basis.
I saw the gradual deterioration.

Appreciated risk of operation.
we waited at the bedside for her to wake up rat 0100.
H - superb.
- she was on a drip
- I was able to feed her & she had a good fluid intake.
out of bed → chair → commode
- walker w/zimmer.

She came off lorazepam - drugs effect?
She had a remarkable recovery.
We were told she'd be 10-12 days recuperation

12/8 - I was shocked I couldn't rouse my mother.

7/4/13.

LR - they'd given (?) something as she was agitated. POINT 17 LL CHANGED?
Oramorph on 12/8.
[illegible] on 11/8. at 16/5.
[illegible] hrs after admission
Not in pain as normal.

- Concern re Mum
- I would have sent her for an x-ray
- Cause of pain not being investigated.
Oramorph for pain.
She'd had uneventful [illegible]
I was becoming concerned.
I did discuss it w/ staff - said they'd x-ray the next day
- around the cottage hospital

- [illegible] contacted hospital at night.
- 14/8/98 - taken to X-ray dept.
- still under oramorph.
given none before she went down.
- let me in with her.

When [illegible] was treated she reacted well.

(X - were you concerned she was going to G?
I was. N said they could only treat her for the [illegible],

- LC [illegible]
- when you came back to G - did you say to PB that Dr at H said?
- I told him they were going to [illegible] back (on PB)
- H said 'if she's in pain, send her back.'
(- did you challenge that? - No I said to [illegible] - Dr is right.
It is only in hindsight that I [illegible] it was wrong

9/4/13

CC- It was my major concern that she be pain free.
- w/ cancer patients can control pain

LC- next thing is a death intervention - totally insensitive.
- she should have been given another chance at recovery.

Cx - your concern is management as to contributed to her death.

LC- death DC cert
→ I gave a truthful statement to police
- I didn't mean that what I mean now they found a number of drugs prescribed.
- I was at that time concerned re: DC
- I couldn't believe

XX by M
- No Haematoma.
Cx - where was it?
- it was not on surface.
- 'massive' - PB or SB.

PCT & MDU - No Q.

Green for GCM.
GX - mobility
- 2 nurses & 2 matrons is a high level of dependance.
not at 12 days.
- ask to use commode.
- I don't recall helping her into commode.
- very little she could do on her own.

[GM - no mention of splint at H not there 2 days ☆]

9/4/13

Gx - nurses remember - 11th she screened a lot.
- It is feasible
- RBW could show difference between anxiety & pain.
- Quite feasible she vomited toilet in L4 by - more ever touch me.
- PB told you Mrs given Oramorph on 11/8
No information
- Next afternoon she was inconsolable.
- Nurse Josie - took concern seriously

Gx prescription chart - page 1 - 11/8 1615 } Oramorph
2345
12/8 0615
13/8 2050 } - after the fall.

13/8 - after being rung by

Critical of delay in diagnosis.
Bruce says she inspected it.
LL - accepts signs may not be obvious.
- Probably could be visited first time round.
- early diagnosis is best for patient.

She was in great pain from X-ray

(Note from 3rd. Mr Green is ignoring dealing w/ cause of pain.
- There is a point about renal blood tests
Nothing on Mrs nursing chart to show she was sober.

I saw injections
& there is nothing on the drugs chart.
We both made separate statements - we both mention it.

9/4/13

Ex - you can't comment on indications a nurse might find.

LL - I don't agree she was unable to swallow on 17/8.
- not able to swallow on 18
- She swallowed fluid from sponges.

CX - How did you put liquid in mouth.
we cleaned her mouth
She swallowed it. - like a baby.

Ex - why unconscious from previous dose of Oramorph.
- She just drops to pain?
? Ave gap between last dose of Oramorph & SD being set up

- Chart is accurate -

- LL - I agreed to SD as ~~she was always pain~~ we were told by

- She was never ~~any~~ in pain on SD.
Sara recalls signs of pain.
LL - what signs
She was unresponsive.

→ Q for Sara

Ave Evening AJX

Haloperidol.
- ~~didn't~~ don't believe ~~get~~ it was during. - 15 yrs ago.
- Have prescriptions p. 110 & 114 bb of Haloperidol
Oramorph. - p62 - can be given as required - 10 mg is 5ml
LL - Dose is 2-5 in 5ml
could it be 2-5 - 5 ml? - probably given by me.

- given straight away on day of admission

7/9/17

AJX – p 29 – Not obviously in pain. Appeared more comfortable.
– Doctor was writing up Versed for nurses stuff.
LL – Yet nurses gave it on the same day.
– If there had been no prescription, GR called?

LL – it was inappropriate. Too wide
– You start on weaker drugs & work up.

Same as Ferner.

LL – one person gave oramorph on 14/8 11:50 PB.
~~Over on~~ Not saying more than on p 62.

– Infusions on 17/8. (JB not there)

– How would H know what she meant? – PB's letter ~~does~~ only says what he's given.

p 30
– photocopied & sent to H.

CX – what H would have known prior to arrival?
Note sent by PB – no change to needs other than add'n of Oramorph
Discharge letter sent with JB's photocopy.
H would have had both of those.

Adjourn 16 40

Return at 1100.

Tomorrow – ① Reid, then ② Prof Ferner, then ③ Warren.

Nothing in clinical notes supporting dehydration

opinion is distributed in body fluids.

- breakdown products of iron & myoglobin

9/4/19

CON w Sw & CM

No evidence visually of haemorrhage.
Any other evidence to justify.

Renal blood tests - If you do blood tests for kidney under clinical density

Sodium	Na^+	140 ish
Potassium	K^+	3.5-5
Urea		< 9 or less
Creatine		120 ish

Blood tests saying is dehydration
can be fluid depleted but some degree without showing on body

dehydration - pre-renal failure

Check - clin dressing etc.
- full blood count. haemoglobin 12-15 + 11 in some people.
If you are in a bad state, you get a pretty

- could be dehydrated or bloated in fluids.

Diamorphine is excreted renally. - if your kidneys are failing you are likely to not excrete morph → it stays in body & you don't

---

Can assume a 91 y- old is sensitive to morphine

9/4/13

(4) rehabilitation v.
PEG & terminal care

(5) he alert is atropine as a lifestyle

(6) Haloperidol - used for big doses in psychosis
- in elderly & mental agitation

(7) - can't rely on systems working with nurses who are over-worked

Systemic rep - optimal prescribing rules re cause of death.

XX of Prof Fenor.
- pos in no letter.
- position con.
- Qs from notes. pts from JW.

Happens to confirm death.

Sensitive to morphine. - can assume 91 yr old is sensitive to morphine.
Oral Morphine acceptable for PC.
Make to diamorphine.
Rec - dr PS mark.
- (haematoma. - nurse. expect to see in skin / bruise.)
- (dementia. - eating in last weeks? / drugs?)

decision in relation to PC - no reason for decision haematoma.

PRN - sub optimal.

Renal tests - show dehydration or other ... ?

INQUEST DAY 2 — 10/4/13

XX of Dr Reid.

R-56 – stopped her Trazodone as daughters was [illegible] w/out it.

Mr W de was suffering

If they took place & were it noted.
would that be appropriate.
It ~~omitted~~ given without ~~the~~ informing JB - would that be ~~relevant~~ subsequent.

PL - No reason given for move to PL.
- No reason for Sc diamorphine prior 100
No reason for ↑ oral morphine to Sc diamorphine.

10/4/98

XX of Prof Ferner

☆ GR - sensitive to morphine - assume in 91 yr old
- knew in GR.

~~☆ Dr Barton [illegible] side effects~~ (Q to JB)

~~☆ No CV she was suffering pain on first discharge from HH.~~
☆ 11/8/98 - Agree - / prof black - no justification for prescribing both low dose oral morphine & high dose diamorphine.

☆ - Note - I am happy for nursing staff to confirm death.
- how would you describe such a comment?
- expect it to be near death?
- if assumption she was near death, any have been proven wrong by successful operation.

~~☆ JB's [illegible] statement - says she got morphine at HH - only co-codamol~~ ~~- says GR - unconscious and unresponsive to 2nd [illegible]~~
☆ Agree prescribing 'PRN' was sub optimal? - why? supp para 12

Agree prescribing a controlled drug without clinical indication is negligent
supp para 13

Agree moving to PC without clinical indication is negligent?

Haematoma - any evidence?
- how would it kill someone.
- see it on skin? - swelling bruising.
- if it was massive?

☆ ☆ With no reason for PC would withdrawing water & ? morphine be neglectful?
leads to death

Dehydration?

BNF?

~~Beat tests~~?

10/4/18

XX 11 of Prof F

~~- Significance of Sandbury - expect to note the end of something effect?~~

Once on Diamorphine - expect re-assessment?
- How do this?
- Border w/ SD?
- move up the ladder better.

But rate can be adjusted easily - PB PPU p. 25/39.

Dosages - BNF guidance at time.
- now

- How ~~close~~ fine is the line between dose for pain relief } diamorphine
- harm } & morphine.

- Is it true to say that putting patient with high dose at start creates effects later relied upon as proof she is dying?
- depressed respiration
- sedated / unresponsive.
- not eating,

SUBCUTANEOUS - build up. Dehydration creates a greater concentration.

Dr Barton's statement Q5 => see other sheet.

18/8/98 - 'please keep comfortable' - administer PC - words exactly same as 11/8/98

~~[illegible]~~

Dr Lord accepted there were periods of sleepiness (lost & unable / missing) - could that be caused by Trazodone?
dementia v. dosing.

10/4/13

INQUEST DAY 2

Cx of Dr REID (R)

C- refers to letter

R - After someone has a hip or other surgery it's normal practice to ask

- I understand from her notes that had happened.

C- admission of Trazodone - clinical decision or simply was daughters described her?

- given her age & co morbidity?

C. What were her chances of full recovery?

R- In general terms dementia

- percentage decreases with subsequent fall

- falls are a marker of frailty.

SMX- did not think she was dying. Not at that time.

AJX- We knew Dr B was at GWMH.

- for 10 yrs.

R- Daedalus (DW) - more for rehabilitation. Original - clinical care.

- Dr B p/t - 1 hr/day.

R- I started at G in '99

Consultant ward round once a week in JB every second one.

- for DW was Lord.

- JB - often came in twice a day - in her own time. (Q for JB)

- visiting in duties.

- responsible for >40 beds. ≃ 1m / patient.

- in normal hospital - positions on JB were to do with her time.

- expect brief notekeeping if Dr is stressed.

- ordinary hospital

- antipsychotic prescribing is common at G & QA.

AJ- if there was antipsychotic prescribing nursing staff would speak to Dr.

JME000002-0033

10/4/13

Dr [illegible]

A7X - anticipatory prescribing.
- practice that was followed at GWMH.
- consultant would be well aware that was prescribed for every patient
- no concerns raised re: this form of prescribing

[illegible] for AL

- letter from Dr Banks p679.
Severe dementia - end stage illness.
- end stage dementia · lack awareness of surroundings.
unaware of surroundings etc.
- some people lose mobility. End up bed bound.
- If people have a fall that can often be pre-terminal or terminal event.
- Bronchopneumonia - due to being bed bound.
- survey rates for 80-90 yo patients. depressingly low.

- Is it difficult to decide to send someone back to hospital.
prognosis becomes poorer, more interventions you have.
→ chances ↓ significantly.

Mr Knowles X (KX)
KX - p62 - Oramorph - 7. 18/8/98
- 45mg of Oramorph over c. 15hrs.

S/C dose. BNF
- generally oral → diam is to reduce dose to ⅓ prescribed orally.
→ 45mg/15hrs oral = 24mg/24hrs

JB 18/8/98 - sc diam - please make comfortable.

After Oramorph was administered JB was still in great pain
20mg - is entirely appropriate & reasonable.

p22-26 : Interview 2.

10/4/13

DAY 2

RX - if it was too high or inappropriate?
R - increase is unlikely to be responsible for her demise.
extremely unlikely.

LLX - Dr Reid - on 18/8/98 JB did not see [illegible]
if she was unconscious would you be surprised.

- if someone was getting enough it would not be appropriate to administer more.

- I am aware of Dr Barton's GMC result.

C - GMC is a judgment of another tribunal

11 ~~[illegible]~~ Break 1210

LLX - sedation record.
↳ may have had an effect on ability to drink.
- do you agree GR regimen re [illegible] meds until SD
- there difference between sleep or unconscious ✓

11/4/13
- transcription must mean 'no discolouration' syntax did not make sense.
- ~~[illegible] it [illegible] like they [illegible] to~~
→ no discoloration.

AJX - 18 yrs as a nurse, 3 as a student.
- only a Dr here for a small part of every day.
- Lord was consultant.
- need to be in v. regular contact w/ JB.
- hour maximum each morning.
then off to GP practice by 0900.
if patients transferred in JB would come back to assess them.
- open visiting policy.

10/4/13

Prof FERNER

Cx - date is the your report
- Intro letter is read. - Start para 7.
- Conclusion of original review - including GR
- matrix for each case. optimal / sub optimal / negligent / intended to cause harm.

Form referred to GR - sub-optimal.
Rough draft
↳ brief view

- they were not changed?
Finding - original inquiry at Harp Hospt. - looking for clear ev. of neg(
- looking for it BRD.
- can't be done in GR's case.

This report was not for criminal prosecution.
- Can you read her medical history out.
- Haloperidol & thioridizine explained [para 22.]

- para 45 - kidney function tests - w/in normal range.
- conducted at time of first admission
can't find any for second admission.
42 - Midazolam - 2mg by I/V.

COMMENTS
- read.

Cx - Concerns relate to commencement of SC pain relief on 18/8/98
F - don't want to give impression that starting PC inevitable hastens death of patients. It may do & in GR's case, it did.
- what happened from 18/8 was an additional factor against GR.
Yes - Dr R said falls go w/ frailty. Her falls are often frail. people who fall are frail enough that they die.

(X of Prof F

- would SD have mattered and from 18/8/98.

I think it did. on B.P.

⇒ 'likely' (B.P)

- 'sub-optimal' - I teach Sr Drs. I have a clear idea of what intention/purpose of a prescript° is.

- clear, unambiguous & precise.

- certainly not on DW.

- In what circs does one give oramorph or diam by sq

pt's from oramorph small doses.

Diamorphine range is 20mg - 200mg

4 /24 hrs is appropriate

200mg - is a fatal dose.

Would possibly lead to sub-optimal prescribing.

Not for me to say

Can't see any on 11/8/98 to make anticipatory prescribing.

Supplementary report?

- Agree largely w/ prof B.

Dose of diamorphine,

BNF 97 - 2 entries for morph & diamorph.

s 4.7 p198 3~~0~~ 30-4 to 1.

BNF 57 (today) . PC 30mg oramorph/day = 3:1

BNF 97 - PC table was of 2

Major disagreement (resolved)

Cx Prof F - prof b days in any anything about

1308 LUNCH 1400

GX - effects & side effects of opioids.
- I'm not sure
In clinical practice people poisoned with opioids - unconscious & breathing slowly.
Some people have pain controlled by dose with no sedat°.
Some get some of both before pain is controlled

- common nursing experience
- people receiving effective pain relief just sleep! (RS)
Does it explain absence or presence of Resp Depris.
- relat°ship between how much you give & what happens is an individual.
- one must not necessarily avoid RD or sedat° (S°)
some people must get pain relief regardless of RD or S°.
- would it have been appropriate to leave her in pain?
One does not want to leave her in pain but not give her so much opioid

SD - BNF on SD
BNF sep 97 p. 14. - patient if unable to take meds by mouth. etc.

GX - missing or other records not detailed.
- from history would you not expect severe weakness would appear
Fluid charts from H show GR was having substantial amounts of fluid.
She is tearful when arrives from H.
Later in severe pain.
- treatment of shock is that she could not swallow.

- p47 prof F - she is pain free.
GX says she is in pain on getting out.

10/4/13

GX - no more discussion than was necessary to elicit her pain
- during P investigation - couldn't see non-natural death
- Is Mi just based on absence of records.
- Drawing conclusion from absence of records?
- If it had been decided & documented that was for PC
but Mi is a worse test for retrieval?

CX - PC in itself can hasten death?
Yes in patients at end of life & in great pain.
This is the doctrine of dual effect

- It hastened her death. But if it was proper PC it would be proper.

AJX - Do you treat patients like GR?
I did for >30 yrs.
Were you really relieved of nursing skill to tell patient.
J. Drs would assess

- Dual effect - patients may experience a level of pain.
- correct in context of PC not acute general medicine.

- Tolerance - opiates - can have side effects.
- can build a tolerance. - Yes over time.
- > pain - less likely RD.
- if there is RD will that lead to serious consequences for patient.
- Person overdose - respiratory depth is short period or limit.
- Intravenous inject° different to s/c
sc - liquid builds up under the skin.
- takes hours to develop max steady state 3-6 hrs. (< 48 hrs)

- 40mg is a high dose.

10/4/13

AJX - if 2 morphine injections given.
- If dose is known. can estimate GR's morphine.
- ~~to any extent~~ -
- if [illegible] would not note 40mg or less Night dose.
- nurses required to raise concerns.

- Opinion first sought in 03 etc.
Meeting on 10/10/04

CX - How she could survive for 4 days
It comes to this range of effects.
If you ~~gave a~~ are in a state of prolonged unconsciousness

could have being on for 4 days.

Because she didn't die sooner than she did. it doesn't mean

CX of Mr WARREN.
leading ambulanceman - like a supervisor
Didn't use patslide in those days.
HH could have a patch slide - military hospitals were advanced than NHS

It can be me & partner more often at small hospitals like GW.
problems would be recorded - eg being in a lot of pain.
No SMX
LOBX - ambulance crew (LOBX.) would she was showing signs of pain.
I can't remember
- We use canvas. Not a sheet.
we may have used a sheet & canvas. Not only on a sheet.
=) ~~Nurse at GW~~
GW would have been poles & straps
poles come from ambulance.

10/4/13

LOBX of W - we haven't noted pass on our worksheet.
Gx. 2 Nobody (?) core assistants at GW
Baldacci (?) & Jean (?)
However to waive.
Can

Rule 37 evidence.

Read {
Dr LORD Taken as read. (statement)
Summary is read.

EDMUNDSON }

Mr K not to attend any more - made a copy of which.

1610. Adjourn to 1000 tomorrow.

11/4/13

INQUEST DAY 3

XX of PB

DRUG Chart - 11/8/98

Prescription - written up.

- nay used blue she went back to HN.

Fall - move to safer seat

17/8/98.

TRANSFER

Pulled over onto new bed.

Sheet pulled out from under her.

put in right position

INJECTIONS

Philip REED - Comes in with an injection.

- Told by GM to go out & get a better pain killer.

- Injects her in front of LL & GM.

next to JB. - 1530 JB agrees to x-ray.

- Injects him with a booster.

Mrs Richards still talking to GM.

Came out of x-ray unconscious.

11/4/13

Cx of Philip BEED

No doctors permanently at GWM.

Met to discuss medical issues
JB made decision on treatment
we told JB patients current state.
discussed by nursing & medical staff. - Included other staff
All patients happy usually Pt & OT.
Usually assessed a few days before.
Did patients always live up to discharge letter?
often patients were not as well as we expected.
Was on duty on 11/8/98
GR - admitted by other nurse. - then discusses general admission.

PB - can't really remember
- GR admitted to single room for MRSA. & family asked for her to be close to nursing station.
- she was confused
(- Did she match letter? - She was as expected
she was moaning - seemed to want something but we couldn't tell what.
What did you make her chances were?
she had come from a nursing home where she had many falls.
I thought it was going to be a longer period of rehabilitation.
- Did you think she might die?
Not that she might die but rehab would be hard.
- Didn't see possibility she'd die at that time.

I thought we would continue w/ rehab plan.
goal was to get her mobile.
Tried to transfer her w/ Zimmerframe.
lower steps of mobility ladder. Barthel 20 → 0 totally independent → totally dependent.
2/20 - on arrival.
p40 - assessment.

Cx of PB

Oramorph

medication for administration by SD

Prepare for nurses to correctly identify.

- not in common for SD to cover all possibilities
- not expecting her to die. But it was recorded in patients notes.
- administer within parameters set by SD
  bit of discretion

11/8/98 - pain relief - I recall oramorph later that day

Saw a lady who - could see her to be in pain & upsetting.
- made sure that she wasn't comfortable.

Walking with Sending like she was in pain.
had a pained expression on her face.
No great success communicating with her.

How did you assess situation of her being in pain.
LL was present on the day she was admitted.

FALL - I was not on duty when she fell. I was off.
- Found out when came Back on duty.
- Nurses contacted the duty doctor.
  I saw her when I came on duty.
  I took a look at her.

Is it normal procedure that a patient need a bath...

Normal to transfer patients straight away - eg fractured NO.
to they were told you would have it next day.
Nurse thought it was discoloured
I can't remember other discoloured hips to compare it to.
Nurses can't do this without Dr's say so.

Ck of PB

Expired meds suggested & that he could be x-rayed.

Oramorph for pain

U generally given by lady.

heard us need to give additional dose.

efforts causing it - noises.

- when he was quiet we assumed the wasn't in pain

Radiologist reported fine.

17/8/98. care on duty @ ~~0730~~ 1215

- when I saw her.

I remember she was in pain

I can't remember what looking at the notes.

I did look at records.

I don't referred memory at all.

X-ray reviewed by a colleague of IB later in day.

Ck - what impression did you get of her.

- She was generally less responsive.

whenever we communicated

- more noise than previously.

- noise when we came for her.

Discussion w daughter re pain.

Daughter - wanted GR to be pain free

- agreed to control pain as best as possible

- didn't discuss options - we were using Oramorph

- no mention of other medications or escalate.

Difficulties with swallowing.

had been eating with difficulty.

reluctance of Mrs R to take things by mouth.

Ca + PB

Decision to make to SD.

JB decided GR was deteriorating.

Input from nurses.

JB decides SD. JB alone.

I don't think it was inappropriate.

GR's pain wasn't in control.

difficulty getting her to swallow.

Thought she couldn't survive.

Thought comfort care.

Didn't discuss in any great depth.

Dose range prescribed

dosage decided by 2 qualified nurses.

She was put on SD on morning of 18

- seemed to control her pain.
- It became possible to provide nursing care.
- no more nourishment.
- practice for PC patients.

On SD - no further manifestations of pain.

- She would die on SD.
- we didn't know how long she would last.

I was in constant communication w/family re: care.

Discussed likely death was expected

I would say we didn't know.

C - She didn't die for 4 days.

longer than average.

I've seen people for shorter to much longer time on SD. up to weeks.

- Chest infection always inevitable?
- SD generally leads to chest infection.

11/4/93

Cx of PB

- can also be a 'natural death'
- In patients [illegible] develop chest infection in a SD.

CCx of PB

Do you remember 17/8/98
- She arrived back & was in extreme pain.
- relieving pain was important. could have happened.
  C - ~~it is possible~~ [illegible] are you changing your story.
- said nothing about an injection.
- don't remember - offered diamorphine injection
  - being told MH would take her back.
  - SB's reply.
  - if I was told GR would be given oramorph.

remember administering SD.
- asking for something to stop pain.

You returned & gave an intramuscular inj^n, in his [illegible]
- I don't remember
- If I gave an inj^n would be on chart.

Nursing notes & drug records ~~are~~ were ~~not~~ criticised.

CCx - SD drugs written up on separate sheet.
- gave second injection

- PB remember talking to you & trying to look after GR.
- You have [illegible] you could come back
- would require a ~~controlled~~ prescript^n

- I recall speaking to you on 11/8/98

LL - Mother had no discomfort at all.

-Y/n said she was agitated & in discomfort.

BRBAM.

AJX 11 (Earlier noted previous)
would discuss concerns w/ JB.
Could be 23 hrs without Dr.
would you phone JB? - if needed medical advice
Anticipatory prescribing - to deal w/ units or reduce.
- Dr Lord never raised any concerns with it.
- concerns not raised with me.

patients weren't always in condit you might have expected them to be.

Seriously under doctored on DW.
JB & PB worked hard to try to provide information we could.

Did daughters have different opinions about treatment.
dr [illegible]
Having a F/T doctor made a huge difference.

☆ JB - notes not obviously in pain p 29
- must mean at that point in time.

Nurses didn't give it every 4 hrs.
- are exercising their judgment.

Many patients died w/o SD being used.
☆ Some patients would rally - eg w SD
not terribly usual. but can happen

11/6/13

On 18/8 SD instituted a plan we probably would call a plan

Had there been problems we would have moved more slowly.

Started at bottom of range. IB had written up IB's decision & she wrote prescript.

It was discussed.

I considered it an appropriate dose & means.

Ex. Concerns re staffing levels on DW? — we were at times stretched

Thus you fail to fulfil all your professional obligations.

No spotted incidents when GR on ward.

- Doses for MH problems
  - Haloperidol

would MH problems affect dose of morphine given

- Nurse Monica completed Barthel score - p40.

- Mostly start on lowest prescribed dose.
- 1308 LUNCH 1405

There were concerns relating to Oramorph.

12/8/98 recorded giving certain doses.

reduce dose to try to control pain w/o sedating her.

Describe system for ordering/storing controlled drugs.

If stock levels were incorrect, we report promptly.

No discrepancy in controlled drugs register.

Diamorphine prescribed SC by SD

What's difference in effect?

Q raised about record of gains.

p46 - no dislocation.

GX - Pain level was increasing → ↑ analgesia.

CX - In relation to decision of 18 → SD

- LL & Cr ask what decision was based on.

- Dr B - decided

I reported on how she had been during handover

Impression on handover was overweight was ? working sufficiently well.

- Did look at patient at that stage.

-

Hypothetical - what would you have advised?

I would say SD was appropriate or even later.

would have wanted radical assessment & medical support.

I would not have taken decision on my own.

All things considered, do you think it was right one?

Yes.

If You didn't have to refer it. You would have done it.

I personally would have held on a bit longer.

☆ would want to wait to see effect at last look at Obs 39

Didn't raise concern at that time.

GX - RK - to what extent does experience equip you to decide on giving meds.

can you PRN meds etc

GX - RK² - X-ray at 1545

- can't you examine if patient is unconscious.

She did experience pain on movement.

11/9/13

Cx - Mrs O'BRIEN

- re-Sworn.
- when did you apply stimuli
- she was unconscious.
  - I know difference between sleeping & unconscious
  - you can rock a sleeper.

Assessment on morning of 18/8.
- I waited to see what he was like.
- previous night she was sleeping soundly.
- I tried talking to her, touching her face.
  No reaction.
- Due to use Bleed & Baton

18/8 - completely unconscious. If transcript read her file she need stronger medicate

No reaction

She was sleeping deeply

No ~~sleep~~ SD JOURNEY - 1500.

Cx - putting pressure on eyebrows - a snapshot at a particular time.

- on 19/8 - someone entered room.
  - Nobody come in to the room. other than to reload SD
  - I offered my mother drink.

PB Said he was going to give discipline.

Nurse Confirm see from x-ray documents.
JB came in at 1530.
PB gave her a booster w inj
mother was written up.

Mother was still talking to me.
LL not allowed into X-ray
GR went in X-ray corridor.
It was very screaming. It was crying
Then sudden silence.
She came out of X-ray, deeply sedated due to 2 x diamorphine injects.

Dr Peters. Saw X-ray.
went back to mother's room.

JB Lane ward.
No oramorph @ 0830.
- seemed to be unconscious.
Hadn't come round.

GX - no xx on injections. already xxed.
- after X-ray - @ 1545 ✓
- oramorph I am not aware that from 1030 on she had more oramorph.
- I was not there at 0030 or 0430.
- Your evidence is there are false entries on nursing chart.
She was still not for the count.
You would see those signatures PB x 3 - that was a cover-up.
That is what I think.
we need a graphologist.
AIX - No RX.

LLX - para 4 2100 hrs.
Mr Beed - did give her oramorph at 2030.
- tabs with prescription record.

CX of PB - heard about how has been said.
Do you recall advising Naughton? No.
It didn't happen as far as I can remember.

1520 - ADJOURN to tomorrow - 10

12/4/13

~~Couchman~~ JOYCE -
Medications given - SD at 0800.
SD was running out.

CX - Mrs COUCHMAN
Qualifications
On DW after delivery ward and disabled.
There are notes initialled by you - did you deal w/ GR on other occasions.
No.

Did you nurse her at other times. Yes.
Originally you were patient's advocate.

It was obvious she wasn't in rt position in bed.
I positioned her & set to write up her notes.

I asked care assistant to take her to toilet & wheel her.
Distress continued.
She was screaming & crying.
Daughter agreed to a small dose of oramorph.
It surprised me that she was so poorly.
I had you phone after the x-ray.
I heard later of the haematoma.
I must have had a ½ day -> until 1330.

Cx or MC

Next on duty? - PB takes over.

Duty after absence - 20/8 - checked the driver.
Not consulted in GR's case.
On duty on 18/8 - did you know she was on SD.
I can't recall.
- I remember talking to her relatives.
3 of us went to a meeting w/ GR.
- Discussions in hospital?
↳
I remember giving GR oral care. - sponge on the end - Np in mouth

She was awake before query on SD.
☆ I tried to talk to her. on morning of 18/8.
I can't remember handover

I remember her shaving pain when she was moved.

Chest was rattly - on 19/20-8-98 - after SD.
- common for patients on SD.
She died w/ Night staff.

SGMX- Notes not legible
☆ Could have scratches.
No splint, no wedge etc.

☆ LLX - I didn't know she was dying at time of SD.
- SD would create contact relief.
- It is possible to drown on a SD
- 2 mg of Midazolam - enough for her to be operated

12/4/13

AJX - Lady on pp 45-66

GX - attended to her on 17/8/98.
- after that we both discussed w/family

Cx of Christine JOICE

Did not know much to do w/ GR.
only when you say needy? other occasions, then - Care staff

Involved in discussions re: her medication/care? Not really, no.
I would have been responsible for caring for her.

Cx - first entry [illegible] 19 p.63
exceptions to prescribed orders.
I didn't give meds on 12/8 as she was drowsy.

- After second admission.
- other staff nurse said she'd a fall. I didn't look at her.
others were dealing with it.

Return from RN Nyler - patient v. distressed. p.45
I felt it was important to record her distress. But I didn't intervene.

Next entry - not hard -

After 17/8/98 - were you aware about what was happening w/GR.

I would have been aware she was on SD. - was it a surprise? I knew she was in a lot of pain.

18/8/98 - recorded response @ 2000 showing signs of pain.
↳ entry at 2000 - comment may have been earlier.
- knew then she was on a SD.

Cx of CJ

Did you think he would die?

I thought it was by pure relief first off.

I can't say when her condn changed

Next entry is on 2/8/no

overall condn deteriorating

chest infection - I can't remember.

pBJ - 18/8 was INR on previous day

LLX - ~~A~~ I decided not to give meds in case that was what was making her drowsy.

AJX - Oximetry monitored up as required

- decided it was not required

- Hyoscine given to dry secretions

ORAL FU Completed.

10 minute Heart. → 1155

Read Nurse BREWER.

9/4/13	RICHARDS	PORTSMOUTH GUILDHALL	INQUEST DAY 1
10/4/13	RICHARDS	"	INQUEST DAY 2
11/4/13	RICHARDS	"	INQUEST DAY 3
12/4/13	RICHARDS	"	INQUEST DAY 4