15/4/13 - 17/4/13 RICHARDS

tooks

PORTSMOUTH CORONER

GLADYS RICHARDS

(DECEASED)

3

15 APRIL - 17/4/13

Criminal Defence Service | Community Legal Service

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Read GMC summary.

Death Certificate

Prof Jones comments.

~~keep coming~~ certify death. – Standard practice? – gave approval overnight all at you? – Dr Lord?.

–

Anticipatory prescribing
– will produce a rattle -> distinguish.

Hatchinson? – no evidence.

Philip Green – gave 2 shots of possibly diamorphine.
Did this influence death or SD dosage.

Prescribing – high.

– BNF – states equivalence at least twice but actually 3 times.

Tres for causes marked deterioration. Para 6
– You consider it inevitable...

2mg midazolam – for an operation. ↑ hugely by you.

write up chronological notes.

Observ obs - can generally assume someone 9/10 sensitive & receptive
to be as sensitive & receptive

11/8/98. Dr Reed's mid visit did not think she was dying
- thought she was time to transfer.

Yr thought it more likely she would deteriorate. para 11. - thought she was near death para 13
Decided to engage in anticipatory prescribing.

DOSE on 11/8/98. ⇒ drugs to continue until.
thought she would die sooner rather than later.
w/in 23 hrs?
Must be wrong about that?

Dr arrival did not appear to be in para para 15

200mg IV 24/hr total dose

13/8/98 - fell out of chair.

PC

14/8/98 - X-ray.

Is this lady still ~~on~~ for another surgical procedure?

Need a reduction at HH. - 2 mg of Medazolam - check BPs.

- Instructions re: splint given.
- Never seen a splint on re-admission?

17/8/98 - GR returns BrW

peaceful on return.
It may become a problem give opioids.
→ give oramorph if in severe pain.

Prepare her daughters for what is to come - inevitable death. para 22
Ward made at this stage a decision to move to PC.

ASM about PB injections

Discussed dest infection - due to immobility.
- also due to morphine causing respiratory depression.
- Mix till daughters back
- police aware.

18/8/98

para 25 - I assessed her as dying
confirmed assessment of her from 17/8/98 she was dying.
marked a ~~differ~~ deterioration from 11/8/98.

So if she was ~~not~~ dying on 17/8
deterioration from 11/8
=) not dying on 11/8.

Yet you were ruling why that you were happy for nurses to confirm death.

para 25 You say she was not eating or drinking at time of Note on 18/8 (para 24)
- ~~as this record~~ she had swallowed Dramocyn @ 0430.

- No note that she had not swallowed.
- No Note of use of PC.
~~No note~~

Said it was based on haematoma - no bruising or swelling on surface of skin.
- nothing in the x-ray report.
- no evidence of haematoma.
In any event a haematoma does up.

Bloods step up in dose for SD.
Double dose Dramocyn.
Missed dose 2nd for manipulation.

You also decided it was bronchial cyst.

Nil simple stopping it up.
dabbing it.

with wide discretion to wean.
limited dosages possible.

- no effort made to re-access her.
she was completely unconscious.
[redacted] → enough?
taper it back.

Or better still taper it up?

Pretty obvious given the analgesic ladder

No effort made.
asked at IV.
No answer.

She was [redacted]. not passing water.
potential renal failure
so concentration of morphine in blood ↑
effects of drugs ↑ all the time.
No consideration made to that.

21/8/98 - Death cert.

- Brain pathology.

- nothing else?

- nothing to do with epilepsy?

Read letter & discuss her.

15/4/98

INQUEST DAY 5

CX - Dr BARTON SB (B) sworn on Bible.

- I've got prepared statement from 2000
- B - reads statement.
  1034.
- 11/8/98 - first assessment.
  - expand on assessment.
  - 'frail' is very broad.
  - she was frightened, elderly confused.
    - lost her hearing aid.
    - quite an unpleasant experience summed up by frail.

- 'Please make comfortable' - prime concern was to ensure key needs of patient - clean, fed (inappropriate), pain free — A
- very common for someone to come in & be left
- happy to confirm death. - administrative matter.
  - not an assumption death was imminent.
- prescript - SC Diamorphine
  - If patient's condition deteriorated
  - if never called could be 48 hrs before seen

Didn't move her about at all.

13/8/98

- slipped out of chair - Dr Brigg contacted B not on duty.
  Transfer would not have altered management?
  Would they do closed reduction? - prob not. - just make her comfortable.

- You arranged for x-ray.
  why concerned about transferring her back.
  Every move carries a morbidity

15/4/13

17/8/98 - transferred back on a letter describing a different form of psychosis.

- May have suffered in transfer?

Nursing staff said she did not seem particularly comfortable.

- How do you convey someone whose Body has started to give up?

She had given up.

There is a tranquil, removed expression, body language, smell everything.

- Reviewed her again next morning 18/8/98

- pain had not been controlled

not eating

not drinking

Crying out, in a lot of pain.

SD - Final Stage - was there really no way back from that.

- not the act of prematurely or resolving death.

- convenient device for steady dose

Haematoma - suggested on x-ray report.

Chest infection - likely

- long period of clinical experience.

- post terror - self discipline can lead to aggravating depression.

is not enough does - yes.

- almost never 4 hours.

- no use of agitating depression

Just as signs of agitated depression.

Nursing staff well experienced

- Rattling developed on 19/8/98.

Bronchopneumonia developed by her?

Antibiotics would not have altered the outcome?

15/4/13

we don't use antibiotics to try to clear up a terminal bp.
couldn't get rid of bacteria.
prescribed hyoscine.
- it dries up the death rattle.

Saw her again on - 20/8/98
She was comfortable.

S - 21/8/98
Things got worse.
No sign of any improvement.
able to tell both etc.

No evidence of resp depr
diamorphine was not increased.
she was developing bloomea.

Earlier evidence - GR less fast than Naught?
we often see ... of diamorph keep them alive rather than kill them.
almost kept alive by diamorph di

15 minute break.

XX by Mrs O'Brien

Very little time w/each patient.
Wessex guideline other "relaxed" environment?
can be used anywhere.
inappropriately applied
Statement - one complication have patients in silence.

Sharing with weight bearing but could not do anything once the weight was borne.

15/4/13

COB X You did not examine my notes on first day.
I don't remember details of each session.
Usually examine patient in bed

I don't remember time of examination

HH discharge letter does not concur w/ barthel score of 2
She could stand, - ~~why~~ weight bear
- eat & drink

Patient recovering well etc - why did you decide for happy for nurses to continue death

I can't remember at what time I visited the ward to see her.

Pro-active prescription not necessarily to be used.

Can't explain analgesic regime at HH.

C - why would more pain relief be required so long after surgery.
No idea how they assess pain or mobilise patients.
- graph of analgesia does it necessarily go down? Yes.

COB X

I was not made aware she had fallen until I started work at 0800 on 19/8/98.

2mg ↑ to 20mg Avanafil
~~pre~~ was not a direct IV bolus.
pharmacokinetics would be different.

Do not accept drugs were not excessive.
BNF correction - correct in theory,
- but lack of response was not controlling her pain.

15/4/13

LDBX - why give such a large dose in SD?

- at 0430 - 5ml of Oramorph.

- I know, that when I came to ward it was reported to me she was distressed etc.

- It was on advice of Sr Staff

I don't know what she was like during the night.

- Nursing staff would not give her the Paracetamol etc

- I had to be back at Surgery at 0830.

- 17/8/98 - Acknowledged she was transferred by Staff?

I was not made aware of any problems w/ transfer

- I was not on ward on day she was having a problem

- In discussion w/ Sr nursing staff - analgesia was going to be inadequate.

It was increased appropriately.

- experts were not present on morning of 18/8 & made decision.

- seeing patients.

- My assessments - were made based on nursing staff.

- It was inappropriate to transfer an ill lady back to unit.

- Not my consultant said she could go to HH.

She was not amenable to treatment by a Surgical consultant.

It was not appropriate to transfer your mother.

She needed PC.

PC is given when there is no cure or Surgical condition to be given.

We didn't know at that time that case could be looked at.

X-ray was done after I came back from HH.

I felt clinically there was not a dislocation.

18/8/98 - [illegible] not requiring

CG - PD did not say she was unconscious at any particular time.

15/4/13

LOB x - PB would have waited longer to apply SD.

- In those days you did not write - the patient is dying.
  1998 it wasn't done.
  LOB disagrees
- As a result of great experience you see whole body is beginning to shut down, may take several days or hours.
- Did not always record enough.

- Haematoma - was one of the causes of significant pain.
  other causes - move to a more unfamiliar surrounding.
  probably frightened & anxious & dying.

CX - Dr Lord - would have to request a transfer.
- hard - less in HH.

It was not appropriate

LOB x - GMC Q.
- I can't remember what GMC said.
- can't really discuss what happens at inquest.
- ~~Is it also true you~~

- ~~Tar thoughts~~
- diamorphine is handled by liver not kidneys

Q for Prof Black

Pcla x - Mrs SM asked about prescribing you said it was based on needs at HH.
- I didn't know what analgesia she had at HH but this would not make a difference.

- prescribing was similar to any PC patient.
- I saw such a deterioration in general condition I thought it was v. unlikely she would survive.
- She need PC on 17/8. I was not hastening her death. 1315 Lunch till 1410

15/4/[redacted]
13

CBrX - Lazo dose stopped → Halo continued.
- recollection of nursing staff.
- 3ore - given oramorph at 0615 on 12/8.
- Agree nursing staff would inform me about diamorphine.
- p. 66 - PRN haloperidol prescription.
- can't remember if Nurse Brewer asked for it.
- written because she was in pain.
- drowsiness from oramorph had worn off.
- Haloperidol - effect on RSH or accident?
Don't think that dose would have much effect on her liability to fall

- Oramorph - agree you should give smallest dose appropriate
Yes.
- On 18/3/18 - record p.47 - pain relief is just adequate in SD.

- Q from 3M - Pneumonia.
CBrX - PB said she had pain all over.
B - all of the experience would give

AJX - did patients always come in am? no.
I preferred to see them in the morning.
- patients who need to wait for a Dr.
- Dr Reid said they often arrived at GRH in worse condition.
- Yes often . . - dementia, confusion, etc.
- demented patient doesn't like transfer.
- Sometimes not as well as discharge letter makes out.
- First admission Barthel score: 2.

- LOB says CBrX was doing well at HH - not what we observed at HH.
- PRN - as required.
- if oramorph was not given it was not necessary to administer it.
- 17/8 - oramorph - 2-5mls at 1300, - - , 1645
- regime altered 2-5 - 5mls every 4 hrs.

15/4/13

ATX - to consume these doses last needs to be able to swallow.
- your assessment is - dislocation to cellnaft but you think that so.
- what would HN do for her.
Nothing
- process of transfer on 17/8 led to deterioration.
- transfer to HN would be again inappropriate.

- Ms ... note para 24 - nursing a problem.
I assume she could swallow

- I didn't set up SD.
- reacted to pain when being moved
slightly contradicts deep unconscious.
wouldn't expect that to be possible.

- chinese whispers.
If nurses have concerns they pass them on.
Best practice - things would be written down.
PB - said it was an understood word.
- B - Tu.
When she resigned she was replaced by permanent Dr - 2.
If F/T dr there would not need to be anticipatory prescribing.
· allow nurses confirm death. - less urgently necessary.

CX - None.
1435. Adjourn until wednesday am 1000.

16/4/13

NOTES TO PREP Submissions as to verdict.

Breach of duty - prescribing.

anticipatory prescribing.

Proof

-

17/4/15

Cx of Prof BLACK.

- CV
- Reads report

Cx - Ginsburg relates to recording of notes.
- Dr B explained that her note taking not of best quality.
  priority was to treat patients in the of workload.
- para 5.2
- How far have failings in note taking influenced her death?
  I have very little evidence upon which to base it.
- my view & other sc - played a role.

- once a decision is made that there is no need to do to cure her. Then it is what you deal w/ symptoms.
- She had significant doses of all 3 drugs.

- It is almost inevitable those doses would hasten death - by hours to days.

- a number of factors lead to death? - Yes
- combination of factors caused death.

- Prof F disagreed. Starting dose of diamorphine.
  Dose was within outside borders.
  Giving nothing would be reasonable.

- ~~I think both~~ I can't judge it was right. There could be occasions to justify 40 etc.
  It is at top end of dec

17/4/13

LCX of Prof B

Prescribing in general.
- Nor in ~~[illegible]~~ notes

My interpretation would be that she had a standard set of drugs & approaches.

My immediate impression was that she had fractured again.

Not a simple problem -> should ask for advice.

I noticed that there is no pain relief between 0430 - 1130.
Possible - not in pain
- given homeopathic.

CGX of Prof B

para 4.8. - justification for overnight on 13/8/98.

Impossible to judge if dose was too high.
There was some evidence of breakthrough pain.

You will gain tolerance.

Change from Oramorph to SD.
Not more dangerous by SD.
-> Dose not method that matters.

Death in or not suddenly would be a plausible explanation for drug prescribing.

AS x of Prof B

Notes are very thin
Can't tell in gaps because there are gaps in notes.
Nurses & Dr B admit Dr
~~This hospital~~ GMC expects records be kept

good in Nephew.
→ declines in Gen

Decision: PC - not properly made.
- Black out Sang
- Fever says it was not

- discrepancy - PB - 18 - would want.
MC " " "
- 36 - 17

she thought was made
30 declines to consider prescription made same day.
Should have asked what it signified & what it meant.

Failed to take to diagnosis while she was in emergency para

17/4/13

<u>AJA of Prof B</u>

- ~~[illegible]~~ undiagnosed medical problem come into GW.

- Med care under consultant & Clin Asst gives day to day care.

- I can't condone poor care.

  First time AS gets criticised.

- I still cannot see anything to explain 200mg/24hrs
  Is it a failure in notekeeping that is the substance of criticism.

- I cannot understand why there were not milder opioids given.

- only gave oramorph in severe pain
  But nothing prescribed for mild pain.

- Nothing in notes about haematoma.
- Agonal - very close to the end.

- SD - didn't raise dose as you might if pain was experienced.

- Can you say any dose actually administered was incorrectly given.
  - Doses on 11 & 12 were

Cx - when you wrote report you didn't see prof F's report.
  - Reasonable to put in analgesia as a factor.

Duty of Care - admitted.

Breach - Terms of Prof Black. para S.2 & S.3.
para

- catalogue of failures.
- Fever - move up in dosage is sub-lethal ~~lethal~~
- Fever & Black -

~~Causation~~.

Causation - Over prescription of morphine led to death - Prof Fever is sure.
Prof Black cannot say.

Make a narrative verdict. - include - 3 Qs

Nature of natural & unnatural ~~verdicts~~ causes.
describing things as failures is permissible.

Neglect. Original clinical decision.

- [redacted]

Peer's comment serious
Not regarded by Black.

Conversation - returned to NH - became well again.

No evidence of being in pain at time SD administered Oramorph
Analgesia doubled.

~~No need~~ No efforts to begin with lower dose.
~~No of~~
Went straight to an unrousable condit[ion].
May have been some more ~~[illegible]~~ pain recorded. But generally agreed she was out of it.

Prof Forrest sure it hastened death
Prof Black analgesia is a factor. - would add to death certificate.
- dosages would hasten death by hours or days.

BREACH.

Injections given by PB - 2 separate witnesses
same descript°
- not recorded.
- not informed to ~~[illegible]~~ the Dr.

~~Complete lack~~ Uncertainty.
Ambiguity
Imprecision

✓/

Terms of Post Breach - paras 5.2 & 5.3
- 4.10 onwards.

~~[illegible]~~
Fever move up in dosage is substantial

[illegible] prescribing inappropriate, too wide, potentially hazardous, not in best interests of patient
echoing conclusion of GMC.
Did not make appropriate steps on analgesic ladder,

Notes - ~~[illegible]~~ faulty agreed by JB, PB, MC, CHI, [illegible] & B, GMC,
- duty on ~~Doctors~~ medical staff to produce adequate notes.

No justification for, SD, Use of Midazolam alongside Haloperidol.

NEGLECT - It would be neglectful to fail to provide ~~food~~ nourishment & someone who was dying.

- Nobody was clear if she was dying.
  - Decision to move to PC - made on 17 by Dr B.
    - made on 18 by PB.
      PB & MC thought decision should wait.

- On the balance of probabilities HB case amounted to neglect.

- No record of her being in pain at time of SD
  - No need for more drugs since 0830 → 1130
  - No evidence she could not swallow.

- Nothing to say the view of NH was wrong that she could move to comfort splint.

17/4

BREACH

Refer you to Prof Black - Conclusion - Para 5.2 & 5.3
- Report para 4.10. Dramorph.

Prescribing of 11th - Prof Black
- Too wide, Inappropriate, potentially hazardous, not in best interests of patient.
- echos conclusions of GMC
- No intervening review to change this prescription or consider discontinuing

~~- is core~~

No justifications for - move to SB - significant change from their notes. PF
- swallowing & his earlier. BNF - not true
2 - failure to follow the analgesic ladder.
3 - use of Midazolam alongside Diamorphine & Haloperidol.
4 Significant rise in dosages to highest end.

Monitoring - clearly unsatisfactory - SB, PB, MC, PF, Prof B, GMC & CHI
- is a duty and essential to providing proper care.

- can never be sure about injections from PB.
2 witnesses separately recall it.

Anticipatory prescribing - clearly given PC dosages on 11 w/o justification.
- Language of PC - Hers contestable.

- death anticipated incorrectly.

17/4

CAUSATION

After 11th - prescribed PC dosages
returned to HN
recovered well.
Nobody can explain what happened her splint
She was mobile.
She only needed co-codamol.

Returns to GW ~~too significant~~
Is in pain but no effort is made to follow analgesic ladder.

Prof Ferner is sure analgesia hastened her death
Prof Black says it is a factor - should be added to death certificate.
Said - dosages would hasten death by hours or days

Remember - Decision to move to SD not supported by evidence.
She was swallowing 4 hrs earlier
she didn't need pain (PRN) at the time
8 hrs later - unrousable

If the decision to move to PC was properly taken, it would be correct.
to give to dosages. But it would need to be recorded to be correct.
It is not a correct decision.

GROSSNESS.

17/4/13

CG Submissions

No view on narrative verdict.
No " on neglect. - Not mandatory it is not open to you.
UK
Unlawful Killing
GN
- No view re: GN by Un Ass.
- No " " GN by Nurses (N)
- resist view drugs administered from 13/8 onwards
-

Don't disagree with JM on law.
JM's evidence is too tenuous
Ev: Prof F - & Injections
↳ Dr & Nurses not recorded
- conclusions on B of P not BRD.

Injections - LL & GM said ~~RB~~ ~~gave~~ injections don't say
- GM denied oramorph was given
- controlled drug register not considered.

AJ ~~R~~ Submissions

Role of Coroner.
Notekeeping plays no role.

CX of AS.
- what do you say of oramorph on 11/8.
of doses actually given were any not appropriate
- on first admission.
causation is more than a clinical criticism.

Adjourn until - 1615.

17/4/13

VERDICT

Subject pts of ev - 91 y. old etc.

etc.

Dev - JB Note that GR would definitely die on 11/4

- Records were sketchy.

poor record keeping scrutinised & criticised elsewhere

- when & how much meds given appears to be correct.

Injections - witnesses were adamant they could have been recorded.

Experts - Prof F & B

- ↳ most likely SD produced GR's death.

↳ took a more holistic approach

analgesia made a contribution.

Answer Q. narrative verdict.

- How? - GR died at GWMH on 21/8/98 due to Bronchopneumonia

factors contributing - accidental falls @ HH & GWMH

- procedures @ HH.

- mobility subsequent to these procedures.

- medical at GWMH

- old age frailty & end stage dementia.

That brings inquest to a close.