Review of records of five patients investigated by Hampshire Constabulary; 23.12.02

The first case reported to the police was that of Gladys Richards. The report of an expert witness, Professor Brain Livesley, was that the patient had been unlawfully killed (this information was obtained from the police file after I reviewed the records and completed the commentary included below).

The police decided to review to care of four other patients from among those whose deaths had been reported to them because they had a number of 'critical factors in common with the Gladys Richards case'. The record review below deals first with the records of Gladys Richards, and then with the four other cases.

Name: Gladys Richards
Date of birth: Code A Date of death: 21.8.98 Age: Sex: F

Admission
Fractured neck of R femur 30.7.98 in Glen Heathers Nursing Home. Admitted E6 Haslar Hospital and had a R cemented hemi-arthroplasty. Discharged to Gosport Daedalus ward 11.8.98. History given by Haslar: deaf in both ears, cataract operation both eyes, six months history of falls, Alzheimer's – worse over last six months, hysterectomy 1955. She was reported as taking: penicillin V, haloperidol suspension 1 mg bd, lactulose 10-15mls bd, co-codamol 2 prn. She was in need of total care with washing, dressing, eating & drinking. Daughters noted to be devoted, although staff nurse in Haslar thought they could do with a rest. Continent, occasionally says recognisable words, but not very often.

Letter from Consultant Physician in Geriatrics, Dr RI Reid 5.8.98 (i.e. seen whilst in Haslar following fracture) notes relatives report patient 'knocked off' on medication (haloperidol & trazodone), and better off trazodone. Clearly confused and unable to give any coherent history. Despite dementia, should be given the opportunity to try to remobilise, and therefore transfer to Gosport arranged.

11.8.98; notes by Dr Barton – Transferred to Daedalus ward continuing care HPL (meaning unclear) R# no femure 30.7.98.
pmh hysterectomy 1953, cataract operations, deaf, Alzheimer's
o/e impression frail demented lady, not obviously in pain, please make comfortable transfers with hoist, usually continent, needs help with ADL, Barthel 2.
I am happy for nursing staff to confirm death JAB (initials)

14.8.98 sedation/pain relief has been a problem, screaming not controlled by haloperidol 1mg tds but very sensitive to oramorph. Fell out of chair last night, R hip shorter and internally rotated, daughter aware and not happy, plain X ray. Is this lady well enough for another surgical procedure? JAB

14.8.98. Dear S Cdr Spalding, further to our telephone conversation, thank you for seeing this unfortunate lady who slipped from her chair at 1.30 yesterday and appears to have a dislocated R hip. Hemiarthroplasty was done 30.7.98. I am sending X-rays across. She has had 7.5mls (or 2.5mls) of 10mg/5ml oramorph at midday. JAB

Notes from Daedalus ward nurse P Beed 14.8.98 – patient to A&E for dislocated R hip. No change in treatment since transfer 11.8.98 except addition of oramorph prn.

Admitted to Gosport Daedalus Ward 17.8.98, from Royal Hospital Haslar, having been admitted to Haslar 14.8.98. She had undergone a closed relocation of R hip hemiarthroplasty under IV sedation. The reduction was 'uneventful', although she was 'rather unresponsive' following sedation. A catheter was inserted, and was still in place on transfer. Given a canvas knee immobilising splint, and was said to be able to fully weight bear.

Consultant responsible in Gosport: Dr Lord

17.8.98 Readmission to Daedalus from RHH. Closed reduction under iv sedation. Remained unresponsive for several hours, now appears peaceful. Please continue haloperidol, only use oramorph inj (??) in severe pain. See daughter again JAB

18.8.98 Still in great pain, using ??? I suggest SC-diamorphine / haloperidol / midazolam. I will see daughters today. Please make comfortable. JAB

21.8.98 Much more peaceful, needs hyoscine for rattly chest. JAB

21.8.98 Condition very poor. Pronounced dead at 21.00hrs by S/N Sylvia Roberta G...? Relatives present (2 daughters) for cremation.

The nursing notes confirm the patient was admitted to a continuing care bed, was fully weight bearing on 11.8.98, walking with the aid of two nurses and a zimmer frame. Patient has no apparent understanding of her circumstances due to her impaired mental condition. Requires feeding. Barthel 3; Waterlow score high risk (27).
Notes confirm 13.8.98 found on floor 13.30, pain at 19.30, transfer to Haslar 14.8.98, returned 17.8.98, when patient very distressed appears to be in pain. Daughter reported as saying mother must not be left in pain again if dislocates, another X ray organised – no dislocation, so for pain control over night. Oramorph 2.5 mls given.

18.8.98 seen by Dr Barton, for syringe driver; treatment discussed with both daughters and they agreed to its use. Diamorphine 40 mg, haloperidol 5mg, medazolam 20mg commenced. Patient noted to be peaceful although daughter angry. 19.8.98 – grandson wants to talk to Dr `Barton or Phillip Beed. Daughters indicated as making a complaint, to be handled officially by ??? nursing co-ordinator.

21.8.98 Patient's overall condition deteriorating, medication keeping comfortable. Pronounced dead at 21.20.

The nursing care plan on 12.8.98 indicates patient had a restless night – had been given haloperidol, but did not seem to be in pain. Given oramorph at 21.00 on 13.8.98 and slept well. Oramorph continued 17.8.98 when re-admitted.

The drug chart indicates oramorph 10mg/5ml 4 hrly being written up and prescribed 1-2 daily from 11.8.98. Diamorphine was also written up on 11.8.98 although none given; hyoscine and medazolam were also written up dated 11.8.98, although not started until 17.8.98. These drugs were all in the as required section of the drug chart. Oramorph 10mg/5ml, 2.5ml qds added to regular list, indicated as PRN, 12.8.98, and given on this basis until 14.8.98, plus 5ml (10mg) nocte. The syringe driver diamorphine is written up on 18.8.98 as 40-200mg in 24hrs. The dose appears to have remained at 40 mg.

Commentary following review of the Gosport notes.
The patient was clearly highly dependent because of advanced Alzheimer's; her general condition must have deteriorated following the fracture and surgery, although when she was admitted to Gosport on 11.8.98 she was not reported as in pain, and was receiving co-codamol only. For some reason that is not recorded in the notes, the co-codamol was replaced by oramorph; it is extraordinary that diamorphine, hyoscine and medazolam were also written up on an as required basis on this date since there is no clinical reason for these drugs indicated in the records (perhaps an explanation is an error over the date, but such errors do not occur elsewhere on the drug chart). Indeed, the decision to start oramorph is not accompanied by any explanation. The over-sedation of a patient primarily admitted to be remobilised is inappropriate.

The phrase 'Please make comfortable' looks initially benign, but the patient had been admitted to be given a trial of remobilisation. The phrase 'please make comfortable' re-appears on 18.8.98 (JAB) when the syringe driver was started, and raises the possibility that this term has sinister implications.

It is possible that over-sedation led to the fall the precipitated the dislocation.

The decision to start the syringe driver appears hasty – essentially it implies that the patient is terminally ill, has uncontrolled pain, and the risks of high doses of opiate are outweighed by the benefits. The cause of the new pain is not diagnosed (although an Xray was taken), and no therapies are tried before resorting to diamorphine. The addition of hyoscine and medazolam indicate that continued high doses were anticipated; the dose allowed for use was 40-200mg per day. I am uncomfortable with the range of dose for which the patient was written up, and it suggests that the doctor in charge of daily care did not take a daily decision about the amount required.

The early use of oramorph and quick resort to a syringe driver in the absence of clear clinical indications are findings that give rise to considerable concern.

Other documents
The controlled drugs registers indicate that oramorph was started on 11.8.98, continued up to and including the 14th (daily dose), then recommenced on 17.8.98, and continued during 18.8.98. The syringe driver diamorphine is recorded from 18.8.98, in 10mg plus 30mg per day.

Death certificate
1(a). Bronchopneumonia
This is misleading; there is no entry in the records to indicate Mrs Richards had bronchopneumonia; the recent fractured hip is not mentioned, and it would have been

usual to have notified the coroner of a death following a fracture and a surgical procedure. This was not done. The R hemiarthorplasty is mentioned on the cremation form.

Notes about care in the nursing home prior to the fall.
I have not studied these in depth, although note that a case conference was held 23.11.98 to review care in the home, and in particular the fall that cause the fracture. The review concluded there was no evidence of deliberate abuse although there seemed to be problems of complacency in some of the care practices which needed review. The records from the nursing home confirm the problems of Alzheimer's and falls.

GP records
Appendicectomy in the 1930s, total abdominal hysterectomy and R salpingo oophorectomy 1958. Reduced memory and confusion noted from 1989. 1987 – polymyalgia, treated with steroids. Noted in 1994 to have senile dementia, and on melleril at that time. 29.12.97 – continual agitation, worse at night, haloperidal and trazodone commenced. Frequent assessments from this time, and some minor injuries/falls.Fall 23.7.98 ?#nose; Dr Barton telephoned the practice 24.8.98 to report the death (Dr Bassett signed the part 2 cremation form). A domiciliary visit by Dr Banks is dated 4.2.98, and confirms end stage dementia; advice about management and medication was given.

X rays
The X ray of 14.8.98 confirms dislocation; that dated 17.8.98 confirms relocation, and reveals no other cause for pain.

Arthur Cunningham

Date of birth: Code A Date of death: 26.9.98 Age: Sex: male

Fairly advanced Parkionson's attending Dolphin Day Hospital.

Nursing notes
21.9.98 Admitted from DDH with Parkinson's, dementia and diabetes (diet controlled). Catherised on previous admission for retention. Large necrotic sore on sacrum. Dropped left foot, back pain from old injury. 14.50 oramorph 5mg given prior to wound dressing.
21.9.98 Remained agitated until approx 20.30. syringe driver commenced as requested. Diamorphine 20mg, midazolam 20mg at 23.00. Peaceful following
22.9.98 Mr Farthing telephoned, explained that a syringe driver containing diamorphine and medazolam was commenced yesterday for pain relief and to allay his anxiety following an episode when Arthur tried to wipe his sputum on a nurse saying ha had HIV and was going to give it to her.
23.9.98 S/B Dr Barton. Has become chesty overnight, to have hyoscine added to th driver. Stepson contacted and informed of deterioration. Mr Farthing asked if this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed. 13.00 Mr & Mrs Farthing very angry that syringe driver has been commenced. Explained that needed for pain and that

consultant would need to give permission to discontinue. 'He is now fully aware that Brian is dying and needs to be made comfortable.'
24.9.98 diamorphine to 40mg
25.9.98 diamorphine to 60 mg, midazolam 80mg hyoscine 1200mg
26.9.98 diamorphine 80mg, midazolam 100mg; died 23.15

When admitted 21.9.98, the desired outcome in the nursing record was to promote healing and prevent further breakdown of the sacral sore. The DDH notes indicate the patient was admitted to Dryad for treatment of the pressure area.

The drug record indicates that oramorph was written up on 21.9.98 2.5-10mg and started that day, being given 2 doses. Diamorphine SC 20-200mg was written up 23.10, with hyoscine 200-800mg. The dose of hyoscine was given as 800mg to 2 gm 25.9.98, and midazolam 20-200mg.

Mr Cunningham had mylodysplasia, but this was reported as stable 29.8.98 (on discharge from Mulberry ward).

Letter from Dr Lord, 23.9.98 – 'I have taken the liberty of admitting him to Dryad ward at Gosport War Memorial Hospital with a view to more aggressive treatment on the sacral ulcer as I feel that this will now need Aserbine in the first instance.'

Inpatient notes

TUR 1992, Appendix 1942, Parkinson's, spinal fusion 1944; stone r renal pelvis 1992, 1994 – NIDDM;
Wt loss noted 20.7.98, no cause for this discovered other than discontent with rest home.
21.9.98 – DDH; very frail, tablets found in mouth, offensive large necrotic sacral ulcer with thick black scar. Plan – stop codanthramer and metronidazole, TCI Dryad today, Aserbine for sacral ulcer, nurse on side, high protein diet, oramorph prn if pain. 'prognosis poor'

21.9.98 Transfer to Dyad ward. Make comfortable, give adequate analgesia, I am happy for nursing staff to confirm death JAB

25.9.98 Remains very poorly. On syringe driver, for TLC Brook

24.9.98 remains unwell, son has visited again today and is aware of how unwell he is. Sc analgesia in controlling pain just. I am happy for nursing staff to confirm death JAB.

26.9.98 died 23.15
28.9.98 death cert (Dr Lord) 1 bronchopneumonia 2 parkinson's disease, sacral ulcer.

Commentary
The patient's sacral ulcer was not treated aggressively; there is no record of the indication for use of a syringe driver, and the early resort to this medication suggests the opposite of aggressive treatment. The patient was certainly ill, although the explanation for the sudden deterioration in the days before admission are not entirely

clear. It is not possible to be certain that more aggressive treatment would have led to a different outcome, but such an approach was not given the chance.

Alice Wilkie

Date of birth: Code A Date of death: 21.8.98 Age: Sex: female

Nursing notes:
6.8.98 Transferred from QAH for 4-6 weeks assessment & observation & then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration. On fluoxetine, co-danthramer and zopiclone
17.8.98 condition has generally deteriorated over the weekend. Daughter seen – aware that mum's condition is worsening, agrees active treatment not appropriate, & to use of syringe driver if Mrs`Wilkie is in pain
21.8.98 condition deteriorating during morning, Daughter and granddaughter visited & stayed. Patient comfortable and pain free
21.8.98 death confirmed

Nursing remarks note dementia, poor mobility and poor food intake. Had originally been admitted to QAH from psychogeriatric care home with unresolved UTI and decreased mobility. The QAH medical notes indicate treatment with intravenous antibiotics, overall prognosis noted to be poor

Drug chart at GWMH
Diamorphine 20-200 mg 20.8.98, with hyoscine 200-800mg, midazolam 20-80 mg. (Hyoscine was not recorded as given). Diamorphine 30 mg and midazolam 20 mg used.

GWMH medical notes
10.8.98 Barthel 2/20, Eating and drinking better. Confused and slow. Give up place at Addenbrookes, R/W in 1/12 – if no specialist medical or nursing problems D to a N/Home stop fluoxetine. Initials ??MW

21.8.98 Marked deterioration over last few days. SC analgesia commenced yesterday, family aware and happy. JAB
21.8.98 death confirmed, family present, for cremation.

Commentary
The cause of the deterioration before death is no stated, and no action appears to have been taken to investigate or actively treat the problem. One can only speculate on what might have happened. Subcutaneous diamorphine was started (30mg/day, not a high dose) with midazolam. The reason for starting this medication is unclear, there is no distinct history of pain, of condition that would give rise to pain. At best, the brevity of the clinical records should be criticised, at worst the patient was given diamorphine instead of more appropriate investigation and management.

Robert Wilson

Date of birth: Code A Date of death: 18.10.98 Age: Sex: Male

15.10.98 S/B consultant in old age psychiatry (Dr Lusznat); fracture L humerus following a fall, alcohol problems, poor mobility, Barthel 5, early dementia ??alcohol related. Tazodone started.

He had been an inpatient in 1997 with a chest infection and high alcohol intake.

Letter from specialist #L greater tuberosity, shoulder 21.9.98, admitted overnight via A&E; feeling sick. On frusemide, spironolactone and thiamine, decided to agree to operative fixation, admitted ? Dickens ward, appears to have been given diamorphine inj 24.9.98 5mg because of pain in arm. 29.9.98 renal function impaired. 'Not for resuscitation in view of poor quality of life and poor prognosis.' Given IV fluids and referred to psychogeriatrician. 7.10.98 – urea 15.8, creatinine 152. 13.10.98 – still needs nursing care and medical care. He is also in danger of falling …

14.10.98 Transferred to Dryad ward continuing care. HPC # humerus L 27.8.98 PMH alcohol problems, recurrent oedema, CCF. Needs help ADL, ??? continent, Barthel 7, lives with wife ?? ??. ?? full mobilisation JAB

16.10.98 decline overnight with SOB. O/E bubbling, weak pulse, unresponsive to spoken orders Oedema ++ in arms and legs ?silent MI ? ?? function. Increase frusemide to 2 x 40mg Knapman

17.10.98 illegible entry

18.10.98 died peacefully 23.40

Occupational therapist notes that Mr Wilson's conception of discharge home is totally unrealistic (9.10.98); placement recommended.

The GWMH drug chart indicates: oramorph 2.5-5ml 10mg/5ml from 14.10.98, given 2 doses, then oramorph 15.10.98 10mg/5ml, 10 mg 4 hrly, given on 15 and 16.10.98, with oramorph 20 mg at night, given 15.10.98. (The decline is noted 16.10.98). Diamorphine 20-200mg sc in 24 hrs started 16.10.98, 20mg on 16, 60 on 17 and 60 on 18.10.98 Also, hyoscine 200-800mg/day (400 16, 600 17.10, 1200 18.10.98), medazolam 20-80 mg, 20 mg given 17.10, and 40 mg 18.10.98.

The nursing record indicates oramorph started on admission 14.10.98 by Dr Barton, for pain in L arm. The patient declined night of 15-16.10.98, seen y Knapman on the 16th, then syringe driver started (the drug chart was completed by Dr Barton, not Dr Knapman).

The nursing record in the Nursing Care Plan notes the administration of oramorph 14.10 & 15.10, and records patient sleeping well but becoming chesty and difficulty swallowing medications, plus incontinent of urine (?symptoms due to oramorph). Some morphine was given immediately after the fracture 3.10.98 and 5.10.98, on Dickens ward, but this was not continued – switched to co-codamol, then discharged on paracetamol, 13.10.98.

Commentary

Discharged on paracetamol to GWMH, where oramorph was immediately started (no reason for switch given), and patient began to decline; started on sc diamorphine and medazolam, not clear why, or which doctor made this decision. At the very least this is poor record keeping; it is also likely to indicate inadequate assessment and a too rapid decision to accept decline and death. It could reflect a locally accepted policy of early use of opiates and a passive attitude towards severe illness in the elderly.

Eva Page

Date of birth Code A Date of death: Age: Sex: female

Nursing notes
27.2.98 admitted for palliative care from Charles Ward; incontinent, dependent and anxious. 28.2.98 – distressed, calling for help and saying she is afraid. Oramorph 2.5 mg given no relief. For regular thioridazine and heminevrin. 2.3.98 commenced fentanyl 25mgs; very distressed, s/b Dr Barton, for diamorphine 5mg im. S/b Dr Lord, diamorphine 5 mg given, for syringe driver.
3.3.98 rapid deteriration, neck and l side of body rigid, r side flaccid. Syringe driver commenced at 10.50, diamorphine 20mg and medazolam 20mg
3.3.98 condition continued to deteriorate, died 21.30.

PMH
1995 – LVF, AF – digoxin, frusemide, amiloride, living in residential home
1997 - fast AF, mild CCF, ?small CVA
6.2.98 – emergency admission via GP, confused, reluctant to eat, becoming dehydrated. CXR 5cm mass L hilum highly suspicious of malignancy; in view of advanced age, bronchoscopy ruled out, and palliative care decided on.

Drug chart
Thioridazine 27.2.98, oramorph 2.5-5ml, 10mg/5ml, from 27.2.98, given once 28.2.98. Fentanyl 25mg 2.3.98, given once on 2.3.98. (Also digoxin, frusemide, ramipril, sotalol, sertraline, lactulose, heminevrin). Diamorphine 20-200mg sc in 24hrs 3.3.98, 20 mg given; hyoscine 200-800mg – none recorded as given; medazolam 20-80mg, 20mg given 3.3.98.

Notes

27.2.98 Transferred to Dryad continuing care. Diagnosis of ca bronchus made on CXR on admission; generally unwell, off legs, not eating, bronchoscopy not done, ??? needs help with eating and drinking, needs ??? (illegible) Barthel 0. Plan get to know, family seen and well aware of prognosis; opiates commenced. I am happy for nursing staff to confirm death. JAB

28.2.98 asked to see, confused, gets lost, agitated especially at night, thiorudazine, heminevrin

2.3.98 no improvement on major tranquillisers. I suggest (illegible) opiods to control fear and pain. Son to be seen by Dr Lord today. JAB

2.3.98 spitting out thioridazine (illegible). On prn sc diamorphine fentanyl patch started today. Agitated and calling out even when staff present. Diagnosis ca bronchus ? cerebral matastases. Ct fentanyl patches. ??initials

2.3.98 son seen
concerned about deterioration today. Explained and about agitation and that drowsiness was probably in part due to diamorphine. He accepts that his mother is dying and agrees we continue present plan of (illegible).

3.3.98 died peacefully 21.30

Commentary
A patient admitted for palliative care who died rather more quickly than expected. It is not clear why she died so quickly. Again, opiates were started early, - evidence for pain was weak, and no analgesic was used before opiates.

General remarks
All these patients had advanced illnesses, and relatively low doses of opiates were used – but they were used earlier than would have been expected. There is no evidence of overdose, but there is evidence of early resort to opiates rather than continued investigation and aggressive management. The use of a cocktail that includes medazolam should be noted.

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