Report, 28th November 2005

Background

This report has been prepared in response to a request by Mr Anthony Tension for further comments on the possibility that patients might have recovered had they not been given opiates. Particular attention was requested to the cases of Mr Arthur Cunningham and Mr Robert Wilson.

In preparing this report I have consulted my files, including the records made during my investigation. I have not consulted any other sources of information.

The specific cases

The cases of Mr Cunningham and Mr Wilson are considered first. The information is taken from the notes I made when reviewing the medical certificates of cause of death (MCCDs) and when reviewing the medical records (provided for me by Hampshire Constabulory).

Arthur Cunningham

1. Information from MCCD.

The information I have relates to Arthur Cunningham, who died 26 September 1998, aged 79, having last been seen on 25th September. The cause of death was given as bronchopneumonia, Parkinson's, and a sacral ulcer. The patient died on Dryad ward.

2. Information from review of records.

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

Fairly advanced Parkinson's attending Dolphin Day Hospital.

Nursing notes
21.9.98 Admitted from DDH with Parkinson's, dementia and diabetes (diet controlled). Catheterised 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 he 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 the 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 is 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.

Further comments, November 2005.
When seen by the specialist 21.9.1998 it was noted that the prognosis was poor and that oramorph could be used if the patient was in pain. However, it was also indicated that the purpose of the admission was for more aggressive treatment of the ulcer, including Aserbine, nursing on his side, and a high protein diet. It is not clear from the nursing or medical records whether this 'more aggressive' treatment was initiated, or whether a more conservative approach was taken from the start. For example, there is no information about nursing position or use of Aserbine.

Oramorph was given prior to wound dressing, but diamorphine by syringe driver was started on the day of admission. Use of other analgesic mediation is not mentioned, although the use of a non-opiate analgesic would have been consistent with the aim of 'aggressive' treatment of the sacral sore. The dose of diamorphine – 20 mg – was high. It is generally recommended that to obtain an equivalent level of pain relief, the dose of diamorphine on transfer from oral morphine should be one third of the total daily oral dose (I have a September 1998 copy of the British National Formulary [BNF] that includes a table on page 14 of the doses of subcutaneous diamorphine equivalent to certain doses of oral morphine. 30mg oral morphine every 12 hours i.e. 60 mg in 24 hours, is given as equivalent to 20 mg of subcutaneous diamorphine). Mr Cunningham was not receiving 60mg per day of oramorph, and the dose of diamorphine given, particularly when used with midazolam, would have had a significant sedative effect. The development of bronchopneumonia (signs of being 'chesty' were noted on 23 September) would not be unexpected in these circumstances.

Given these observations, it appears that on the day of admission it was decided that aggressive treatment to heal the ulcer and prolong life was not appropriate and that care should be palliative only, and that death within a short time should be expected. The reasons for this decision are not documented. The commencement of diamorphine by syringe driver, by promoting the onset of bronchopneumonia, would have played a significant role in leading to death. It is not possible from the information in the records to judge whether Mr Cunningham's ulcer would have responded to 'aggressive' treatment, how long he would have otherwise lived, or whether he would have been discharged from Dryad ward alive.

Robert Wilson

1. Information from MCCD.
Date of death 18.10.1998. Dryad Ward. Last seen alive 18.10.1998. Cause of death given as 1a CCF, 1b renal failure, 2 liver failure. Age 75.

2. Review of records

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 by 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.

Further comments, November 2005.
Mr Wilson was clearly frail, and the prognosis was noted as poor. However, instead of attempting to control pain from the fractured humerus with non-opoid analgesia, oramorph was commenced on admission. Paracetamol had been used before admission, but there is no statement in the records to indicate that paracetamol was not effective, nor any record of use of other analgesic medication as recommended in the Wessex guidelines, nor an assessment of pain such as was recommended in the 1998 version of the guidelines.

Was the commencement of opiate analgesia premature? Since there is so little about this decision in the records it is very difficult to reach a firm conclusion. When viewed in the context of the other cases that I reviewed, there must be concern that opiates were started too soon.

Were lives shortened by premature use of opiates?
In my review, I noted a liberal use of opiate medication, amounting to almost routine use reflecting a culture of 'making comfortable' rather than treating vigorously. The records did not indicate that detailed clinical assessments were undertaken of the causes of pain or the reasons for deterioration in a patient's condition. In some cases, therefore, it seems to me very likely that conditions that could have been readily treated were instead followed by the administration of opiates and subsequent death. This means that some patients would not have lived as long as they would have done if they had received more vigorous treatment. I do not know how many patients' lives were shortened and cannot identify individual cases with confidence, although those in which concerns about the decision to start opiate medication were identified during the review of medical records would be the cases to assess in more detail (Chapter Two of my report).

In those lives that were shortened, the amount of life lost is very difficult to estimate. The patients of Gosport War Memorial Hospital were generally old and frail, and did not have a long life expectancy. Nevertheless, I did feel that some patients, who I could not identify, would have lived long enough to be discharged from hospital.

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