DUDLEY

FINAL REPORT

regarding

Elsie DEVINE (Ref No. BJC/16)

PREPARED BY

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AT THE REQUEST OF

Hampshire Constabulary

Date of report

20 March 2005

CONTENTS

1. SUMMARY OF CONCLUSIONS

Code A

Code A In the 9-12 months prior to her final hospital admission, she had suffered with chronic memory loss and had become unable to look after herself. She was admitted as an emergency to hospital with an acute confusional state for which

Code A

and worsening agitation and restlessness. Although it may have been possible to stabilise her condition with relatively simple measures, this would not have materially changed her prognosis as death was inevitable. She was treated appropriately in the terminal phase of her illness with strong opioids to ensure comfort and calm, to enable nursing care and to maintain her dignity.

2. INSTRUCTIONS

I was asked to prepare this report on the instructions of Detective Sergeant Dave GROCOTT of Hampshire Constabulary based at Fareham Police Station, Quay Street, Fareham, Hampshire PO16 0NA.

3. ISSUES

I was asked to consider the following issues:

3.1 Beyond all reasonable doubt, was Mrs Devine dying due to her failing renal condition?

3.2 If Mrs Devine was beyond all reasonable doubt dying of renal failure, would any simple measures that were available and appropriate have had any reasonable chance of making a difference?

3.3 Would the acute confusional state that Mrs Devine developed be in keeping with dying from renal failure?

3.4 At the time when Mrs Devine's renal function declined, would a better assessment have identified appropriate treatment options that would have had a reasonable chance of stabilising or improving her situation?

3.5 Would the acute confusional state be untypical of someone dying of renal failure?

3.6 A comment on the use of strong opioids to "calm, keep comfortable and enable nursing care" in someone dying of renal failure who is not in obvious pain.

4. BRIEF CURRICULUM VITAE

I am a full time NHS Consultant in Renal Medicine at the Richard Bright Renal Unit, Southmead Hospital, North Bristol NHS Trust and an Honorary Senior Clinical Lecturer at the University of Bristol. I have been in post since January 1995. I hold post-graduate qualifications in General Internal Medicine. I am included in the Specialist Register of the General Medical Counsel. I am experienced in all aspects of renal medicine and renal transplantation, and confirm that I have experience relevant to this case. A copy of my brief curriculum vitae is available in the appendix of this report.

5. DOCUMENTATION

This Report is based on the following documents:

(1) A copy of Mrs Elsie DEVINE'S medical records
(2) A copy of a statement made by Dr Judith STEVENS (statement number S237), Consultant Nephrologist, Portsmouth Hospitals National Health Service Trust
(3) A copy of a statement made by Dr. Tanya CRANFIELD (statement number S254), Consultant Haematologist, Haematology Department, Michael Darmady Laboratory, Queen Alexandra Hospital, Cosham, Portsmouth
(4) A copy of a statement made by Dr Jane BARTON (no statement number), General Practitioner, Forton Medical Centre, White's Place, Gosport, Hampshire and Clinical Assistant at Gosport War Memorial Hospital from 1988 to 2000

Detective Sergeant GROCOTT provided all these records in a single lever arch file. The quality of some of the photocopied medical records was poor and difficult to read and in places was unreadable. Similarly, the size and quality of the copy of the drug treatment charts is such that these could not be read clearly (e.g. page 277).

The copy of the medical records has been paginated. In my report reference to the relevant page number from the medical records is given in parenthesis.

6. CHRONOLOGY/CASE ABSTRACT

SEQUENCE OF EVENTS PRIOR TO ADMISSION TO HOSPITAL

Code A

Following a clinic visit on the 15th April 1999, Dr LOGAN referred Mrs DEVINE to Dr TANYA CRANFIELD for a further opinion on whether the paraprotein was associated with a haematological malignancy such as myeloma with the nephrotic syndrome related. In his referral letter he noted that Mrs DEVINE was *"moderately frail but very bright mentally"*.

Code A

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Code A

Code A

8. OPINION

8.1 Beyond all reasonable doubt, was Mrs Devine dying due to her failing renal condition?

In my opinion, beyond all reasonable doubt, Mrs DEVINE was dying from a combination of amyloidosis, progressive renal failure and dementia. It is probable that the acute deterioration in her condition noted on the 15th November was precipitated by an unidentified infection.

8.2 If Mrs Devine was beyond all reasonable doubt dying of renal failure, would any simple measures that were available and appropriate have had any reasonable chance of making a difference?

It is difficult for me to comment on her diuretic therapy as I cannot read her drug chart clearly. However, the patient's weight chart shows no marked change in weight to suggest significant fluid depletion. In my opinion, any simple measures such as stopping diuretics, the use of intravenous fluids and/or antibiotics were unlikely to have had any significant effect on the eventual outcome. Although her clinical condition may have improved or stabilised for a few days, a further deterioration culminating in her death was inevitable.

8.3 Would the acute confusional state that Mrs Devine developed be in keeping with dying from renal failure?

Mrs Devine appeared to have a chronic confusional state (dementia) which had acutely worsened, resulting in her admission to the Queen Alexandra Hospital. During this admission and after her transfer to Gosport War

Memorial Hospital, her confusional state fluctuated. This chronic confusional state with episodes of exacerbation was likely to be due to a number of factors including progressive renal failure on a background of multi-infarct dementia.

8.4 **At the time when Mrs Devine's renal function declined, would a better assessment have identified appropriate treatment options that would have had a reasonable chance of stabilising or improving her situation?**

Mrs Devine's renal function declined progressively over the course of 1999 with a further acute deterioration in the final phase of her illness. As stated above, although simple measures such as stopping diuretics, the use of intravenous fluids and/or antibiotics may have improved or stabilised her clinical condition for a few days, further deterioration culminating in her death was inevitable. Treatment options such as dialysis would not have been appropriate given her age, frailty and general medical condition.

8.5 **Would the acute confusional state be untypical of someone dying of renal failure?**

Death from renal failure is usually characterised by increasing drowsiness leading to coma. However, in a proportion of patients, renal failure is characterised by an acute confusional state (reference 4) and such an observation would not be untypical in a patient with terminal renal failure particularly when a previous chronic confusional state exists.

8.6 **Comment on the use of strong opioids to "calm, keep comfortable and enable nursing care" in someone dying of renal failure who is not in obvious pain.**

Strong opioids are commonly used in the terminal care of patients dying with renal failure who are agitated and restless to ensure comfort and calm, to enable nursing care and to maintain dignity.

9. LITERATURE/REFERENCES

Reference 1 Kyle RA. Diagnosis and differential diagnosis of multiple myeloma. UpToDate Version 13.1 2005 http://www.uptodate.com/

Reference 2 Kyle RA. Primary (AL) amyloidosis and light and heavy chain deposition diseases. UpToDate Version 13.1 2005 http://www.uptodate.com/

Reference 3 Table 10 Stages of Chronic Kidney Disease from Part 4 Clinical Practice Guidelines, DOQI, National Kidney Foundation http://www.kidney.org/professionals/kdoqi/guidelines_ckd/toc.htm

Reference 4 Cohen, LM, Germain, M, Poppel, DM, et al. Dialysis discontinuation and palliative care. Am J Kidney Dis 2000; 36:140.

10. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: 20/3/05