05/04/09

Dr Wilcock

Summary of Conclusions

1. (S)(3) You state that my Mother was admitted with an episode of confusion to the QAH and was thereafter diagnosed with having multi-infarct dementia. This is not true; my Mother was suspected to have had a urinary tract infection and she was transferred to the GWMH for rehabilitation. There are no notes to state that she was diagnosed with MID or to what stage this dementia was at. The MME of 9/30 cannot be taken with any credit since it is unlikely that my Mother heard the questions. (as stated by Dr Taylor)
2. (S)(3) You report that the medical care provide by Dr Barton was suboptimal. Not only was there a failure to keep clear, accurate and contemporaneous records there was inadequate assessment of my Mother's condition. The treatments prescribed were excessive for my Mothers needs and the prescription of Fentanyl and diamorphine were unjustified and appeared excessive for my Mother's needs.
3. (S)(3) You state that the use of Chlorpromazine and midazolam appear justifiable on the grounds of my Mother's alleged confusion, although the doses were excessive.
    a. I would like to state here that the large doses of fentanyl as give to my Mother a non-opioid tolerant patient could have resulted in Overdose Typical side effects of Fentanyl transdermal therapy include abdominal pain, anxiety, confusion, constipation, depression, diarrhea, dizziness, dry mouth, euphoria, hallucinations, headache, impaired or interrupted breathing, indigestion, itching, anorexia, nausea, agitation, shortness of breath, sleepiness, sweating, urinary retention, vomiting, and weakness. It would surely have been more appropriate to have called the family and removed the fentanyl patch.
4. (S)(3) You state that in your opinion there is reasonable doubt that my Mother had entered the terminal phase. And that Dr Barton breached the duty of care owed to my Mother by failing to provide treatment with a reasonable amount of skill and care. Barton exposed my Mother to inappropriate an excessive doses of medications, as with the fentanyl transdermal patch, which could have resulted in a worsening of her agitation and confusion. Barton's response to this was to further expose my Mother to inappropriate and/or excessive doses of midazolam and diamorphine that could have contributioed more than minimally, negligibly or trivially to her death.

As a result Dr Barton leaves herself open to the accusation of gross negligence.

Chronology/Case Abstract

1. (S)(7) You state that my Mother was admitted to the QA on the 9th (38)with confused, aggression and wandering, suspected to be an infection as she had a raised white cell count. She continued on her medication of
    a. thyroxine (100mg)
    b. frusemide 120mg
    c. amiloride (5mg)
2. (S)(7) my Mother had previously been diagnosed with an underactive thyroid and impaired kidney function, most likely resulted from longstanding glomerulonephritis (an inflammation damaging a particular part of the kidney) leading to nephrotic syndrome. (50)
    a. This leads to excessive loss of protein in the urine and can lead to fluid retention, for example in the legs – which my Mother had. Important to note that on this letter from Consultant Haematologist Dr Cranfield She states that my Mother is looking much

Continuation of Statement of: GILLIAN IRENE KAYE

B842 I have been shown a document referred to as file number F58632 exhibit number RS/3068. This document is a Becpharm fax dated 25 September 1996 from John Gordon to Michael Daly of Athlone Pharmaceuticals. I do not recognise this document.

B729 I have been shown a document referred to as file number F4024 exhibit number RS/16. This document is an extract of Jon Close's diary for 6, 7 and 8 January 1997. I was referred to the entry for 8 January 1997. I do not recognise the handwriting. I have not heard of "IGA" and do not know what the abbreviation is for. I assume that "JC" is either Jon Close or John Clark, "JJ" is John Josephs, "KM" is Keith Maddison, and "NF" is Nick Foster.

B601 I have been shown a document referred to as file number F63956 exhibit number RS/3101. ~~Page 10 of~~ this document is a receipt from Sheraton Skyline Heathrow London. I recognise the handwriting on the document as that of John Josephs and I presume "J ~~Hsiao~~ Hsaoi" the name to be Dr Jane Hsiao, a senior Vice-President of Ivax in Research & Development.

B569 I have been shown a document referred to as file number F13967 exhibit number RS/3062. ~~Page 3 of~~ this document is a letter from Norton Healthcare Limited dated 24 July 1997 from Phil Cockcroft (Director of

Signature

Code A

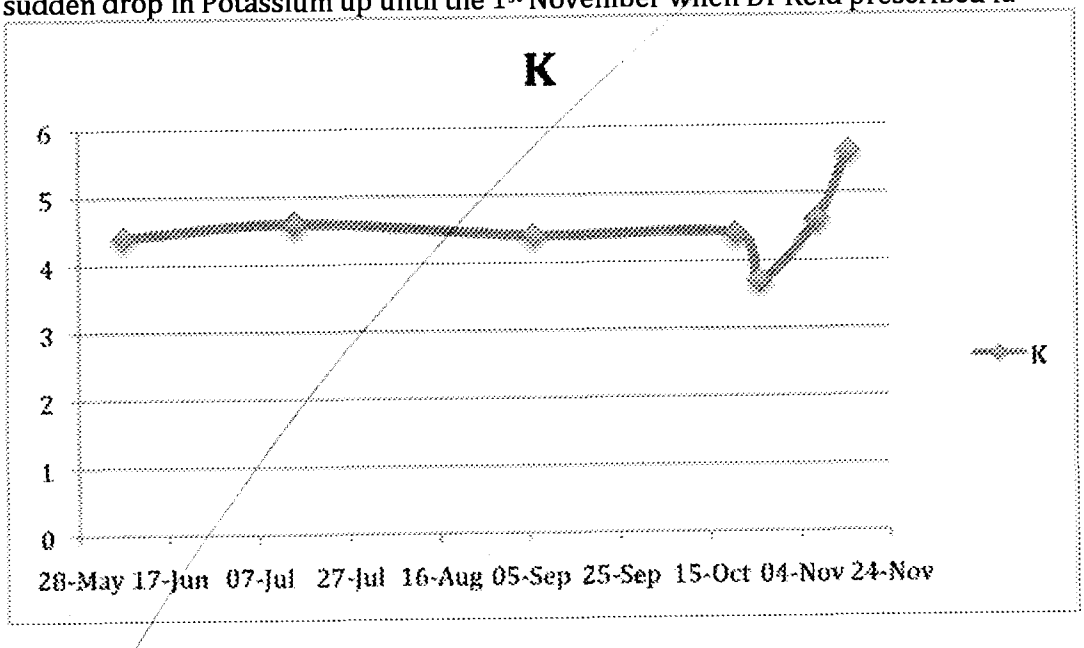
Code A

Doc No

better. There has been no significant change in haematolotgical or biochemical parameters even though her Creatinine is **192**

3. (S)(8) My Mother was incorrectly labelled as having myeloma in several entries in her medical notes. (28,29,154,245,395,411,412)
4. (S)(8) You state that an examination confirmed impaired cognitive funtion with a low score of 3/10 on the mini-mental test, On the 14th Dr Taylor, Clinical assistant elicited a history of a slow decline in my Mother's functional abilities since Jan 1999 and concluded that she was likely to have dementia. She notes a score of 9/30 on the MMSE however she also noted that my Mother was very deaf and may not have heard or understood **A LOT** of what was being said. (29) (note also 399 which is the test script and Taylor writes at the top V.Deaf)
    a. How can this test be upheld?
    b. Where did Taylor elicit the decline since Jan 1999; my Mother remained independent and was able to dress, wash and cook for herself.
5. (S)(9) Entries made on the 15th-18th Oct, around one week after my Mother's admission she is reported to be "much more settled, not aggressive, more orientated and less confused. (166)
6. (S)(9) You state that a CT Scan of the head revealed changes in keeping with areas of the brain becoming starved of oxygen due to blockage of small blood vessels with no other obvious cause of her confusion. A final diagnosis was made of multi-infarct dementia (MID).
    a. This CT Scan has yet to be produced.
7. (S)(10) My Mother was transferred to the GWMH for rehabilitation on the 21st.
8. (S)(10) You state that my Mother was prescribed on the day of admission to Dryad ward, oramorph (10mg/5ml). No reaon is given for this. This analgesic was never given and although you state she was given no analgesic until the 19th November, this is incorrect – it was in fact the 18th November via the 25 milligram Fentanyl transdermal patch.
9. (S)(10) My Mother was also prescribed her usual medication – excluding Amilioride (5mg)
    a. Thyroxine (100mg) not amended from QA
    b. Frusemide (40mg) reduced by 80mg from 120mg

By removing the Amilioride my Mother was exposed to a reducing in potassium, this was always balanced in her blood by taking Amilioride. The chart below shows the sudden drop in Potassium up until the 1st November when Dr Reid prescribed it.



Continuation of Statement of: KIM NUGENT

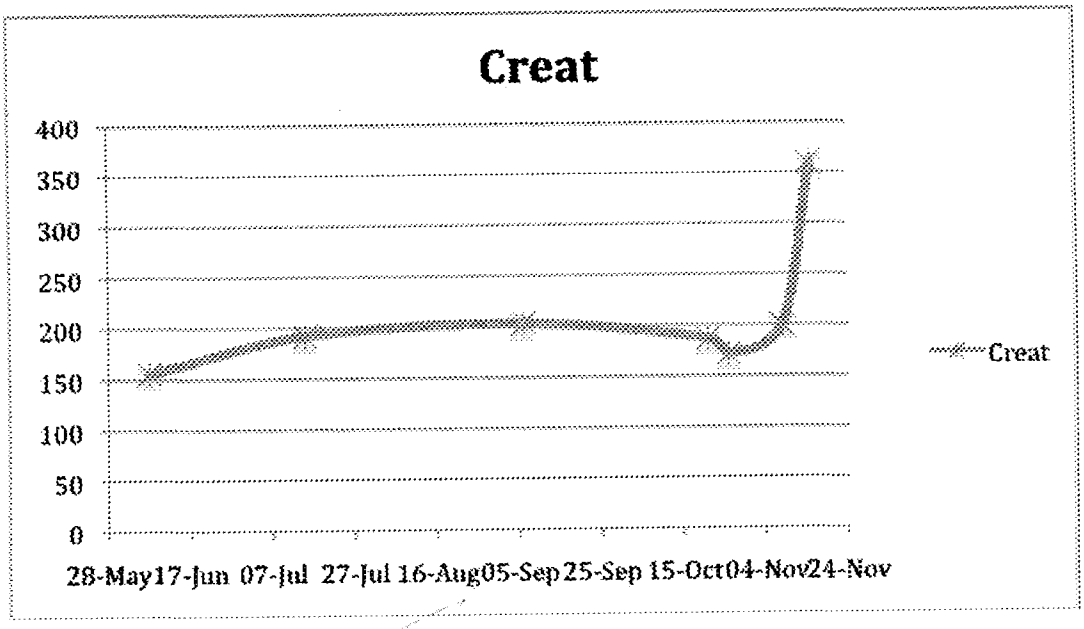
F109430 Exhibit KN/41

This document consists of two pages. Page 1 is a function reservation sheet on Holiday Inn headed notepaper that records Clonmel Healthcare booked the Getty Room for a meeting on 29 June 1998. The room was to be laid out in a board room style for 10 people at a cost of £255. Across the middle of page 1 is a handwritten annotation "CXL" this means that the function was cancelled. The terms and conditions of the booking are printed on the reverse of page 1. Page 2 is a fax dated 03 June 1998 from Liz Cronin (shown as the secretary to Karl Roberts) to Linda, who I believe to be Linda Saran at the Crowne Plaza, and is headed "Meeting room booking on Monday 29th June". The fax confirms the meeting reservation.

Signature Code A

Signature Witnessed by: Code A

10. (S)(11) You state that on the 11th, my Mother was started on Trimethoprim for a suspected urinary tract infection. Although on the 15th The test which was taken on the 11th came back clear
    a. You note that from the on the 16th November her Creatinine had risen from 200 to 360 and her potassium had also rised to 5.6 from 4.6. (this results were not available until lunchtime on the 18th.
    b. This is in keeping with the side-effects of Trimethorprim;
        i. Trimethoprim (TMP) is known to cause reversible increases in serum creatinine, reportedly by inhibiting its renal tubular secretion without causing a change in the glomerular filtration rate.
        ii. The use of trimethoprim in combination with other potassium-sparing drugs or potassium salts may increase the risk of hyperkalemia. Trimethoprim inhibits sodium reabsorption and potassium excretion by blocking sodium channels in the renal distal tubules. Studies of patients treated with standard and high dosages of trimethoprim compared to similar controls treated with other antibiotics indicate that reversible increases in serum potassium are fairly common with trimethoprim use.



11. (S)(10) My Mother was also prescribed Thioridazine (10mg) as required from the 11th Nov. She was given 1-2 doses daily up until the 17th Nov.
    a. Note that on the 16th and 17th of November her dose was reduced and my Mother only required 1 10mg dose on each of those days. (277)
12. (S)(11) On the 18th at 9.30am a fentanyl transdermal patch (25 microgram) was applied to my Mother, there are no entries to explain why this was done.
    a. It is stated that she was refusing medication, but at 0600 my Mother took her Amilioride and on her prescription chart there is no note of refusal of medication – only that her frusemide and thyroxine were stopped. (276)
13. (S)(11) My Mother is seen by Dr Taylor on the 18th who NOTED that my mother had (156) deteriorated being more restless and aggressive again – it is unclear that Taylor witnessed this for herself. She puts my Mother on the waiting list for Mulberry War and recommends no changes in Medication. She obviously does not witness any pain. As you state in a separate entry relating to this assessment, Dr Taylor noted 'reviewed on ward – happy, no complaints, waiting for daughter, not obviously paranoid. **Says tablets make her mouth sore. (405)**
    a. It is unclear at what time DR Taylor saw my Mother since it is not recorded either in her notes or in the visitors book. However it must have been after 0800 but before the

IN THE PROPOSED ACTION

B E T W E E N :

KATHLEEN MARY O'CONNOR

Claimant

- and –

NORTH BRISTOL NHS TRUST

Defendant

INSTRUCTIONS TO COUNSEL TO ADVISE IN CONFERENCE

ON THURSDAY 12 FEBRUARY 2009

Counsel will find enclosed copied of the following :

1 GP records

2 Records received from North Bristol NHS Trust

3 Royal National Orthopaedic Hospital records

4 Medical report of Mr Parvin

5 Medical report of Mr Foy

6 Medical report of Mr Simon Bridle

7 Condition and Prognosis Report prepared by Professor Kennard

8 Witness statement of Kathleen O'Connor

9 Witness statement of Mr Timothy O'Connor

Counsel is instructed by Vanessa Aston of Clarke Willmott Solicitors, who has conduct of this matter on behalf of the Claimant, Mrs O'Connor. Mrs O'Connor is funding this matter through a Before-The-Event Legal Expenses Insurance Policy.

application of the fentanyl. Since she states she is refusing medication but does not record the fentanyl patch.

b. Barton states that she administered the patch after Dr Taylors assessment and after the blood results, since she went against Taylor's suggestion of transfer and keeping in line with current medication – HOWEVER the blood results were not available till Lunchtime - this leaves Barton wide open to intend to expose my Mother to life-threatening levels of drugs for no reason other than to shorten her life. Barton states that the Fentanyl was administered for pain which my Mother could not express she was in, but as we already know my Mother had previously complained of a sore mouth. That day my Mother was visited by 2 family members and was neither, agitated or confused. She signed her pension book and my ex-sister in law asked if she could take my Mother out for coffee to the hospital coffee shop – this was refused. (see statement Sandra Briggs)

c. Why would Barton not write in the notes that day – that the Fentanyl was administered for pain – instead she writes on the 19th – "marked deterioration overnight. Confused aggressive, creatinine 360, fentanyl patch commenced yesterday" (156)

14. (S)(12) You state that on the 19th my Mother is notes to be extremely aggressive and refusing all help from staff. (222)
    a. Chlorpromazine 50mg given IM at 0830. Taken 2 staff to special.
    b. At 9.25 Syringe driver commenced with 40mg Diamorphine and 40mg Midazolam
    c. Fentanyl is removed at 12.30
15. (S)(12) At 1300 my Brother was made aware of the situation for the first time. He had visited the previous day when my mother was wearing a fentanyl patch; When Barton had stated that she had taken my mother off the transfer to Mulberry because she knew her creatinine was 360 and my Mother was now in the terminal phase of kidney failure – BUT neither Barton or a member of her staff told my Brother that day of anything – not even that his Mother had had to start receiving opioids for her alleged chronic pain.
16. (S)(12) You state that on the death certificate the cause of death was 1a Renal Failure and 2 Chronic glomerulonephritis (this was the second attempt made by Barton since her first was refused by the coroner for only stating renal failure.

Technical Background/Examination of the facts in issue

17. (S)(13) MID - is a form of dementia due to multiple small strokes that starve the brain of oxygen resulting in damage. Patients often experience sudden losses in cognitive and functional ability and deterioration over time often occurs in a stepwise fashion.
18. (S)(13) Delirium is common in the elderly with many possible causes. E.g. infection, drugs (to include opioid analgesics)
    a. As stressed by Portsmouth Hospitals and Portsmouth Healthcare Compendium of Drug therapy guidelines, 1998 – elderly patients presenting delirium should have an appropriate examination to exclude the commonest causes. (this did not happen in my Mother's case)
    b. When non-drug measures do not improve the patient's behaviour, e.g. a well-lit environment, ensuring the patient can see and hear well, familiar nursing staff etc. Drug measures generally include the use of antipsychotic drugs. Haloperidol is commonly used and is the treatment of choice for aggressive confused patients; however when severe thought disturbance or abnormal behaviour is present, inducing drowsiness may become necessary and antipsychotics such as thioridazine or chlorpromazine are used. The dose is titrated to improve the patient's thoughts

Background to the Claim

In April 2006 Mrs O'Connor suffered an accident at home, when she slipped injuring herself. She was taken to the Accident and Emergency Department at Frenchay Hospital. She was diagnosed with a fracture of the neck of the right femur and underwent surgery to stabilise it. The fracture was fixed using a gammon nail with two distal locking screws. Surgery was performed on the 23 April 2006.

On the 5 May it was noted that Mrs O'Connor was complaining of swelling in her right leg and a feeling of tension. This swelling was not thought to be due to thrombosis and she was discharged home on the 16 May with a 6 week follow up in the Fracture Clinic.

Following her discharge her leg became more swollen and painful and she attended to see her GP. He advised that she needed a priority duplex ultrasound to exclude DVT.

Unfortunately the referral form was lost. In the interim Mrs O'Connor was admitted to Southmead Hospital via her GP on the 6 June. A swollen right leg was noted and she was commenced on anticoagulants. A duplex scan was performed which confirmed DVT in the right leg starting in the peroneal vein and extending through to the popliteal. She was commenced on the DVT protocol and then discharged.

Unfortunately her right calf remained swollen and painful and the sensation in her leg was greatly reduced. She attended the A&E Department at Frenchay Hospital on the 16 June 2006. A diagnosis of oedema causing poor sensation was made. She was again discharged.

Mrs O'Connor remained in severe pain and returned on several occasions to see her GP. On the 23 June her GP arranged for her to be admitted to Southmead Hospital. She was admitted for neurological review.

On the 28 June an ultrasound was performed, which showed a large mass in the lower thigh consistent with a partially thrombosed false aneurysm. She was seen by Mr Lear, Consultant Vascular Surgeon, on the 30 June and he ordered an angiogram. This showed frilling of the femoral vein suggesting an arterialvenous connection. There was a jet from the proximal popliteal artery supplying the large false aneurysm. Consent was taken for fixing the hole in the artery in the right leg and surgery was performed under general anaesthetic by a Mr Neary and Mr Lear. The hole in the artery was repaired and the injury was presumed to be due to orthopaedic drilling.

Post-operatively Mrs O'Connor was reviewed by Mr Neary and it was noted she had lost all power in her muscles just below the knee. She was referred to see Dr Ferguson, Consultant Neurosurgeon. He believed that Mrs O'Connor had lower sciatic nerve or combined peroneal and posterior tibial nerve palsy, which he felt was due to compression of the false aneurysm. He arranged nerve conduction studies and EMG's which showed that there is evidence of severe right sciatic neuropathy, estimated to be at the level of the middle third of the femur. No evidence of recovery was noted.

Mrs O'Connor requested a second opinion and was referred to see Mr Birch at the Royal National Orthopaedic Hospitals. He advised that the nerve should be left alone and that repair would not be practical.

Mrs O'Connor has been severally affected by the injury. Her mobility has greatly diminished and she is virtually housebound. She is also still in severe pain.

and behaviour with the least level of drowsiness. Typical starting doses as you state are

i. Thioridazine – 25mg every 12 hours
ii. Chlorpromazine – 25-50mg every 8 hours

In the elderly, lower doses, a 1/3 – to 1/2 are advised (BNF)

iii. Thioridazine – 10mg every 12 hours
iv. Chlorpromazine – 10-20mg every 8 hours

19. (S)(15) Fentanyl is a strong opiod analgesic. In 1999 **Fentanyl transdermal patches were only licensed for the relief of chronic intractable pain due to cancer.** The prescribing advice states that if used as a first line opiod, it would be in patients who had failed to get adequate relief from weaker opioids. This was a safety consideration, as the lowest patch 25 micrograms can deliver 135mg of morphine a day.
    a. This exceeds the recommended starting dose of morphine in adults (60mg under the BNF, PCF a and 20-40mg under the Wessex protocol. And FAR EXCEEDS that advised in the frail and elderly which is 30mg a day or less).
    b. You state that the risk of it being an excessive dose would be greatest in opioid-naïve patients – just as my Mother was.
    c. After application it can take upto 23 hours to take effect, therefore it is important to mention here that my Mother was given not as much as a paracetamol prior to this. So she was allegedly in such chronic pain as to need a Fentanyl patch, however Baront and her Staff were happy to leave her upto 23 hours until the analgesic started to work? Yet still when family visited and the patch was not yet in full effect my Mother spoke of no pain or discomfort.
20. (S)(16) You state that Diamorphine is a strong opioid that can be used in syringe drivers as it is more soluble, allowing large doses to be given in very small volumes. The intial daily dose of diamorphine is usually determined by dividing the daily dose of oral morphine by 3 (BNF, 1999). Based on this the typically recommended starting dose equated to 20-30mg diamorphine a day and at most 10-15 mg a day in the frail elderly. The Wessex protocol suggests a range with the lowest dose of 10mg a day. This would be titrated upwards every 24-48 hours if pain relief is inadequate. My Mother was therefore exposed to 135mg through the fentanyl and then an additional 40mg, **which is 17-30 times greater the recommended dose under the Wessex protocol?**
21. (S)(17) You state that Midazolam is commonly used in syringe drivers as a sedative in patients with terminal agitation; most practioners caring for patients with cancer in their terminal phase would generally aim to find a dose that improves the patients symptoms rather than to render them unresponsive. Unlike Barton, who placed my Mother unconscious within hours.
    a. The Wessex protocol suggests a range with the lowest dose of 5mg a day.
    b. As an active metabolite of midazolam is excreted by the kidneys, caution is required in patients with impaired kidney function.

Opinion

22. (S)(18) You state that on the background of a gradual deterioration in her cognitive abilities my Mother was admitted with an episode of acute confusion, investigation was in keeping with a diagnosis of MID – To clarify my Mother had no background of deterioration.

Medical evidence

Instructing Solicitors initially obtained a report from Mr Simon Parvin, who provided his comments upon both liability and causation. He identified various failings with the orthopaedic care, the care provided by the GP and also the A&E SHO who treated her on the 16 June. However he did not identify any failings with the vascular care. He did however advise that the surgical repair of the artery would have had to have been performed before 15 June to have avoided permanent neurological sequlae.

As Mrs O'Connor was under the care of the orthopaedic surgeon at the time of the injury we obtained a report from Mr Michael Foy, Consultant Orthopaedic Surgeon. Mr Foy felt that the care provided to Mrs O'Connor was reasonable and in line with what could have been expected from a reasonable body of orthopaedic surgeons. Instructing Solicitors had concerns about the conclusions that Mr Foy reached and therefore a second opinion was obtained from Mr Simon Bridle, Consultant Orthopaedic Surgeon. Counsel is referred to his reports.

Counsel will note that Mr Bridle concluded that on the balance of probabilities the superficial femoral artery was damaged and the adductor canal during drilling for distal femoral locking. Mr Bridle stated that this represented treatment which fell below normally accepted standards. He believed that the treating clinician failed to take due care and attention to avoid damage in the artery which they should have known was closely related to the medial femur at that level. He believes that the rest of her orthopaedic management was entirely appropriate.

Mr Bridle made the point that the Defendant may argue that the injury was a recognised complication of the procedure. However on this occasion he believes that the complication is a result of substandard care. Instructing Solicitors believe that we need to discuss this point further in conference and ask Mr Bridle to expand upon his views as to why he believes the complication was negligent in these circumstances.

Counsel will note that Mr Bridle, as did Mr Parvin, also queried why it took so long for Mrs O'Connor to be seen following her GP referred on the 22 May 2006. He was also somewhat surprised that the ultrasound duplex scan did not demonstrate the pseudo aneurysm, which was subsequently identified following her admission on the 23 June. He queries whether a radiologist should be instructed to review them. At present Instructing Solicitors have not explored the potential criticisms against the GP or radiologist. Obviously if we have a strong argument in relation to the initial surgery, it may not be necessary to do this.

Proceedings to date

A Letter of Claim was sent to the Defendant Trust and at present their response is awaited. This is overdue and we hope that we may be in receipt of it shortly before the conference. If this is the case we shall obviously fax it through to Counsel.

Counsel will be aware that limitation is shortly approaching in April 2009.

Instructions

Counsel is asked to review the papers and to advise in conference. In particular Counsel is asked to consider the following:

23. (S)(18) You state that an infection may have been a possible contributing cause of the confusion, Although Trimethoprim didn't help the change to Cefaclor did show an improvement in her mental state.
24. (S)(18)You state that infrequent entries in the medical notes make it difficult to closely follow my Mother's progress. Her physical condition appeared to change little, although her level of confusion was reported to increase (although this was never seen by the family or reported to the family)
25. (S)(19) You state that my Mother's was administered 25 microgram Fentanyl on the 18th, on morning of the 19th she was given 50mg chlorpromazine IM, 40mg Diamorphine SC and 40mg Midazolam SC. 2 days later my Mother died and the onset of the chronic renal failure and death was stated as 3 days. You state this is incorrect as it had been identified as a problem for several months. Why then would Barton state 3 days? Suspected that the acute decline was over the 3 days – not the chronic?
26. (S)(19)You state that my Mother's death was not typical of patients dying from chronic renal failure and in your experience it is generally more gradual in onset, showing increased weakness and drowsiness. That in fact in our opinion my Mother's mental state would be more suggestive of an underlying aggravating factor, eg. An infection, cerebrovascular event or a **drug**.
27. (S)(20) You state that the overall care given to my mother was suboptimal, particularly I note that in your opinion you must prescribe only the treatment or drugs that serve the patients needs and in provide care you must keep clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decisions made and the information then given to patients.
    a. Specifically that my Mother did not respond to trimethoprim in the QA and that an alternative was not offered even though clinical benefit was not obtained. Lack of this knowledge could lead to a doctor thinking any further decline was irreversible.
    b. Failure to carefully read my Mother's notes and see that she did not have Myeloma and thus thinking that an 'expected' irreversible terminal event was due to her cancer-like condition.
    c. No entry to explain the reason for prescribing morphine as required upon admission and fentanyl on the 19th. Pain had not been recorded nor had my Mother received any other kind of analgesic. E.g. paracetomal or codeine.
    d. In the medical notes entry of the 19th, although a marked deterioration was recorded a lack of clear and accurate information means that it is impossible to know if there had been a sufficient consideration of the possible reversible causes. For expample, the strong dose of opioid delivered by the fentanyl may have resulted in my Mother's worsening delirium. If my Mothers deterioration was being attributed to her worsening renal function why were the possible causes not considered, e.g. dehydration, drug therapy.
    e. The drugs given to my Mother used in response to her worsening confusion, in your opinion were excessive for her needs, even if it were considered that she was dying from natural causes.
    f. After the administration of **double the recommended dose of Chlorpromazine, there was no opportunity given to assess the long-term effect of this dose**; it is possible you think that my Mother's thoughts and behaviour would have improved as the peak effects of the chlorpromazine wore off. **Instead within one hour a syringe driver was commenced with diamorphine and midazolam.**
    g. There is no indication or assessment of what pain the diamorphine is referred to and the daily dose of 40mg with scope to increase to 80mg a day is not justified at all. You state that **increasing doses in opioids excessive to a patient's needs increases the risk of delirium and respiratory depression.**
    h. You highlight that once unresponsive and not drinking, my Mother's renal function would have declined further and although the dose of morphine was unchanged it

1 The prospects of the claim being successful

2 The strengths and weaknesses of the medical evidence

3 Whether any further medical evidence should be obtained

4 The most appropriate steps to progress the claim and in particular whether an offer of settlement should be put forward

5 Any other matters that Counsel deems appropriate.

If Counsel has any issues that he wishes to discuss prior to the conference, then he is asked to contact those instructing him on 0845 209 1248 or at Vanessa.aston@clarkewillmott.com

Dated

Signed : .....

would have increased in effect as the retention of the active metabolites of morphine increased.

i. The daily dose of midazolam was prescribed at 20-80mg. It was commenced at 40mg with no indication of why 20mg was not considered appropriate. This dose is excessive in the elderly.

28. (S)(24)In your view for my Mother a safe starting dose for pain would have been 2.5mg given every 6 hours or as required.
29. (S)(24) You state that the fentanyl patch was not appropriate and was likely to deliver too high a dose of a strong opioid.
30. (S)(27) You state that Barton does not appear to have provided my Mother with a good standard of clinical care as defined by the GMC.
31. (S)(27) you State that it is possible that my Mother's deterioration was temporary or reversible and she was not in the terminal phase. That my Mother's deterioration appears rapid and mainly in her mental state, which contrasts with the gradual physical decline over days or weeks more typical of the terminal stage of chronic illnesses.
32. (S)(28) You state that with the excessive use of diamorphine and midazolam it would be difficult to exclude with any certainty that they did not contribute more than minimally to my Mother's death.
33. (S)(28) You state that Barton disregarded my Mother's safety by unnecessarily exposing her to the excessive doses of medications such as fentanyl which could have worsened her confusion and agitation. That Barton's response was to further expose my Mother to inappropriate and or excessive doses of midazolam and diamorphine. **As a result Barton leaves herself open to the accusation of gross negligence.**

IN THE PROPOSED ACTION

B E T W E E N :

KATHLEEN MARY O'CONNOR

Claimant

- and –

NORTH BRISTOL NHS TRUST

Defendant

INSTRUCTIONS TO COUNSEL

Counsel : Mr Tom Leeper
Outer Temple Chambers

DX 351 LONDON

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Solicitors for the Claimant

Ref: 1197/10/003/356039.1