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ABBATT	**VICTOR**	HCO001653, p4	A2	HCO003779, p18	B2	HCO003793, p4	B2	HCO001653, p3	B2	B2	HCO002103 HCO000641, p102	"Mr Abbatt was admitted to the Gosport War Memorial Hospital on 29 May 1990 as an emergency. Dr Barton requested this as his wife could no longer cope with him at home. On admission he was diagnosed as having a chest infection with mild heart failure. He was noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on the day of admission. He was then administered 10mgs Temazepam apparently which had been written up for him. The experts criticised the use of a small dose of Temazepam in a patient who is cyanosed. They note, though, that Mr Abbatt was already very unwell." (HCO002105)
AMEY	**DENNIS**	PLA000019 HCO001654, p4	B No conclusive categorisation	HCO003779, p19	B2	HCO003793, p4	B2	HCO001654, p3	A2	B2	HCO002055 HCO000641, p102	"Mr Amey was admitted to Gosport War Memorial Hospital on 14 November 1990 following a request from Mrs Amey. Mr Amey at that time had problems with his catheter, he was incontinent and was having spasms. Mr Amey had very severe Parkinson's disease. He was admitted for terminal care. Mr Amey was started on Morphine elixir on 11 December 1990 and by the time of his death on 19 December 1990 he was on 120mgs of Diamorphine subcutaneously per twenty-four hours. Dr Lawson notes that Mr Amey was very unwell and in pain. The experts have determined that this dose of Morphine was high and possibly sub optimal but without additional documentary evidence cannot be clear as to whether the doses of Diamorphine was escalated only in response to uncontrolled pain." (HCO001654, p8)

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ATTREE	**LILY**	PLA000020 HCO000583, p4	A1	HCO003779, pp20–1	A1	HCO003793, p4	A2	HCO000583, p3	A1	A1 / 2	HCO005152, p2 HCO000583, p9 HCO000641, p103	"Mrs Attree was admitted to Gosport War Memorial Hospital on 26 July 1996 from Queen Alexandra Hospital for palliative care and to recover from Deep x-ray therapy. On admission Mrs Attree's notes state she was suffering from depression and doubly incontinent. Prior to this Mrs Attree was a widow who lived in a nursing home. She had been diagnosed with cancer of the tongue and at the time of her admission had not been able to feed herself and needed a pureed diet. She had some mobility but needed assistance with washing and dressing. The experts noted that she was terminally ill with an extremely advanced malignancy and had difficulty swallowing. Her treatment included opiates, first orally, then intravenously. The conversion to Diamorphine was noted by the experts to have been a high dose but was given with no intent to harm. Since from the medical records the experts perceived a concern to treat pain in a patient with an extensive tumour who may have been unable to verbally report pain because of her primary cancer and mental state." (HCO000469)
AUBREY	**EDITH**	PLA000021 HCO002142, p7	B1 or B2	HCO003779, pp22–3	B2	HCO003793, pp4–5	C3	HCO002142, p6	B1	B2	HCO000456 HCO000641, p102	"Mrs Aubrey lived at home with her husband until April 1994 when she was admitted to a nursing home. Her past medical history included probable cerebrovascular disease, depression with paranoid features, and ischaemic heart disease. Whilst the experts have described this case as end stage dementia more probably of vascular origin, it is unclear from the medical notes what led to Mrs Aubrey's final demise. She was given transdermal Fentanyl explicitly to calm her and this dose was progressively escalated. In June 1996 a syringe driver was prescribed as required and was commenced on 7 June 1996. The conversion of therapeutic treatment to Diamorphine via a syringe driver was reasonable in the experts' views. From a review of the case by the Key Clinical Team it was noted that the patient was unable to communicate and was clearly distressed and agitated, perhaps due to pain. In their view the doctors could have been criticised for not trying to treat the possible pain." (HCO001925, p2)

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AUBREY	**HENRY**	PLA000025 HCO002143, p7	B3	HCO003779, pp24–5	B2	HCO003793, p5	B3	HCO002143, p6	B2	B2	HCO000456 HCO000641, p102	"Mr Aubrey was admitted to the Royal Hospital Haslar in May 1999. He was transferred to Gosport War Memorial Hospital on 1 June 1999. The history of the presenting complaint was noted on admission to be carcinoma of the lung, plural effusion and query cerebral secondaries. The notes also record that Mr Aubrey was depressed waiting to die. Mr Aubrey was commenced on a Fentanyl patch at 3.30 p.m. that afternoon and 10mgs of Oramorph [morphine oral solution] was given. Mr Aubrey's treatment was continued the next morning with high dose Morphine and Midazolam. The experts noted in their analysis that although Mr Aubrey had a terminal diagnosis and was recognised to have given up, the need for such a large dose of Diamorphine and Midazolam was not clear. The experts noted that size of the dose was open to criticism and although not the 'best treatment' it was unclear that this was negligent." (HCO001925, p3)
BAKER	**ELLEN**	HCO000595, p3	A1	HCO003779, p26	A1	HCO003793, p5	A1	HCO000595, p2	A1	A1	HCO000641, p104	"Mrs Baker was eighty at the time of her admission to Gosport War Memorial Hospital on 7 November 1990. She had a previous history of epilepsy, osteoarthritis and ischaemic heart disease. Mrs Baker was admitted from home under the care of Dr Peters. The referral noted that Mrs Baker had a venous ulcer on her left leg and the nurse was to continue dressings. On admission she was noted to have three episodes of angina which was reduced by use of GTN. Mrs Baker continued to deteriorate on 8 November 1990 complaining of chest pain and profuse sweating. She was seen by Dr Peters and prescribed 5mgs of Diamorphine intravenously. Despite this medication and continued oxygen therapy there was no improvement in her condition and she died the following morning at 10.35 a.m. The expert opinion is that the death was consistent with acute myocardial infarction which was treated appropriately. Part of that treatment included a small dose of Diamorphine which was therapeutically indicated." (HCO005679)

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BATTY	**CHARLES**	PLA000024 HCO002970, p9	B2	HCO003779, p28	B2	HCO003793, p5	C2	HCO001655, p4	B2	B2	HCO000641, p102	"Mr Batty was admitted to Gosport War Memorial Hospital in September 1990 for long stay care. He had a previous history of Parkinson's disease, epilepsy and Menieres. He was treated with Coproxamol regularly for a period of years for pain although its origin was not clear. In December 1993 he was complaining of generalised pain and started on Oramorph [morphine oral solution]. Dr Lawson notes that Mr Batty went from little analgesia to Oramorph 60mgs in twenty-four hours. The dose was gradually increased and when he had difficulty swallowing it was changed to a syringe driver. It was difficult to assess his pain because of his dementia but it is not clear on the face of the notes whether his condition was deteriorating prior to starting opiate treatment. The experts' review has determined that the treatment was sub optimal due to the high doses, especially Midazolam. Cause of death was felt to be unclear by the expert team." (HCO001724, p7)
BRENNAN	**IRENE**	HCO000587, p4	A1	HCO005394, p68	A1	HCO000587, p5	1A	HCO000587, p3	B1 / A2	A1	HCO000613, p11	The Panel has not seen any documents.
BRICKWOOD	**DENNIS**	PLA000025 HCO002970, p10	B2	HCO003779, p30	B2	HCO003793, p6	A2	HCO003787, p4	B2	B2	HCO000641, p102	"Mr Brickwood was admitted to hospital on 15 January 1998 after a fall where he sustained a fracture to his neck of femur. On 3 February 1998 he was transferred to Gosport War Memorial Hospital for rehabilitation. His medical history included carcinoma of the prostate, osteoporosis and myoma. He was assessed in March 1998 with a view to being discharged home but, following a trial visit on 6 April 1998, this was not considered a possibility. In May 1998 he developed musculoskeletal chest pain together with a chest infection. The infection did not respond to antibiotics despite a change in treatment. Opioids were started when Mr Brickwood's condition was failing on the second antibiotic tried. The experts note that the Morphine/Diamorphine was escalated and a large amount of Hyoscine and Midazolam added to the syringe driver although it was not felt death was accelerated as a result of this treatment." (HCO001656, p10)

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CARBY	**STANLEY**	PLA000026 HCO002970, p11	A2	HCO003779, p32	A2	HCO003793, p6	A2	HCO003787, p5	A2	A2	HCO000613, p10 HCO000641, p103	"Mr Carby was admitted to Gosport War Memorial Hospital on 26 April 1999 for rehabilitation. He was transferred from the Royal Haslar Hospital where he had been admitted in April 1999 suffering a stroke. The stroke affected the left hand side of his body, this required Mr Carby to have assistance with eating and drinking. On 27 April 1999 Mr Carby suddenly deteriorated becoming cyanosed dyspnoeic. This clinically appeared to be an extension of his previous stroke. A syringe driver was set up with a high dose of Diamorphine and Midazolam. Mr Carby died forty-five minutes later. All the experts agree that he would not have received enough of either drug to have influenced his survival. Dr Naysmith noted that he may well have received less than normal since he had low blood pressure and was peripherally cyanosed. The cause of death was shown as cerebral vascular accident and was certified by Dr Barton. Mr Carby was cremated. The large dose of Diamorphine makes the care sub optimal but it had no effect on Mr Carby's prognosis." (HCO001661, p11)

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CARTER	**EDWIN**	PLA000027 HCO002970, p12	A3	HCO003779, p34	A3	HCO003793, p6	A4	HCO116117	A1	A3	HCO000641, p49 HCO000641, p102	"Mr Carter was a widower and was admitted to Gosport War Memorial Hospital on 8 November 1993 for pain control and long term care. He had a previous history of cerebrovascular accident and believed to have stomach cancer. On admission, it was noted that Mr Carter was reluctant to eat, needed help with personal hygiene and used a zimmer frame for mobility. The notes on admission state that Mr Carter was not suffering but on 20 November 1993 Mr Carter began deteriorating and was commenced 20mgs of morphine sulphate. Although Mr CARTER requested his medication be stopped on 22 November 1993, he was complaining of pain again on 11 December 1993 when Oramorph [morphine oral solution] 10mgs was given. Mr Carter was seen by Dr LORD on 20 December 1993 where it was noted a syringe driver could be commenced when necessary. This proved to be the case on 22 December 1993. Mr Carter died two days later. Some of the experts note that the dose of opiates was quadrupled at the time of transfer to a syringe driver. Although some experts questioned why such dosage should have been given, they acknowledge that Mr CARTER was already so close to death that it would not have made any significant difference to his length of life. There was a variation in initial views amongst the experts but they concluded on reviewing the notes that although treatment may have been negligent, it did not appear there was any attempt to cause harm to Mr Carter." (HCO002663, p6)
CHILVERS	**EDITH**	PLA000028 HCO002970, p13	No conclusive categorisation	HCO003779, p36	No conclusive categorisation	HCO003793, p7	B1	HCO116118	No conclusive categorisation	2 No conclusive categorisation	HCO005152 HCO000641, p104 HCO000589	The Panel has not seen any documents.

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CHIVERS	**SIDNEY**	PLA000029 HCO002970, p14	B2	HCO003779, p38	B2	HCO003793, p7	B2	HCO003787, p6	A2	B2	HCO000641, p102	"Mr Chivers was admitted in May 1999 to the Gosport War Memorial Hospital from the Queen Alexander Hospital for rehabilitation after suffering a cerebrovascular accident as well as being treated for congestive cardiac failure and a chest infection. In early June 1999, Mr Chivers' condition deteriorated and he complained of a pain in his hands and also abdominal pain. Soon after this he was commenced on Fentanyl together with Oramorph [morphine oral solution] and on 19 June, having been seen by Dr Brooks, a syringe driver was commenced. The experts felt that cause of death was probably unclear and noted the opioids were escalated without trying other ways of stopping the pain but did not feel the treatment was negligent." (HCO001657, p10)
CLARKE	**HUBERT**	PLA000030 HCO002970, p15	A1	HCO003779, p40	A1	HCO003793, p7	A1	HCO003777, p3	A1	A1	HCO000641, p104	"Mr Clarke was ninety-four when he was admitted to Gosport War Memorial Hospital on 5 June 2000. His previous medical history had included angina and a history of transient ischaemic attacks ('TIA'). Prior to admission Mr Clarke, who was a widower, lived alone; he had two daughters one of whom would help cook and clean. He coped well but was admitted to hospital on 5 June 2000 following a fall at home. At the time of admission he was described as unsteady on his feet and very sleepy. On 6 June 2000 he was found on the floor in the corridor having attempted to walk unsupervised and a question was raised at the time whether he would need a placement due to the fall. On 9 June 2000 Mr Clarke became breathless and restless and was diagnosed with pneumonia. By 12 June 2000 he was deteriorating and was prescribed subcutaneous Diamorphine 5mgs every four hours. By 15 June 2000 the Diamorphine was being given via a syringe driver at a dose of 5mgs over twenty-four hours. Mr Clarke died on 17 June 2000. The expert review of this case confirmed that Mr Clarke was managed with very small doses of drugs including Diamorphine. The prescribing was within fixed doses and demonstrated good management prior to his natural death. In short he was well looked after with good use of medication." (HCO003326)

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CORKE	**JAMES**	HCO002970, p63	A1	HCO003779, p148	A2	HCO003793, p22 HCO003054, p4	A2	HCO002149, p4	No conclusive categorisation	A2	HCO000613, p10 HCO000641, p103	"Mr Corke was discharged home from Gosport War Memorial Hospital 5 August 1989, having been prescribed antibiotics for a presumed urine infection. Mr Corke was found to be comatosed on his arrival at home and was readmitted to hospital with acute renal failure and sceptic shock and died on 14 August 1989. Mr Corke's death was unrelated to opioids and was felt by the experts to be due to septicaemia shock secondary to urinary tract infection." (HCO001927, p4)
COUSINS	**ARTHUR**	HCO110362, p1	A1	HCO110362	A1	HCO110362	A1	HCO000608, p7	A1	A1	HCO110362	The Panel has not seen any documents.
CRESDEE	**OLIVE**	HCO002165, p6	No conclusive categorisation	HCO005394, p79	No conclusive categorisation	HCO002165, p7	A2	HCO002165, p5	Unable to grade	No conclusive categorisation	HCO000613, p11 HCO000641, p103	"Mrs Cresdee was sixty nine when she was admitted to Gosport War Memorial Hospital on 3 April 1990. In May 1989 Mrs Cresdee had undergone a left mastectomy for carcinoma of the breast which was then treated with radiotherapy and Tamoxifen. In February 1990 Mrs Cresdee had started to complain of weakness in her right upper and lower limbs and was receiving treatment for long term care following multiple small strokes. Unfortunately, there are large portions of Mrs Cresdee's Medical Notes which are not available, including the drug charts. Two of the expert doctors have concluded that this patient cannot therefore be graded. Dr Naysmith, who has graded this patient 2A, has done so on the basis that the actual death was a sudden collapse, which is not the mode of death in opioid over dosage. Dr Naysmith did indicate, though, that in her opinion the treatment of the sacral sores with opioids, combined with a failure to give antibiotics, was inappropriate management in as much as she could be certain with so much documentary evidence missing." (HCO001927, p9)

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CRESDEE	**RONALD**	PLA000034 HCO002970, p19	A1	HCO003779, p48	A1	HCO003793, p9	A2	HCO003777, p4	A1	No conclusive categorisation	HCO005152, p2 HCO000641, p103	"Mr Cresdee was a widower living on his own at home. At the time of his admission to Gosport War Memorial Hospital on 17 June 1996 the district nurse was visiting him twice a week. Mr Cresdee's son had also been on leave from the Navy to look after him as Mr Cresdee was finding it hard to manage on his own. On admission Mr Cresdee was noted to have carcinoma of the bronchus with oesophageal metastases. He was nauseous, disorientated and had reduced mobility. The expert review noted that this patient had pain from advanced carcinoma of the bronchus and was clearly dying. On reviewing the medication given to Mr Cresdee it was noted that there was a possibility he may have developed morphine toxicity after a dose increase, although this was still at a modest level. Increasing agitation, hallucination and deterioration were managed with sedation. The notes are not clear as to whether the diamorphine was being used as a sedative or whether GPs were worried about the underlying pain. Experts agreed death was inevitable from advanced cancer." (HCO000468)
CUNNINGHAM	**ARTHUR**	PLA000035 HCO002970, p20	B2	HCO003779, p50	B3	HCO003793, pp9–10	B4	HCO003777	B2	B3	HCO005151, p2 HCO000641, p102	The records indicate that Matthew Lohn did not produce a summary on Category 3 patients.
DEVINE	**ELSIE**	PLA000036 HCO001766 HCO002970, p21	No conclusive categorisation	HCO003779, p52	C2 / B3	HCO003793, p10	C4	HCO003778, p10	B2	B3	HCO005151, p2 HCO000641, p102	The records indicate that Matthew Lohn did not produce a summary on Category 3 patients.

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DICKS	**CYRIL**	PLA000037 HCO002970, p22	A2	HCO003779, p55	B2	HCO003793, p10	A2	HCO003787, p12	B2	B2	HCO110362 HCO000641, p102	"Mr Dicks was admitted to Gosport War Memorial Hospital on 28 December 1998. On admission he was doubly incontinent with urinary tract infection and had an indwelling catheter. It is recorded in medical notes that he had a number of falls where he only sustained minor cuts & bruising whilst at Gosport War Memorial Hospital. The notes recall on 4 January 1999 that he remained poorly and was not eating or drinking well. The expert review notes that Mr Dicks was deteriorating gradually following admission and then rapidly over the weekend 20/21 March 1999. Although there is no record available in medication cards or in the medical notes, one nursing record states that subcutaneous analgesia and midazolam was started on 20 March 1999. The experts concluded the care on the ward was reasonable and that it was likely that Mr Dicks would have died no matter how well he was cared for." (HCO001658, p12)
DONOGHUE	**MARY**	HCO002163, p8	A2	HCO005394, p64	A1	HCO003054, pp7–8	A1	HCO002163, p7	B2	A1 / 2	HCO000613, p11 HCO000641, p103	"Mrs Donaghue was sixty six at the time of her admission to Gosport War Memorial Hospital on 16 May 1991. Mrs Donaghue was a widow and had recently been admitted to the Royal Haslar Hospital where she had undergone an anterior resection for carcinoma of the rectum. The Officer's Report records that the family had previously believed that the tumour was benign. Following the operation Mrs Donaghue suffered a total dense left cerebrovascular accident. On admission to Gosport War Memorial Hospital it was clear that Mrs Donaghue had developed a fistula which is a recognised complication of the surgery. Mrs Donaghue was vomiting and in pain. Large doses of opiates were used but were titrated against the level of pain. The experts agreed that there was good management of the pain to opiates although the vomiting was not dealt with optimally. Dr Naysmith concludes this was good management of terminal cancer." (HCO001927, p7)

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DUMBLETON	**HARRY**	HCO002159, p7	A3	HCO005394, p54	B2	HCO003054, pp7–8	A1	HCO002159, p6	B2 / B3	2 No conclusive categorisation	HCO000641, p104	"Mr Dumbleton was admitted to Queen Alexandra Hospital on 26 April 1993 suffering with cerebrovascular disease, parkinsonism and fits. Mr Dumbleton did not improve significantly during his stay and was transferred to Gosport War Memorial Hospital 26 May 1993 for long stay continuing care. It was recorded in the Gosport War Memorial Hospital notes that he had multiple falls and was very confused and immobile. At one point Mr Dumbleton was verbally and physically aggressive prior to being sedated. An entry in the Notes on 11 June 1993 records that Mr Dumbleton 'Deteriorated over the last couple of days'. Mr Dumbleton was started on a syringe driver containing Diamorphine 40mgs, Hyoscine 40mcgs and Midazolam 20mgs. Mr Dumbleton died less than twelve hours later. The experts have all noted the difficulty of making a firm conclusion in the absence of a medication card in the Notes. Nevertheless Dr Naysmith noted that 'There had been a rapid deterioration in general condition for about five weeks prior to the acute admission and the deterioration was such that death was neither unexpected or untimely'." (HCO001926, p13)
ELLIS	**KATHLEEN**	PLA000038 HCO002970, p23	A2	HCO003779, p57	A1	HCO003793, p11	A1	HCO116128	A1	A1	HCO000641, p104	"Mrs Ellis was transferred to the Gosport War Memorial Hospital on 23 June 1999 from Queen Alexander Hospital where she had initially been admitted on 7 June 1999 as an emergency with acute confusion, cerebrovascular accident and a lower left chest infection. The transfer to Gosport War Memorial Hospital was for continuing care and assessment. Mrs Ellis' past medical history included fractures of her fibula and pelvis following falls in 1996 and 1997. On admission Mrs Ellis was noted as being confused but compliant and, moreover, did not appear to be in any pain. According to the notes at the time of transfer, Mrs Ellis was immobile, using a hoist for transfers. It was noted that she takes little diet and had a leg wound on her left leg. She was also noted as having dementia, a chest infection and was dehydrated. Mrs Ellis had severely impaired swallowing and had been deteriorating for several months. With her further chest infection she was unable to swallow antibiotics and was kept on subcutaneous fluids. A nasogastric tube was attempted to be placed unsuccessfully on four occasions. On 5 July 1999 Mrs Ellis died at 6.15 a.m. The expert review concluded that she probably died of recurrent aspiration pneumonia. The care provided to Mrs Ellis was of a good standard." (HCO005682)

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GERMAN	**MARY**	PLA000039 HCO002970, p24	A1	HCO003779, p59	A1	HCO003793, p11	A1	HCO003777, p6	A1	A1	HCO000641, p104	"Mrs German was admitted to Gosport War Memorial Hospital on 28 November 1998. Mrs German had previously been diagnosed as suffering from carcinoma of the lung and had a secondary deposit in her spine. At the time of admission she was already receiving Morphine, Diclofenac and Carbamazepine to treat a mixture of lung, bone and neuropathic pain. She had been admitted from St Mary's General Hospital following a course of radiotherapy. She was admitted for palliative care and received a comprehensive nursing assessment. By 30 November 1998 Mrs German was noted as being confused as well as breathless which continued. On 2 December 1998 Mrs German became increasingly short of breath although she denied any pain or discomfort. She died on 3 December 1998. The expert review noted she was described an appropriate dose of diamorphine having previously received a carefully calibrated dose of Oramorph [morphine oral solution]. Conversion from Oramorph to Diamorphine via a syringe driver was undertaken in an appropriate manner." (HCO003299)
GONELLA	**NATHANIEL**	HCO000169	B2	The Panel has not seen any documents	The Panel has not seen any documents	HCO000167	C2	The Panel has not seen any documents	The Panel has not seen any documents	The Panel has not seen any documents	The Panel has not seen any documents	The Panel has not seen any documents.

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GRAHAM	**LEONARD**	PLA000040 HCO002970, p25	A1	HCO003779, p61	A1	HCO003793, p11	A1	HCO003777, p7	A1	A1	HCO000641, p104	"Mr Graham was seventy five when he was admitted to Gosport War Memorial Hospital on 16 August 2000. Mr Graham was admitted to Queen Alexander Hospital on 16 August 2000 with a chest infection, urinary tract infection, poor mobility and swallowing difficulties. Following treatment he was transferred to GWMH for continuing care. The transfer form noted that Mr Graham was incontinent of both urine and faeces, that he required a hoist to transfer and needed a pureed diet and thickened fluids together with a requirement for feeding. Mr Graham's past medical history at the time of admission included lewy body dementia, hallucinations, carcinoma of the lung and idiopathic parkinson's disease. On 14 September 2000 Mr Graham was noted by nursing staff to be unresponsive and had a grey colour. He was given 2.5mgs Diamorphine subcutaneously and a possible diagnosis of a clot moving from his legs to his lungs was put forward. The expert review of the notes noted the Diamorphine prescription at the time of collapse as being appropriate pain relief in the circumstances of this case. In conclusion Mr Graham had a sudden terminal event and was given an appropriate small dose of Diamorphine." (HCO005684)
GREGORY	**SHEILA**	PLA000041 HCO002970, p26	B2	HCO003779, p63	B3	HCO003793, p11	A2	HCO003787, p15	B2	B3	HCO005151, p3 HCO000641, p102	The records indicate that Matthew Lohn did not produce a summary on Category 3 patients.
HADLEY	**HARRY**	PLA000042 HCO002970, p27	B2	HCO003779, p65	A2	HCO003793, pp11–12 HCO003054, p8	A1	HCO003787, p16	A2	A2	HCO000613, p10 HCO000641, p103	"Mr Hadley was admitted to Gosport War Memorial Hospital on 5 October 1999. At the time he was fully aware of his condition having been diagnosed with carcinoma of the bladder in July 1999. Mr Hadley was immobile and required the assistance of nurses plus aides. Mr Hadley died 10 October 1999. In the last five days before his death Mr Hadley was inexpertly treated with opioid analgesics although this did not in any way substantively alter the prognosis." (HCO001663, p9)

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HALL	**CHARLES**	PLA000043 HCO002970, p28	B3	HCO003779, p67	B2	HCO003793, p12	A2	HCO003787, p17	A2	B2	HCO005281, p2 HCO000641, p103	"Mr Hall was admitted to Gosport War Memorial Hospital on 5 July 1993 after he had undergone a sigmoid colectomy & colostomy following diverticulitis and a gangrenous bladder. On admission, in addition to the rehabilitation issues following his abdominal surgery, he was suffering pain in his left foot which was associated with vascular disease. He was started in August on oral morphine which was converted to diamorphine via syringe driver on 5 August 1993. The experts note that although he undoubtedly had a severe underlying disease the acceleration from one dose of oramorph [morphine oral solution] to 40mgs diamorphine was sub optimal treatment." (HCO001659, p9)
HALL	**NORAH**	PLA000044 HCO002970, p29	A1	HCO003779, p69	A1	HCO003793, p12	A1	HCO003787, p18	A1	A1	HCO000641, p104	"Mrs Hall was eighty three at the time of her admission to Gosport War Memorial Hospital on 1 June 1999. In April 1999 Mrs Hall was admitted to hospital for a palliative gastrostomy for carcinoma of the stomach. She was readmitted to Gosport War Memorial Hospital for symptom control since she was increasingly suffering from pain, nausea and vomiting. Mrs Hall died on 19 June 1999. During her stay she was treated with Diamorphine which was first injected subcutaneously and then latterly via a syringe driver. The expert review of this case confirmed that Mrs Hall received excellent palliative care throughout her stay and that in particular she had good pain control." (HCO005685)
HARRINGTON	**WILFRED**	HCO002160, p7	A2	HCO005394, p57	A2	HCO003054, p8	A1	HCO002160, p6	B2	A2	HCO000641, p103	"Mr Harrington was admitted to Gosport War Memorial Hospital on 8 June 1993 for a 2 week period of respite care. Mr Harrington was suffering from severe heart failure and chronic renal failure. He did not walk without aid. In the last week of life he developed contractions of the arm and severe hip pain which was initially thought to be a fracture. Given Oramorph [morphine oral solution] for the first time on 20 July 1993 at a dose of 20mgs four times a day. A syringe driver was set up the following day but within an hour Mr Harrington had died. The experts were agreed that Mr Harrington died of end stage heart failure despite active management and although the dose of Diamorphine could be criticised for being too high, it was clear that Mr Harrington was already dying and that this therapy did not significantly influence the outcome." (HCO001926, p14)

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HILL	**EDITH**	HCO000170, p2	A2	The Panel has not seen any documents	The Panel has not seen any documents	HCO000612, p2	A2	The Panel has not seen any documents	The Panel has not seen any documents	2	HCO004918	The Panel has not seen any documents.
HILLIER	**EILEEN**	PLA000045 HCO002970, p30	A1	HCO003779, p72	A1	HCO003793, p12	A1	HCO003787, p19	B1	A1	HCO000641, p104	"Miss Hillier was admitted to Gosport War Memorial Hospital on 23 May 1995. She was aged seventy six at the time of admission. She was a retired French teacher and lived in her own home. She was treated in January 1995 for psychotic depression with electro convulsive therapy and discharged in March 1995. Her previous medical history included carcinoma of the breast for which she had undergone a mastectomy and radiotherapy. Although she had no recurrence of her carcinoma she had developed post radiation damage to her chest wall with a discharging sinus. Following admission in May 1995 care plans were commenced for poor diet and food intake, low mood and treatment of the sinus. During her inpatient stay she had several falls, one of which required sutures to a scalp injury. At this time her mood fluctuated, the clinical notes recording at times that Miss Hillier was quite bright and at others 'still low'. On 28 July 1995 there was a significant bleed from the upper sinus on the chest wall during the night. A further dramatic blood loss occurred on 30 July 1995 and at that time a diagnosis was made that the chest wall sinus was eroding into a main blood vessel. Miss Hillier's clinical condition deteriorated on 31 July 1995 and she was prescribed at that time Diamorphine 10mgs four hourly together with modest doses of Diazepam for agitation. The expert review of this case noted that Miss Hillier was physically deteriorating and, following the consensus opinion for palliative care, appropriately low doses of opiates were used." (HCO005686)
HOBDAY	**ALAN**	PLA000046 HCO002970, p31	A2	HCO003779, p75	A2	HCO003793, p12	A2	HCO003787, p20	A2	A2	HCO005281, p3 HCO000641, p103	"Mr Hobday had suffered a stroke in July 1998 and was admitted to hospital. He was transferred to Gosport War Memorial Hospital on 24 July 1998 for further rehabilitation. On the clinical notes it would appear that he extended his stroke on 6 September 1998 and thereafter developed focal seizures with increased pain in his arm. Diamorphine was started via a syringe driver and Mr Hobday died on 11 September 1998. The expert report confirmed that although higher doses of opiates were used than may have been necessary, Mr Hobday's cause of death was due to his stroke." (HCO001664, p8)

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HOOPER	**ALBERT**	PLA000047 HCO002970, p32	A1	HCO003779, p78	A1	HCO003793, pp12–13	A1	HCO003787, p21	A1	No conclusive categorisation	HCO005281, p2 HCO005152, p2 HCO000641, p103	"Mr Hooper was living alone at his home at the time of admission on 12 September 2000 at Gosport War Memorial Hospital. Mr Hooper had previously been admitted to Royal Haslar Hospital on 18 August 2000 with diarrhoea, reduced mobility and an inability to cope at home. He was transferred to Gosport War Memorial Hospital for rehabilitation and continuing care. The transfer form noted that Mr Hooper needed help with all aspects of hygiene and dressing, that he was occasionally incontinent and hard of hearing. Clinical notes made reference to his multiple medical problems including chronic obstructive pulmonary disease, ischaemic heart disease and anaemia. Whilst an inpatient, Mr Hooper developed a chest infection which was treated symptomatically in view of his deteriorating general condition. He was prescribed hyoscine to begin with and as he continued to complain of pain not relieved by paracetamol, diamorphine 10mgs and midazolam 10mgs were introduced. The doses were doubled on his day of death because Mr Hooper remained uncomfortable whilst being suctioned. The experts did note he received very reasonable care under the overall circumstances. The experts did note that a combination of drugs may have contributed to Mr Hooper appearing sedated. Overall , the nursing input was also commended for appropriately identifying his care needs and maintaining good communication with family." (HCO000470)

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HORN	**FRANK**	HCO002167, p7	B2	HCO005394, p22	B2	HCO003054, p9	B3	HCO002167, p6	B2	B2	HCO000641, p102	"Mr Horn was an elderly man with an extensive medical history including carcinoma of the larynx, Bell's palsy and multiple small strokes. Although suffering a severe stroke in 1995 he was rehabilitated at St Mary's Hospital and eventually went to live with his daughter. He was frail but fully mobile at that time. Mr Horn was admitted in October 1999 to Queen Alexandra Hospital with shortness of breath and chest pain. A diagnosis was made of heart failure with a chest infection and the possibility was raised that he was aspirating his food. Mr Horn was transferred to Gosport War Memorial and it was hoped after rehabilitation he would be transferred to a residential home. Mr Horn was made DNAR on admission without any detailed assessment or any evidence of discussion with either patient or family. He deteriorated markedly a few days after transfer and was started on Diamorphine 20mgs together with Midazolam and Hyoscine. Mr Horn was very sleepy within twelve hours and by twenty-four hours later was twitchy, distressed and objecting to nursing care. Dr Naysmith raises the possibility of Mr Horn being opioid toxic. The experts agreed that the starting dose and increase was more than they would have expected but do not think that the medication contributed to Mr Horn's death." (HCO001926, p5)

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HORNE	**PHYLISS**	HCO002169, p7	B2	HCO005394, p29	B2	HCO003054, p9	B3	HCO002169, p6	B2	B2	HCO000641, p102	"Mrs Horne was a widow who suffered from deteriorating health including severe Alzheimer's disease and in 1996 moved into Acorn Lodge Residential Home. Mrs Horne was unable to look after herself and after a number of years she was unable to move any part of her body and became completely bedridden. Mrs Horne was admitted to Queen Alexandra Hospital on 16 March 1988 suffering from dizzy spells. Two weeks previously she had suffered a minor stroke with facial palsy. She was subsequently transferred to Gosport War Memorial Hospital on 26 March 1988 for continuing care. The management of Mrs Horne's agitation was a difficult issue. She was noted as being frightened, agitated and appearing in pain. On 3 May 1998 she was started on a Fentanyl 25mcgs patch. Mrs Horne's condition continued to deteriorate and forty-eight hours later she could not swallow. A syringe driver was set up containing Diamorphine 40mgs and Midazolam 40mgs. Mrs Horne died the following day. The experts note that Mrs Horne was frail, agitated and unwell but expressed concern as to the high starting dose of opioids and the fact that there was no attempt to use non opioid analgesics. It is recognised that dementia and cerebrovascular disease are both terminal illnesses and it was felt that Mrs Horne would have had a relatively short prognosis in any event notwithstanding the opioid medication." (HCO001926, p8)

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HOUGHTON	**CLIFFORD**	PLA000048 HCO002970, p33	B3	HCO003779, p80	A3	HCO003793, p13	A2	HCO001646, p3	A3	A3	HCO005281, p3 HCO000641, p102	"Prior to his last admission to Gosport War Memorial Hospital Mr Houghton lived with his wife in a bungalow. Mr Houghton had suffered a right hemiparesis in 1991 which impaired his mobility and power of speech. In October 1993, since Mrs Houghton was finding it increasingly difficult to cope, Mr Houghton was admitted for two weeks care at the Gosport War Memorial Hospital at six weekly intervals. Because of suspected transient ischaemic attacks, Mr Houghton was admitted on 31 January 1994, prior to the completion of the six week period at home. On 3 February 1994 Mr Houghton's condition was described as deteriorating, he was breathless and distressed. He was written up for a syringe driver which was commenced on 6 February 1994. The initial dose of Diamorphine 40mgs over twenty four hours which was increased to 60mgs following review by Dr Peters. Mr Houghton died that evening. The experts in reviewing this case, note that the dose of Diamorphine which was started was high but Mr Houghton was clearly in the terminal phase of his life already. The experts felt that the high starting dose was negligent but needed to be viewed in the context of a man who was dying in any event." (HCO002663, p7)

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HURNELL	**JOAN**	HCO002166, p8	A1	HCO005394, p82	A2	HCO003054, p10	A2	HCO002166, p7	A2	2 No conclusive categorisation	HCO000613, p11 HCO000641, p104	"Mrs Hurnell was diagnosed with breast cancer in November 1998 and treated with a mastectomy, chemotherapy and radiotherapy. Mrs Hurnell was admitted to Gosport War Memorial Hospital on 14 May 1999 as an emergency, being confused, agitated and in pain with discharge from her breast. The Hospital Records record that Mrs Hurnell was acutely confused and was admitted under the Mental Health Act. Mrs Hurnell was treated with Haloperidol and Oral Morphine. She continued to appear to be in pain and deteriorated rapidly on 18 May 1999 with very poor breathing and being very pale in colour. The experts have postulated that there may have been a possible pulmonary embolism. The opioid drugs prescribed and administered were modest and entirely appropriate and were considered by the KCT not to have been implicated in Mrs Hurnell's death. The KCT considered Mrs Hurnell's overall treatment to be entirely reasonable but have classified her as a 2, ie sub optimal since Mrs Hurnell was admitted and nursed in arguably the wrong setting; ie. she may have received better nursing care on a medical rather than on a psycho geriatric ward. The Officer's Report states Mrs Hurnell's year of birth as 1920 which contradicts the Medical Records." (HCO001927, p10)
JARMAN	**THOMAS**	PLA000049 HCO002970, p34	A3	HCO003779, p82	A3	HCO003793, p13	A2	HCO003787, p22	A1	A3	HCO005281, p3 HCO000641, p102	"Prior to his move to the Red House Residential Home in June 1999 Mr Jarman was a widower who lived alone in his own house. Mr Jarman had been diagnosed with hairy cell leukaemia in May 1999. Mr Jarman was admitted to Queen Alexandra Hospital on 27 October 1999 for rehabilitation following an episode of bronchopneumonia. Mr Jarman was recorded, on admission, to be choking on his feeding and was seen by the speech and language therapist. On 7 November 1999 Mr Jarman was noted to be distressed and agitated and was given oral morphine with no effect. That night Mr Jarman remained distressed and screaming louder; a syringe driver was commenced with Midazolam and low dose of Diamorphine. Further deterioration was noted on 8 and 9 November 1999 and the doses of Diamorphine were increased. Mr Jarman became unresponsive and was felt to be pain free. Although there was some concern expresssed by the experts in reviewing this case at the escalating levels of Diamorphine, it was felt that the underlying medical problems would account for his death and there was no evidence of any intent other than to make Mr Jarman comfortable in his terminal phase." (HCO002663, p5)

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LAKE	**RUBY**	HCO110362	B3	HCO005394 HCO110362	A2	HCO003054, p10 HCO110362	C3	HCO001679, p6	B2	B3	HCO000641, p102	The records indicate that Matthew Lohn did not produce a summary on Category 3 patients.
LAVENDER	**ELSIE**	PLA000050 HCO002970, p35	B3	HCO003779, p84	B3	HCO003793, pp13–14	B3	HCO003787, p23	B3	B3	HCO005281, p3 HCO005151, p3 HCO000641, p102	The records indicate that Matthew Lohn did not produce a summary on Category 3 patients.
LEE	**CATHERINE**	PLA000051 HCO002970, p36	B2	HCO003779, p87	B2	HCO003793, p14	B3	HCO003787, p24	No conclusive categorisation	B2	HCO005281, p3 HCO000641, p102	“Catherine Lee was admitted to Gosport War Memorial Hospital on 14 April 1998 from the Royal Hospital Haslar where she had been admitted for surgery to repair a fractured neck of femur. On admission, it was noted that Mrs Lee had poor mobility, was confused at times and needed full assistance with eating and drinking due to poor eyesight and that she had a poor appetite. She needed care for hygiene and dressing. On admission she was settled on the ward and given oral Morphine. This was gradually increased during her stay on 5mgs four times a day to 10 mgs by 18 May. She was transferred to subcutaneous analgesia on 21 May when she was started on Diamorphine and Midazolam. The experts have raised a question as to whether the indication for Opiates was clear but note that the medical problems were probably enough to account for the final cause of death.” (HCO001660, p9)

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LEEK	**MABEL**	HCO002155, p8	B2	HCO005394, p35	B2	HCO003054, p10	A1	HCO002155, p7	B2	B2	HCO000641, p102	"Mrs Leek had a long history of pain due to osteoarthritis, suffered from osteoporosis with multiple fractures. she had limited mobility & suffered with chronic pain, from 1996 had been treated with Morphine, 10mgs twice a day. Mrs Leek had problems with incontinence and was also noted as having angina and chronic obstructive airways disease. She lived on her own with extended home care visiting twice daily and had meals on wheels and a home help. Following her left tibia and fibula fracture, which was treated at Royal Haslar Hospital, Mrs Leek, was transferred to Gosport War Memorial Hospital on 6 August 1998 for further rehabilitation. On admission she was prescribed 60mgs twice a day of Morphine because of the severe pain in her joints and the pressure ulcers. The dose of morphine was gradually increased and a syringe driver was commenced on 14 December 1998 following a deterioration which was recorded in the clinical notes. The conversion to syringe driver increased the Diamorphine by thirty percent but Mrs Leek was described as not swallowing and unresponsive. The experts concluded unanimously that although the rate of increase of analgesia was sub optimal there was no negligence in the terminal care of Mrs Leek." (HCO001926, p9)

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MARSHALL	**RHODA**	HCO002157, p6	B2	HCO005394, p41	B2	HCO003054, pp10–11	A2	HCO002157, p5	B2	B2	HCO000641, p102	"Ms Marshall lived in Hedley House Residential Home before being admitted to Queen Alexandra Hospital on 14 December 1995 following a fracture of her pubic rami when she fell getting out of a chair. Mrs Marshall was admitted to Gosport War Memorial Hospital on 29 December for long-term rehabilitation. Her medical history included dementia, Parkinson's disease, hypothyroidism and heart failure. There were difficulties noted by the experts in interpreting whether Ms Marshall was frightened of moving or was in fact in pain. She was not weight bearing at that time although had been before the fracture. The clinical notes record that her pain control was inadequate and she was started on 10mgs Oramorph [morphine oral solution] four hourly on 30 December 1995. This was changed to a syringe driver to give continuous pain relief on 2 January 1996. The starting dose of 40mgs Diamorphine was doubled to 50mgs on 4 January and raised again that day to 120mgs. Ms Marshall was noted to be deteriorating slowly on 6 January and died the following day. The experts considered that the pain suffered by Ms Marshall was unskilfully managed, and there was a possibility of opioid toxicity, but were unanimous that no negligence occurred in the management of Ms Marshall's terminal phase." (HCO001926, p11)
MARTIN	**STANLEY**	PLA000052 HCO002970, p37	A1	HCO003779, p89	A1 B2	HCO003793, p14	A1	HCO003787, p25	B2	2 No conclusive categorisation	HCO005281, p2 HCO000641, p103	"Mr Martin was an eighty four year old man who was admitted to Gosport War Memorial Hospital on 6 January 1998. He lived at home with his son and had a shared care arrangement with Gosport War Memorial Hospital. On admission on 6 January 1998 he had bronchopneumonia. Mr Martin was nauseated the following day and complaining of a sore abdomen and deteriorated quickly thereafter, becoming anuric. The experts considered his death was probably due to a mixture of congestive cardiac failure and infection. Although given a single dose of diamorphine intramuscularly 5mgs to relieve dyspnoea he died 20 minutes after and therefore probably absorbed very little of it, if any." (HCO000467, p2)

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MIDDLETON	**DULCIE**	PLA000053 HCO002970, p38	A1	HCO003779, p90	A1 A3	HCO003793, pp14–15	A1	HCO000600, p2	A1	A1	HCO005281, p2 HCO000641, p104	"Mrs Middleton was eighty six at the time of her admission to Gosport War Memorial Hospital on 15 August 2001. Mrs Middleton died on 2 September 2001 in Petersfield Hospital under the care of Dr Varden. Her past medical history had included left ventricular failure, angina, together with a dense stroke which required her to be fed through a gastrostomy feeding tube which was inserted on 31 July 2001. Unfortunately, subsequent to the insertion of the tube, Mrs Middleton developed abdominal pain and vomiting. A possible abdominal obstruction was diagnosed and Mrs Middleton was commenced on Diamorphine which was 2.5-5mgs as required. This dose was increased when the pain was more severe and Midazolam was added when she became agitated and distressed. The expert review of this case confirms that Mrs Middleton was very unwell and was made comfortable with small amounts of analgesia which was gradually increased appropriately." (HCO003282)
MIDFORD-MILLERSHIP	**DOUGLAS**	HCO002970, p62	A1	HCO003779, p146	A1	HCO003793, p21	A1	HCO000602, p3	A1	A1	HCO000641, p104	"Mr Midford Millership was eighty two at the date of his admission to Gosport War Memorial Hospital on 8 July 1999. He had been admitted by his GP to the Royal Haslar Hospital after his wife had been finding it difficult to cope and he was subsequently transferred to Gosport War Memorial Hospital for general nursing care. Mr Midford Millership's past medical history included severe chronic obstructive pulmonary disease and congestive cardiac failure. Whilst being cared for at the hospital he collapsed suddenly on 19 July 1999 by the side of his bed. No injuries were sustained. On 20 July 1999 he became very breathless and deteriorated suddenly. It was thought that he had suffered either a cerebrovascular accident or a myocardial infarction. He died shortly afterwards. The expert review of this case has confirmed that there was no evidence of misprescribing to Mr Millership and, moreover, that he received a reasonable standard of care at Gosport War Memorial Hospital." (HCO005691)

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PACKMAN	**GEOFFREY**	PLA000054 HCO002970, p39	A3	HCO003779, p91	A2	HCO003793, p15	A1	HCO003787, p28	A2	B3	HCO005152, p2 HCO000641, p103 HCO002616, p8	"Mr Packman was admitted to Gosport War Memorial Hospital in July 1999, following the development of an irritating rash on his side and groin. It appears from the medical notes that he had an episode of black stools prior to being discharged from Portsmouth Hospitals NHS Trust. Following admission to Gosport War Memorial Hospital on 23 August 1999 he was noted as remaining very poorly with no appetite. It was noted in Mr Packman's nursing records that he was passing fresh blood per rectum on 25 August 1999. On 26 August 1999 he complained of feeling unwell with indigestion pain in his throat together with nausea and vomiting. At this point he was commenced on opiate medication. No active measures were taken to resuscitate Mr Packman and, following rapidly increasing doses of Diamorphine, he died on 3 September 1999. There is a variation in the view taken of this case by the experts reviewing the Notes. Concern is expressed by Dr Lawson that although the death was natural, the gastrointestinal bleed was potentially treatable. An expert report from a gastrointestinal surgeon/physician is to be sought." (HCO001925, p5)
PARR	**GWENDOLINE**	PLA000056 HCO002970, p41	A2	HCO003779, p96	A2	HCO003793, pp15–16	A2	HCO001666, p4	A1	A2	HCO005281, p3 HCO000641, p103	"Mrs Parr was admitted to the Royal Hospital Haslar in December 1998 following a fall where she sustained a fractured neck of femur. She underwent surgery for a dynamic hip screw on 14 December 1998. During her stay at the Royal Haslar Mrs Parr developed acute abdominal pain and underwent umbilical hernia repair on 24 December 1998. She was admitted to Gosport War Memorial Hospital on 31 December 1998 for rehabilitation. The family note in the officer's report that they visited Mrs Parr daily at the Hospital and stated that 'she was very chirpy and stated that she would soon be walking and going home'. Mrs Parr was noted to have deteriorated by 23 January 1999 and was commenced on Oramorph [morphine oral solution] and thereafter remained poorly. Mrs Parr died on 29 January 1999. Dr Naysmith notes that Mrs Parr was deteriorating before the opioids were started but that the first dose of Diamorphine given would have been high even for a lady with normal renal function. This contrasted with Dr Ferner who records the treatment as being optimal with the drugs being given in 'proportional doses'." (HCO001666, p8)

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QUEREE	**MARGARET**	HCO002970, p43	A2	HCO003779, p101	A2	HCO003793, p17	A2	HCO002280, p5	A2	A2	HCO000641, p103	"Mrs Queree was admitted to the Queen Alexander Hospital in May 1994 where she underwent surgery for pelvic abscesses. She had a permanent colostomy put in place. She was transferred to Gosport War Memorial Hospital on 29 July 1994 for rehabilitation. As noted by the experts, Mrs Queree had significant medical problems prior to her operation and both urine and vaginal infections after the operation. She became frail and confused and was commenced on Morphine Sulphate. After three days she was then started on a high dose of Diamorphine via a syringe driver with a five fold increase in the relative dose over two days. The experts confirm that in their view she died of natural causes. The use of opiates and sedation was rapidly increased although this properly appears to be reasonable in response to the distress demonstrated by the patient." (HCO001668, p10)
RAMSAY	**JOAN**	HCO002145	A1	HCO003779, p106	A2	HCO003054, p13	2A	HCO002145, p8	A1	No conclusive categorisation	HCO000613, p10 HCO000641, p103	"Mrs Ramsey is still alive. Mrs Ramsey has an extensive medical history, including right and left fractured hips in 1998 and 2000. Following her operation in July 2000, Mrs Ramsey was admitted to Gosport War Memorial Hospital having been treated in Haslar Hospital. Mrs Ramsey was in severe pain and being treated with increasing analgesia. The sub optimal grading of this patient was due to the length of time it took to diagnose that the dynamic hip screw was cutting into the acetabulum and causing pain. The type of medication and the doses prescribed to treat the pain appear to be appropriate for the symptoms complained of. The experts did not think the level of opioid treatment was unreasonable in this case." (HCO001927, p3)
REEVE	**VIOLET**	HCO002970, p45	A2	HCO003779, p109	A2	HCO003793, p17	B1	HCO003787, p31	A2	A2	HCO000641, p103	"Miss Reeve was admitted to the Queen Alexander Hospital on 18 October 1996 following a stroke affecting her left side. She developed marked weakness and later swallowing difficulties. She was transferred on 11 November 1996 to Gosport War Memorial Hospital for rehabilitation. During the admission she remained very distressed and was seen by Dr Gibb a neurologist. The experts have concluded that Miss Reeve clearly had a poor prognosis and very difficult mental state problems. Dr Lord seemed to have decided, not withstanding the advice of Dr Gibb, to continue sedation and the experts concluded that she was likely to be made more comfortable at the end with the treatment regime of Midazolam and Diamorphine." (HCO001669, p12)

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RICHARDS	**GLADYS**	HCO002970, p46	A2	HCO003779, p112	A2	HCO003793, p17	A2	HCO003787, p32	A2	A2	HCO000641, p103 HCO001921, pp6–7	"On 30 July 1998, Mrs Richards suffered a fall at the Glenheathers Nursing Home where she lived. She fractured her right neck and femur and was admitted to the Royal Hospital Haslar where she underwent a closed relocation of her right hip. She was transferred to Gosport War Memorial Hospital on 11 August 1998 for continuing care. She was readmitted to the Royal Haslar Hospital on 14 August 1998 for a reduction of her dislocated right hip and was readmitted to Gosport War Memorial Hospital on 17 August 1998. Plan on admission was to continue Haloperidol and only to give Oramorph [morphine oral solution] in severe pain. Mrs Richards on the 18 August, was still noted to be in great pain at which point it was proposed that she was started on subcutaneous Diamorphine/Haloperidol/Midazolam. Mrs Richards was noted to be much more peaceful on 21 August although her condition was noted to be very poor. There is criticism made that the starting dose of 40mgs Diamorphine seemed excessive when starting the syringe driver but it was noted that Mrs Richards opiate requirement had increased considerably in the fifteen hours before the driver was started. Dr Lawson considered that the opiates were not considered to be implicated in her death. Dr Naismith [sic] felt the Diamorphine dose was too high and probably shortened her life but she seemed 'unlikely to survive unless she had been left in severe pain (screaming)'. I have not seen an officer's report from the family in this case." (HCO003051, p25)
RIPLEY	**JAMES**	HCO002970, p47	A2	HCO003779, p113	A2	HCO003793, p17	No conclusive categorisation	HCO003787, p33	A2	A2	HCO000641, p103	"Mr Ripley was admitted in August 2002 for worsening renal function and pain from osteoarthritic hips. He was started on Morphine Sulphate, the dose of which was increased after twenty-four hours. Having become drowsy he was transferred back to the Royal Haslar as an emergency where he recovered consciousness. The expert opinion concluded that the escalation in Morphine Sulphate was rapid but non negligent." (HCO001739, p6)

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ROGERS	**ELIZABETH**	HCO002970, p49	A2	HCO003779, p116	B2	HCO003793, p18	B3	HCO003787, p34	A1	B2	HCO000613, p10 HCO000641, p102	"Mrs Rogers was transferred from the Royal Haslar Hospital to Gosport War Memorial Hospital on 30 January 1997. She had been treated at the Royal Haslar Hospital with a chest infection and a urinary tract infection. She had severe Parkinson's disease. On transfer it was noted she had a catheter in place, was bed bound, slightly dysphagic and her sacrum was red but intact. On 2 February 1997 she was prescribed oral Morphine due to an increase in pain. On 3 February 1997 in view of the pain not being controlled by oral Morphine, a syringe driver was commenced with 40mgs of Diamorphine, 20mgs of Midazolam and 400mcgs Hyoscine. The experts note that the dose of Diamorphine approximated to a doubling of opioid medication but agreed that most practitioners would have used opiates to control this patients pain. Some criticism was made of the dose of diamorphine given but this was felt to not to have shortened Mrs Rogers life." (HCO002146, p14)
SERVICE	**HELENA**	HCO003778, p22	B3	HCO005394, p48	B3	HCO003054, pp13–14	B3	HCO003778, p23	B2	B3	HCO000641, p102	The records indicate that Matthew Lohn did not produce a summary on Category 3 patients.

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SKEENS	**EUPHEMIA**	HCO002156, p7	A2	HCO005394, p38	A2	HCO003054, p14	A2	HCO002156, p6	B2	A2	HCO000641, p103	"Mrs Skeens lived at home on her own with the help of a carer prior to her admission to Queen Alexandra Hospital on 10 October 1995 after suffering a stroke which left her with a left hemiparesis. On 20 October 1995 Mrs Skeens was transferred to Gosport War Memorial Hospital for long stay rehabilitation. Following admission, she became increasingly chesty and unable to clear secretions and had pain from her left arm where she fell when she had the stroke. Mrs Skeens became pyrexial and consideration was given as to whether or not to prescribe antibiotics. A decision was taken to pursue symptomatic management only and Oramorph [morphine oral solution] 5mgs PRN was commenced. This was increased to 10mgs the next day. On 28 October Mrs Skeens was noted as being distressed and restless, a syringe driver was commenced at 40mgs of Diamorphine. This controlled the agitation and restlessness and she was recorded as being peaceful and relaxed. The experts conclude, at this stage, Mrs Skeens was inevitably dying and she did so the following day. Dr Naysmith noting that she doubted the opioid made any significant difference to Mrs Skeens' outcome." (HCO001926, p10)
SMITH	**HORACE**	HCO002162, p7	A1	HCO005394, p66	A1	HCO003054, pp14–15	A1	HCO002162, p6	No conclusive categorisation	A1	HCO000613, p11 HCO000641, p103	"Mr Smith had been admitted to Royal Haslar Hospital on 9 March 1999 with acute alcoholic pancreatitis in association with alcoholic liver disease and chronic obstructive pulmonary disease. Mr Smith was transferred to Gosport War Memorial Hospital on 30 March 1999 for continuing care but was transferred back to the Royal Haslar Hospital on 31 March since he had become acutely unwell with severe abdominal pain. It was clear that he had acute abdomen which was painful and distended and was transferred back to Haslar. Mr Smith's drug treatment at Gosport War Memorial Hospital included a single dose of Pethidine for the acute abdominal pain which the experts concluded was entirely appropriate medication in the circumstances and would not have influenced his death six days later." (HCO002162, p9)
SPURGIN	**ENID**	HCO002970, p50	B3	HCO003779, p119	B3	HCO003793, p18	B2	HCO003787, p35	2A / 3A	B3	HCO005151, p3 HCO000641, p102	The records indicate that Matthew Lohn did not produce a summary on Category 3 patients.

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STANFORD	**DOROTHY**	HCO002151, p8	B3	HCO005394, p10	B2	HCO003054, p15	A2	HCO002151, p7	B2	B2	HCO000613, p11 HCO000641, p102	"Mrs Stanford was a widow living at Egremont Rest Home when she suffered a severe stroke in November 1993. She was admitted to Queen Alexandra Hospital suffering with a right hemiplegia and was catheterised and fed via a naso gastric tube. Prior to her transfer to Gosport War Memorial Hospital on 23 November 1993 Mrs Stanford was noted as having been pyrexial with scattered crepitations and was thought by the expert team to have a probable chest infection. On arrival at Gosport War Memorial Hospital Mrs Stanford was described as 'very poorly' and the Nursing Admission Form noted that 'Mrs Stanford was highly dependent and her levels of consciousness varied'. The expert team noted that opioid pain relief was started but without any obvious need. The comment 'needs analgesia' was made in the notes but without any indication of concurrent pain. Since Mrs Stanford was unable to take anything by mouth a syringe driver was set up containing Diamorphine 40mgs with Hyoscine and Midazolam. Mrs Stanford died two days later. The experts concluded that Mrs Stanford was likely to die because of the severity of the stroke and probable chest infection but they have criticised the use of opiates without clear indication." (HCO001926, p2)
STEVENS	**JEAN**	HCO002970, p51	A2	HCO003779, p121 HCO000613, p10	3B	HCO003793, p18 HCO003054, p15	A1	HCO003787, p36	B2	B2	HCO003787, p36 HCO000641, p102 HCO000613, p10	The Panel has not seen any documents.

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TAYLOR	**DAPHNE**	HCO002970, p52	A2	HCO003779, p123	B2	HCO003793, p19	B2	HCO003787, p37	B2	B2	HCO000641, p102	"Mrs Taylor was admitted to the Royal Haslar Hospital on 29 September 1996 after suffering a cerebrovascular accident. She was transferred to Gosport War Memorial Hospital on 3 October 1996 for rehabilitation. On 7 October 1996 she was felt to be in pain and was prescribed Fentanyl patches. She was noted to be in a great deal of pain and the strength of the Fentanyl patches were increased. On 18 October, following a very unsettled night when Mrs Taylor appeared to be distressed and in pain, a syringe driver was set up with 40mgs of Diamorphine and 20mgs of Midazolam over twenty-four hours. Although Mrs Taylor had a severe stroke which left her unable to swallow or speak, she was being tube fed. However, she was prescribed rapidly escalating doses of opioids without there appearing to be a comprehensive assessment made for her pain. The experts note that she had an irrecoverable cerebrovascular and would have died soon in any event." (HCO001671, p11)
TAYLOR	**LILLIAN**	HCO000609, p9	2A	HCO000609, p5	A2	HCO000609, p9	A2	HCO000609, p6	B2	A2	HCO110362	The Panel has not seen any documents.
TILLER	**SYLVIA**	HCO002970, p53	B2	HCO003779, p125	A2	HCO003793, p19	A2	HCO003787, p38	A2	A2	HCO000641, p103	"Mrs Tiller was admitted to Queen Alexandra Hospital on 3 November 1995 after suffering with congestive cardiac failure and a background of ischaemic heart disease. The experts note that she was 'clearly a dying woman'. She was transferred to Gosport War Memorial Hospital on 4 December 1995. Mrs Tiller was given small amounts of Oramorph [morphine oral solution] and only in the last twenty-four hours was set up a syringe driver with Diamorphine, Hyoscine and Midazolam. Although Dr Naysmith questioned the rationale for making 'more adequate analgesia available' in the admission plan, the experts noted the appropriateness of using high levels of analgesic in patients who are about to die to provide solace. To withhold such treatment in their view would be unacceptable." (HCO001925, p7)

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TOWN	**CHRISTINA**	HCO110362, p1	A2	HCO110362	A2	HCO000610, p7	A1	HCO000610, p6	A2	A2	HCO110362	The Panel has not seen any documents.
WALSH	**FRANK**	HCO002970, p55	A1	HCO003779, p129	A1	HCO003793, p19	A1	HCO000601, p3	A1	A1	HCO000641, p104	"Mr Walsh was eighty three at the time of his admission to Gosport War Memorial Hospital on 9 June 1994. He was admitted as an emergency from home after deteriorating and suffering from a cerebrovascular accident. On admission Mr Walsh was noted as being vague and slow to respond. He had a poor appetite and needed assistance with his mobility. On 9 June 1994 he was noted as being incontinent of both urine and faeces. On 13 June 1994, when being taken to the bathroom for a wash, Mr Walsh collapsed before he could be put in to the bath and was returned to his bed. Although he was apyrexial on examination he died the following day. The expert review of this case noted nothing suspicious and no evidence of misprescribing." (HCO005688)
WELLSTEAD	**WALTER**	HCO002970, p56	A1	HCO003779, p132	A2	HCO003793, pp19–20	A1	HCO003777, p19	B1	No conclusive categorisation	HCO000641, p104 HCO005152, p2	"Mr Wellstead was admitted to Gosport War Memorial Hospital on 7 April 1998. He had been admitted to Queen Alexandra Hospital on 12 March 1998 following a fall in his room at the nursing home where he lived. He underwent surgery on 14 March and received a dynamic hip screw. On admission to Gosport War Memorial Hospital noted that Mr Wellstead had dementia and was uncooperative and aggressive at times. Although he was continent in the day he was incontinent at night and needed full nursing care. His mobility was impaired by his recent operation and he had multiple falls during the admission. Mr Wellstead was noted to be in severe pain and started on syringe driver with diamorphine 15mgs and haloperidol 20mgs. The experts in view of his psychiatric history and recent medication considered this dosage reasonable. A question was raised as to whether Mr Wellstead's agitation was aggravated by opioid toxicity but the experts concluded that he died peacefully with terminal bronchopneumonia and have rated him as having received optimal care." (HCO000471)

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WILKIE	**ALICE**	HCO002970, p57	No conclusive categorisation	HCO003779, p134	No conclusive categorisation	HCO003793, p20	B2	HCO003787, p40	B2 / B3	2 No conclusive categorisation	HCO000641, p20 HCO000641, p104	"Prior to admission to Gosport War Memorial Hospital on 6 August 1998 Mrs Wilkie received twenty four hour psycho geriatric care at Addenbrooke Residential Hospital. Mrs Wilkie was admitted to Queen Alexandra Hospital on 31 July 1998 with an unresolved UTI, decreased mobility and pyrexia. She was transferred to Gosport War Memorial Hospital on 6 April 1998 for a four to six week observation. The experts have noted that in the absence of any Medical Notes in respect of her final admission it is difficult to make a firm assessment. Dr Naysmith postulated that Mrs Wilkie would have died of her dementia in Gosport War Memorial Hospital whatever management had been carried out. A question was raised as to why a frail, elderly lady, with no malignant disease or fracture, required a dose of Diamorphine 30mgs over twenty-four hours but, in the absence of the above Medical Notes, the experts have felt it difficult to conclude, with any degree of certainty, as to their view of the level of the standard of care provided to this patient. No expert rated this case lower than 2B." (HCO002148, p11)
WILLIAMSON	**IVY**	HCO002970, p58	A1	HCO003779, p137	A1	HCO003793, p20	A1	HCO003777, p20	A2	A1	HCO000641, p104	"Mrs Williamson was seventy seven on her admission to Gosport War Memorial Hospital on 3 August 2000. Mrs Williamson had been admitted to Queen Alexandra Hospital in July 2000 after suffering a fall and was found to have large pulmonary metastasis. She was diagnosed as suffering with advanced metastatic malignant melanoma and was informed that her outlook was poor. Since her husband was undergoing bilateral knee amputations at the Royal Haslar Hospital it was decided to transfer them both to the Gosport War Memorial Hospital so they could be together as Mrs Williamson did not have long to live. Mrs Williamson became breathless towards the end of August 2000 and became pyrexial. She suddenly collapsed on 30 August 2000 and was commenced on small doses of Oramorph [morphine oral solution]. She was prescribed Diamorphine in case she was in pain and distress. She died on 1 September 2000. The expert review of this case confirmed that the analgesia, by way of Opioids, together with the sedatives were prescribed in only very small doses and for good indications." (HCO005689)

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WILLIAMSON	**JACK**	HCO002970, p59	A1	HCO003779, p140	A1	HCO003793, p21	A1	HCO003777, p21	A1	A1	HCO000641, p104	"Mr Williamson was aged eighty at the date of his admission to Gosport War Memorial Hospital on 29 August 2000. His previous history had included ischaemic heart disease and he had suffered for many years with leg ulcers. He had been admitted to hospital on a number of occasions and had had skin grafts taken to improve his legs. Mr Williamson eventually underwent bilateral below knee amputations on 18 August 2000 following which he was transferred to Gosport War Memorial Hospital for rehabilitation and, moreover, to be with his wife who was there having been diagnosed with cancer. Prior to his amputation he was on Morphine Sulphate 40mgs twice a day and needing Oramorph [morphine oral solution] 10mgs for breakthrough pain although this was stopped post operatively. On 31 August 2000 it was noted that his right stump area was sloughing and by 11 September 2000 there was oozing from both stumps. Microbiological testing confirmed MRSA in the wound on 16 September 2000 and consideration was given as to whether to transfer him to the surgical team at Haslar. On 17 September 2000 his condition deteriorated and it was considered that he was unlikely to survive much longer. He was commenced on Oramorph 2.5mgs four hourly. Mr Williamson died at 21.55 p.m. on 18 September 2000. The expert review of this case has confirmed that he was only given very small doses of analgesia appropriately at the correct dose." (HCO005690)
WILSON	**ROBERT**	HCO002970, p60	B3	HCO003779, p142	B3	HCO003793, p21	B3	HCO003778, p29	B3	B3	HCO000641, p102	The records indicate that Matthew Lohn did not produce a summary on Category 3 patients.

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WINDSOR	**NORMA**	HCO002970, p61	A3	HCO003779, p144	A3	HCO003793, p21	A1	HCO003777, p22	A3	A3	HCO000641, p102	"Mrs Windsor was admitted to Gosport War Memorial Hospital on 27 April 2000 complaining of weakness, exhaustion and depression following a recent bout of diarrhoea and vomiting. Prior to her admission, Mrs Windsor had been waiting a heart bypass following a sub endocardial infarction in 1998. On 5 May 2000 Mrs Windsor suddenly deteriorated with low blood pressure and a thready pulse. Mrs Windsor was transferred to St Marys General Hospital for acute medical care but died two days later. The experts in reviewing this case, have questioned whether the GP caring for her in Sultan Ward had appreciated how ill she had become. Differential diagnosis were considered including severe sepsis or an adrenal crisis. In the context of the investigation being undertaken by Op Rochester, it should be noted that there is no evidence of any significant analgesia being prescribed to Mrs Windsor while she was an inpatient at Gosport War Memorial Hospital." (HCO002663, p4)
Patient A	**Patient A**	HCO002168, p5	B2	HCO005394, p26	B2	HCO002168, p6	B3	HCO002168, p4	B2	B2	HCO000641, p102	No family consent.
Patient B	**Patient B**	HCO002164, p12	A2	HCO005394, p77	A2	HCO002164, p13	A2	HCO002164, p11	B3	A2	HCO000613, p11 HCO000641, p103	No family consent.
Patient C	**Patient C**	HCO002158, p8	B2	HCO005394, p52	B2	HCO003054, p6	A2	HCO002158, p7	B3	B2	HCO000641, p102	No family consent.
Patient D	**Patient D**	HCO002153, p7	A1	HCO005394, p20	A2	HCO002153, p8	A2	HCO002153, p6	B1	A2	HCO000641, p103	No family consent.

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Patient E	**Patient E**	HCO002161, p8	B2	HCO005394, p61	B3	HCO002161, p9	A2	HCO002161, p7	B2	B2	HCO000613, p10 HCO000641, p102	No family consent.
Patient F	**Patient F**	PLA000031 HCO002970, p16	A1	HCO003779, p42	A1	HCO003793, p7	A1	HCO116121	A1	A1	HCO000641, p104	No family consent.
Patient G	**Patient G**	PLA000032 HCO002970, p17	B2	HCO003779, p44	A2	HCO003793, pp7–8	B3	HCO003787, p8	B2	A2	HCO000641, p103	No family consent.
Patient H	**Patient H**	PLA000033 HCO002970, p18	A1	HCO003779, p46	A2	HCO003793, p8	B3	HCO003787, p9	A2	A2	HCO000641, p103	No family consent.
Patient I	**Patient I**	HCO002150, p8	A1	HCO005394, p8	A1	HCO003054, p5	A1	HCO002150, p7	1B 2B	2 No conclusive categorisation	HCO000613, p10 HCO000641, p103	No family consent.
Patient J	**Patient J**	HCO000168	A2	The Panel has not seen any documents	The Panel has not seen any documents	HCO000166, p2	A2	The Panel has not seen any documents	The Panel has not seen any documents	The Panel has not seen any documents	The Panel has not seen any documents	The Panel has not seen any documents.

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Patient K	**Patient K**	HCO002154, p7	A2	HCO005394, p24	A2	HCO002154, p8	A2	HCO002154, p6	B2	A2	HCO000641, p103	No family consent.
Patient L	**Patient L**	PLA000055 HCO002970, p40	A2	HCO003779, p93	A2	HCO003793, p15	A2	HCO001665, p4	A2	A2	HCO000641, p103	No family consent.
Patient M	**Patient M**	HCO003778, pp21–22	3B	HCO005394, p46	B3	HCO003054, p12	C3	HCO003778, p22	B3	B3	HCO000641, p102	The records indicate that Matthew Lohn did not produce a summary on Category 3 patients.
Patient N	**Patient N**	PLA000057 HCO002970, p42	A2	HCO003779, p99	A2	HCO003793, p16	B2	HCO003787, p30	A2	A2	HCO005281, p3 HCO000641, p103	No family consent.
Patient O	**Patient O**	HCO002970, p48	No conclusive categorisation	HCO003779, p114	No conclusive categorisation	HCO003793, p18	A1	The Panel has not seen any documents	The Panel has not seen any documents	No conclusive categorisation	HCO005152, p5	“There is a question amongst the experts as to whether the Medical Notes for this patient have been correctly identified. The files that I have been provided with relate to [Patient O] date of birth 20 April 1928, whereas the Officer’s Report deals with [Patient O] date of birth 7 June 1899.” (HCO001927, p2)
Patient O	**Patient O**	The Panel has not seen any documents	The Panel has not seen any documents	HCO005394, p58	No conclusive categorisation	HCO003054, p13	No conclusive categorisation	The Panel has not seen any documents	The Panel has not seen any documents	Lack of notes no grading	No conclusive categorisation	The Panel has not seen any documents.

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Patient P	**Patient P**	HCO002970, p54	A1	HCO003779, p127	B1	HCO003793, p19	A1	HCO000590, p4	B1	B1	HCO000641, p104	No family consent.
Patient Q	**Patient Q**	HCO002152, p11	A2	HCO005394, p17	A2	HCO003054, p16	A2	HCO002152, p10	B2	A2	HCO000641, p103	No family consent.