Portsmouth HealthCare NHS Trust MEMORANDUM

From

Operational Director

Ref

IP/db

Portsmouth Health Care NHS Trust

Received

-6 APR 2001

General Manager, Fareham / Gosport

То

Trust Board

CC

Fiona Cameron
David Barker
Lorna Green
Health Authority
Regional Office

04 April 2001

CONFIDENTIAL

Anticipated Further Media Attention

Following the recent media coverage regarding patient GR at Gosport War Memorial Hospital, as anticipated, another complainant, [Code A], has contacted the Evening News.

The Evening News plan to run a story based on Code A experience on Thursday April 5 2001.

Mr Wilson complained to the Trust about the care provided to his relative Code A, who died at Gosport War Memorial Hospital in 1998. The complaint was investigated internally but Code A was unhappy with the investigation and referred his complaint to the Health Service Ombudsman. In his recent report, the Ombudsman concludes that "I have not found evidence of unsatisfactory medical or nursing care and I am satisfied that Code A was not given excessive doses of morphine. I do not uphold the complaint".

The only criticism of the Trust made by the Ombudsman was for an error relating to the microfilming of some nursing records, for example fluid charts. This was identified and acknowledged by the Trust during the initial investigation and an apology given to Code A. The Trust has amended its microfilming policy following this complaint.

It appears that **Code A** will go to Gosport Police Station on Thursday morning and request the Police investigate his complaint as another unlawful killing.

The Trust's response to the Evening News has been:

- 1. To acknowledge that **Code A** complaint has been investigated by the Trust and the Ombudsman.
- 2. The Trust has co-operated fully with the Ombudsman's investigation.
- 3. The Ombudsman has **not** upheld **Code A** complaint.
- 4. The Trust identified and apologised to **Code A** for the error in microfilming medical records.

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- 5. The vast majority of the medical records were available for the Ombudsman to examine.
- 6. The Ombudsman's report makes clear that "although incomplete, the records provide evidence of nurses having systematically assessed [Code A] needs, formulated a care plan and delivered that care".
- 7. The Trust has amended its microfilming policy following this complaint.
- 8. If the Police wish to pursue an investigation into [Code A allegations, the Trust will co-operate fully with them.

For your information, please find enclosed a copy of the Health Service Ombudsman's Report into Code A complaint. Sections 24 to 28 summarise the Ombudsman's findings.

Code A



OFFICE OF THE HEALTH SERVICE COMMISSIONER FOR ENGLAND

Millbank Tower,	Millbank, London	1 SWIP 4QP
Fax: Code A	Telephone:	Code A

2.72 March 2001

Your Ref: MM/BM/ncd Our Ref: E2313/99-00



M Millett Esq
Chief Executive
Portsmouth Healthcare NHS Trust (Central Office)
St James' Hospital
Locksway Road
Portsmouth
Hampshire
PO4 8LD

Jan M. Millett

Thank you for your letter of 15 March about the draft report of the results of the investigation into the complaint to the Health Service Ombudsman by Code A against your Trust. I am grateful to you for replying so promptly.

In accordance with statute, I now enclose a copy of the final report which has been sent to Code A A copy of the report has also been sent to the Secretary of State for Health. It is for your Trust to decide on, and arrange, any distribution of the report to staff directly concerned.

I am grateful to you for the additional information provided about the action your Trust has taken to prevent a recurrence of the error which led to some of **Code A** medical records being destroyed prematurely. Paragrah 29 of the report has been amended accordingly.

As Mr Jones said in the penultimate paragraph of his letter of 28 February, it is now open to you to write direct to Mr Wilson if you wish.

Code A Code A

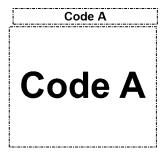
COLIN HOUGHTON Investigations Manager

Enc: 1



Health Service Commissioners Act 1993

Report by the Health Service Ombudsman for England of an investigation into a complaint made by



Complaint against: Portsmouth Healthcare NHS Trust

Complaint as put by Code A

1. The account of the complaint provide	ed by Code A was that on 25 October
1998 his late mother, Code A	fell and broke her hip. Code A was
admitted under the NHS to Royal Hospi	ital, Haslar (the first hospital), which is
administered by the Ministry of Defence. V	
an operation on her hip, after which she i	made a steady recovery. On 29 October
Code A was able to sit out of bed and	by 3 November she could be pushed in a
wheelchair to the hospital shop and cafete	eria. By 6 November she was no longer
taking painkillers and on 11 November	she was transferred to Dryad Ward at
Gosport War Memorial Hospital (the sec	cond hospital). The second hospital is
administered by Portsmouth Healthcare NF	HS Trust (the Trust).
2. When Code A visited Code A condition had deteriorated. Code A bell On 14 November Code A complained a under and on 15 and 16 November he notice 17 November Code A noticed that C to the attention of a nurse and asked that informed Code A that a drip was not aw was asked to leave the hospital. On the formed	lieved that Code A had been sedated. about the level of sedation his mother was ced an improvement in her condition. On Code A was dehydrated and brought this Code A be put on a drip. The nurse vailable, a dispute ensued, and Code A

was asked to review Code A treatment. As a result of this Code A was
given subcutaneous fluids. Code A condition continued to deteriorate and on
23 November instructions were given for diamorphine to be administered
subcutaneously if required. Code A died of bronchopneumonia on 3 December 1998.
3. Code A had written to the medical director on 27 November 1998 complaining about the care was receiving at the second hospital. The chief executive of the Trust replied in January 1999 and Code A met the medical director in February. In September the Trust arranged for an independent clinician to review Code A care. Code A remained dissatisfied and requested that an independent review panel be convened to consider his complaint. The Trust's convener refused that request.
4. The matters subject to investigation were that:
(a) Gode A did not receive reasonable medical and nursing care after her transfer to the second hospital on 11 November 1998; and
(b) the doses of morphine administered to Code A after her transfer to the second hospital were excessive.
Investigation 5. The statement of complaint for the investigation was issued on 25 May 2000. The Trust's comments were obtained and relevant papers were examined. Those papers included records of CodeA care and treatment in the first and second hospitals, correspondence concerning CodeA complaint to the Trust, and the written observations of the consultant geriatrician (the consultant) responsible for CodeA care while she was a patient in Dryad Ward. I obtained advice on the medical aspects of the complaint from one of the Ombudsman's professional advisers. Another of his professional advisers gave help with the nursing aspects. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked.
6. The investigation was somewhat hindered as a result of the Trust being unable to supply all of the records relating to Code A care and treatment in the second hospital. In April 1999 the original records were sent for microfilming and

destruction. The Trust's policy required some documents, such as temperature charts and daily fluid balance charts, to be destroyed without being microfilmed. As a result I had access to only those documents which had been microfilmed and I could not be certain what other documents existed before their destruction. The early destruction of the records was contrary to the Trust's own policy and went against official guidance. The Trust expressed their deep regret for what had happened and said that it was the only time such an error had been made. I return to this issue in my findings and conclusions.

Code A evidence
7. In letters to the Ombudsman's office Code A wrote that he could see no
reason, in the light of Code A not needing morphine based drugs during the last
week of her stay in the first hospital, why she was given such medication within 24
hours of being transferred to the second hospital. He did not accept the Trust's
explanation that Code A needed the medication because she had developed
extremely painful pressure sores and had pain in her neck and back.
Notwithstanding those problems Code A considered that the choice of
medication was inappropriate and that his mother was given excessive amounts of
oramorph and diamorphine (both of which contain morphine). His other main
concerns centred around what he saw as a failure to try and help Code A regain
her mobility and a failure to ensure that she did not become dehydrated.

The Trust's formal response to the complaint

8. In their formal response to the complaint the Trust commented as follows:

'We do not consider that Code A complaint is justified and wholly reject
his previously stated claim that Code A was "helped on her way". We do
recognize, however, that we may have failed Code A by not helping him
to a better understanding of his mother's prognosis. In the course of our
investigation, a number of areas where practice could be improved were
highlighted. We do not believe, however, that these areas contributed to Code A
Code A deterioration nor to her subsequent death. This view was upheld by
[the independent clinician who reviewed the complaint in September 1999].'

After commenting on individual aspects of the complaint the Trust gave details of the areas of practice which, following the meeting in February 1999 between Code A and the medical director, they had undertaken to review. They were:

admission protocols, including support for relatives; pain control; fluid protocols; and medical cover during weekends and bank holidays.

Code A clinical and nursing records
9. Entries in the clinical and nursing records relating to the time Code A was a
patient in the first hospital include a post-operative instruction indicating that she
should be helped to regain mobility as soon as possible. Another entry, made on the
day of Code A hip operation (26 October 1998), records that a doctor had
spoken to Code A and told him she was unlikely to recover. Over the next few
days I Code A condition fluctuated a little. On 29 October it was recorded that
she was chesty but felt better after sitting up in a chair. The next day there are
entries in the nursing records indicating that Code A heels and sacrum were
red. On 31 October a nurse recorded that she was much improved and had tried to
walk but with little success. Her pressure areas continued to be a cause for concern
and on 2 November, when a doctor recorded a 'dramatic improvement in her
general state', there is a note that the area around her sacrum was deteriorating.
10. On 3 November the records show that a referral was made to the consultant for
her advice on I Gode A future management. In a note to the consultant a doctor
wrote that Code A was 'sitting out and beginning to mobilise', but the nursing
records for that day included an entry stating that 'mobility remains poor'. After
seeing Code A on 5 November the consultant wrote:
' Code A son and daughter-in-law were present when I visited and
I have pointed out to them that rehabilitation was going to be very difficult
given her mental state and pressure sores. They have agreed to a month's
gentle rehabilitation in a NHS continuing care bed for a month initially.
Unless there is a dramatic improvement I feel she will need a nursing
home'.
nome.

The nursing records for the remainder of Code A time in the first hospital show that, despite regular attention to her pressure areas and the use of a special mattress, by the time of her transfer to the second hospital the sores on her heels had blackened and she had a sore on her right elbow. Other entries indicate that during the latter part of her stay in the first hospital the staff there were experiencing difficulty maintaining a satisfactory fluid balance. She also had oedema (an accumulation of fluid) in both legs and her left arm.

11. The prescription and drug administration records in respect of Code A stay in the first hospital show that on 25 October she was prescribed morphine, 10 mg to be given as required. Only one dose was given, at 1.15am on 26 October. A prescription was also written that day for up to two tablets of co-codamol to be given as required. (Co-codamol is a proprietary non-opioid drug used for pain relief – it does not contain morphine.) Scode A was given co-codamol 14 times between 25 October and 5 November, but none after that. Between 6 and 11 November she was given no pain relief medication other than aspirin.	
12. The prescription and drug administration records in respect of Code A stay in the second hospital include a prescription dated 11 November authorising the administration of co-codamol, if required; Code A was given two tablets at 8.30am the next day. Later on 12 November a doctor wrote a prescription for 2.5 mls to 5 mls oramorph (a solution that would have contained 5 mgs to 10 mgs of morphine) to be given orally, as required, at intervals of four hours or longer. That afternoon, Code A was noted to be in a great deal of pain and was given 2.5 mls of oramorph at 2.05pm. She was given a further 2.5 mls at 6.30pm and 5 mls at 10.37pm. The two evening doses were given after nurses observed that Code A was still in pain.	
13. Between 13 November and 24 November Code A was given a total of 15 further doses of oramorph. No dose exceeded 5 mls and she was never given more than two doses in one day. On 24 November, a doctor wrote a prescription for diamorphine to be given subcutaneously on a regular basis. Code A was given 20 mgs of diamorphine each day between 24 and 30 November. On 1, 2 and 3 December she was given 40 mgs each day. The nursing records indicate that Code A was in pain on the day she was admitted to Dryad Ward and there are many subsequent references to her being in pain and needing pain relief to help her sleep at night.	
14. On 14 November the ward manager recorded at 4.30pm that Code A had expressed concerns about the amount of sedation being given to his mother. On checking Code A she was described as 'rousable but not very communicative'. She had been given 2.5 mls of oramorph at approximately 10.35 am that day. The ward manager's note continued:	

"Code A is aware of [Code A] poor prognosis [and] that she may need opiates to control her pain [and] he agrees to this'.
15. An entry made by one of the doctors who attended Code A referred to a conversation which she had had with Code A during the evening of 17 November. She wrote:
Code A seen. Very angry. Feels his mother is not being cared for adequately, is accusing nursing staff of murdering his mother by giving her oramorph She is clearly in distress when moved e.g. for washing/dressing and as such does require analgesia Code A is not happy for her to have any analgesia). She is clearly also very poorly and I do not feel any active intervention is appropriate'
After discussion with the consultant the doctor concerned wrote a prescription for Code A to be given fluids, subcutaneously (under the skin).
16. A slightly later entry, in the nursing records for 17 November, referred to a conversation which one of the nurses had with Code A She wrote:
Code A expressed his dissatisfaction with the treatment at [the second hospital]. He was concerned his mother was nursed in bed, did not have [intravenous fluids] in progress and had been given oramorph.
'Explained she was in bed because she had pressure sores on admission and was nursed on a pressure relief mattress.
'That I did not comment on the use of [intravenous] fluids as it was not my area of practice and that oramorph was used as [Code A] was in pain. [Code A] was verbally abusive to myself and the doctor'
In a further entry the nurse wrote that [Code A] had requested, and been given, a complaints form before leaving the ward and saying that he would not be coming back.
17. Another entry that evening, by the hospital's medical director, records that is

despite Code A wishes to the contrary. Because Code A was incapable of
making decisions for herself the staff should act in what they believed to be her best
interests. In order to increase Code A intake of fluids the medical director
approved their administration, subcutaneously, for between five and seven days, to
see if her condition improved. In doing so, he expressed concern that, in view of her
general condition, giving fluids might not be appropriate. The medical director
returned to the ward at 8.00am the next day in order to check on Code A
18. The next day, 18 November, a nurse wrote that staff and the police had tried to
contact Code A but that he was not at either of the addresses in the hospital's
records and the telephone number in the records was unobtainable.
19. As at the first hospital, the staff at the second continued to nurse Code A
on a special mattress designed for patients with pressure sores, or at risk of
developing them. Her Waterlow score (giving an indication of the degree to which
her pressure areas were at risk) was assessed on 11 and 23 November. Her scores
on both those dates identified her pressure areas as being at very high risk. Staff
also assessed her level of dependency on those days. She was incontinent of urine
and faeces, and was totally dependent on staff for bathing, dressing and grooming.
On 11 November she was described as needing help to feed herself but by 23
November she was unable to do so at all. With regard to her mobility she was
assessed on both occasions as being completely dependent on others, unable to
stand, and unable to transfer (e.g. from her bed to a chair) without a hoist.
times, and analysis to maneral (vig. nominor out to a chair) without a motor
20. On 11 November a care plan was produced with details of the action that was
to be taken to address Code A needs. Among other things she was to have
regular mouth and pressure area care, be encouraged to take food and fluids, and
receive adequate pain relief at night. Documents recording the care that was given
indicate that her mouth care and personal hygiene were attended to daily. There are
entries, on 14 November and 17 November (before Code A was given
subcutaneous fluids) recording that her urine was either dark or concentrated, and
that she was to be encouraged to drink more fluids. Corresponding entries
elsewhere in the records indicate that on 13 and 14 November Code A could
manage only small amounts of food and fluids and that staff continued to encourage
them after 17 November, when fluids were being given subcutaneously. There are
specific entries relating to pressure area care given on 13, 14, 20 and 22 November,
and to Code A being turned and encouraged to lie on her side. On other dates

nurses recorded that care was given fully in accordance with the nursing care plan. The plan included instructions on how Code A was to be moved and on the care and treatment of her pressure areas.

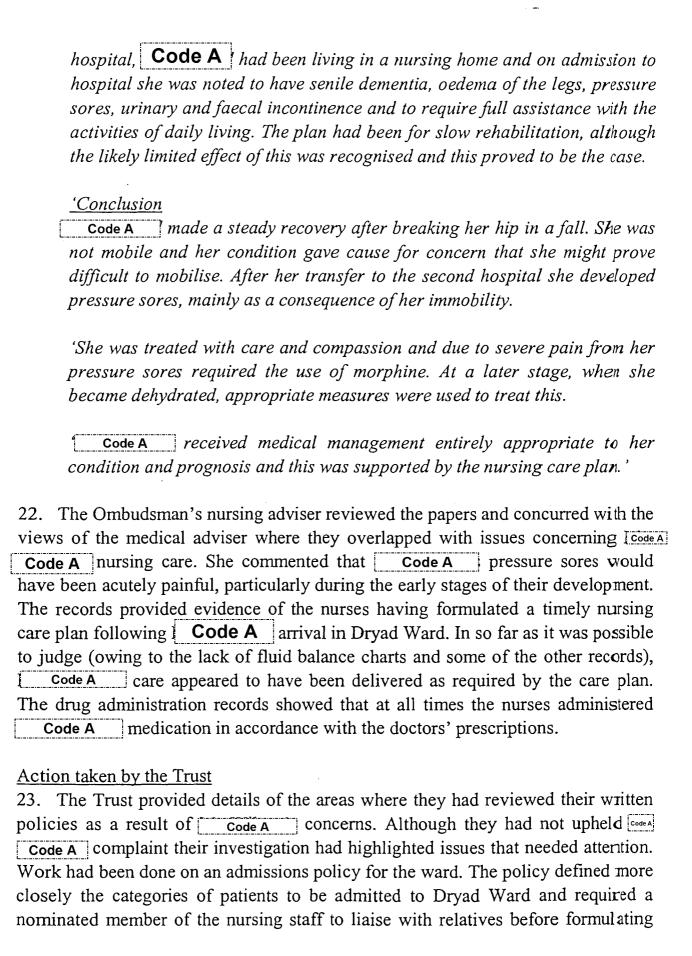
Advice of the Ombudsman's Professional Advisers

21. The Ombudsman's medical adviser, Dr Ann Naylor, M.B., B.S., F.R.C.A., a consultant anaesthetist with wide experience in an acute pain team and in palliative medicine, commented as follows:

'Having reviewed the clinical and nursing records on the	complaints file, I
consider that the choice of pain relieving drugs for	Code A was
appropriate in terms of the type of drug, doses, methods	of administration
and frequency of administration. Staff were correct in the	rir judgement that
Code A required palliative care (active total care for	r a patient whose
disease is not responsive to curative treatment). The drug	s and doses used
are within the ranges recommended in the BNF (British Na	tional Formulary)
for palliative care. There is no evidence that Code A	received excessive
doses of morphine.	

'In my view, the same comments could be made about the management of Code A hydration. When Code A was admitted, she was able to take small amounts of fluid and food with assistance. There is no evidence that Code A was not sufficiently encouraged to drink during her first week on Dryad Ward. Over enthusiastic attempts to encourage a patient to drink can be very disturbing and not in their best interest. When her condition deteriorated, an appropriate regime of subcutaneous fluids was instituted. Earlier use of subcutaneous fluids would have made no significant difference to the outcome.

Following the fall when she broke her hip, Code A did not regain mobility. She was able to sit out of bed with assistance and at one time was fit to sit in a wheelchair. There is evidence of the staff having kept this aspect under regular review and I am convinced that all was done that could be done to increase Code A mobility. Given her age, her general physical and mental health, and her recent fracture, sadly it was impossible to improve her mobility and she developed pressure sores which made attempts at mobilisation considerably more difficult. Prior to her admission to



the nursing care plan. There was now an agreed policy for the prevention and management of malnutrition, under which every patient was assessed on admission to ascertain the degree to which s/he was at risk of malnutrition and to help identify the appropriate nursing interventions. A multi-professional policy was also being prepared for the assessment and management of pain, with patients' needs being reviewed on a regular basis. In addition to that the Trust had introduced new forms for the prescribing and administration of drugs using a syringe driver (an automated device for delivering a preset dose of medication). Since February 1999 consultant cover on the ward had been increased from one ward round every fortnight to one every week.

Findings.

- 24. The Ombudsman's medical adviser has stated that in her opinion the medical management of Code A was appropriate, having regard to her condition and prognosis. I see no reason to believe otherwise. In caring for Code A the staff had to strike a balance between doing all they could to facilitate her rehabilitation (as long as that remained an option) and not doing anything that would cause her unnecessary suffering. I believe they approached Code A management in a considered and professional manner. Sadly, Code A prospects of recovery were very poor. That was explained to Code A while his mother was in the first hospital, and after she was transferred to the second.
- 26. Central to Code A concerns was his belief that the medication his mother was given was excessive. In his correspondence with the Trust he placed much emphasis on the fact that she had needed no pain relief during her last week in the

first hospital. I can see how it might have appeared to him that the second hospital were giving Code A more medication than she needed; however the records show clearly that she was in a great deal of pain and that pain relief was essential for her comfort. As for the choice of oramorph and diamorphine, the dosages prescribed, and the frequency of administration, the Ombudsman's medical adviser has commented that those were appropriate in the circumstances. I see no reason not to accept her view.
27. In their formal response to the complaint the Trust commented that they may have failed Code A by not helping him to a better understanding of his mother's poor prognosis. It appeared to Code A that his mother was improving up to the time she was transferred to the second hospital. His hopes may have been heightened by the consultant's plan 'for a month's gentle rehabilitation' and the prospect of her eventually going to a nursing home. It is entirely understandable, therefore, that he was greatly upset by the changes which followed so soon after Code A move to the second hospital. It seems, however, that when he raised his concerns on 14 November, the nurse to whom he spoke believed that she had reassured him. It was only later, on 17 November, that the full extent of his feelings became apparent, and for a time after that the staff were unable to contact him. In the circumstances I consider that the staff probably did all they could to try and help
28. To sum up, I have not found evidence of unsatisfactory medical or nursing care, and I am satisfied that Code A was not given excessive doses of morphine. I do not uphold the complaints.
Conclusions My findings are given in paragraphs 24 to 28. I have not upheld the complaints. However, I hope that the Trust's actions following Code A complaint to them will reassure him that his concerns have resulted in improvements being made. I have been told by the Trust their procedures have also been improved to ensure that errors in the selection of records for microfilming are picked up before the records are destroyed. In addition to that the Trust have extended their microfilming

contract to include fluid charts and other items of clinical relevance which were not previously filmed. I regard that as a satisfactory outcome to my concerns about the premature destruction of some of the records in this case.

Code A

Colin Houghton
Investigations Manager
duly authorised in accordance with
paragraph 12 of Schedule 1 to the
Health Service Commissioners Act 1993

22 March 2001