HAMPSHIRE CONSTABULARY

HENRY AUBREY

DOCUMENT RECORD PRINT

Officer's Report

Number: R11G

TO:
STN/DEPT:

REF:

FROM: Code A YATES
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 23/01/2003

Sir,

Re Action 186

I visited Margaret Yvonne BARNEY (Code A
(Code A on 16th January 2003 (16/01/2003).

Mrs BARNEY wished to report her suspicions about the death of her mother Edith Mary AUBREY nee LEE-LOVEJOY at the Gosport War Memorial Hospital on 15th June 1996 (15/06/1996) and that of her father Henry Charles AUBREY on the 2nd June 1999 (02/06/1999). The circumstances are as follows. Mrs AUBREY who was born on Code A was divorced from her husband and was referred to a psychiatrist in 1991 suffering from paranoid thoughts and depression. She was treated as a day patient at Addenbrook where she received some form of injections, believed weekly, for this disorder. Some when just before 1994 she was being cared for at Treloare Rest Home, Anglesea Road, Alverstoke and during this period she suffered a fall. Mrs AUBREY was taken to the QA Hospital where she was treated and then admitted to Daedalus Ward at the Gosport War Memorial Hospital where she spent the rest of her life. Mrs BARNEY stated that the care at the hospital was good at first but towards the end of her life she was placed on Diamorphine via syringe driver and was heavily sedated. Mrs AUBREY died on 15/06/1996 and the certificate was signed by Dr Jane BARTON giving the cause of death as bronchopneumonia and senile dementia, she was buried at Henley Road Crematorium.

Mrs BARNEY queried the death of her mother at the time and entered into correspondence with the hospital. Mrs BARNEY stated that in her opinion, her mother was administered Diamorphine via syringe driver to advance her demise and questioned why fluids or nourishment by drip had not been given. She received a reply from Dr LORD who explained that Mrs AUBREY's mental and physical condition had deteriorated by early July 1996 and she was becoming increasingly anxious and distressed. It was felt that Diamorphine administered via a syringe driver would alleviate the distress, anxiety and discomfort she was suffering. A drip would have provided some fluids but no nourishment, her deterioration was gradual and the overall outlook was poor. Dr LORD did not consider it appropriate under these circumstances to either give fluids by drip or feed by naso-gastric tube.

Henry Charles AUBREY (Code A was admitted to the Royal Navy Hospital Haslar in May 1999 with a throat ailment and was diagnosed as having throat cancer. Two weeks later (01/06/1999) he was

transferred to the GWMH where he died the next day (02/06/1999). Mrs BARNEY did not have much more information on her father other than his death was certified by Dr BARTON and the cause of death was given as Carcinoma of Bronchus and left ventricular failure.

Both her parents were patients of Dr EVANS and Partners, Gosport Health Centre, Bury Road, Gosport .

Mrs BARNEY states that her sister Mavis BARKER of Code A Code A is also interested in the outcome of this investigation.

I informed Mrs BARNEY that Operation Rochester is an ongoing police investigation which will take some time before it reaches a conclusion. I have given her a contact number for Operation Rochester and informed her that the FLO Code A would make contact in the near future.

HENRY AUBREY

Henry Aubrey

Date of Birth: Code A Age: **88**
Date of Admission to GWMH: **1st June 1999**
Date and time of Death: **18.30 hrs on 2nd June 1999**
Cause of Death:
Length of Stay: **1 day**
Post Morten: **Cremation**

Mr Aubrey's past medical history:-
CA Lung
Left plural effusion 2nd to CA lung

In May 1999 Mr Aubrey had cancer of the lung and was given the news that he had months to live. He had been married twice, his first wife died and after five years he remarried. He had a daughter who lived in Reading but was estranged from the rest of his children. His wife was his main carer and had been very supportive but was finding it increasingly difficult to cope with him as he appeared to have given up. Mr Aubrey was admitted to the Gosport War Memorial Hospital on 1st June 1999 from Haslar Hospital. It was noted that he was referred for support and with increasing shortness of breath.
On admission the nursing needs assessments of sleeping, personal hygiene, moving and handling and a mouth assessment were completed.

1st June 1999

Admitted to Gosport War Memorial Hospital from Haslar Hospital with CA lung and left venticular failure. S.C. analgesia was prescribed.
Mr Aubrey was transferred to Dryad Ward for continuing care.
The nursing notes state Mr Aubrey has increased shortness of breath, confused, disorientated and has a poor diet and is unwilling to mobilise.
A care plan for sleeping was commenced which noted that Mr Aubrey had no complaints of pain. An assessment also identified personal hygiene and constipation as problems and care plans were made.
A handling profile was completed. Mouth care assessment done.

2nd June 1999

The nursing notes state **Fentanyl patch given at 15.30 hours and oramorph 10mgs also given.**

Suggest syringe driver 60mgs diamorphine. Mr Aubrey is noted to be drowsy. Review dosage if persistently drowsy.
11.45 hours Mr Aubrey unresponsive – pulse strong. Not distressed at all now.
Dr Barton visited and was satisfied with condition.
Family contacted.
Deteriorated, 18.30 hours died wife present. For cremation.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**

Code A) **HENRY AUBREY** **BJC-05**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Terminally ill and uncomfortable, but high doses, especially of midazolam		
Unexplained By Illness C				

General Comments

Very distressed on morning of 2nd June 1996.
Syringe driver commenced, with
diamorphine 60 mg/24h ≡ 30 mg morphine every 4 h
midazolam 40mg/24h, i.e about 660 micrograms/kg/day, or 25 micrograms/kg/hr
[of the same order as given on ITU for sedation]

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/05
HENRY AUBREY
87

Unproven but probable diagnosis of lung carcinoma

No records for episode prior to transfer to Dryden except Dr Reid's letter and nursing transfer letter. Neither mention significant pain. Dr Bee Wee mentions opiates for control of cough.

Was on oramorph 10mg BD on 25/5/99
Transferred to Dryden on 1/6/99
Immediately put on fentanyl 25mcg patch and also given oramorph 10mg
Following day at 09.25 given syringe driver with 60mg diamorphine and 40mg midazolam. He died at 18.30

He had a terminal diagnosis and was recognised to have given up.
However the need for such a large dose of diamorphine is unclear (distress is mentioned but not pain).

PL grading B3 because the doses cannot be justified by the available notes.

Exhibit No	Patient Identification	Assessment Note	Assesement score
BJC/05	Aubrey, Henry	Terminally ill on admission with ca lung. Rattly cough described before leaving Haslar, which is never a good prognostic sign. Breathlessness was main symptom. Had been on low dose opioids in Haslar, apparently with benefit, but these appear not to have been continued to the date of transfer, or at least they are not listed on the transfer letter. Was immediately started on high dose opioid – fentanyl on the day of admission, then high dose diamorphine and midazolam the following morning. Even given that his distress on the morning of 2.6 was agonal, and not related either to opioid toxicity or a reversible chest infection, management was with excessive doses of diamorphine and midazolam. Even had fentanyl 25mcg been an appropriate starting point (which is questionable given his previously low intake) it would have just reached saturation point probably by the following morning and would have remained in his system after removal (assuming it was removed – not mentioned in medical or nursing notes) for 13-17 hours. To change to diamorphine 60mg/24 hours (which is 50% more in equivalent dosage) with no allowance for washout would have meant effectively a higher level of opioid during the day of death. And midazolam 40mg/24 hours is a very high starting dose which, because no loading dose was given, should theoretically have taken about 10 hours to reach steady state. In fact, he was unresponsive in a little more than 2 hours, suggesting these doses were excessive. They may have accelerated death, though probably only by days to a week or two.	B3

Expert Review

Henry Aubrey

No. BJC/05

Date of Birth: Code A

Date of Death: 2 June 1999

Mr Aubrey was admitted to the Royal Haslar Hospital 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 records 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 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.