Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7V

TO: REF:
STN/DEPT:

FROM: Code A REF:
STN/DEPT: MCD E TEL/EXT:

SUBJECT: DATE: 04/08/2003

I visited Code A at her home address on Tuesday 29th July 2003 (29/07/2003) in relation to her aunt, Code A Code A b Code A

Code A will say that Code A was born in Ireland and moved to the UK, specifically Gosport whilst in her late teens.

She met and married Code A and lived at Code A They had no children Code A

Code A was in the ATS during the war and afterwards worked in Gosport as an assembler in the Ultra factory (electrical components).

She is described as being in good health and travelled extensively. She was visited and spoken to regularly by her family in Ireland.

As she grew older, her mobility decreased and she altered her accommodation to suit her needs (living on the ground floor only). Around Christmas 1994 Code A fell and hit her head.

In February/March 96 the family were contacted and informed that Code A had again suffered a fall.

They visited her at home and could see the deterioration in her health. She was admitted to the Queen Alexandra Hospital, Cosham where she underwent surgery. From there she was discharged to the Gosport War Memorial Hospital and placed in Mulberry Ward.

Family members visited her, she was dressed and sitting in the day room. At this point Code A was unintelligible in her speech but she was alert and fully aware of what was going around her. Approximately one month later the family were contacted and informed that the doctors were going to section Code A under the Mental Health Act and that she was to receive electric shock treatment for her condition.

Code A believes it was at this point that her aunt was moved to Daedalus Ward.

On Friday 31st May 1996 (31/05/1996), Code A contacted the hospital in order to speak to the

doctor in charge of her aunts case. During the course of the conversation the doctor informed her that Code A had died that day.

On Saturday 1st June 1996 (01/06/1996) Code A went to the GWMH in order to establish what had happened and to make the necessary arrangements for her aunts funeral. She was not able to speak to any medical staff as there were none in attendance and neither was she able to see her aunt as no one knew where her remains were.

Code A then went to arrange the funeral and chose to use the same funeral directors who dealt with her uncles funeral in 1980, these being, Crossland Undertakers in Gosport.

Code A visited the premises in person and having explained that she was unable to say where her aunts remains were, was informed by Mr CROSSLAND that Code A remains were at his funeral parlour. He would not let Code A view her aunts body, saying that he hadn't yet prepared her yet.

He also informed Code A that he would obtain the necessary documentation and take it to the registrar in order to register the death.

On Monday 3rd June 1996 (03/06/1996) Code A spoke with a member of the medical team and was informed that her aunt had died whilst receiving her electric shock treatment. She was informed that it was "very unusual circumstances".

Code A made notes of the conversation concerning Code A having the treatment and noted that her aunt did not have cancer.

When Code A went to register her aunts death on 6th June 1996 (06/06/1996) she discovered that her aunt had undergone a post mortem and that cancer was a cause of death.

Code A doctors were Dr BANKS , Dr MUNRO and her GP was Dr DOWNEY .

Her death was certified by J R KENROY , Coroner for Portsmouth and South East Hants. Code A was cremated at Portchester Crematorium.

The family is concerned about the speed of Code A demise, the fact that her body was released to an undertaker without any consultation taking place.

Included with this report is Code A death certificate and a copy of a letter sent to Liam DONALDSON .

Code A

Code A

Date of Birth: Code A Age: **86**
Date of Admission to GWMH: **20th May 1996**
Date and time of Death: **09.50 hours on 31st May 1996**
Cause of Death: **1. (a) Carcinomatosis**
(b) Carcinoma of sigmoid colon
2. Multi infaract dementia. Chronic renal failure

Post Mortem: **yes**
Length of Stay: **11 days**

Code A past medical history was noted to be:-

- Right CVA
- IHD
- DM
- Epilepsy
- HTN

Code A was born in Southern Ireland and moved to England when she was 20 years old. She was married but her husband died suddenly after the war. They had no children. Code A was a retired clerical worker who lived in her own home. She had a home carer and a good neighbour who did her shopping, washing and cleaning. Code A had a nephew who was noted as her next of kin. Code A was becoming increasingly confused and not eating. There was some evidence of self-neglect and poor mobility. Code A was admitted to Gosport War Memorial Hospital on 3rd May 1996 but after developing swallowing problems was transferred to Queen Alexandra Hospital on 9th May 1996 for investigations into possible carcinoma. After test results being negative Code A was transferred back to Gosport War Memorial Hospital on 20th May 1996.

Care plans commenced for total assessment, dietary intake and fluid intake.
A lifting/handling risk calculator was recorded with a score of 23 recorded.
When Code A was transferred to Daedalus ward on 29th May 1996 care plans were commenced for hygiene, catheter, at risk of pressure sores, nasogastric food tube and settle at night.
A Barthel ADL index was completed with a score of 1 recorded.

A Waterlow was also completed with a score of 18 noted.
A nutritional assessment plan also commenced on 29th May 1996 as Code A was fed via a nasogastric tube.

Daily summary
3rd May 1996
Clinical notes – emergency admission with increased confusion, self-neglect and poor mobility. Needs full assistance.
7th May 1996
Clinical notes – swallowing problems.

9th May 1996
Clinical notes - transfer agreed to Queen Alexandra Hospital. Possible carcinoma.
20th May 1996
Transfer form – self-neglect/depression. Poor nutritional and fluid intake. Sacrum red but not broken.
Clinical notes – transferred back to Gosport War Memorial Hospital, Mulberry Ward. No carcinoma.
Nursing notes – transfer back from Queen Alexandra Hospital. Remains on IVI normal saline. Assessed for ECT. Quite cheerful.
21st May 1996
Clinical notes – alert, refusing oral fluids and medication. Says she does not want examination and treatment. Moderate dehydration for IV fluids. Very depressed and very confused. Discussed ECT with nephew. Right arm swelling. Dr Banks to review.
Nursing notes – IV drip running. Encourage to take sips of drink.
22nd May 1996
Clinical notes – slow IV fluids.
Nursing notes – restless night – drip would not run through. Taken small diet but no fluids. Refused medication. Mood very low. Does not want ECT. Hand/arm noticed to be swelling. Dry draining into tissues arm to be elevated.
23rd May 1996
Clinical notes – is accepting liquid and porridge says she does not want ECT. Discuss with Dr Banks with hold ECT for moment.
Nursing notes – catheter draining. IV running. Full nursing care given. Ate some porridge but refused lunch.
24th May 1996
Clinical notes – secondary hypoparthyroidism. Need transfer for long-term investigations. For IV fluids. Chest clear.
Nursing notes – full nursing care given. IV continues. Seen by Dr Munroe small amount of blood found on sheet ? from urethra or rectum.
26th May 1996
Nursing notes – restless. Food taken but no fluids.

27th May 1996
Clinical notes – breathing very noisy. Looks dehydrated, mouth very dry. Encourage oral fluids.
Nursing notes – breathing noisy. Seen by doctor. Few sips oral fluids but refused diet.
28th May 1996
Clinical notes – physically less well despite rehydration. Drowsy, apathetic. Oral intake negligible. Refusing medication.
Agreed to NG tube for feeding. ECT treatment might make a difference. No for NG tube at present. Code A refusing ECT treatment.
General deterioration over weekend. Refusing food and drink. Withdrawn eyes closed. Not keen ECT. Section 3 and Section 62 Mental Health Act explained to niece fully appreciates this course of action.
Nursing notes – refusing fluids/diet. Very withdrawn. To be placed under section 3 of the Mental Health Act and section 62 for 2 emergency ECT's.
29th May 1996
Clinical notes – treatment plan and review. Plan for up to 12 ECT treatments bilateral to start with then change to interim? Once eating and drinking. Consider future at home. ? res care with family.
Nursing notes – transferred to Daedalus Ward.
Transfer form – low in mood. Not eating or drinking. Pressure areas intact. Immobile at present. All nursing care needed. Nursed on pegasus mattress.
Summary – Transfer from Mulberry ward after ECT treatment. Commence NG feeding. Further ECT treatment on Friday. Seen by Dr Banks – nil ordered. Slept for short periods.
30th May 1996
Clinical notes – ECT required and performed. Issued form to authorise 11 more treatments.
Nasogastric feeding continues with pump for ECT tomorrow.
Summary – seen by dietician. Tolerating NG feeding. Code A continues to refuse all fluids and diet. Complaining of pain ? heartburn. Oramoph prescribed by duty doctor. 20.40 hours oramorph given 2.5mls with good effect. No further chest pains.
31st May 1996
Clinical notes – ECT (2nd treatment carried out) at 9.15am. Started breathing after anesthetic about 9.40am. Vomited coffee ground vomit. Aspirated but no response to oxygenation. Certified death at 09.50 hours by anesthetist Dr Page. Nasogastric tube removed after death. Death reported to coroner's office.
Summary – transfer to Phoenix Day Hospital for ECT.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
Code A 1909-06-03 Q621536

Exhibit number
BJC-59 [Hants 03001]

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B	Clearly extremely ill, and apparently very depressed. ECT sounds reasonable; consequence not directly foreseeable.	Poor prescription for Diamorphine, but none given; oramorph irrelevant		
Unexplained By Illness C				

General Comments

84-year-old widow and retired clerical worker, living alone, stroke 10 years before

1996-05-03	EA. Confusion, falls, self-neglect, poor mobility; MTS 5.5/10
1996-05-08	Calcium 3.05 (albumin 33; 3.19 corrected)
1996-05-09	Transferred to QA
1996-05-14	Pamidronate infusion
1996-05-20	ReAdmitted GWMH. No c/a lung, breast, no myeloma, ESR normal; await PTH
1996-05-23	Creat 52, PO4 0.17, Ca 1.6, Alb 22, K 4.1
1996-05-29	Decision taken to section for compulsory treatment; has first ECT
1996-05-30	Transferred from Mulberry to Daedalus; prescribed DIAMORPHINE 40-100mg; but in fact only received Oramorph 2.5 mg x 1 at 20.48 hours
1996-05-31	'2nd treatment' ECT, then sweating, vomiting coffee grounds, and aspirated. Died. PM = carcinomatosis + carcinoma sigmoid colon + multiinfarct disease

Final Score:

Screeners Name: R E Ferner
Date Of Screening: 27th December 2003

Signature

BJC/59

Code A

86

Vascular dementia with a previous stroke. Depressed and not eating or drinking. She was transferred for improvement of her medical condition ie high serum calcium and renal impairment. She was then transferred back but deteriorated and it was decided to feed via an NG tube and perform ECT. She died at the time of ECT. Her NG feed had been stopped at an appropriate time before ECT and I can find no real problems with her management.

PL grading 1A
Group grade 1A

Exhibit No	Patient Identification	Assessment Note	Assessment Score
BJC/59	Code A N 70 /	Two sets of notes and the wrong date of death on the index – actually died on 31.5.96. Emergency admission to Dr Banks care on Mulberry, GWMH, with self neglect. Found to be hypercalcaemic and transferred to QAH for investigation. They excluded the common cancers, sent blood for PTH, gave pamidronate and sent her back. Dr Banks felt she was seriously depressed and deteriorating, so that she would take nil by mouth and needed NG tube feeding. Sectioned her for ECT. First treatment uneventful but on second treatment, on 31.5.96, had coffee ground vomit immediately after the ECT and aspirated, and ws not able to be revived. Sent to Coroner for PM. The night before her death she had some chest pain, referred to as Heartburn but it did not respond to MagTriSil. Given Oramorph 5mg by the duty doctor and the pain settled. Dr Barton on 31.5.96 wrote up her standard syringe driver of diamorphine 20-100mg, hyoscine 200-800mcg and midazolam 20-80mg. This was never given, since the lady died that morning. But I am unclear why Dr Barton felt she had jurisdiction to do that or why she felt it was appropriate to treat as dying a lady who had been sectioned for treatment. I do not think the single dose of oramorph had any bearing on her death.	1A

Expert Review

Code A

No. BJC/59

Date of Birth: Code A

Date of Death: Code A

Code A was eighty-six at the time of her admission to Gosport War Memorial Hospital on 20 May 1996.

Dr Banks had arranged for an emergency admission for Code A having found evidence of self-neglect and poor mobility.

After admission to Gosport War Memorial Hospital, Code A was transferred to Queen Alexandra Hospital on 9 May 1996 for investigation to a possible carcinoma, before being transferred back to Gosport War Memorial Hospital on 20 May 1996.

It was felt that Code A was seriously depressed and deteriorating and she was sectioned for electro convulsive treatment.

During the second treatment, on 31 May 1996, Code A had coffee ground vomit immediately after the treatment and aspirated and was not able to be revived.

The experts note that a prescription for Diamorphine was made but not given. A single dose of Oral Morphine was thought to have no effect on Code A death.