Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7DR

TO: REF:
STN/DEPT:

FROM: Code A REF:
STN/DEPT: OPERATION ROCHESTER TEL/EXT:

SUBJECT: DATE: 28/06/2004

I visited Code A at her home address at 1000 hrs, Monday 28th June 04 (28/06/2004).

Code A states that her late husband, Code A was born in Hull.

He was one of two brothers, the other brother died in infancy.

His parents were Code A who both died of cancer in their middle 70's. Code A was married twice and had a daughter from each.

He travelled widely and lived in Africa for a time.

Upon his return to the UK he settled in Oxford. He was a quantity surveyor by profession and had a number of businesses. He married Code A in 1974.

They moved to Lee-on-Solent in 1996 upon his retirement to pursue their hobby of sailing.

Code A didn't cope well with retirement, he became depressed. He was diagnosed as a diabetic which was managed by tablets and diet. He also suffered from high blood pressure. He was a smoker and regular drinker.

In February 1997, aged 67 yrs Code A suffered a severe stroke. He was admitted to the Queen Alexandra Hospital and later transferred to Southampton General . Code A was at this stage in a coma and not expected to live.

Code A did improve through a period of time and was taken back to the QA. His stroke left him completely paralysed and unable to swallow. Code A describes him as living in his own world.

In May/June 1997 Code A was transferred to the GWMH Daedalus Ward, due to his total dependency. He was fitted with a peg at the QA in order to receive nourishment.

Code A describes her husband's treatment at the hospital as 'wonderful'. She states that the staff went out of their way to accommodate him.

He contracted MRSA whilst at the QA, a condition which remained with him until his death. Because of this he was kept isolated by staff would sit him out in the reception area so that he wouldn't feel excluded.

Code A remained at the hospital until his death. He was in constant pain due to his immobility and bed sores. His left leg was drawn up on spasm as a result of his stroke.

Code A believes that he received pain relief and antidepressants to combat his pain.

Code A visited her husband regularly over the two years and cannot speak highly enough of the staff and the care her husband received.

At Christmas 1998, Code A began to deteriorate. He had to return to the QA to have a new peg fitted.

He was depressed and disorientated and his pain was increasing.

Code A could see that her husband was in pain and distress. He would cry out and would physically cry.

The nursing staff informed Code A that they would increase his pain management and 'make him comfortable'.

In the last two weeks of his life Code A is described as being unconscious. Code A was aware that her husband was being given morphine.

On 15th February 1999 (15/02/1999) Code A received a phone call from the hospital telling her that her husband was "very poorly". She went to the hospital and sat with her husband. She states that he was lying perfectly still and staff told her that he would die soon.

Code A states that he appeared to have a very strong pulse and she didn't think that his death was imminent.

In the early hours of 16th February 1999 (16/02/1999) Code A received a telephone call from the hospital informing her that her husband had just passed away.

His cause of death is given as Cerabrovascular Accident and the certificate is signed by Dr J BARTON .

Code A is buried in Stubbington cemetery.

Code A states that she spoke with Dr BARTON and didn't have any concerns about her or the rest of the nursing staff whom she describes as 'brilliant'. She says that he couldn't have been treated any better and that he was happy there.

Code A has spoken with her daughter and step daughter who both now live in Australia and they to support mother's view.

Code A

Code A

Date of Birth: Code A Age: **69**
Date of Admission to GWMH: **9th April 1997**
Date and time of Death: **06.10hours on 16th February 1999**
Cause of Death:
Post Mortem:
Length of Stay: **22 months**

Code A past medical history:-

- Diabetes mellitus
- Intracerebral haemorrhage
- Hypertension

Code A lived with his wife. They had a daughter who lived in Australia. Code A was allergic to shellfish. In February 1997 Code A suffered a dense left side hemiparesis and was admitted to the Queen Alexander Hospital as an emergency admission via his GP. Code A underwent an insertion of a PEG tube in March and April 1997. He was transferred to Gosport War Memorial Hospital on 9th April 1997. In letters in August 1998 and September 1998 it was noted that Code A was to have continuing care on Daedalus ward and was not eligible for a Nursing Home. It was also noted that he was MRSA positive.
On admission regular Waterlow and Barthel scores were recorded as well as nutritional assessments and handling assessment and evaluations were recorded.
A number of care plans were completed on admission, and throughout Code A Code A long stay, for PEG tube, catheter, hygiene, MRSA, constipation, shoulder pain, sleep, pressure sore right heel, pressure care left ankle, swollen scrotum and broken areas, diabetes, pain and left sided weakness.

Daily summary
9th April 1997
Transfer form – transferred from Queen Alexandra Hospital. Suffered a right intra cerebral bleed on 11/3/97. PEG[1] inserted 4/4/97 to supplement oral intake of soft diet and thickened fluids. Appetite very poor since CVA. Catheter insitu. Some constipation. Two pressure areas on back and sacrum. Nursed on Pegasus mattress. MRSA+ during hospital stay in nose/throat/anxillas/catheter and wound sites. This is being treated. Wife aware of transfer.

[1] PEG. Percutaneous endoscopic gastrostomy.

1st May 1997
Contact record – seen by Dr Lord. Ask infection control if discharge is possible to Nursing Home if MRSA positive.
2nd May 1997
Contact record – can be discharged if remains MRSA +.
13th May 1997
Contact record – diarrhoea for 3 days.

22nd May 1997
Contact record – multidisciplinary team meeting. Continues with modified feeds. Transfer to continuing care bed. Wife to obtain power of attorney.
27th May 1997
Contact record – infection control last set of swabs clear. Stop treatment.
2nd June 1997
Contact record – seen by Dr Lord. Generally improved over last two weeks.
6th June 1997
Contact record – still MRSA + in throat. Commence treatment again.
12th June 1997
Contact record – seen by Dr Lord moved to slow stream stroke bed. Continue with physio. Seen by dietician.
24th June 1997
Contact record – general situation discussed with wife.
25th June 1997
Contact record – MRSA + throat and catheter treatment to recommence.
10th July 1997
Contact record – seen by Dr Lord to transfer back to continuing care bed. Will stay until MRSA negative.
28th July 1997
Contact record – seen by Dr Lord wife present. She has seen and likes Tudor Lodge Nursing Home. Plan for discharge when clear of MRSA.
8th August 1997
Contact record – complaining of pain and requesting increase in analgesia.
10th August 1997
Contact record – **found on floor**. Accident form completed. Banged head. Doctor informed.
19th August 1997
Contact record – **foaming** at mouth. Doctor informed.
28th August 1997
Contact record – MRSA negative.
29th August 1997
Contact record – MRSA positive.
25th September 1997
Contact record – Catheter washout. **Rigors**. Seen by Dr Lord.
10th October 1997
Contact record – positive MRSA nose and throat. Treatment commenced.
1st November 1997
Contact record – **frothing at mouth**.
10th November 1997
Contact record – right groin positive MRSA on 3/11 negative nose and throat.

27th November 1997
Contact record – MRSA negative.
1st December 1997
Contact record – seem by Dr Lord refer to OT for assessment **for discharge to Nursing home in January 1998**.
2nd December 1997
Contact record – increasingly restless at night. Sleeping very little. Uncomplaining regarding pain.

5th December 1997
Contact record – swab taken. MRSA + on axilla. Continue treatment regime.
19th December 1997
Contact record – MRSA negative.
21st December 1997
Contact record – frothing at mouth.
29th December 1997
Contact record – MRSA negative.
12th January 1998
Contact record – seen by Dr Lord for discharge. Refer to social services.
23rd January 1998
Contact record – MRSA negative.
27th January 1998
Contact record – message received from social worker. May be difficult to place due to having MRSA.
3rd February 1998
Contact record –MRSA+ in throat.
9th February 1998
Contact record – Seen by Dr Lord social services referral to be followed up.
11th February 1998
Contact record – health summary and OT assessment sent.
23rd February 1998
Contact record – seen by Dr Lord **suspend discharge** for 1 month then review.
9th March 1998
Contact record – seen by Dr Lord to discontinue MRSA treatment for 2 months. To remain here for this period.

20th April 1998
Contact record – continue until MRSA status reviewed.
23rd April 1998
Contact record – social services file closed.
15th May 1998
Contact record – MRSA + throat.
5th June 1998
Contact record – confused/apyrexial.
9th June 1998
Contact record – MST increased to 20mg.
15th June 1998
Contact record – seen by Dr Lord medical condition stable. Now ready for discharge to Nursing home refer to social services.

25th June 1998
Contact record – wife to look for nursing home.
29th June 1998
Contact record – seen by Dr Lord. Happy for Norman to stay until placement found.
14th July 1998
Contact record – spoke to Tudor Lodge Nursing Home aware PEG feed and MRSA positive and smokes. Happy to have.

23rd July 1998
Contact record – discharge discussed.
29th July 1998
Contact record – Nursing home to accept when social services funding agreed.
5th August 1998
Contact record – Nursing home unable to take due to being unable to cope with his needs.
21st August 1998
Contact record – scrotum swollen and causing distress. **MST increased** to 30mg.
27th August 1998
Contact record – **MST increased to 50mg**.
30th August 1998
Contact record – vomited +++.
4th September 1998
Contact record – very distressed and crying. **Complaining of pain** across lower pelvic area. Given oramorph 10mg with good effect.
10th September 1998
Contact record – very distressed complaining of pain returned to bed. Oramorph 10mg given.

18th September 1998
Contact record – tried to stand fell to floor. No injuries accident form completed.
21st September 1998
Contact record – seen by Dr Lord referred for replacement of PEG feed.
25th September 1998
Contact record – seen by Dr Barratt blisters on right foot. 2 more broken areas. Swabbed. Do daily blister count.
28th September 1998
Contact record – Dr Barratt notified of increase of blisters.
29th September 1998
Contact record – itching causing agitation and discomfort.
1st October 1998
Contact record – MRSA +
5th October 1998
Contact record – seen by Dr Lord to commence steroids. Stop MST. **Diamorphine via syringe driver**. Photograph blisters. **80mg diamorphine commenced.**

7th October 1998
Contact record – daughter informed of condition.
11th October 1998
Contact record – **syringe driver renewed.**
21st October 1998
Contact record – commence **fentanyl patches. Syringe driver discontinued.**
22nd October 1998
Contact record – **fentanyl patch found on floor. MST 50mg prescribed.**
24th November 1998
Contact record – **oramorph given 10mgs.**
31st December 1998
Contact record – PEG replaced at Haslar.
8th January 1999
Contact record – syringe driver completed 24-hour dose. Skin improved does not appear itchy. PEG fell out reintroduced.
10th January 1999
Contact record – catheter found to be out. Recatheterised.
11th January 1999
Clinical notes – prognosis poor. Keep comfortable. PEG tubes come out ? pulled out replaced at Nursing Home. No new blisters.
25th January 1999
Clinical notes – blisters left heel now ulcerated. Much better in himself. **Pain reasonably controlled.** Continue NHS C/C.
1st February 1999
Contact record – **in severe pain and distress. Syringe driver 100mg diamorphine.**
2nd February 1999
Clinical notes – deteriorating.
3rd February 1999
Contact record – reported to be in pain. **Diamorphine increased to 120mg.** Appears comfortable and pain free.
7th February 1999
Contact record – **continue to be in pain + on movement. Syringe driver x 2 dimorphine 200mgs.**
8th February 1999
Clinical notes – very distressed and calling out. Very little oral input today. PEG feeds stopped 6/2/99. Calm in himself but frightened. No new blisters.

Contact record – **diamorphine dose range increased.** Driver renewed. Diamorphine increased to 250mgs. Sips of fluid taken. Whimpering in sleep.

Clinical notes – **increase diamorphine to 250mgs S/C via syringe driver.** (upto 300 mgs). If still distressed and frightened change midazolam to haloperidol via syringe driver. Stop all oral medication and insulin. Stop checking sugars. No further PEG feeds. Wife aware he is dying. If he dies could **nursing staff please confirm.**
11th February 1999
Clinical notes – agitated very restless last night. Dry, pyrexial and chesty. Bronchopneumonia.
Contact record – **driver charged diamorphine 300mgs.**

14th February 1999
Contact record – **in pain on movement**. Awake and anxious. **Diamorphine 400mgs via syringe driver.**
15th February 1999
Clinical notes – Haloperidol not effective back on midazolam asleep. No apparent distress. Marked general deterioration. Continue syringe driver.

Contact record – seen by Dr Barton boarded for review of syringe driver. No change in treatment to be kept comfortable. Condition deteriorated. Family notified.
16th February 1999
Clinical notes – 06.10 hours died. Confirmed by C Marjoram. Staff Nurse.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification Code A Code A **Exhibit number** BJC-61

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		frail and distressed; dying; but v rapid dose escalation at the end		
Unexplained By Illness C				

General Comments

71-year-old man with tablet-treated NIDDM and mild hypertension treated with atenolol
1997-02-11 A. dense left hemi + dysphagia = intracerebral bleed > Barthel 2
1997-02-23 Analgesia paracetamol or co-dydramol
1997-04-09 A. Daedalus 'for Rehabilitation'
1997-11-03 Pain (L) shoulder > NSAID gel
1997-12-04 Oramorph 5-10 ml start
1998-01-26 Pain worse when MST withdrawn
1998-02-23 MST 10 mg twice daily and again 1997-08-10 MST 10 mg twice daily
1998-08-24 'Prognosis poor DNR'
1998-08-27 Oramorph 2.5 to 5 ml (10mg/5ml)
1998-10-05 Stop MST... start diamorph, nozinan, midazolam... 80 mg diamorphine
1998-11-02 Pemphigoid > good response to pred, but DM worse
1998-12-14 Morphine MST 80 mg twice daily [~ 50 mg diamorphine/24 h sc]
1999-02-02/-08 'Deteriorating' 'Markedly worse...Very distressed & calling out.'
Plan ^ Diamorphine to 250 mg sc in syringe driver...
1999-02-11 Diamorphine 40-300 mg; 1999-02-13 Diamorphine 400-800 mg dose escalated v. fast

Final Score:

Screeners Name: R E Ferner
Date Of Screening: 13th Nov 2003

Signature

BJC/61

Code A

69

This was a young older adult with a severe stroke requiring PEG feeding. He had a lot of pain initially treated with low dose MST. Over 18 months the dose was gradually increased. In October 1998 he went onto diamorphine via driver - the dose conversion was excessive. He then returned to MST at the same dose. In Feb 1999 the pain became worse and a driver was started again. The pain was not controlled and the dose of opiate was rapidly increased. This was probably not opiate responsive pain or pain that could have been treated with lower doses plus other analgesics. However the stroke was severe and caused his death.

PL grading 2A
Group grade 2A

Exhibit No	Patient Identification	Assessment Note	Assessment Score
BJC/61	Code A	Highly dependent following left hemiparesis. PEG fed. In NHS continuing care since 1997. NIDDM. Autumn 1998 developed bullous pemphigoid, which worsened despite topical steroids and became superinfected with MRSA. Lesions all over his body. Very itchy. Needed oral prednisolone in moderate doses (20-40mg/day) which could not be reduced below 20mg without relapse. Severe itch. Distressed by lesions. Had pre-existing pain, certainly in R hip and L shoulder, one reference also to L thalamic pain. On long term MST and amitriptyline. MST remained very low dose, 10mg BD then 20mg BD, for more than a year. Dose steadily increased with worsening of the pemphigoid, but still stepwise- 50mg BD then 60mg BD then 80mg BD then 100mg BD. PRN Oramorph dose was only 10mg – not appropriate for the MST. Tried a fentanyl patch briefly, but he picked it off. Lot of chopping and changing – MST to S/D to fentanyl to MST and finally back to S/D – seem not to have thought of using PEG for oramorph throughout. Finally felt to need large doses of midazolam to quell the distress of the itch and blisters, and calm his terror as death approached – noted several times to be agitated and frightened. Also episodes of severe pain – not clear which one but carbamazepine started so may have been thalamic. Both times he went on to S/D the conversion was over-generous – October from MST 50mg BD to diamorphine 80mg (=MST 120mg BD) and February 99 from MST 100mg BD to diamorphine 100mg (=MST 150mg BD). Diamorphine then rapidly escalated, finally to 400mg/day. But he was agitated and distressed. Motive seems solely to keep him comfortable. Felt to be unavoidably dying.	2A

Expert Review

Code A

No. BJC/61

Date of Birth: **Code A**

Date of Death: **Code A**

Code A prior to a stroke in 1997, had non-insulin dependent diabetes and hypertension which was treated with Atenolol.

Following his severe left sided hemiparesis, Code A was admitted to the Queen Alexandra Hospital. Having been operated on to insert a PEG tube in March and April 1997 Mr Willis was transferred to the Gosport War Memorial Hospital on 9 April 1997.

In Autumn 1998 Code A developed Bullous Pemphigoid, which worsened despite topical steroids and became super infected with MRSA. Alongside the distress caused by these legions, Code A had pre-existing pain in his hips and shoulders and possibly left thalamic pain.

Code A was on long term MST and Amitriptyline. The MST was increased gradually. A Fentanyl patch was tried briefly but this was picked off. Midazolam was added to the medication to quell the distress of the itch and blisters and to calm Code A

The conversion to syringe driver was described by the experts as excessively over generous but they noted that Code A, at that point, was agitated and distressed and the motive seemed solely to keep him comfortable. The experts all agreed that he was unavoidably dying from his stroke.