Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7S

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 26/06/2003

I visited Code A at his home address, Code A
Code A

Code A

He will say that his mother, Code A in Basingstoke. She suffered from high blood pressure throughout her life.

As far as he can recollect Code A was a V.A.D nurse during the war and then went on to work as a nurse in the Portsmouth area.

She then became an 'instalment collector' for a local shoe club and had to retire at an early age due to ill health.

Code A had two children, the first a daughter, died prior to Code A being born.

Code A suffered a fractured skull in her 40's and was generally not in good health.

After her retirement she suffered a series of strokes, she was initially cared for by her son at home but the strokes became more frequent (petitmal?) and she was taken to Gosport War Memorial Hospital for assessment, she was admitted to the female ward.

It was then decided that Code A would spend six weeks at the hospital and then return home to the care of her son for two weeks.

This carried on for approximately two years and Code A would stay at the Redcliff Annex.

During her last home visit Code A and was readmitted to the Redcliff Annex. She is described as being mentally alert but poorly.

Code A

He also recalls that a couple of days before his mother died (12/02/1995) he received a telephone call from a member of staff informing him that his mother had suffered another stroke and was very unwell.

He visited and found his mother was in a coma. He also saw that she was on what he describes as a morphine driver (syringe driver). He is not aware what medication was in the driver but his concerns are, if his mother was in a coma why did she require pain relief.

Code A was cremated at Portchester crematorium and her GP was Dr TAYLOR from Brockenhurst Rd Surgery, Gosport.

Code A was divorced for many years prior to her death, her maiden name being Code A A copy of her death certificate has been obtained.

Code A

Code A

Date of Birth: Code A Age: **87**
Date of Admission to GWMH: **6th February 1995**
Date and time of Death: **04.30 hours on 12th February 1995**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **6 days**

Mrs Clements's past medical history:-

- Dementia
- Parkinson's disease
- Chronic renal failure
- Incontinence
- Appendicetomy
- CRF
- Recurrent UTI's
- Immobility

Code A was a widow. She lived with her son at his home. She had a home help and private help was also employed. She was admitted to Gosport War Memorial Hospital on 6th February 1995 as an emergency admission. She was not eating or drinking well, her mobility was poor and she was passing large amounts of clots.

Daily summary
6th February 1995
Clinical notes – readmission ahead of time. Restless, not eating/drinking well. 2 skin flaps on forearms. ? needs long-term care. ? not well enough for general anesthetic for cystoscopy or other procedures.
Nursing notes – readmitted as emergency from home. Has been seen by GP twice at weekend. Code A Not eating/drinking well and mobility is not what it was. On arrival looks poorly, colour very pale. Seen by Dr Barton to be catheterised. Draining gross haematuria. Very confused during the evening and found trying to get out of bed. Cot sides now in place.

7th February 1995
Nursing notes – condition remains poor. Code A Seen by Dr Barton. Remains reluctant to have any intervention in medical care and does not wish to be transferred to acute bed. Peaceful evening complaining of some abdominal pain but refuses analgesia. Night – remains poorly, Code A Slept peacefully.

8th February 1995
Clinical notes – Code A NOK informed. Understand that she needs blood transfusion but would rather take her chance here. Catheter in situ.
Discussion with son – understand possible outcome agrees that mother wishes are permanent. To stay here in event of deterioration. Keep comfortable.
Nursing notes – condition remains poor. Seen by Dr Tandy and Dr Barton. Adamant does not want to be referred to acute bed. Remain here for TLC. Bladder washout performed. Code A Continues on antibiotics but refuses supplements. PM – **oramorph 2.5mls given 6 hourly**.

9th February 1995
Clinical notes – deterioration suddenly while on commode. Pale unrousable ? CVA. No improvement. S/C analgesia commenced. Son well aware and present.
Nursing notes – became very unresponsive whilst on commode. Also vomited fairly large amounts of coffee grounds. Put back to bed and remained unresponsive. Colour very poor. 12.05 **oramorph 5mg given** which was immediately vomited back. **Syringe driver commenced with diamorphine 40mgs**. Complaining of being uncomfortable.
Nursing notes – condition remains poorly. Syringe driver in situ. No further vomiting.
Night – condition deteriorated rapidly at 21.00 hours breathing laboured. Condition stabilised t 01.30 hours. Position changed. Suction used. Remains comfortable and peaceful.

10th February 1995
Nursing notes – poorly condition continues to deteriorate. Son visited. Seen by Dr Barton **diamorphine increased. Syringe driver renewed with diamorphine 80mgs.** PM – further deterioration peaceful.
Night – condition remains poor, breathing slightly laboured when on right side. Appears comfortable. Syringe driver satisfactory.

11th February 1995
Nursing notes – further deterioration. **Syringe driver renewed with diamorphine 80mgs.** Breathing remains shallow and laboured at times.
Night – condition continues to deteriorate. Now chest very bubbly, suction given ++ with little effect. Fingertips becoming cold. Died peacefully at 04.30 hours.

12th February 1995
Clinical notes – 04.20 hours breathing became very shallow and infrequent. Son informed and visited. Breathing ceased 04.30 hours death verified by S/N Tubbritt.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
Code A

Exhibit number
BJC-77

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		some evidence discomfort, but dose diamorph ~ 4 x dose Oramorph		
Unexplained By Illness C				

General Comments

An 87-year-old widow, with dementia and incontinence, in hospital for extended periods

1993-11-20	Seen on Sultan Ward
1993-11-29	Assessed Phillip Ward
1993-12-13	Redcliffe Annex
1994	Home to care of son
1994-07-12	Readmitted ?UTI, then care 2:6
1995-02-06	Early admission because of bleeding PU, Hb 6.9
1995-02-07	Some abdo pain, but refuses analgesia
1995-02-08	No documented pain; Oramorph 5 mg qds x 4 doses
1995-02-09	Deterioration suddenly while on commode. Pale unrousable ?CVA Became more rousable after about 90 min, Vomited 5 mg Oramorph, then 'sc analgesia' Given sc diamorph 40 mg, then 80 mg, then 80 mg on successive days 'was quite restless and complaining of being uncomfortable...'
1995-02-12	Breathing became very shallow and infrequent... Death verified 04-30

Final Score:

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

Signature

BJC/77

Code A

87

This lady had multiple problems such as dementia, immobility, urinary incontinence, previous stroke. She had been receiving shared care but was readmitted ahead of time with haematuria and clots. Her haemoglobin was 6.9 and it appears they cannot give blood transfusions at GWMH and she was not well enough to have a cystoscopy. They all came to the decision to give her iron and fluids. She then collapsed which was put down to a possible stroke but was probably micturition syncope/anaemia/hypovolaemia. They tried oramorph which she vomited and then diamorphine via syringe driver starting at a high dose (40mg). She was reported to be comfortable and peaceful but the dose was increased the following day. Serious medical problems for conservative care but the opiate doses appear excessive.

PL grading 2B (3B considered)
Group grading 2B

Exhibit No	Patient Identification	Assessment Note	Assessment Score
BJC/77	Code A	Admitted unwell with Haematuria ?cause. Hb 6.9g/dl. Refused acute transfer for blood transfusion. Continued to bleed. Collapsed on commode, probably from postural hypotension leading to CVA but possibly PE, became unrouseable. Immediately started on diamorphine 40mg and midazolam 20mg by syringe driver, diamorphine doubled next day, although she had never been on anything stronger than paracetamol as far as I could see. Entirely unnecessary doses of opioid and probably sedation. But she would almost certainly have died in any case following this episode of collapse. Just changed the timing a little.	2A

Expert Review

Code A

No. BJC/77

Date of Birth:

Date of Death: **Code A**

Code A was eighty-seven at the time of her admission to Gosport War Memorial Hospital on 6 February 1995.

Code A was living at home with her son prior to being admitted. She was not eating or drinking well, her mobility was poor and she was passing large clots of blood in her urine.

Although **Code A** had abdominal pain she refused analgesia on admission.

On 9 February 1995 **Code A** deteriorated suddenly whilst on a commode. She was pale and unrousable and vomited large amounts of coffee ground like material.

The staff questioned whether **Code A** had suffered a stroke.

Following the episode, **Code A** was started on Diamorphine 40mgs and Midazolam 20mgs by syringe driver. The Diamorphine was doubled the next day although it would seem that **Code A** had never had any previous medication stronger than paracetamol.

The experts felt that the Diamorphine was unnecessary but that **Code A** would have almost certainly have died, in any case, following the episode of collapse.