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Preliminary and draft REPORT

SPECIALIST FIELD:- NURSING CARE

NURSING CARE GIVEN TO 61 PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL

PREPARED BY:- IRENE WATERS LL.M, M.Sc, M.N.,R.H.V., R.G.N.

DATED:- DECEMBER 2003

ON THE INSTRUCTIONS OF:- DETECTIVE CHIEF INSPECTOR NIGEL NIVEN
HAMPSHIRE CONSTABULARY
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SUBJECT MATTER:-

This report addresses the appropriateness of the nursing care given to 61 former patients of Gosport War Memorial Hospital during the period 1989 and 2001 and whether the nursing care fell below a standard that would be expected from reasonably competent nurses.
The preliminary report concentrates on the administration of medication and highlights other areas for concern but does not go into detail.

CONTENTS:

Appendices:

Synopsis

Thank you for seeking my opinion about the standard and appropriateness of the nursing care given to 61 former patients, of the Gosport War Memorial Hospital, who died during the period starting 1989.

1. Introduction.

1.01 The writer

I am Irene Waters. My specialist field is nursing and nursing care. I am a registered general nurse and hold a community nursing qualification. I have a Master of Nursing degree and was formerly Director of Nursing, responsible for 1408 nursing staff, with the Bart's NHS Group, this included a general acute Hospital and a Community Health Services Unit. I am a none executive dirstor of a Primary Care Trust which includes a Community Hospital and am a regular panel member for due regard on the Professional Conduct Committee for the Nursing and Midwifery Council NMC. I am currently employed as a clinical and professional adviser, health consultant and expert witness. Full details of my qualifications and experiences are in appendix 1.

1.02 Background

The Gosport War Memorial Hospital (GWMH) is a community hospital managed by the Portsmouth Health Care NHS Trust. It has 47 beds and is operated on a day-to-day basis by nursing and support staff, all employed by the Trust. Medical expertise is provided by visiting general practitioners and clinical assistants, consultant cover/supervision from Haslar Hospital is also provided.
Elderly patients are admitted for care including palliative, rehabilitation and respite care. Referrals are made by local hospitals and GP's.

The staffing levels and skill mix would have been specified for each shift. Duty rotas would be available which would assist if it is necessary to identify trends and poor practice associated with an individual nurse or team of nurses.

A total of 950 patients at the Gosport War Memorial Hospital have died since 1994.

Operation Rochester is an investigation by Hampshire Police Major Crime Investigation Team into the deaths of a large number of elderly patients at the Gosport War Memorial Hospital. It is alleged that some elderly patients who were admitted to the hospital, from as far back as 1989, for rehabilitative or respite care, were inappropriately administered Diamorphine by use of syringe drivers, resulting in their deaths.

A number of deaths have already been investigated on three separate occasions. The first investigation commenced in 1998 following the death of Gladys Richards when her family complained about her rapid deterioration. Officers from Gosport CID carried out an investigation and a file was submitted to the Crown Prosecution Service. In March 1998 the Crown Prosecution Service gave the opinion that on the evidence available they could

not consider a prosecution. The family expressed their concerns about the police investigation and made a formal complaint against the officers involved. The complaint was upheld and a review of the police investigation was carried out.

In April 2000 the Major Crime Investigation Team opened a re-investigation into the death of Gladys Richards. In August 2001 the Crown Prosecution Service advised that there was insufficient evidence.

Local media coverage resulted in other families raising concerns about the deaths of their relatives at the Gosport War Memorial Hospital. Four more patients who had also died in 1998 were selected for review. Two medical professors were instructed to review the medical records and prepare reports.

In August 2001 the police were sufficiently concerned about the care of elderly people in Gosport to share their concerns with the Commission for Health Improvement (CHI) and in October 2001 CHI launched an investigation into the management, provision and quality of health care for which Portsmouth Health Care NHS Trust was responsible in Gosport War Memorial Hospital. A report of the findings was published in May 2002 concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality patient care.

Following the CHI report, Sir Liam Donaldson, Chief Medical Officer, commissioned Professor Baker to contact a statistical analysis of the mortality rates at the Gosport War Memorial Hospital.

On 16th September 2001 staff at the Gosport War Memorial Hospital were informed of the intended audit. Immediately after the meeting a nurse who had been employed at the Gosport War Memorial Hospital handed over to the hospital management a bundle of documents. The bundle contained details of concerns of nursing staff., which were raised at a series of meetings held in 1991 and 1992, about the increased mortality rate and the sudden introduction of syringe drivers. The existence of the documents was reported to the police and an enquiry team was set up.

On 23rd September 2002 Hampshire Major Crime Investigation Team commenced enquiries and relatives of 61 elderly patients have contacted police with regards to the death of the patients. Since then Professor Baker has identified another 20 patients who have also died at the Gosport War Memorial Hospital
This report contains a review of the nursing care given to the first 61 patients but concentrates in the first instance on the administration of medication.

1.03 Nurses and the standard for nursing care

Nurses.

Trained nurses have successfully completed a programme of basic nursing education and are qualified and authorised to practise nursing.
A first level registered nurse (RGN) is a practitioner registered on Parts 1,3,5 or 8-15 of the register, this takes 3 years.
A second level nurse (formerly known as an enrolled nurses EN) is a practitioner registered on Parts 2,4,6 or 7 of the Register, this took 2 years rather than 3, this training was discontinued in the 1990's with the introduction of the pre-registration diploma education. These nurses are not trained to take charge of a shift in their training. Recent advice has been given that in certain circumstances a second level nurse can take charge of a shift providing the they have had training and been assessed as competent to do so.
It would be expected that there would be evidence of a local Trust protocol and training for any enrolled nurse given this responsibility.

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC)[1] is the registering statutory body and is responsible for the regulation of these professions in the interest of the public.
Nurses are responsible and accountable for their practice.

Standards were set by the UKCC in the **Code of professional conduct**[2].
Additionally the **Scope of professional practice**[3] was produced to ensure that nursing practise could develop in a dynamic way, respond to change and recognise the changing educational needs of nurses to expand their knowledge base and extend their clinical practice safely.
I have also referred to the **Standards for records and record keeping**[4], **Administration of medicines**[5], **Standards for the Administration of Medicines**[6]
All of these were in circulation at some time during the period in question and provide the framework against which acceptable standards for nursing are measured and judged.

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[1] Since April 2002 the UKCC has been replaced by the Nursing and Midwifery Council. NMC.
[2] UKCC Code of Professional Conduct. Nov 1984, June 1992, 1998.
[3] UKCC Scope of Professional Practice. June 1992
[4] UKCC Standards for records and record keeping 1993.
[5] Administration of Medicines.UKCC. April 1986.
[6] UKCC Standards for the Administration of Medicines is dated October 1992. Guidelines for the administration of medicines was introduced in 1998 It has now been replaced by NMC Guidelines for the administration of medicines dated October 2000. These papers will be used as appropriate for the dates in question.

The UKCC Code of professional conduct requires each registered nurse to act in such a manner as to :-

- Safeguard and promote the interests of individual patients and clients.

The nurse is personally accountable for his/ her practice and, in the exercise of their professional accountability, must:-

- Act always in such a manner as to promote and safeguard the interests and well being of patients and clients.
- Ensure that no action or omission on their part, or within their sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients.
- Maintain and improve their professional knowledge and competence.
- Acknowledge any limitations in their knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner.
- Work in an open and co-operative manner with patients, clients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care.

The UKCC Scope of professional practice says that the registered nurse, midwife or health visitor must:-

- Be satisfied that each aspect of practice is directed to meeting the needs and serving the interests of the patient or client
- Endeavour always to achieve, maintain and develop knowledge, skill and competence to respond to those needs and interests.
- Honestly acknowledge any limits of personal knowledge and skill and take steps to remedy any relevant deficits in order effectively and appropriately to meet the needs of patients and clients.

The UKCC states that there is substantial evidence to indicate that inadequate and inappropriate **record keeping** concerning the care of patients and clients neglects their interests through:-

- impairing continuity of care
- introducing discontinuity of communication between staff.
- creating the risk of medication or other treatment being duplicated or omitted
- failing to focus attention on early signs of deviation from the norm.
- failing to place on record significant observations and conclusions.

Administration of medicines[7]

This document was intended to provide a framework for nurses to ensure that they complied with Statutory Instrument 1983. No 873[8] (The Nurses, Midwives and health Visitor Rules) and the Code of Professional Conduct. The relevant primary legislation at this time was the **Medicines Act 1968** and the **Misuse of Drugs Act 1971.**
The word **"medicine"** refers to controlled drugs and **"prescription only"** medicines as defined in those Acts. It includes "General Sales List" medicines in those settings where they are normally subject to prescription. The above was released after consultation with the GMC and the Pharmaceutical Society.

Rule 18 (1) noted that **different competencies** for registered nurses, RGN, RMN, RNMH, RSCN (1st level nurses) and Rule 18 (2) for enrolled nurses, EN, EN (G), EN (M), EN(MH)(2nd level nurses).

The following definitions were used:-

Professional Judgement in health care is personal judgement based on special knowledge and skill, and always and above all is exercised in the interests of the patient.

Professional responsibility in health care is personal responsibility based on special knowledge and skill for actions, attitudes and policies always and above all directed to the best interest of the patient/client.

When administering medication the nurse is required to use **professional judgement.** This involves the application of the nurse's knowledge and experience to the situation faced and will lead to the decision whether the nurse is satisfied that they are competent to administer the medication and is prepared to be accountable for that action.
A series of steps is to be followed to ensure the safety and well being of the patient which will be based on a sound knowledge of the patient's assessment and the environment in which the care is given.

- **Correctness**. Right person, dose, prescription.
- **Appropriateness and the possible need to withhold**. Check expiry date, dosage, method and route, timing. Where contra indications exist the senior nurse should be notified and the prescribing doctor contacted without delay. (could be pharmacist in absence of doctor)
- **Reinforcement.** The nurse should reassure themselves that there is a positive effect of treatment on every occasion the medication is administered.
- **Recording and reporting.** The effects and side effects of the treatment should be noted. Taking appropriate action in the case of side effects is essential. Positive and negative effects should be reported to the appropriate doctor and recorded.

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[7] April 1986.
[8] The Nurses Midwives and Health Visitors Rules 1983.

- **Record of administration.** Thorough and accurate records of the administration must be maintained. This includes the date and time and the administering practitioner's signature, all legibly written.

The UKCC regarded **those nurses on the first part of the register as competent** to administer medicines on their own and to be responsible in so doing.
A second person may be involved, the responsibility lies with the senior person.
The UKCC was **opposed to the involvement of personnel who are not professionally registered** in the administration of medicines.
The UKCC was **opposed to the use of the second level nurse** to administer medication unless under the direction of a 1st level nurse.
Employers could use the second level nurse to administer medication if:-

- Additional instruction had been provided relevant to the medicines and the setting
- The individual had been assessed as competent by the employer to perform the task.
- The employer accepted responsibility for any errors as a result of using a second level nurse.

Standards for the Administration of Medicines[9]

The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council's register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner. It requires thought and the exercise of professional judgement, which is directed to:

- Confirming the correctness of the prescription
- Judging the suitability of administration at the scheduled time of administration
- Reinforcing the positive effect of the treatment
- Enhancing the understanding of patients in respect of their prescribed medication and the avoidance of misuse of these and other medicines
- Assisting in assessing the efficacy of medicines and the identification of side effects and interactions.

To meet the standards in this paper is to honour in this aspect of practice the Council's expectation set out in the **Code of Professional Conduct.**
The nurse must, in administering any medicines, in assisting with administration or overseeing any self -administration of medicines, exercise professional judgement and apply knowledge and skill to the situation that pertains at the time.

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[9] UKCC Standards for the Administration of Medicines is dated 1992 became UKCC Guidelines for the Administration of medicines in 1992. It has now been replaced by NMC Guidelines for the administration of medicines dated October 2000.

This means that, as a matter of basic principle, whether administering a medicine, assisting in its administration or overseeing self- administration, the practitioner will be satisfied that he or she:-

- Has an understanding of substances used for therapeutic purposes
- Is able to justify any actions taken
- Is prepared to be accountable for the action taken

In addition, acting in the interests of the patient, the practitioner will:

- Carefully consider the dosage, method of administration, route and timing of administration in the context of the condition of the specific patient at the operative time.

Patient Care

I have used popular publications available at the time about care of the patient and these are listed in appendix 2

Basic care for nursing patients includes:-

- Nutrition
- Pressure area care
- Falls
- Infection control
- Call buzzers

Under those headings I looked for evidence of:-

- Initial assessment
- Documentation
- Communication with the carers
- Involvement/ referral for specialist or medical advice. (not the same)
- Review date for reassessment
- Care planning

1.04 Summary of my conclusions

1. In all the circumstances did the individuals indentified receive the proper standard of care/treatment from the nursing staff?

- I have reviewed the nursing documentation of the 61 former patients of the Gosport War Memorial Hospital and found many examples of nursing care, which was below an acceptable standard. I have cited acts of omission later in the report.

2. Any action or omission by the nursing staff or attendant GP's contributed to the demise of any of the individuals?

- There were examples of poor care in the nursing records, which had the potential to contribute adversely to the health of these frail, elderly and vulnerable residents. Whether or not this care, which was below an

acceptable standard expected of competent nurses at this time caused the death of the individuals concerned is outside my field of expertise. This should be referred to the medical experts who have been engaged to review matters in that field.

- There were also examples of poor outcomes to the care and insufficient documentation that showed any evidence of adequate assessment or care planning or appropriate review of the care as an individual deteriorated.
- There was little evidence of supervision of staff or of an acceptable level of knowledge for the administration of medicines, of relevant training and development of the staff.
- There was doubt whether the doctors always attended to sign the death certificate before the undertakers removed the body. This is poor practice.
- There was evidence of poor standards of medicine administration, storage and ordering. This contravenes the then UKCC documents for administration of medicines and is not acceptable.
- There was no evidence that the nurses questioned the prescribing of controlled medication to people without an obvious need.
- There was little evidence that the nurses withheld medication when it was unclear why the medication had been prescribed. This is an example of poor professional judgement when the nurses may not have used their special knowledge and skill in the best interests of the patients or clients.
- There has been a significant use of syringe drivers when the use of diamorphine was not indicated from the problems identified in the nursing care assessment. The doctors also must bear some of the responsibility for this.
- The use of some of the medications together is contra indicated and it should have been within the nurses knowledge that this was inappropriate. The nurses should have noted their concerns, withheld the medication and contacted the prescribing doctor or pharmacist.
- Some of the medication prescribed was contra indicated with the patients' diagnosis, the nurses should have had some knowledge of this.
- Some of the Practice described above contravenes standards of professional conduct and Administration of Medication documents produced by the UKCC.
- In my opinion the examples cited above were below an acceptable level of nursing care expected of competent nurses at this time.

3. Any acts or omissions as identified amount to a breach of duty of care, which is so serious as to amount to gross negligence?

- The Clinical Team developed a grid for assessing the cases and, during our joint discussions, based on the work and review of cases that we had completed prior to the meeting we were able to identify cases which had been of concern to us individually but when the information was combined it became clear that there were a few cases which merited further investigation and gave cause for concern
- At this stage the emphasis is on the prescribing and administration of medicines. There were some areas which were clearly below an

acceptable standard but, coupled with the opinion of the medical experts, it is likely that some of the cases reviewed could amount to serious breaches of duty which may have caused significant harm.

- As the cases have been reviewed it has been clear that there are other aspects of nursing care which are below an acceptable standard. These have been highlighted at this stage but a further analysis would need to be made before any conclusion could be made about whether the poor nursing care caused harm.
- There was also evidence that some of the nursing care was of an acceptable standard.

4. **The nursing/medical records provide evidence/information to substantiate/ support the certified cause of death.**

    - Diagnosis of illness is the province of the medical profession. There were examples in the nursing documentation where the health care needs identified, the medication and the care being given, did not match the care needs one would have expected to have been identified for the condition listed as the cause of death on the death certificate.

5. **In addition it is requested that you identify/comment upon any additional lines of enquiry which may be appropriate for the review to pursue, thus ensuring the review is as comprehensive as possible to enable a full report to be prepared for the Coroner.**

    - I am aware of the great distress that this review will have caused the relatives of the deceased. However from the review of the nursing records and some attention to the other aspects of nursing care, it was not possible to exclude evidence of poor practice.
      I have not attempted to see if it was possible to find any trends at this stage. In my opinion it may be necessary to have sight of the statements and interviews with staff and follow up any issues raised about individual nurses, before it is safe to exclude the possibility of deliberate harm.

2.00 The parties involved

Staff section to be completed.

A total of ?? staff were employed at the Gosport Memorial Hospital. They include qualified nurses Care Assistants, Domestic staff, Kitchen staff and Maintenance staff.

The registration details of the nurses have been checked with the NMC and, with the exception of ,, retired, died.. XXXl are currently on the register and have a PIN number. YYY appear to have let her registration lapse.

The qualified nursing staff employed by the Hospital during this time are as follows:-.

Name	*Registration*
Sultan	
Daedalus	
Dryad	
o	*RGN*
o	*SEN*

Elderly care

The patients who have been reviewed 1989 until 2001 :-

	Dob	**Admitted**	**Died**
• Victor Abbatt	Code A	29.05.90	30.05.1990
• Dennis Amey		14.11.90	20.12.1990
• Lily Attree		26.07.96	24.08.1996
• Edith Aubrey		12.06.95	15.06.1996
• Henry Aubrey		01.06.99	02.06.1999
• Ellen Baker		07.11.90	09.11.1990
• Charles Batty		.09.90	02.01.1994
• Dennis Brickwood		03.02.98	12.06.1998
• Stanley Carby		26.04.99	27.04.1999
• Edwin Carter		08.11.93	24.12.1993
• Edith Chivers			19.08.1990
• Sidney Chivers		11.05.99	20.06.1999
• Hubert Clarke		05.06.00	17.06.2000
•	Code A		
• Arthur Cunningham	Code A	21.09.98	26.09.1998
• Elsie Devine		21.10.99	21.11.1999
• Cyril Dicks		28.12.99	22.03.1999
• Kathleen Ellis		23.06.99	05.07.1999
• Mary German		28.11.98	03.12.1998
• Leonard Graham		16.08.00	14.09.2000
• Sheila Gregory		03.09.99	22.12.1999

• Harry Hadley	Code A	05.10.99	10.10.1999
• Charles Hall		05.07.93	06.08.1993
• Nora Hall		01.06.99	19.06.1999
• Eileen Hillier		23.05.95	01.08.1995
• Alan Hobday		24.07.98	11.09.1998
• Albert Hooper		12.09.00	09.10.2000
• Clifford Houghton		31.01.94	06.02.1994
• Thomas Jarman		27.10.99	10.11.1999
• Elsie Lavender		22.02.96	06.03.1996
• Catherine Lee		14.04.98	27.05.1998
• Stanley Martin		06.01.98	08.01.1998
• Dulcie Middleton		15.08.01	02.09.2001
• Geoffrey Packman		23.08.99	03.09.1999
• Eva Page		27.02.98	03.03.1998
• Gwendoline Parr		31.12.98	29.01.1999
Code A			
• Margaret Queree	Code A	29.07.94	10.10.1994
• Joan Ramsey		01.06.01	13.12.2001
• Violet Reeve		11.11.96	14.04.1997
• Gladys Richards		17.08.98	22.08.1998
• James Ripley			
• Code A			
• Elizabeth Rogers	Code A	30.01.97	04.02.1997
• Enid Spurgin		26.03.99	13.04.1999
• Jean Stevens		20.05.99	22.05.1999
• Daphne Taylor		03.10.96	20.10.1996
• Sylvia Tiller		04.12.95	13.12.1995
• Code A			
• Frank Walsh	Code A	09.06.94	14.06.1994
• Walter Wellstead		07.04.98	13.05.1998
• Alice Wilkie		06.08.98	21.08.1998
• Ivy Williamson		03.08.00	01.09.2000
• Jack Williamson		29.08.00	18.09.2000
• Robert Wilson		14.10.98	18.10.1998
• Norma Windsor		27.04.00	07.05.2000
• Douglas Midford Millership		08.07.99	20.07.1999
• James Corke		22.07.99	14.08.1999

3.00 Publications

I have included in appendix 2 a list of some relevant publications in circulation 2001, many predate this time, the contents of which, if not the exact articles, I would expect a competent nurse to know and use in practise.

3.01 Documentation examined

- Medical and Nursing records from Gosport War Memorial on DVD disc.
- Briefing document.
- Reports of Professor Brian Livesley dated November 2000 and July 2001.
- Report of Dr K Mundy.
- Report of Professor G A Ford.
- Disclosure material.

4.00 Issues to be addressed

I have been asked to examine the nursing notes and other documents of the first 61 cases and specifically concentrate on the nursing issues surrounding the administration of medications.

5. Limitations of the review

I have gone through the documentation provided and the nursing records of the listed residents who have died in the period in question.

I have concentrated my search around the issues of nursing assessment and care which a competent nurse would have been expected to give at the time. I have also looked at how the nurses complied with the requirements of their Code of Conduct and whether the care, in the broadest sense, complied with the standard of the Nursing and Midwifery Council, formerly UKCC. The only source for this was the nursing documentation at this stage.

At this stage all the relevant evidence may not be available. When or if more evidence becomes available it may be necessary to review my opinion. The information contained in the nurses' documentation is helpful but in some cases the standard was poor and therefore cannot be relied upon to give the complete picture.

I am very aware of the observation made by Professor Baker that on the first trawl of the medical records of Dr Shipman nothing untoward was identified.

6.00 Summary Review of the facts surrounding the care of the 61 patients.

6.01. BJC/01A Victor Abbatt

Code A

Date of Admission to GWMH: **29th May 1990**
Date and time of Death: **00.05hours on 30th May 1990**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **1 day**

Mr Abbatt was married and had a son and daughter. He had had recent bouts of chest infections, confusion and poor mobility. It was noted that he was a heavy smoker.
Mr Abbatt was admitted to the Gosport War Memorial Hospital on 29th May 1990 as an emergency, requested by Dr Barton. His wife could no longer cope with him at home. (page 3)
On admission Mr Abbatt was assessed and his medication was boarded. (page 4)
The foot of his bed was elevated because his ankle and foot were oedematous.
During the night Mr Abbatt became very confused and incontinent of urine.
He was given Temazepam 10 mgms at 22.15 hours.
Mr Abbatt died at 00.05 hours on 30th May 1990, his son and daughter were informed and his death certified by Dr A? and S/N Bro?.
It was noted that Mr Abbatt was to be cremated.

Comment
Mr Abbatt was written up for Temazepam. It is not a common treatment for insomnia in the elderly because benzodiazepines can accumulate and have residual effects particularly on the elderly.
There were no drug charts.
Mr Abbatt was in hospital for a very short time there was little time for much nursing intervention.
I would have expected the nurses to query the use of Temazepam.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.02 BJC/02 Dennis Amey

Code A

Date of Admission to GWMH: **14th November 1990**
Date and time of Death: **16.30 hours on 20th December 1990**
Cause of Death:
Post Mortem:
Length of Stay: **38 days**

Mr Amey past medical history shows that he suffered from:-
Parkinson's disease

Prior to his admission to the Gosport War Memorial Hospital Mr Amey lived at home with his wife. He was admitted on 7th November 1990 for terminal care, he suffered from Parkinson's disease. (page 2)
Mrs Amey requested that her husband was admitted.
Mr Amey had problems with his catheter, he was incontinent and was having spasms and was in pain.
He needed help with feeding and had difficulty with swallowing. He wa noted to be irritable by the duty doctor. (page 11)
He was nursed on a Pegasus mattress and had red sores.
It was noted in the clinical notes that he had pus discharging from his penis and had gangrenous areas around his scrotum (p26-63) and that he needed pain relief.

On 19th December 1990 Mr Amey was written up for **Diamorphine to be administered using a syringe driver**. The dosage was 120mgs over a 24 hours period.
On 20th December 1990 Mr Amey died at 16.30 hours.

Comment
There was no drug chart. Mr Amey had very severe Parkinsons disease.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.03 BJC/03 Lily Attree

Code A

Date of Admission to GWMH: **26th July 1996**
Date and time of Death: **04.45 hours on 24th August 1996**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **30 days**

Mrs Attree was treated and suffered from a number of conditions:-

1960 – Breast lump
1970 – Vaginal repair
1979 – Oesophagectomy
- Depression
1992 – Mild dementia
1994 – Carcinoma base of tongue
1995 – 2nd degree tumour right tonsil and post nasal space
1995 – December – radiotherapy unable to complete due to marked deterioration. Dementia.

Mrs Attree was a widow with 2 daughters and a son. She lived in a Nursing Home. Mrs Attree was diagnosed with cancer of the tongue. She was not able to feed herself and had a puree diet, she had some mobility but needed assistance with washing and dressing.
She was transferred to Dryad Ward on 26th July 1996 from the Queen Alexander Hospital for palliative care and to recover from DXT.
Her notes state that she was suffering from depression and was doubly incontinent. It was also noted that her family were dissatisfied with her nursing care in the nursing home.
A **Waterlow** assessment was dated 27th August 1996 with a score of 15 recorded noting Mrs Attree to be at a high risk of developing pressure sores.
On 9th August 1996 it was noted that Mrs Attree had a sore on her sacrum and that she was being nursed on a Pegasus bed and cushion.
A care plan was commenced on 22nd August 1996 noting position changing and bed bootees.
A nutritional assessment was completed on 26th July 1996 noting a score of 8 to refer to dietician if necessary and that she takes maxifeed.
A Barthel ADL index was completed with a score of 9 recorded on 27th July 1996.
Lifting and handling assessment was carried out with a score of 10 noted and notes to be accompanied when walking.

23rd July 1996

Fall. Required 4 sutures to forehead. Graze to nose, red areas knees and shins.

26th July 1996

Transferred from Queen Alexander Hospital to Dryad War at the Gosport War Memorial Hospital to recover from DXT and for palliative care.

12th August 1996

CT scan.

15th August 1996

Result from CT scan showed tumour back. Oramoprh commenced. It was noted that Mrs Attree was suffering from confusion and was agitated. Her drugs were re-arranged.

20th August 1996

Deteriorating – unable to swallow oramorph. (p94)

50mg diamorphine commenced via syringe driver.

21st August 1996

Diamorphine increased to 75mgs.(page 93)

24th August 1996

04.45 hours died peacefully pronounced dead by S/N Ray in presence of S/N Jarman.

Mrs Attree to be cremated.

Comment

The GP was expecting Mrs Attree to be in pain. There may have been an error in converting to the syringe driver. *(Drs to comment)* A morphine range was written up. The nurses initially gave less. There was a reasonable escalation of doses. A drug chart for diamorphine was kept (p103)Mrs Davies received a standard of care that was an acceptable level., she was terminally ill and had a comfortable death.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.04 BJC/04 Edith Aubrey

Code A

Date of admission to GWMH: **12th June 1995**
Date of Death: **06.05 hours on 15th June 1996**
Cause of Death:
Post Mortem:
Length of Stay: **Nearly 1 year**

Mrs Aubrey's past medical history:-

Probable CVA
Depression with paranoid features (p480)
Ischaemic heart disease
Deafness
Arthritis of finger
Diabetes – non insulin dependent (diet controlled)(p484)
Dementia/schizophrenia

Mrs Aubrey lived at home with her husband until April 1994 when she was admitted to a Nursing Home. She had a son and 3 daughters.
She was admitted to hospital on numerous occasions.

2nd October 1994

Mrs Aubrey was admitted to hospital with a fracture to her right neck of femur. She had a 2cm x2cm graze on her right shin and a pressure sore at the top of her right lower leg.

12th June 1995

Admitted.

July 1995

Family query medication Haloperidol and asked why they were not informed.
Mrs Aubrey is noted to be agitated.

25th July 1995.

Small broken area on skin. (p881 on)
(Notes end 6/8/95 start again 11/9/95{p504})

9th September 1995

Small break on sacral area.

November 1995

Small break on sacral area.

January 1996.

Mrs Aubrey had problems with swallowing. She was assessed using the Waterlow Pressure Sore tool and had a score of 31 which is very high (p528)

March 1996

One of her daughters became unhappy with the nursing care that Mrs Aubrey was receiving.(p508)
The notes described her as becoming quite abusive. Other members of the family apologised and said that they were happy with the care she was receiving.

April 1996.

Mrs Aubrey became agitated when nails cut. Diazepam given. Fentanyl patches to control Edith's pain, which she has. (p510)

May 1996

(p512)Agitated, Fentanyl changed. Fentanyl changed to 75 mgms.

30th May 1996

Marked deterioration. Not swallowing.

June 1996

Syringe driver prescribed if required. (p514). Pressure areas in tact.

7th June 1996

Breathing deteriorated. Syringe driver commenced at 15 00 hours.

8th June 1996

Family started to stay overnight. (p512-4)

15th June 1996

Mrs Aubrey deteriorated overnight, she died at 06.05 hours. Death verified by S/N Treadore witness by S/N Tubb? Family present..

December 1997

After Mrs Aubrey's death a complaint was made from the family over the use of morphine.

Comment

Fentanyl patches used to "calm her", then increased twice. There was a risk of respiratory depression. Co Codamol used only on a few occasions.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.05 BJC/05 Henry Aubrey

Code A

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 (p24) from Haslar Hospital (p50) 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.

Comment

The main concerns here appear to be around the high doses of medication. A Fentanyl patch was applied on the day of admission and it is not clear why. Pain was not identified as a problem on admission.

The plan was to make Mr Aubrey comfortable. The nurses confirmed death.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.06 BJC/06 Ellen Baker

Code A

Date of Admission to GWMH: **7th November 1990**
Date and time of Death: **10.35 hrs on 9th November 1990**
Cause of Death:
Post Mortem:
Length of Stay: **2 days**

Mrs Baker's past medical history:-

Blackouts
Angina
Epilepsy
Osteoarthritis
Ischaemic heart disease

Mrs Baker was admitted to the Gosport War Memorial Hospital from home under the care of Dr Peters. The GP referral noted that Mrs Baker had a venous ulcer on her left leg the nurse were to continue dressings. An OT assessment was needed

7th November 1990

Mrs Baker was admitted with venous leg ulcers. She had a poor night, her pain was not controlled with regular co-proxamol. She was noted to have had 3 episodes of angina reduced by GTN.

8th November 1990

Mrs Baker continued to deteriorate. She was complaining of chest pain, sweating ++. She was seen by Dr Peters. Diamophine 5mg was given intra venously. (p18, 20, 22) Oxygen therapy continues.
No improvement in condition. Died at 10.35 am. Seen by Dr Peters and certificate in office. Death confirmed at 11.20am.

Comment

This lady was only in Gosport for 2 days. She was unwell and in pain which had been poorly controlled.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.07 BJC/06A Charles Batty

Code A

Date of Admission to GWMH: **September 1990**
Date and time of Death: **10.55 hrs on 2nd January 1994**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **3 years 3 months**

Mr Batty's past medical history states that she suffered from:-

1969 – Menieres
1973 – Partial gastrectscomy
1975 - Gastrectomy
1976 – Cervical spondylosis
1981 – Epilepsy
1984 – Prostatectomy benign
1989 – Colostomy – CA descending colon
Parkinson's Disease
History of depression.

Mr Batty lived at home with his wife. They had a daughter. Mrs Batty had CVS disease and felt that she was unable to cope. Mr Batty was admitted to the Gosport War Memorial Hospital in September 1990 for Geriatric long stay and for physio and investigation for his Parkinson's disease. It was noted that as his Parkinson's worsened he was unsteady on his feet and needed a stick and the help of a nurse.

Care Plans for sleep, colostomy, catheter, noting urinary tract infection and retention and mobility noting problem right foot, personal hygiene, epilespy and agitated were completed dated 14th November 1993.
A care plan for commenced on 27th September 1993 for red sacrum.

20th December 1993

Seen by Dr Lord – no change.

28th December 1993

Complaining of generalised pain. Seen by Dr Barton. **Oramorph 10mg 6 hourly.**

30th December 1993

Nightmare end of last week disturbed and agitated. Quick and complete recovery.
Appears in pain **Oramorph increased** 10mg 4 hourly and 20mg nocte. ? whether pain is being controlled, difficulty taking oral medication. Discussed with Carol/Rhonda happy to put syringe driver.
11.30 hours syringe driver commenced **Diamorphine 40mgs.**

31st December 1993

General condition deteriorates. Nursed on side left buttock very red. Red/blackened area noticed. Syringe driver satisfactory. Assisted when patient turned. Twitching at times.

1st January 1994

Unchanged. Nursed on side. Skin marking also on right heel.

2nd January 1994

Mr Batty died at 10.55 hours. Next of kin informed. For cremation. Seen by Dr Brand who is unable to sign death certificate as has not seen patient before. Any problems contact at surgery on Thursday and he will contact coroner.

Comment

There was a rapid increase in medication. Mr Batty was assessed for pressure damage risk using the Waterlow score. P (88) I could only find evidence of 1 assessment which showed 13, which is at risk of developing pressure damage. This should have been assessed regularly during his admission and pressure relieving surfaces supplied. I found no evidence of this in the care plan (p100/1)

This is a poor standard of care and a more aggressive approach should have been taken so that pressure damage should have been prevented.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.08 BJC/06B Dennis Brickwood

Code A

Date of Admission to GWMH: **3rd February 1998**
Date and time of Death: **21.15 hrs on 12th June 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **19 weeks**

Mr Brickwood's past medical history:-

Masangio-proliferative glomerulonephritis due to chronic renal failure
Fracture neck of femur
CA prostate
Myeloma diagnosed on bone marrow
Spinal osteoporosis
Artrial fibrillation

Prior to his admission to hospital in February 1998, Mr Brickwood lived at home with his wife. He fell and sustained a fractured neck of femur. Mr Brickwood had been his wife's main carer as she had also had hip replacements and was not mobile. It was hoped that he would be discharged home with a complete care package or go into residential care. He had deteriorating vision and had cataracts in both eyes. Mr and Mrs Brickwood had a son.
It was noted in Mr Brickwood's notes that he was allergic to morphine and was on warfarin.
Prior to his admission Mr Brickwood had a history of falls. He was a very alert man but slow at times.
He was admitted to Gosport War Memorial Hospital from Queen Alexander for rehabilitation following an operation where a dynamic hip screw was inserted.

A Waterlow score of 25 was recorded on 22nd April 1998 going down to 17.
A Barthel ADL index was completed noting 11 on 18th April 1998 going up to 17 later. The aim was to rehabilitate Mr Brickwood with a view to him going home with a complete care package.
A nutritional assessment of 3 was recorded on admission.

15th January 1998

Admitted to Hospital after fall where he sustained a fracture to the neck of femur on the right side.

20th January 1998

Operation dynamic hip screw.

3rd February 1998

Transfer to Gosport War Memorial Hospital for rehabilitation. He was nursed in a side room because he tested positive for MRSA. He was nursed on a Pegasus biwave mattress and needed the help of two nurses for transfers.

March 1998

OT assessment.

5th March 1998

Clinical notes state GP contact by nursing staff. Gets **drowsy with small amount of morphine.** Need to be cautious previously been on MST.

6th April 1998

Unsuccessful home visit.

14th May 1998

Sore heels noted. Skin intact.

24th May 1998

Complained of excessive chest pain. Impression musculoskeletal pain.

4th June 1998

No improvement. Chesty very rattly. **For morphine**. Family happy with care and **syringe driver discussed**.

5th June 1998

Higher dose of oramorph given.

9th June 1998

Changed oramorph to MST. Complaining of chest pain.

10th June 1998

Taking MST/oramorph. For syringe driver is pain not adequately controlled.

11th June 1998

Painful back- swallow and appetite poor. Seen by Dr Knapman syringe driver commenced. Family informed.

12th June 1998

Deteriorating pronounced dead by S/N Giffin at 21.15 hours. Relatives present.

15th June 1998

Death certified. For cremation.

Comment

Mr Brickwood was sensitive to morphine, this has been noted. It made him drowsy. There is no evidence that the nurses asked if other appropriate medication was available before increasing his morphine levels.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.09 BJC/07 Stanley Carby

Code A

Date of Admission to GWMH: **26th April 1999**
Date and time of Death: **13.00 hrs on 27th April 1999**
Cause of Death:
Post Mortem:
Length of Stay: **1 day**

Mr Carby's past medical history states that he suffered from:-

Left hemiplegia secondary to CVA
Angina
Obese
Hypertension
Cardiac failure
Non insulin dependent diabetic (tablet controlled)
Prostatic hypertrophy depression.

Mr Carby was married and lived at home with his wife. They had five children. Mr Carby was more or less housebound and had been for sometime. Mr Carby was transferred to Daedalus Ward after suffering a CVA. He had undergone a CT scan which showed a right parietal infarct and an old infarct. His speech was slurred and he transferred using a hoist. He was eating and drinking with assistance.

A handling evaluation was completed noting a pressure relieving mattress was in place and his skin intact. It was noted that Mr Carby needed 2 nurses and a hoist for transfers.

On 26th April 1999 a Barthel ADL index was completed and scored 1, a Waterlow score of 23 was recorded noting Mr Carby to be at very high risk of developing pressure sores. A nutritional assessment was also completed with a score of 15 recorded.

Numerous care plans were started on 26th April 1999 including personal hygiene, constipation due to mobility, swallowing, left shoulder pain, pressure sore noting Waterlow score, air mattress pressure relieving cushion and no pressure noted but unable to move to observe all areas, dysplasia, incontinent catheter insitu and assistance to sleep.

26th April 1999

Admitted to Gosport War Memorial Hospital. Daedalus ward for rehabilitation.

Clinical notes state more than happy for nursing staff to confirm death.

27th April 1999

Contact record states Mr Carby is very agitated when family left, unable to get to swallow. Referred to speech and language therapist.

Breath very shallow – colour poor.

Dr Barton contacted and will attend. Seen by Dr Barton and family spoken to. Cyanosed and clammy. Wife thinks he will not survive.

Dr said **"I will make him comfortable".** (p40)

Subcutaneous analgesia commenced.

Clinical notes state further deterioration this AM. Further extension of CVA.
Wife and daughter with him and aware. I will make more comfortable.
Mr Carby died at 13.00 hours. Family present.
Death confirmed by S/N Joyce and S/N Neville.
Family distraught and distressed.

Comment

The nursing care seems to have been an acceptable standard. The assessment of risk and of care needs and care planning was acceptable.
Mr Corby died 45 minutes after syringe driver set up. Therefore only small amount of morphine absorbed.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.10 BJC/08 Edwin Carter

Code A

Date of admission to GWMH: **8th November 1993**
Date of and time of Death: **12.05 hrs on 24th December 1993**
Cause of Death:
Post Mortem: **Burial**
Length of Stay: **47 days**

Mr Carter's past medical history shows he suffered from:-

1978 – Left Hemi (possibly stroke)
1990 – Prostatectomy
Extensive diverticular disease
Tinnitus
1980 – Cataract extraction
1993 – CA stomach
1998 – Small CVA

Mr Carter was a widower with a son and lived in a rest home in Southsea. He was a retired civil servant for the Department of Health. He was noted to be deaf and nearly blind and had a slightly slurred speech.
A number of care plans were completed dated the 8th November 1993 for catheter care, small broken area – nursed on air mattress, dry skin – hydro cream daily, hygiene, mobility, constipation, communication – due to deafness and poor sight.
A care plan for sleep was commenced on 9th November 1993.
Mr Carter was admitted to the Gosport War Memorial Hospital for pain control and long term care.
A Waterlow score of 26 was recorded on admission showing Mr Carter was at a very high risk of developing pressure sores. He had an air mattress.
An activities of daily living assessment was completed noting that Mr Carter's feet tended to swell, that he was reluctant to eat, had a catheter, needed help with personal hygiene, use of Zimmer frame for mobility, he can see shapes and needs to be spoken into his right ear. It was noted that he required sleeping tablet to help him settle at night.

8th November 1993

Transferred from Queen Alexander Hospital to Daedalus Ward. To be put on long stay list and bed at St Michael's Lodge cancelled. He was admitted for pain control due to CA stomach, Pagetts disease and bronchopneumonia.
He was noted to be immobile and needing the help of two nurses.
Notes state Mr Carter had **no pain**.

10th November 1993

Vomiting after taking MST **not complaining of pain.**

13th November 1993

Unresponsive – unable to swallow – oramorph 10mgs. Family informed if becomes restless/distress **syringe driver** to commence.

20th November 1993

Deteriorating **MST 20mg** given.

21st November 1993
Improving sat out of bed.

22nd November 1993
Seen by Dr Barton – **Mr Carter requested to stop medication.**

11th December 1993
Complaining of pain – oramorph 10mgs.

12th December 1993
Complaining of pain – oramorph 20mgs. MST dose to be reviewed.

13th December 1993
Seen by Dr Barton MST increased with top up oramorph.

20th December 1993
Seen by Dr Lord – can **commence syringe driver** when necessary.

22nd December 1993
Syringe driver commenced.

23rd December 1993
Syringe driver continues – peaceful.

24th December 1993
Pain not controlled on movement. Seen by Dr Barton.
Mr Carter died at 12.05 hours – son informed – surgery informed. For burial.
Certified by Sister Jones.

Comments

Mr Carter had a rapid increase in the dosage of morphine. The dosage in the syringe driver was high. The nurses should have questioned the large amounts of morphine especially as initially Mr Carter was not complaining of pain.

The nursing care on other aspects of care was acceptable.

Yet again a nurse has certified the death of a patient.
It would be helpful to see the hospital protocols for signing a death certificate.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A			3A	
Unclear B				
Unexplained by Illness				

The **administration of medicines** is an important aspect of the professional practice of persons whose names are on the Council's register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner. It requires thought and the exercise of professional judgement on the part of the nurse who must also apply knowledge and skill to the situation that pertains at the time.

This means that, as a matter of basic principle, whether administering a medicine, assisting in its administration or overseeing self- administration, the practitioner will be satisfied that he or she:-

- Has an understanding of substances used for therapeutic purposes
- **Is able to justify any actions taken**
- Is prepared to be accountable for the action taken

In addition, acting in the interests of the patient, the practitioner will:

- Carefully consider the dosage, method of administration, route and timing of administration in the context of the condition of the specific patient at the operative time.

6.11 BJC08A Edith Chivers

Code A

Date of admission to GWMH:
Date and time of Death: **00.50 hrs on 19th August 1990**
Cause of Death:
Post Mortem:
Length of Stay:

Mrs Chivers past medical history:-
1988 – CVA
Long term geriatric list

Mrs Chivers was a widowed in 1985 and then went to live with her elderly blind sister. It became clear that she could not cope at home so was admitted to a home.

8th November 1989

Transferred to Red ? ? Niece notified.

10th August 1990

Further deterioration – pain relief.

19th August 1990

Died at 00.50 hours. Confirmed by S/N Barrington.
16.00 hours death confirmed.

Comments

It has not been possible to form an opinion in this case as the information supplied is inadequate.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B				
Unexplained by Illness				

6.12 BJC/09 Sidney Chivers

Code A

Date of admission to GWMH: **11th May 1999**
Date and time of Death: **19.10 hrs on 20th June 1999**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **40 days**

Mr Chivers past medical history:-

CCF
Confusion
Hypertension
Register partial sighted
IHD
Varicose veins
Hallucinations

Mr Chivers was widowed in 1995 and lived alone. He had lived in the same council house for twenty years and had just applied for a flat nearby. He had a daughter who helped with shopping and cleaning but managed without help apart from meals on wheels. Mr Chivers also had two sons in Gosport and two other sons in Southampton and Havant. Prior to his admission he had started to neglect himself.
Mr Chivers had numerous admissions to hospital. In May 1999 he was admitted to the Gosport War Memorial Hospital from the Queen Alexander Hospital for rehabilitation after suffering another CVA, CCF, CXR right plural effision and chest infection.

On admission an assessment and patient profile was completed. A handling evaluation was also completed noting that Mr Chivers needed the help of 1 or 2 nurses.
A nursing assessment was completed and several care plans were commenced including hygiene, constipation, transferring and help to settle at night.
A Barthel ADL index was completed ranging from 10-15. A nutritional score of 17 was recorded.
A Waterlow score of 15 and 17 was also recorded.

11th May 1999

Admitted to Gosport War Memorial Hospital from Queen Alexander Hospital where he had been admitted as an emergency by his GP with right CVA, CCF, CXR right pleural effision, possible chest infection. He was admitted onto Dryad Ward for continuing care.

14th May 1999

Complaining of increased pain – feeling unwell.

17th May 1999

Depressed – Seen by Dr Reid – scan at Haslar to be arranged.

21st May 1999

Brain scan – CVA at Haslar.

24th May 1999

Walking unaided.

2nd June 1999

Very confused at times. ? aim for home for trial period three to four days next week. Discuss with family.

7th June 1999

Hallucinating/distressed.

15th June 1999

Catherised – complaining of feeling weak and pain. Had to be fed. Oramorph commenced 5mgs. ? Lewi body disease.
To be discharged to rest home not for home.

16th June 1999

Fentanyl commenced 25mgs plus oramorph 5mgs.

17th June 1999

Slept long periods.

18th June 1999

In a lot of pain on movement. Bowels not open for a few days. Oramorph given. Syringe driver to be considered.
Deteriorating.

19th June 1999

Seen by Dr Brooks syringe driver commenced 40mgs diamorphine.

20th June 1999

Deteriorated. Bronchopneumonia on S/C analgesia. Syringe driver (2 drivers) reprimed diamorphine 60mgs.
19.10 hours died. Death confirmed S/N F? and Nurse B?
For cremation.

Comment

The nurses only gave half the dose of diamorphine on16th June 1999.
Respiradone may have contributed to immobility.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.13 BJC/10 Hubert Clarke

Code A

Date of admission to GWMH: **5th June 2000**
Date and time of Death: **13.55 hours on 17th June 2000**
Cause of Death:
Post Mortem:
Length of Stay: **13 days**

Mr Clarke's past medical history shows he suffered with:-

Gastric ulcer
TIA
Angina
Glaucoma
Chronic leg ulcer
TB
Appendicectomy

Mr Clarke was a widower who lived alone. He had two daughters, one would help cook and clean. He coped well and had the use of a stair lift in his home and meals on wheels would visit. He was admitted to Gosport War Memorial Hospital following a fall at home.

On admission an assessment was completed. A handling profile was completed noting a Waterlow of 18 an airwave mattress was provided. It was noted that Mr Clarke needed the help of 2 nurses to transfer and move.
A Barthel ADL index was completed with scores of 11 and 0 recorded.
A nutritional assessment with a score of 11 was also completed.
Care plans were completed for hygiene, reduce mobility, settle at night, graze left knee after fall, catheter and constipation.

5th June 2000

Admitted to Gosport War Memorial Hospital from home following a fall. It was noted that he had suffered with CVA, Trans Ischaemic Attack, falls and chest infection. He was described as unsteady on his feet and very sleepy.

6th June 2000

Chest pain. Fall – found on floor in corridor attempted to walk unsupervised. Abrasion left knee. Accident form completed. Daughter informed.

7th June 2000

May need placement due to falls.

8th June 2000

Chest pain – GTN spray O2 and oramorph given. Family GP agree to treat palliatively only.

9th June 2000

Restless/breathless. Catherised. Diagnosed with pneumonia.

12th June 2000

Deteriorating – S/C **diamorphine** 5mgs 4 hourly.

15th June 2000

Add diamorphine to syringe driver 5mgs.

17th June 2000

Died at 13.55 confirmed by nurse. Seen by Dr Burgess at 14.40 hours. No one was present when Mr Clarke died but nurse had been in to see him a short time before.

GosDoc visit to Sultan Ward – Dr Burgess confirmed death at 14.40 hours.

Comments

This was an elderly man. He was admitted after a fall. The nursing assessment appears to have been comprehensive and the care plans appropriate. 5mgms diamorphine by syringe driver. His family were present and he died a comfortable death.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

Code A

Code A

Code A

Code A

Code A

Code A

REPORT BY:- IRENE WATERS RGN, RHV, LL.M., M.N. M.Sc.Public Health
SPECIALIST FIELD:- NURSING CARE
REPORT ON THE NURSING CARE AT GOSPORT WAR MEMORIAL HOSPITAL
INSTRUCTED BY:- HAMPSHIRE POLICE

Code A

6.17 BJC/14 Ronald Cresdee

Code A

Date of Admission to GWMH: **17th June 1996**
Date and time of Death: **23.40 hours on 7th July 1996**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **21 days**

Mr Cresdee's past medical history:-
CA Lung

Mr Cresdee was a widower living on his own at home. He had two sisters, a son and daughter. Mrs Cresdee's son was in the Navy and prior to his admission Mr Cresdee's son had been on leave to help look him as he was finding it hard to manage. The district nurse was visiting twice a week. Mr Cresdee was admitted to the Gosport War Memorial Hospital as he had deteriorated.

On admission to GWMH care plans for elimination, PEG feed, sleep and hygiene were all completed.
A nutritional assessment for June and July with scores of 12-18 was completed as well as a lifting and handling risk calculator for the same period was also recorded with a score of 10-13.
A Waterlow score of 15 and 23 and a Barthel ADL index with a score of 8 were all recorded in June.

17th June 1996

Admitted to Gosport War Memorial Hospital with CA bronchus, oesophageal metastases noted.
The notes indicate that Mr Cresdee was PEG fed, nauseous, disorientated, continent, had reduced mobility and that his pressure areas were intact.
It was noted at 23.00 hours Mr Cresdee had a fall where he fell backwards onto the floor. He was checked for injuries – none found and helped back to bed. 5mgs oramorph given. Accident form completed.

19th June 1996

To have regular 4 hourly oramorph. Swab for MRSA.

21st June 1996

Minimal pain. MRSA negative.

27th June 1996

Increase oramorph 10mgs 4 hourly.
Condition worsening – coughing up blood coloured sputum.

29th June 1996

Unlikely to tolerate syringe driver – very agitated.

1st July 1996

Paranoid delusions.

3rd July 1996

Unconscious but rousable. Very bubbly breathing, pyrexial. Chest infection developing.

Notes state got up from chair and staggered backwards and sat on bottom. No injuries. Has carpet burns on knees from crawling up the corridor.

4th July 1996

Agitation increasing – syringe driver 50mgs over 24 hours. Oramorph 20mgs.

6th July 1996

Syringe driver with diamorphine – quite bubbly. Seen by Dr Yound increased to 10mgs over 24 hours.

7th July 1996

Not restful, coughing, bubbly. Up diamorphine to 150mgs over 24 hours. 23.40 died verified by S/N Jarman and SEN Nelson. For cremation. Next of kin notified.

Comments

Nursing assessment and care appears satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.18 BJC/15 Arthur Cunningham

Code A

Date of admission to GWMH: **21st September 1998**
Date and time of Death: **23.15 hrs on 26th September 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **6 days**

Mr Cunningham's past medical history:-

Dementia
Spinal injury
Parkinsons
Diet controlled diabetes

Mr Cunningham was an RAF pilot who was invalided out after an air crash where he injured his spine and broke his legs. Mr Cunningham had been married twice and widowed twice, he had 7 stepchildren who he had little contact with. Mr Cunningham had lived in warden-controlled accommodation until he could not longer manage. A place at Merlin Park Rest Home was found for him and he arrived there in April 1998. It was noted that he was unhappy there and difficult to manage. He was transferred to Alverstoke House Rest Home in June 1998. After a brief spell in hospital Mr Cunningham was transferred to Thalassa Nursing home where notes on 11th September states he had settled in well and there were no problems but could be awkward. His place was to be reviewed a month later and Mr Cunningham was to be monitored at the Dolphin Day Hospital for his condition.
Mr Cunningham was admitted to the Gosport War Memorial Hospital on 21st September 1998 because of his physical decline and a large necrotic sacral pressure sore.

On admission a patient profile was completed noting that he had a pressure area broken on his sacrum. Has spenco mattress and wheelchair cushion. It also noted that a catheter was in situ.
An assessment sheet was completed noting the Mr Cunningham was unaware of his condition. An assessment of daily living was also completed noting occasional shortness of breath, diabetic diet – appetite poor, ankles swell at times, back pain, walks short distance with a stick and uncomfortable at night – difficult to turn.
A mouth assessment was completed. A Barthel ADL index was completed on 22nd September 1998 with a score of 0.
Care plans for personal hygiene, catheter, settle at night, assist position change, sacral sore – oramorph 10mgs and one for blister on left heel.
A Waterlow of 20 was scored on 22nd September 1998 noting sacral wound swab taken 14th September 1998.
A handling profile was completed with notes stating turning with difficulty, Pegasus airwave mattress, guidesheet and 2 nurses needed to transfer in bed.
A nutritional assessment on 24th September 1998 scored 21.

21st September 1998

Admitted from Dolphin Day Hospital to Dryad ward. Physical decline, large necrotic sacral sore ulcer. For more aggressive treatment to pressure sore. Oramorph to be given 5mgs prior to dressings.

Nursing notes state terminally ill not expected to live past the weekend, sister on ward.

Daily summary notes seen by Dr Lord – pressure sore looked worse although Nursing Home thought it had improved. Photograph taken, black are now on buttocks.

Plan:- admit Dryad Ward for treatment to pressure area.

Ask Thalassa to keep place for 2/3 weeks at least contact social worker.

Sleep care plan notes driver commenced at 23.10 hours diamorphine 20mgs and midazolan 20mgs. Sacral sore oozing exposed as requested.

22nd September 1998

Syringe driver charged 20mgs appears less agitated.

Sleep care plan states syringe driver running as charted.

23rd September 1998

Letter states admit for more aggressive treatment to wound. Keep place at Nursing home open for next 3 weeks.

Sleep care plan states agitated at 23.00 hours syringe driver boosted. In discomfort when moved. Syringe driver prior to position change.

24th September 1998

S/C analgesia controlling pain. **Happy for nursing staff to confirm death.**

In pain syringe driver renewed 40mgs. Dressing renewed nursed on alternate sides.

Sleep care plan, nurse side to side. Syringe driver running, sounds chesty.

25th September 1998

Diamorphine 60mgs.

Sleep care plan notes peaceful night – position changed.

26th September 1998

Deteriorating – diamorphine 80mgs.

Died 23.15 hours. Cremation.

Confirmed by S/N Turnbull and S/N Tubbritt. Stepson notified.

Comments

This gentleman had difficult and challenging behaviour. He had a Grade 4 pressure sore on admission and the nurses were taking steps to improve this and prevent further damage by regular turning and nursing on alternate sides. The pressure damage would have been painful.

On very high doses of midazelan and rapid escalation of diamorphine.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness				

6.19 BJC/16 Elsie Devine

Code A

Date of admission to GWMH: **21st October 1999**
Date and time of death: **20.30 hrs on 21st November 1999**
Cause of death:
Post Mortem:
Length of Stay: **31 days**

Mrs Devine's past medical history:

Chronic renal failure with small kidneys
Nephrotic syndrome
LgA lambda paraprotein
Hypothyrodism
Dementia
Mycloma

Mrs Devine was born in Gosport. She was a widow and lived with her daughter and son in law. She also had a son who lived in Kent. Due to Mrs Devine's son in law having cancer and her daughter feeling she could no longer cope, a referral was made to social services for residential care as Mrs Devine needed 24 hour care.
Mrs Devine was admitted to Queen Alexander Hospital on 9th October 1999 for increased confusion and ?UTI. In notes on 11th October 1999 it noted that Mrs Devine's daughter was upset about the standard of care her mother was receiving. Mrs Devine underwent a CT scan on 13th October 1999 before being transferred to the Gosport War Memorial Hospital for rehabilitation and continuing care on 21st October 1999.

On admission care plans were commenced dated 22nd October 1999 for personal hygiene, sleep and constipation. A handling profile was completed noting skin dry but intact, assistance of 1 nurse and a hoist.
A Waterlow score of 20 was recorded on 21st November 1999.
A Barthel ADL index of 1 was also recorded on that day. A nutritional assessment on 21st October 1999 scored 11 noting that Mrs Devine was confused and weighed 52.5kgs.

21st October 1999

Daily summary states admitted from Queen Alexander Hospital after confusion and increased aggression. Aggression resolved but still confused. Pleasant lady – appetite not good little unsteady on feet. Cold on admission – feet swollen. Seen by Dr Barton.
Transfer to Dryad ward for continuing care. Barthel 8, transfer with 1 and continent. Plan:- to assess rehabilitation to continue, looking for Residential Home in due course.

25th October 1999

Seen by Dr Reid – continue.

1st November 1999

Daily summary states seen by Dr Reid commenced amiloride 5mgs to be weighed twice weekly, for home visit.
Home visit to see if function better in own home.

3rd November 1999

Contact record – son and daughter in law concerned safety of Mrs Devine returning home. Referral made to social services.

12th November 1999

Seen by social worker 24 hour chart to be completed

15th November 1999

Very aggressive/restless at times.
Daily summary states seen by Dr Reid referral made to Dr Luznat.

18th November 1999

Put on waiting list for Mulberry Ward.

19th November 1999

Marked deterioration overnight. Confused/aggressive. **Fentanyl patch started** yesterday. Further deterioration today. Need S/C analgesia with Midazalon. Son seen and aware of condition.
Please make more comfortable happy for nursing staff to confirm death.
Daily summary notes marked deterioration over last 24 hours extremely aggressive, refusing help.
Syringe driver commenced at 9.25 diamorphine 40mgs and Midazolam 40mgs. Fentanyl patch removed. Seen by Dr Barton situation explained.
Peaceful night syringe driver recharged 07.35 hours diamorphine 40mgs.
Contact record - social services to close case. Mulberry ward also informed.

20th November 1999

Daily summary states condition remains poor, family aware of condition.
Seen by pastor Mary.
Peaceful night – skin marking. Condition changed regularly. Extremities remain oedamatous. Syringe driver recharged 07.15 hours diamorphine 40mgs rate 50.

21st November 1999

Daily summary states condition continues to deteriorate slowly. Family visited. Driver satisfactory
Asked to see at 20.30 hours died peacefully.
Death verified by S/N Dunleavy in presence of E/N Wigfall.

Comments

No pain why diamorphine. Fentanyl patch taken off, when on? Aggressive sedation- no pain recorded.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness		2C		

6.20 BJC/17 Cyril Dicks

Code A

Date of Admission to GWMH: **28th December 1998**
Date and time of Death: **22.00 hrs on 22nd March 1999**
Cause of Death:
Post Mortem:
Length of stay: **85 days**

Mr Dicks' past medical history:

1955 – Cervical polyp
1980 – Loss of vision left eye, sub-retinal haemorrhage
1987 – left colles fracture
1996 – AF – digoxin
1999 - Cognitive impairment confirmed dementia.
1999 – CVA
2001 – Chest Infection
2001 – August – CVA
2001 – CVA with persistent dysphagia – insertion of PEG tube

Mr Dicks was the youngest of six brothers. He was a retired taxi driver. His wife died in 1993 they had been married for 50 years and had a daughter and son. Mr Dicks lived at Pier House Residential Home. He wore a hearing aid in his left ear and glasses. It was noted that he smoked 2/3 cigarettes a day and was reluctant to eat. He was dependent on nursing staff for all hygiene needs and could only walk a few steps at a time. Mr Dicks was admitted to the Haslar Hospital from the home with pneumonia. It was noted that while at Haslar Hospital Mr Dicks was nursed on a bed with a pressure relieving mattress and cot sides and that he had some red marks in places that were dry but unbroken. Mr Dicks was admitted to the Gosport War Memorial Hospital on 28th December 1998 with pneumonia that had been treated with IV and oral antibiotics, confusion, doubly incontinent and urinary tract infection. It was also noted that he had a catheter insitu.

On admission a Barthel ADL index was completed from 29th December 1998 scoring 2 to 14th May 1999 also scoring 2 the scores reached no higher that 4. An abbreviated mental study was completed on 29th December 1998 with a score of 3 recorded.
A Waterlow score of 14 was recorded on 29th December 1998. With a handling profile also completed on that day noting that Mr Dicks skin was intact need a pressure relieving cushion and 2 nurses and a hoist to help transfer.
Care plans for confusion, reduce mobility, retention of urine – catheterised size 12 and help to settle at night were completed starting on 29th December 1998.

Whilst at Gosport War Memorial Hospital Mr Dicks had a number of falls where he only sustained minor cuts and bruising. Treatment was administered and he was helped back to bed.

28th December 1998

Admitted from Haslar with pneumonia that had been treated with IV and oral antibiotics, confusion, he was doubly incontinent and had a urinary tract infection and had been catheterised.

4th January 1999

Remains poorly not eating or drinking well. Please make comfortable. **Happy for nursing staff to confirm death.**

11th January 1999

Daedalus ward/NHS continuing care. Barthel 4/20 – reluctant to do much not eating or drinking. Prefers to be in bed. Plan:- to give up Pier House for Nursing Home if stable in early February 1999.

15th January 1999

Contact record – found on floor in lounge PM, examined small grazes on left hand – reassured and put to bed. Son informed.

17th January 1999

Contact record - found on floor in lounge- no apparent injury. Behaviour very irrational PM.

18th January 1999

Did not wake up this morning, stiff unrousable, not in pain – please make comfortable. **Happy for nursing staff to confirm death.**

Contact record – reviewed by Dr Barton. Extremely sleepy. Family wish Dad to be made more comfortable.

19th January 1999

Remains poorly – unresponsive. Family aware – no active treatment required not for any fluid replace. Use S/C analgesia if necessary.

20th January 1999

Catheterisation due to urinary retention.

22nd January 1999

Contact record – Mr Dicks got off commode and sat on floor. Accident form completed.

25th January 1999

Spent a lot of time in bed. Can transfer unaided. Barthel 3/20 – aggression short lived.

Daughter seen – aware very unwell and may not survive. Agreed not for NG feeds, not for antibiotic if pyrexial and NHS continuing care until early March 1999.

Contact record – seen by Dr Lord – daughter seen and is aware of prognosis in event of change of condition or chest infection to be kept comfortable.

8th February 1999

Small black spot on left heel.

15th February 1999

A bit better – eating more. Barthel 1-2/20.

1st March 1999

Not drinking much. Barthel 1/20 – no new medical problems. Heels vulnerable.

2nd March 1999

Contact record – found on floor by chair, cut to upper lip, contusion to left eye.

3rd March 1999

Podiatry – left 1st lat side toe red and inflammed.

5th March 1999

Podiatry – sat in chair. Right 2nd toe red medical side. Left 1st still red.

8th March 1999

Fall – left perior? Bruising + upper limb. Barthel 2/20. Review end of month.

9th March 1999

Contact record – seen by Dr Lord – no change.

10th March 1999

Podiatry – left 1st much improved virtually healed. Right 2nd also improved.

13th March 1999

Contact record – found on floor by side of bed. Checked for injuries.

15th March 1999

No great change. Barthel 2/20.

16th March 1999

Contact record – fell to floor in lounge. Abrasion right eye. Accident form completed.

18th March 1999

Contact record – bruising also noted on right side hip.

20th March 1999

Not so well – in pain when being moved in bed. Generalised twitching and distressed.

22nd March 1999

Marked deterioration over weekend. Family happy with treatment. Died at 22.00 hours found by S/N Basher. Death confirmed at 23.10 hours by SSN Farrell.

Contact record – 22.00 hours found in bed dead. Daughter informed does not want to see.

Comments –

The drug administration charts are missing. It is not clear if diamorphine infusion given.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.21 BJC/18 Kathleen Ellis

Code A

Date of admission to GWMH: **23rd June 1999**
Date and time of Death: **06.15 hours on 5th July 1999**
Cause of Death:
Post Mortem:
Length of Stay: **13 days**

Mrs Ellis' past medical history:-

1994 – Right colles fracture
1996 – Right elistat fibula fracture
MI
1997 – Fractured pelvis after fall.

Mrs Ellis lived in a council house with her son. There were 5 children. In 1997 Mrs Ellis' son was no longer able to cope so Mrs Ellis went to live in Merlin Park Residential Home. She had lived there for 18 months when during the last 6 months she had had a number of falls and her mobility decreased. She was admitted to the Queen Alexander Hospital on 7th June 1999 as an emergency admission via her GP with acute confusion, CVA and a lower left chest infection. Mrs Ellis was transferred to the Gosport War Memorial Hospital on 23rd June 1999 for continuing care and assessment.

On admission an assessment sheet was completed noting Mrs Ellis does not know why she is in Hospital, she was hard of hearing, had poor sight and was confused and disorientated.
A Barthel ADL index was completed on 28th June 1999 and 4th July 1999 both scoring 0.
A Waterlow score of 28 was recorded on admission.
A Handling profile was completed on 23rd June 1999 noting that Mrs Ellis was vague, confused but complaint, does not appear to be in any pain, wound to left leg, nursed on Nimbus mattress and needs 2 nurses and a hoist for transfers.
Care plans commenced on 24th June 1999 for incontinent – catheter care, reduced mobility, pressure area care – bottom very red, cream applied and dressing to legs intact, personal hygiene, nutrition and night care.

23rd June 1999

Transferred from Queen Alexander Hospital. The transfer form notes that Mrs Ellis is immobile, uses a hoist for transfers, takes little diet, has a leg wound on her left leg, a Waterlow score of 30 and a Barthel score of 0. It notes that she had dementia, chest infection, dehydration and had fractured left arm 2 months ago. It also states Mrs Ellis is for continuing care and assessment.

27th June 1999

Contact record – appears chesty today. Unsure if she can swallow.

28th June 1999

Clinical notes state Barthel 0, eats and drinks small amounts, skin left elbows red and has problem with short term memory. Plan: to keep Residential Home

place open for 1 month, SLT to assess swallow, Collar and cuff left arm, son feels she has been depressed for months, 4-6 weeks NHS continuing care decided end July if Residential Home place needs to be kept open.
Contact record – seen by Dr Lord and son present. Not fit enough to return to Merlin Park assess for another 4-6 weeks.

29th June 1999

Generalised ? not unwell. Make comfortable**, happy for nursing staff to confirm death.**
Seen by SLT.
Contact record – NG attempted- spoke with son.

30th June 1999

Contact record – four attempts to pass nasogastric tube without success.

1st July 1999

Failed NG tube. Son tried to give ice-cream last night. Seen by Dr Lord.

2nd July 1999

Contact record – legs oedamtous and marking – discussed with Dr Barton. Family informed and aware of condition.

5th July 1999

06.15 hours died. Daedulus ward. Certified **by SSN Farrell.**

Comments

The nurses appear to have made a comprehensive assessment and appropriate care plans. The prescription was incorrect but not administered.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.22 BJC/19 Mary (Marie) German

Code A

Date of admission to GWMH: **28th November 1998**
Date and time of Death: **00.05 hours on 3rd December 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **6 days**

Mrs German's past medical history:-
CA Lung
Osteoporosis

Mrs German lived alone in a 2nd floor flat. She had two daughters, one lived in Gosport and the other in Southampton. Both helped with Mrs German's domestic chores and apart from that Mrs German had no outside help. It was noted that Mrs German wore glasses and had occasional problems with swallowing. In November 1998 Mrs German's GP wrote that she was in a great deal of pain, had not slept, was depressed and had limited support as she lived alone and needed help with pain control. Mrs German was discharge from St Mary's General Hospital following radiotherapy on 27th November 1998 and was admitted to the Gosport War Memorial Hospital on 28th November 1998 for palliative care.

On admission to Gosport War Memorial Hospital an assessment was completed noting that Mrs German was aware of her condition. A Handling profile dated 28th November 1998 stated that Mrs German had pain in her back, dry skin on her legs and that she was nursed on a biwave plus mattress.
A Barthel ADL index score of 14 was completed on 28th November 1998 with a Waterlow score of 11 also recorded on that day.
A nutritional assessment also dated the 28th November 1998 was recorded with a score of 9.
Care plans commenced on 29th November 1998 for shortness of breath, oedema to legs and sacral area ? secondary to heart failure, hygiene and help to settle at night.

28th November 1998
Recently discharge from St Mary's Hospital after radiotherapy to CA left lung. MST 35g b/d. Cannot cope at home.

29th November 1998
Sacral pud/ankles swelling. Impression heart failure.

30th November 1998
Confused as well as breathless.

2nd December 1998
Increasingly short of breath and secretions. Denies pain/discomfort.
Oramorph 7.5ml 4 hourly. Still eating and drinking a little.
30mg Diamorphine syringe driver.

3rd December 1998

Died peacefully 00.05 hours. Death verified by S/N Dorrington. For cremation. Daughters visited.

Comment

This lady was admitted for palliative care. The nurses made a comprehensive assessment and appropriate care plans were made.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.23 BJC/20 Leonard Graham

Code A

Date of admission to GWMH: **16th August 2000**
Date and time of Death: **13.40 hours on 14th September 2000**
Cause of Death: **Bronchopneumonia**
Lewy Body Dementia
Post Mortem: **Yes**
Length of Stay: **31 days**

Mr Graham's past medical history:-
Lewy Body Dementia
Hallucinations
Prostatectomy
BOO
CA lung
Hernia
Bronchoscopy
UTI
Idiopathic Parkinson's disease

Mr Graham was born in Scotland. He joined the Navy and moved to the south coast in 1946 where he met and married his wife. They had 2 daughters and up until 1987 Mr Graham worked in a dockyard. Mr Graham lived with his wife in their own three bedroom house. Mr Graham's wife was his main carer. Mr Graham was admitted to the Gosport War Memorial Hospital on 4th September 2000 after being admitted to the Queen Alexander Hospital on 16th August 2000 with chest infection, urinary tract infection, poor mobility and with swallowing difficulties. It was noted that Mr Graham was allergic to codeine and haloperidol.

On admission a handling profile was completed on 4th September 2000 noting that Mr Graham did not appear to be aware of his surrounding, he was not complaining of pain and was to be nursed on an air mattress.
A Barthel ADL index was completed on the 4th and 10th September 2000 both scoring 0.
Care plans commenced on 4th September 2000 for catheter care/hygiene/ constipation and night care.

4th September 2000

Admitted to Daedleus ward from John Pounds ward Queen Alexander Hospital for continuing care. The transfer form notes that Mr Graham incontinent of urine and faeces, requires hoist to transfer, needs a pureed diet and thickened fluids and requires feeding. It also noted that Mr Graham was being nursed on a Huntley bed.
Clinical notes state prognosis poor.
Contact record seen by Dr Lord – soft moist diet. Wife offered bed at St Christopher House will put on waiting list.

5th September 2000

Remains the same. No reports of agitation.

6th September 2000

Brighter today. Engaging with other people. Less dehydrated.

9th September 2000

Catheterised.

11th September 2000

Barthel 2/20 – poor oral intake. Can be aggressive to nursing staff. Very confused. Overall prognosis poor.

Wife seen discussed Lewy Body Dementia appreciates that Mr Graham is quite unwell and too dependent now for Discharge planning.

In the event of chest infection need to discuss transfer back to acute with wife if antibiotics required.

Contact record seen by Dr Lord wife seen and is aware of poor outlook would like husband home if possible.

12th September 2000

Seen by SLT continue puree diet. Monitor chest status and review oral feeding if signs of chest infection.

14th September 2000

Unresponsive, nursing staff noted grey colour. Became agitated unable to obtain BP or oxygen sats. Given 2.5mg diamorphine S/C explained to wife that difficult to know exactly what was happening possible clot from legs going to lungs.

13.40 hours death confirmed by P ? C Nurse and S Webb.

15th September 2000

Cause of death: Lewy Body Dementia. Contacted by wife concerned re cause of death – surprised and asked if people could die of dementia – given details about post mortem.

Discuss with Dr Lord discussion with wife – best to refer to coroner for post mortem.

Discussion with coroner's office – for post mortem.

Discussion with wife – explained case referred to coroner for post mortem tomorrow.

Comment

Nursing assessment seems comprehensive and care plans appropriate

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.24 BJC/21 Sheila Gregory

Code A

Date of admission to GWMH: **3rd September 1999**
Date and time of Death: **17.20 hours on 22nd November 1999**
Cause of Death:
Post Mortem:
Length of Stay: **111 days**

Mrs Gregory's past medical history:-

CVF
Hypertension
Asthma
Hypothyroidism
Left ventricular failure
Depression
Confusion
Mitral regurgitation

Mrs Gregory was a widow. Her husband died in 1983 and was a postman. Mrs Gregory lived alone in a warden controlled flat with her family helping out. She had a daughter, 3 grandchildren and 5 great grandchildren. One of her granddaughters was noted as her next of kin. Mrs Gregory was admitted to the Gosport War Memorial Hospital on 3rd September 1999 from the Royal Haslar Hospital after being admitted on 15th August 1999 after a fall at home in which she sustained a fractured right neck of femur. Mrs Gregory underwent surgery on 16th August 1999 and had a dynamic hip screw inserted. The transfer form notes that Mrs Gregory mobilised with the help of one nurse and a Zimmer frame, a catheter in place due to repeat incontinence, that she was allergic to penicillin and at times became confused.

During her stay at the Gosport War Memorial Hospital care plans commenced on 3rd September 1999 for sleep, wound to skin on lower right leg, constipation, catheter and personal hygiene. Other care plans were commenced on 1st October for wound just below left knee, 16th October skin flap right forearm, 22nd October poor appetite, 27th October 2nd skin flap right hand, 28th October catheter removed and 17th November skin flap left lower arm.
The nurses took photographs of Mrs Gregory's skin as it bruised easily. (p53).took

Comment

The drug chart does not note that Mrs Gregory had a penicillin allergy (p136)
P70. Dr Barton happy for the nurses to confirm death.
Diamorphine and Hyacine written up on 3rd September but not given.
From 18th November "allowed to die".
P 224. Oramorph for distress.
P66 3rd September, should have checked creatinine levels. Weighed 45.3KG, aged 91.
Cause of breathlessness not investigated, chest infection, over sedation.

Double dose of oramorph at night, standard at that time.
High dose of opiates for someone with poor liver function.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness				

6.25 BJC/22 Harry Hadley

Code A

Date of admission to GWMH: **5th October 1999**
Date and time of Death: **06.50 hours on 10th October 1999**
Cause of Death:
Post Mortem:
Length of Stay: **5 days**

Mr Hadley's past medical history:-
CA bladder – diagnosed July 1999

Mr Hadley was a widower and lived alone in a flat. He had a daughter who was his main carer and a son. She became unable to cope any longer.
Mr Hadley was admitted to Gosport War Memorial Hospital on 5th October 1999. Mr Hadley had a long term catheter in situ, had to wear compression stockings for lymphoedema. Mr Hadley was immobile and required the help of two nurses plus aides. It was noted that Mr Hadley's genitalia was quite swollen and that his sacrum was red and grazed and dressed with granuflex and looked likely to breakdown.

On admission an assessment sheet was completed noting that Mr Hadley appears fully aware of his condition stated that he is dying but wishes it was sooner rather than later. It noted that he wore glasses for long distances and reading and that he had a small appetite and had difficulty with chewy food.
Care plans were commenced on 5th October 1999 for hygiene, catheter care – penis oedematous and scrotum swollen and skin excoriated, pain in pressure area – broken area x 2 to left buttock, cleft of buttock excoriated and heels discoloured and at risk, constipation, reduced appetite and help to settle at night.
A nutritional screening tool was also completed on 5th October noting a score of 17.
A Waterlow score of 15 was recorded on 5th October, pressure sore documentation noted that Mr Hadley was nursed on a Pegasus mattress and that dressing of duoderm was applied to buttocks.
A Barthel ADL index also dated 5th October scored 3.
A handling profile on 5th October noted that Mr Hadley was able to communicate effectively, that he had pain in the lower half of his body when turned, that he had 2 broken areas on his left buttock and that the cleft of his buttock was excoriated. It also noted that Mr Hadley needed the help of two nurses and nursed on a Pegasus airbed.

5th October 1999

Clinical notes state CA bladder with metasteses. Has been in a little discomfort. For TLC. Family concerned re: change in medication.
Summary states admitted from C3 Royal Haslar Hospital admitted there on 22th September 1999 with acute retention of urine.
15.00 hours seen by Dr Pennels MST discontinued for diazepam 5mgs.

19.30 hours relatives expressed concern over medication and analgesia control. Dr Shawcross to rewrite MST.

6th October 1999

Clinical notes state that Mr Hadley is fine to have MST.

7th October 1999

Summary states seen by Dr Pennells commenced on syringe driver 60 mgs diamorphine 100mg cyclonize happy for that to be increased. Daughter visited and explained about syringe driver and poor prognosis.

8th October 1999

Summary notes seen by Dr Shenton second syringe driver commenced.

9th October 1999

Clinical notes state agitated, restless, twitchy ++, seems unable to speak yet looking around. Rattly chest.
Was on 20mg MST bd changed to syringe driver from past 48 hours with 60mg diamorphine for past 24 hours.
Wonder if agitation is due to rapid increase in diamorphine or hyoscine. Try reducing diamorphine back to 30 mgs in 24 hours (equiv to 50mg MST bd).
PM – getting chesty and distressed increase rate from 60mm/day to 99 and then change to 60mg diamorphine over 24 hours when it runs out.
Hyoscine can be given 4-5 hourly.
Summary state seen by Dr Yeo diamorphine reduced to 30 mgs very chesty.
21.30 hours distressed seen by Dr Chilvers syringe driver increased from **60mm to 99mm over 24 hours**. When infusion complete resume to 60mm with 60mg diamorphine.

10th October 1999

Patient confirmed dead at 06.50 hours by S/N Pe?

Comment

Rapid escalation of diamorphine.
Nurse have made comprehensive assessment and appropriate care give with exception of querying drug dosage.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.26 BJC/23 Charles Hall

Code A

Date of admission to GWMH: **5th July 1993**
Date and time of Death: **11.25 hours on 6th August 1993**
Cause of Death:
Post Mortem:
Length of Stay: **32 days**

Mr Hall's past medical history:-
Peripheral vascular disease
Non insulin dependent diabetic
Iron deficiency anemia

Mr Hall was married and lived with his wife in their own home. They had a daughter and received good help form their neighbours. Mrs Hall was finding it increasingly difficult to cope.
Mr Hall was admitted to the Royal Haslar Hospital where he underwent a sigmoid colectomy and colostomy following diverticullitis and a gangerous gall bladder. He was transferred from Haslar Hospital to Gosport War Memorial Hospital on 5th July 1993 for nursing care and assessment.

Care plan were commenced on 5th July 1993 for a blackened area to left heel, 7th July 1993 right elbow red and flaky, sacrum red and dry, 10th July 1993 sacrum slightly red, 14th July 1993 hygiene, poor mobility, vomiting, urinary incontinence, settle at night and colostomy.
An assessment of daily living was completed noting that Mr Hall had some shortness of breath on exertion, needed a diabetic diet, colostomy satisfactory, mobilises short distances with Zimmer frame.
A Waterlow score of 21 was recorded on 5th July 1993 and one of 22 was recorded on 29th July 1993.

5th July 1993
Admitted to Sultan ward from Haslar for nursing care and assessment.
Sigmoid colectomy and colostomy five weeks ago following diverticullitis and gangerenous gall bladder. Readmitted to Haslar one week ago wife could not cope, appetite down, colostomy working ok.
Nursing report – admitted from Haslar refer to Social Worker.

10th July 1993
Clinical notes state vomited x 3 brown fluid.
Nursing report – vomited x3 complaining of pain in abdomen. Fainted at lunchtime when stood up.
15.10 hours fall getting off commode. Accident form completed.

13th July 1993
Clinical notes state waiting physio and OT assessments. Abdomen soft.

14th July 1993
Clinical notes state Mr Hall was in renal failure.

15th July 1993
Clinical notes discussion with wife re poor prognosis.

Nursing report – seen by Dr Walters who has spoken with wife and patient re poor prognosis. Boarded for diamorphine 2.5mg-5mgs IM 4 hourly.

19th July 1993

Clinical notes state slightly better – pain at night from left foot. Morphine 5-10mg 4 hourly as required.

Nursing report – seen by Dr Walters boarded for oramorph 5-10mgs 4 hourly for neck pain.

22nd July 1993

Clinical notes state low R and diet. Continues to vomit. Sleeping better.

23rd July 1993

Nursing report – seen by physio wound treatment to heel discussed.

28th July 1993

Clinical notes state has necrotic heel – gradually improving.

Nursing report – referred to Dr Lord for long term care.

29th July 1993

Nursing report – seen by Dr Lord to be transferred to Daedulus ward.

Transferred to Daedulus Ward.

Clinical notes state seen by Dr Lord, Daedulus ward – renal failure much better. Diuretics stopped. Heel ulcer – black, sacrum red and vulnerable, confused. Suggest oral fluids and oramorph.

2nd August 1993

Clinical notes state black heel – 2" diameter, offensive, surrounding heel very red. Barthel 5. Encouraged fluids and oramorph if required.

Nursing report, seen by Dr Lord dressing to heel changed.

5th August 1993

Clinical notes state further deterioration needs analgesia and chat with wife.

Nursing report – condition deteriorating. Commenced on oramorph patient comfortable and appears pain free. Turned 2 hourly day and night.

6th August 1993

Nursing report – visited by wife at 10.30 hours fully aware of poor prognosis. Died peacefully 11.25hours certified by Sister Jones. Daughter contacted and Dr Barton informed.

Comment

Nursing assessment comprehensive and care plans appear appropriate.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.27 BJC/24 Nora Hall

Code A

Date of admission to GWMH: **1st June 1999**
Date and time of Death: **18.00 hours on 19th June 1999**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **19 days**

Mrs Hall's past medical history:-

Chronic venous disease
Varicose veins
Hysterectomy
Oopharectomy
Gastric carcinoma
Lumpectomy
Non insulin dependent diabetic – diet controlled
Angina

Mrs Hall was married and lived with her disabled husband in a bungalow. She was his main carer, the district nurses visited once a week and friends would do the shopping. They had a daughter who had died of cancer and a son who lived in Evisworm. Mrs Hall was allergic to penicillin.
In April 1999 Mrs Hall was admitted to hospital where she had a palliative gastrostomy performed. She was later readmitted to Gosport War Memorial on 1st June 1999 for terminal care.

An assessment sheet was completed noting her readmitted to Sultan Ward that she was alert, able and concerned over husband's ability to cope. It was noted that she wore glasses, needs a soft diet although she had a poor appetite and that she had pain in her back under rib cage and across abdomen.
Care plans were commenced on 1st June 1999 for phlebetis left inner thigh, nausea and vomiting, settle at night, constipation, personal hygiene and appetite.
A Waterlow score of 12 was recorded on 1st June 1999.
A lifting/handling risk calculator was completed on 1st June 1999 with a score of 7 noted. A handling profile was then completed noting that Mrs Hall needed 2 nurses to transfer.
A Barthel ADL index was completed on 1st June 1999 scoring 13 and another one on 16th June 1999 scoring 6.

1st June 1999

Clinical notes states readmitted for symptom control CA stomach/oesophagus. Vomiting +++ for syringe driver cyclomine and diamorphine.
Summary states Mrs Hall was admitted to Sultan Ward for symptom control and that she was increasingly vomiting and suffering from nausea. The notes state that she was for terminal care. Seen by Dr Morgan prior to admission boarded for diamorphine 10mgs via syringe driver.

2nd June 1999

Clinical notes nausea still persists try Haloperidol.

Summary states nausea still continues.

5th June 1999

Clinical notes states no further vomiting since changing to Haloperidol.

6th June 1999

Clinical notes state vomited again ++ tired and weak. Need to change syringe driver site daily.

Summary states still vomiting.

7th June 1999

Summary states syringe driver reviewed diamorphine 10mgs.

15th June 1999

Summary states seen by Dr Collins feels Mrs Hall is depressed.

16th June 1999

Clinical notes state vomiting.

19th June 1999

Summary states Mrs Hall is restless diamorphine increased to 20mgs.

17.45 hours appeared more bubbly. Seen by Dr Lynch.

18.00 hours died for cremation.

Comment

Mrs Hall was admitted for terminal care. She had a comprehensive nursing assessment and appropriate care plans were made.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.28 BJC/25 Eileen Hillier

Code A

Date of admission to GWMH: **23rd May 1995**
Date and time of Death: **21.45 hours on 1st August 1995**
Cause of Death:
Post Mortem: **Burial**
Length of Stay: **71 days**

Miss Hillier's past medical history:-

Psychotic depression
CA breast
Infected cyst
Cervical spondylitis
Radiation damage to chest wall

Miss Hiller was single. She lived in her own home and had lived there with her mother since she was 10 years old. She had 3 brothers and 1 sister and was close to one of her brothers who lived nearby and managed her affairs. Miss Hiller was a retired french teacher and up until her last illness still taught privately.
Miss Hiller was discharged from Knowle on 11th March 1995 after ECT for psychotic depression and was discharged to York House Residential Home for 2 weeks convalescence they noted that she was low in mood, isolated herself, had a poor appetite and no energy and sat in her chair on her own for most of the day. She then attended Cedarwood Day Hospital from April 1995.
Miss Hiller had undergone a mastectomy and radiotherapy after being diagnosed with breast carcinoma some years earlier. She had no reoccurrence of the carcinoma but developed post radiation damage to her chest wall with 2 discharging sinus.
Miss Hiller was admitted to Gosport War Memorial Hospital on 23rd May 1995 for assessment.

Care plans commenced on 29th May 1995 for poor dietary and fluid intake, low in mood and open sinus.
A wound assessment chart for her chest sinus started on 25th May 1995.

23rd May 1995

Clinical notes state informal admission complaining of increased depression and agitation. For assessment.

26th May 1995

Clinical notes state mood continues to sink.

30th May 1995

Clinical notes state seen by Dr Lusznat need to push fluids and diet. ECT to start next week.

9th June 1995

Clinical notes state reviewed after ECT very confused and disorientated less desperate and brighter in mood.

Specific events – complaining of sore on head – lump which is red and looks sore.

16th June 1995

Specific events – Miss Hiller shouting then bang on floor. Found beside bed of another patient. Pyjamas got caught and staggered backwards until she hit the other bed. Found small broken area on right side head. Accident form completed.

17th June 1995

Specific events – heard to be shouting – found to be covered in blood. Had fallen knocking her head on the end of the bed. Taken to casualty 3 sutures needed. Brother and GP informed. Accident form completed.
Minor injuries form – fell on ward banging head. ¾" laceration to scalp – had bleed profusely. 3 sutures. Ward staff to complete accident form and inform GP.

19th June 1995

Clinical notes had ECT today, head injury on ward 2 days ago. Has 3 silk sutures on vertox, she cannot remember details of fall.
Seen by Dr Lusznat had 2 falls over weekend second required 3 silk sutures to scalp. A little brighter but still confused.

23rd June 1995

Clinical notes state much brighter and more animated in conversation.

26th June 1995

Clinical notes state brighter – Abbeyfields discussed.

30th June 1995

Clinical notes quite bright – talking about wanting to leave.

17th July 1995

Clinical notes still low. Reddish sinus discharge. Redness extending to neck. Also lump in lower sinus.
Specific events – fell in bedroom graze to right side. Cold compress applied. Accident form completed.

18th July 1995

Specific events - crying out in pain. Will not let staff touch.

21st July 1995

Clinical notes state severe pain from back, look drawn, distracted and tearful. Spoke with brother who asked if terminally ill described as very ill but not terminally ill.
Specific events – in a great deal of pain.

24th July 1995

Clinical notes state low in mood back pains continues x-ray lumbar spine.

26th July 1995

Specific events – night dressing on chest leaking profusely.

28th July 1995

Clinical notes significant bleed from upper sinus chest wall during the night. Sinus not oozing and dressed. Back pain still a problem on movement.
Radiologist reports crush fracture L4.
Discussion with brother he feels Eileen is dying and we should help to make comfortable.

Specific events – a lot of blood on sheet/pillow case and clothing from sinus. Very distraught. Appears frightened at times and cries out in pain.

30th July 1995

Clinical notes state dramatic blood loss this PM not in pain redressed for TLC. Nurse flat with raised foot of bed.

Specific events – excessive blood loss ? eroding of tumour. Advised to nurse flat with feet raised dressing replaced. Cot side put insitu.

31st July 1995

Clinical notes has deteriorated.

16.00 hours unresponsive. Family visited. 20.45 hours increasing agitation and ? in pain. Diamorphine 10mgs 4 hourly IM. Ought to be on syringe driver with diamorphine and haloperidol.

Specific events – diamorphine 10mg given at 09.20 family notified of deteriorating condition. 5mg diamorphine given at 13.35.

PM – 5mg diamorphine given and at 19.00 hours.

Nocte – seen by Dr Collins increase diamorphine to 10mgs 8 hourly IMI given at 21.30 with little effect. 23.40 10mgs given and 04.25 10mgs given. Needs syringe driver.

1st August 1995

Clinical notes state restless this AM, more settled rest of day. Increase diamorphine 15mg 4 hourly.

21.45 hours died peacefully verified by SR Broughton. Relatives informed. For Burial.

Comment

This lady deteriorated rapidly in hospital. The nurses did make a comprehensive assessment but did not succeed in keeping her safe from falling and sustaining several minor injuries.

Otherwise care appears to have been appropriate.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.29 BJC/26 Alan Hobday

Code A

Date of admission to GWMH: **24th July 1998**
Date and time of Death: **22.45 hours on 11th September 1998**
Cause of Death:
Post Mortem:
Length of Stay: **50 days**

Mr Hobday's past medical history:-
1990 – TURProstatectomy

Mr Hobday lived with his wife in a bungalow. They had a son and daughter and very supportive family. Mr Hobday was a very well man prior to his collapse. He was allergic to penicillin.
Mr Hobday collapsed while out eating and was taken by ambulance to St Mary's Hospital and diagnosed with suffering a left CVA and right hemiplegia. Mr Hobday was admitted to Gosport War Memorial Hospital on 24th July 1998.

On admission care plans commenced on 25th July 1998 for sleep, catheter, shoulder pain, dysphagia, elimination, hygiene and communication.
A lifting/handling risk calculator was taken on 24th July 1998 scoring 23. So a handling profile was completed on 25th July 1998 noting that Mr Hobday needed the assistance of 2 nurses and a hoist, that his skin was intact and that he was to be nursed on a Pegasus biwave plus mattress.
A nutritional assessment plan was completed on 4th September 1998 with a score of 12 recorded.
An assessment sheet was completed noting that Mr Hobday was unable to communicate,
A Waterlow score of 25 was recorded on 24th July 1998.
A Barthel ADL index wad recorded weekly starting on 24th July 1998 scoring 0 and the last one recorded on 9th September 1998 also scoring 0.

24th July 1998

Clinical notes admitted to Daedulus ward. Barthel 0 needs all help with ADL. In view of poor prognosis please make comfortable. **Happy for nursing staff to confirm death.**

25th July 1998

Contact record – wife and daughter seen aware of condition and prognosis and recovery will be limited.

30th July 1998

Clinical notes state catheterised. Pulling out S/C fluids does not want NG feed. Prognosis poor. Wife and daughter seen they feel he has settled and improved from a week ago. Poor swallow, aspiration and possible chest infection. Diamorphine/haloperidol PM if distressed.

31st July 1998

Clinical notes seen by SLT continue with puree diet and thickened fluids.

3rd August 1998

Clinical notes remains poorly.

6th August 1998

Contact record – found on floor in lounge. No injury apparent. Accident form completed.

12th August 1998

Clinical notes has made some progress. Family seem realistic about future.
Contact record – discussion with wife and daughter definite improvement made with physical condition. Discussed future care they seem realistic about his capabilities.

16th August 1998

Contact record – found on floor in day room. Put back to bed. Accident form completed. Wife informed.

17th August 1998

Clinical notes very agitated at times. Suggest S/C haloperidol.

20th August 1998

Clinical notes seen by dietician continue on puree diet and thickened fluids. Slow progress can push himself out of chair.

22nd August 1998

Contact record – found on floor in day room. No apparent injury. Hoisted into bed. Accident form completed.

7th September 1998

Contact record – twitching (facial) complaining of not feeling well. Dr Barton and wife informed.
Seen by Dr Barton commence **diamorphine 20mgs via syringe driver**. Wife and daughter seem to understand may deteriorate.

9th September 1998

Contact record – **diamorphine increased 40mgs** became very restless and appeared in discomfort.

10th September 1998

Clinical notes extended stroke on 6th September 1998 with facial seizures affecting right side of face. Now on syringe driver secretions +++ but seems comfortable. He's dying, family aware.
Contact record – seen by Dr Lord coughing and bubbling chest. Move to continuing care bed.

11th September 1998

Contact record – syringe driver renewed at 9.45 diamorphine 40mgs.
Clinical notes condition deteriorated rapidly.
Pronounced dead at 22.45 hours by S/N Roberts relatives present.

Comment

Mr Hobday had a poor prognosis. The nursing assessment was comprehensive but it failed to put in place a care plan to prevent his falls.
Diamorphine administered by syringe driver, increased with no complaint of pain

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.30 BJC/27 Albert Hooper

Code A

Date of admission to GWMH: **12th September 2000**
Date and time of Death: **23.42 hours on 9th October 2000**
Cause of Death: **1a) Bronchopneumonia**
2) COPD
IHD
Post Mortem: **Cremation**
Length of Stay: **28 days**

Mr Hooper's past medical history:-
Hypertension.
COPD.
Anemia.
CCF.
Cholecystectomy for gallstones.
Right Nephrectomy.

Mr Hooper lived alone in a 3 bedroom house. He was a retired Sales Manager. His wife who was blind had just been admitted to a Residential home on a long-term basis. They had a daughter who lived in Gosport and a son. Mr Hooper refused all daily help expect for meals on wheels.
Mr Hooper was admitted to the Royal Haslar Hospital on 18th August 2000 with diarrhoea, oedematous ankles, reduced mobility and not being able to cope at home. He was admitted to the Gosport War Memorial Hospital on 12th September 2000 for rehabilitation and continuing care.

On admission care plans were commenced on 13th September 2000 for hygiene, elimination, catheter care, superficial sacral sores, oxygen therapy and to help settle at night.
A Bartel ADL index was completed on 13th September 2000 and weekly thereafter scoring 5 at the beginning and going down to 0 at the end.
A Waterlow score was also recorded weekly starting on 18th September 2000 scoring 22 and the last one recorded on 2nd October 2000 with a score of 24.
A mouth assessment was completed on 14th September 2000 as well as a handling profile on 18th September 2000 noting that Mr Hooper had a sore sacral area was nursed on a biwave mattress and needed the assistance of 2 nurses and a hoist.

12th September 2000

Transferred from Haslar to Dryad Ward for continuing care and rehabilitation. The transfer form notes that Mr Hooper needs help with all aspects of personal hygiene and dressing, encouraged with his diet as he has lost 2 stone. He mobilises and transfers with a hoist, is occasionally incontinent, is hard of hearing and wears glasses. He has a pressure sore on his buttocks that is dressed every 3-4 days and nursed on carewave mattress.
Clinical notes – transferred from ward A5 Haslar with anemia, sacral sore, immobility, COPD, AF and IHD.

Summary – Transferred from Ward A5 with sacral sore superficial duoderm dressing. Condition fair on arrival though frail. Seen by Dr Wilson oxygen therapy. For blood investigation.
Seen by Dr Sankon for gentle rehabilitation to get fit for transfer to Broofield Residential Home where his wife is resident.

19th September 2000

Summary – for further assessment.

20th September 2000

Clinical notes – confused intermittently – fainted 2 days ago. Depressed and low. Scrotum skin improving.

27th September 2000

Clinical notes – discussion with son and daughter-in-law very frail and continuing to deteriorate due to a number of problems of chest infection, sacral sore, blood and age. They are keen for him to be kept comfortable.
Summary – unresponsive and twitching.

29th September 2000

Clinical notes – complaining of left leg pain when moving.

2nd October 2000

Clinical notes – frail continues to deteriorate and drowsy.

4th October 2000

Clinical notes – catheterised.
Summary – commenced sub cutaneous fluids.

6th October 2000

Clinical notes – seen by Dr Banks increasingly frail and rather stiff.
Summary – chesty. Daughter contacted and told of deteriorated sores. Hold off decision to commence Hyoscine. Hands and lips swollen. Nursed on alternate sides.

7th October 2000

Summary – deteriorated becoming distressed states he is in pain. Family contacted happy for him to be made comfortable. **Syringe driver recharged at 16.00 with diamorphine 10mgs.**

8th October 2000

Summary – remains poorly. Syringe driver recharged at 14.55 diamorphine 10mgs.

9th October 2000

Clinical notes – continues to deteriorate. Imp: bronchopneumonia. Continue diamorphine via syringe driver.
00.00 asked to certify – certified dead at 00.05 by Dr Wilson, Locum Staff Physician.
Summary – continue to deteriorate. Syringe driver recharged at 5.45 hours diamorphine 20mgs. 23.42 hours died – no relatives present.

10th October 2000

Death certificate. GP contacted for cremation.

Comment

Mr Hooper was admitted for rehabilitation with a view to being discharged to the Care home where his wife was a resident. His condition deteriorated. The nurses made a comprehensive assessment. Mr Hooper had been admitted with a pressure sore, which was being dressed. The nurses ensured that there was an appropriate pressure-relieving mattress and that he was turned regularly and nursed on alternate sides. There appears to have been good communication with the family and appropriate care needs identified.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.31 BJC/28 Clifford Houghton

Code A

Date of admission to GWMH: **31st January 1994**
Date and time of Death: **20.50 hours on 6th February 1994**
Cause of Death:
Post Mortem:
Length of Stay: **7 days**

Mr Houghton's past medical history:-
MI with LVT

Mr Houghton lived with his wife in a bungalow. They had a daughter. They lived independently with no outside help. Mr Houghton had poor mobility and had been admitted several times to Gosport War Memorial Hospital for respite care to give his wife a break.

Mr Houghton was admitted to Daedalus Ward, Gosport War Memorial Hospital on 31st January 1994 as an emergency admission with a history of several Trans Ischaemic Attacks and poor mobility for respite care. Care plans commenced for poor mobility, hygiene, sleep, bowel and catheter care.

31st January 1994
Admitted to Daedulus Ward as an emergency. Seen by Dr Barton and medication boarded. Mrs Houghton was advised to stay away for a couple of days to rest.

1st Febraury 1994
More relaxed and quieter (p22)

2nd February 1994
The nursing report noted that Mr Houghton needed the assistance of 2 nurses when walking. (p3) Very drowsy.

3rd February 1994
Condition deteriorating. Breathless and distressed. Seen by Dr Barton, written up for syringe driver if and when necessary. Wife aware, to visit in afternoon.

4th February 1994
Noisy and distressed all night. (p22)

6th February 1994
Nursing report – relatives informed of deteriorating condition.
Commenced on syringe driver (p40)at 07.45 very restless, agitated and distressed. Dr Peters contacted.
Cheyne Stokes Respiration. Pulse feeble but regular.
Diamorphine 5mg IM given at 11.05. Seen by Dr Peters diamorphine increased 60mg via syringe driver. Wife seen by Dr Peters.
Quieter on syringe driver (p22)
Clinical notes – very restless on diamorphine 40mgs increase to 60mgs.
Relatives visited at 16.00 hours (p4)
Died at 20.50 hours pronounced dead by Sister Goldsmith, present at death.

Wife present. Not sure if for burial or cremation. Will inform 7/2/94, to collect certificate 8/2/94

Comment

Mr Houghton was admitted for respite care. The nurses made a care assessment and wrote care plans to meet his nursing needs.

Administration of medicines.

Midazolam was prescribed which was likely to make the patient unconscious. Large doses of diamorphine were written up for syringe driver. No apparent pain. Nurses did not query.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A			3A	
Unclear B				
Unexplained by Illness				

6.32 BJC/29 Thomas Jarman

Code A

Date of admission to GWMH: **27th October 1999**
Date and time of Death: **14.50 hours on 10th November 1999**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **15 days**

Mr Jarman's past medical history:-
Cararact operation 1987
Orchidectomy right side.
Hairy cell leukemia May 1999

Mr Jarman was a widower and lived alone in his own house. He had a son and daughter who were his main carers. He had a home help who would visit once a week. In June 1999 Mr Jarman moved to The Red House Residential Home as he was unable to cope at home and had been diagnosed with Hairy cell leukemia in May. Mr Jarman was admitted to the Queen Alexander Hospital and then transferred to Gosport War Memorial Hospital on 27th October 1999 with bronchopneumonia and for continuing care and rehabilitation.

On admission a handling profile was completed noting that Mr Jarman was confused and in no obvious pain. It noted that his skin was intact and that he was to be nursed on a pressure relieving mattress and needed the help of two nurses and a hoist for transfers.
Care plans commenced on 27th October 1999 for personal hygiene, night care, nutrition and pressure sores.(p93-112)
Waterlow score 24 was noted on admission. Barthel ADL index completed on 27th and 31st October and 7th November 1999 all scoring 1.

27th October 1999
Clinical notes – transferred from Queen Alexander House to Daedulus Ward with bronchopneumonia and Hairy cell leukemia. In view of poor prognosis not for "999". **Happy for any nurse to verify death**. Mainly for TLC.

28th October 1999
Clinical notes – choking on feeding. Speech and Language Therapist (SALT) to review.

29th October 1999
Seen by SALT for slow moving thickened fluids/soft moist diet.

1st November 1999
Clinical notes. Hairy cell leukaemia, large spleen. Recently transfused. (p81)

2nd November 1999
Clinical notes not eating well. Barthel 0-1. Make more comfortable. **Happy for nursing staff to confirm death.**

7th November 1999
Contact record – distressed and agitated. Oramorph give at 15.30 with no effect. 23.55 hours more distressed and screaming louder. Oramorph 10mgs orally given. **New syringe driver commenced**.

8th November 1999
Clinical notes – further deterioration having S/C analgesia.
Contact record – diamorphine 20mg renewed.
9th November 1999
Clinical notes – comfortable on S/C analgesia.
10th November 1999
Clinical notes – died at 14.50 hours for cremation.
Verified by RGN Couchman and RGN Pearce.

Comment
Mr Houghton was admitted for respite care. The nurses made a care assessment and wrote care plans to meet his nursing needs.
Administration of medicines.
Midazolam was prescribed which was likely to make the patient unconscious. Large doses of diamorphine were written up for syringe driver. No apparent pain. Nurses did not query.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A			3A	
Unclear B				
Unexplained by Illness				

6.33 BJC/30 Elsie Lavender

Code A

Date of admission to GWMH: **22nd February 1996**
Date and time of Death: **21.28 hours on 6th March 1996**
Cause of Death:
Post Mortem:
Length of Stay: **13 days**

Mrs Lavender's past medical history:-

Brain stem stroke
Insulin dependent diabetes mellitus
Registered blind
AF
Iron deficient anemia

Mrs Lavender lived alone. She had a son. She was registered as blind. Her bed had placed downstairs and her son did all the shopping.
She was admitted to the Royal Haslar Hospital following a fall down some stairs and sustained a head injury. Mrs Lavender was transferred to Gosport War Memorial Hospital on 22nd February 1996 for rehabilitation.

On admission care plans (p88-112)commenced for painful shoulders and upper arms, reduced mobility, hygiene, leg ulcer right leg and dry skin, catheter, settle at night. Care plans also commenced on 29th February 1996 for red and broken sacrum and 1st March 1996 for constipation.(p108)
Pressure sore documentation also completed on 22nd February 1996 for grade 2/3 right leg ulcer (p96-8) to be nursed on nimbus mattress and dressed with Kaltastat and normal saline.
A Barthel ADL index score of 4 was recorded. As well as a abbreviated mental study of 10 recorded.
A Waterlow score of 21 was also recorded on admission.(p158) With a lifting/handling risk calculator of 15 recorded.(p160)
A nutritional assessment plan was also completed on 22nd February noting a score of 3.(p162)

22nd February 1996

Admitted from Haslar to Daedulus Ward for rehabilitation. Transfer documentation notes that Mrs Lavender had been admitted following a fall down stairs, sustaining a head injury. She was now immobile, had pain in her shoulders and arms, had a catheter in situ for long standing incontinence. It also noted that she had no problems eating or drinking and that her pressure areas were intact, very red but not broken.(p150-2)

24th February 1996

Summary – pain not controlled. Seen by Dr Barton boarded for MST 10mg BD. Night – MST 10mg at 06.15.
Sacral area red and skin broken (p104)

25th February 1996

Summary – in pain screaming when moved. Son would like to see Dr Barton.

26th February 1996

Summary – seen by Dr Barton. MST 20mgs BD. Son and daughter seen by Dr Barton prognosis discussed. Son is happy to make comfortable and pain free. Syringe driver explained.

27th February 1996

Summary – air mattress needed. MST 10mgs given prior to moving onto Pegasus mattress.

4th March 1996

Summary – complaining of pain. Extra analgesia oramorph sustained release tablets dose increased 30mg by Dr Barton.

5th March 1996

Summary – pain uncontrolled very poor night. Syringe driver commenced at 09.30 hours diamorphine 100mgs and midazolam 40mgs.

6th March 1996

Summary – 21.28 hours died peacefully. Son informed.

Comment

Mrs Lavender was admitted for rehabilitation after a fall at home. She had pain in her arm and shoulder. A nursing assessment was made and care plans drawn up (p88-112). On admission the nurses planned to help mobilise Mrs Lavender to improve her independence.

Mrs Lavender was unable to manage her personal hygiene, it was noted on March 3rd that the night staff "gave her a wash", this is poor practice.

Her sacrum was red and the skin broken (p104) since she was admitted. There is no evidence that the nurses tried to prevent further pressure damage by ensuring that Mrs Lavender was turned regularly as well as having a pressure relieving mattress.

Mrs Lavender was catheterised on admission, there is no evidence of an attempt to try and help her to manage to be continent.

The nursing care was below an acceptable standard and the nursing records do not contain the rationale behind some of the decisions made.

<u>Administration of medicines.</u>

There were inappropriate and large doses of opiates and sedation. There was an equivalent of a 5 fold increase when 100 mgms of diamorphine was given after the 30 mgms bd of slow release oral morphine. Nurses did not query.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness				

6.34 BJC/31 Catherine Lee

Code A

Date of admission to GWMH: **14th April 1998**
Date and time of Death: **14.45 hours on 27th May 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **44 days**

Mrs Lee's past medical history:-
1998 Fracture neck of femur
1998 TIA
IHD
Glaucoma
Rectal prolapse

Mrs Lee lived at Addenbrookes Residential Home. She had a daughter and grand-daughter. It was noted that she had poor mobility and was confused at times. Mrs Lee sustained a fractured neck of femur at Addenbrookes on 2nd April 1998 and was admitted to Haslar Hospital for surgery to correct the fracture. She was then admitted to Gosport War Memorial Hospital on 14th April 1998 for continuing care.

On admission a Waterlow score of 30 was recorded with another score of 29 recorded on 8th May 1998.(p56)
A nutritional assessment plan was completed on 15th April 1998 with a score of 4. (p84/5)
Barthel ADL index was recorded on 14th April 1998 scoring 0, another on 25th April 1998 scoring 1 and another one on 9th May 1998 scoring 4.(p58-60)
A handling profile was completed on 16th April 1998 noting that Mrs Lee needed the assistance of 2 and a hoist for transfers. (p62-4)
A mouth assessment was completed on 15th April 1998.
Care plans commenced on 14th April 1998 for MRSA screening, 15th April 1998 for sleep, 16th April 1998 for hygiene, nutrition, constipation and on 26th April 1998 for small laceration right elbow.

14th April 1998

Clinical notes – transferred to Dryad Ward from Haslar for continuing care. Barthel 0. Make comfortable, **happy for nursing staff to confirm death**.
It was noted that Mrs Lee has sustained a right fracture neck of femur and had undergone surgery of canulating screws on 3rd April 1998. It noted that Mrs Lee had poor mobiltiy needed the assistance of 2 nurses, was confused at times, needed full assistance with eating and drinkng due to poor eye sight and that she had a poor appetite. She needed all care for hygiene and dressing and her pressure area were intact and that she needed nursing on a pressure relieving mattress.
Summary – Cold on arrival on Dryad Ward, been sick in ambulance. Settle on ward and given 2.5ml oramorph. Nursed on Pegusus airwave mattress.

15th April 1998

Summary – oramorph 5mgs 4 hourly.

17th April 1998

Summary – restless, confused. Oramorph 5mg 4 hourly.

18th April 1998

Summary – oramorph 5mgs 4 hourly.

23rd April 1998

Clinical notes – MRSA negative. Bottom slightly sore. Start gentle mobilisation will not be suitable for Addenbrookes. Seen by Dr Banks has severe dementia.

24th April 1998

Summary – fell while attempting to get up from commode. Sustained skin flat to right elbow. Accident form completed. Daughter informed. (p70-71)

27th April 1998

Clinical notes – gentle rehabilitation here for next 4-6 weeks probably for Nursing home on discharge. (p24)
Pleased with progress agree Nursing Home would be best option.

11th May 1998

Pain in left chest.

15th May 1998

Summary – seen by Dr Barton re pain oramorph increased to 10mgs 4 hourly (20 mgs nocte).

18th May 1998

Clinical notes – increasingly uncomfortable when I called much better on oramorph.(p25)

20th May 1998

Summary – visited by daughter. For cremation.

21st May 1998

Clinical notes – further deterioration uncomfortable and restless. Needs S/C analgesia. **Happy for nursing staff to confirm death.**
Summary – restless, agitated. Seen by Dr Barton. Syringe driver commenced diamorphine 20mgs at 09.40. Fentanyl patch 25mgs removed at 13.30.

22nd May 1998

Summary – grimacing when turned. Syringe driver renewed at 09.30 diamorphine 20mgs and midazolam 40mgs. Continues to mark, position changed every couple of hours.

23rd May 1998

Summary – syringe driver recharged at 7.35. 20mgs diamorphine 40mgs midazolam. Position changed every 2 hours.

25th May 1998

Summary – further deterioration. Syringe driver renewed at 07.00 in some distress when being turned. Syringe driver renewed at 14.55 diamorphine 40mgs.

26th May 1998

Clinical notes – died peacefully at 14.45.
Death verified by SR Hamblin and SN Barrett.

Comment

Administration of medicines.

The nurses noted that they were unable to administer oramorph because Mrs Lee was too sleepy.(p41)

There appears to have been a Fentanyl patch at the same time as Oramorph was being given. It is not clear why oramorph was given. Nurses did not query.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.35 BJC/32 Stanley Martin

Code A

Date of admission to GWMH: **6th January 1998**
Date and time of Death: **08.20 hours on 8th January 1998**
Cause of Death:
Post Mortem:
Length of Stay: **2 days**

Mr Martin's past medical history:-
Left CVA right hemiparisis
Dysphasia
Stroke
Epilepsy

Mr Martin lived with his son, there was a shared care arrangement where his son would look after him at home for six weeks and then he would have a two weeks stay at Gosport War Memorial Hospital in Daedulus Ward.
Mr Martin was admitted on 6th January 1998 with bronchopneumonia for 2 weeks shared care.

On admission care plans were completed for incontinent – catheter, hygiene and dressing, constipation, poor mobility and settle at night.
A Barthel ADL index (p358)was completed scoring 2 and a Waterlow score of 29 was recorded.(p360)

6th January 1998
Contact record – seen by Dr Knapna and admitted.
7th January 1998
Contact record – still nauseated, dinner still retained in mouth, abdomen sore. 15.00 hours catheterised.(p364-5)
8th January 1998
Contact record – deteriorated, vomited thick dark mucous. Very wheezy, noisy breathing, no urine passed overnight. Son contacted and asked to come in. 5mgs diamorphine given to assist breathing.
08.20 died. Confirmed by Dr Barton.

Comment
Mr Martin was admitted with bronchopneumonia. The nurses assessed his care needs and drew up appropriate care plans. He was clearly unwell and deteriorated and died 2 days later.
The nursing care appears to have been of a satisfactory standard.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B		2B		
Unexplained by Illness				

CANNOT GET INTO THIS FILE.

6.36 BJC/33 Dulcie Middleton

Code A

Date of admission to GWMH: **15th August 2001**
Date and time of Death: **hrs on 2nd September 2001 in Petersfield Hospital**
Cause of Death:
Post Mortem:
Length of Stay: **19 days**

Mrs Middleton's past medical history:-

Comment
Died in Petersfield Hospital. Should have been referred to Coroner.
Care in Gosport appeared acceptable. Score below for Gosport only.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A		3A	
Unclear B				
Unexplained by Illness				

CANNOT GET INTO THIS FILE.

6.37 BJC/34 Geoffrey Packman

Code A

Date of admission to GWMH: **23rd August 1999**
Date and time of Death: **hrs on 3rd September 1999**
Cause of Death:
Post Mortem:
Length of Stay: **12 days**

Mr Packman's past medical history:-

Obesity
Immobile
Cellulitis

Comment

Diamorphine increased from 60-90mgms on 1st September 1999 with no explanation.(64-5)
Possible diagnosis perforated ulcer, Gastro intestinal bleed.
Clinical notes P46 in A&E inaccurate. Mr Packman was not fit for surgery.
In August 1999 Mr Packman was complaining of pain in the throat and abdomen.
A syringe driver was put up for abdominal pain (p78-81)
Waterlow score 18-21 on 24th and 30th August 1999.
Had pressure damage, not mobile.
Nurses assessed and drew up care plans.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.38 BJC/35 Eva Page

Code A

Date of admission to GWMH: **27th February 1998**
Date and time of Death: **21.30 hours on 3rd March 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **5 days**

Mrs Page's past medical history:-

Confusion
1995 - Atrial fibrillation
CCF
1995 – LVF
1997 – TIA
1995 – Digoxin Toxicity

Mrs Page was widowed and lived at Chesterholm Lodge Residential Home. She had a son.
Mrs Page was admitted to Queen Alexander Hospital as an emergency suffering with anorexia, decreasing mobility, sleeping a lot and becoming dehydrated. She was transferred to Gosport War Memorial Hospital on 27th February 1998 for palliative care.

On admission a Barthel ADL index score was recorded of 2. (p138) Care plans commenced on the day of admission for settle at night, constipation, catheter care and personal hygiene.
An handling profile which noted Mrs Page can make her wishes known, she had pain on movement, dry paper thin skin, to be nursed on Pegasus biwave mattress, she had a catheter insitu for retention of urine and needs help of 2 nurses and a hoist was completed on 28th February 1999. A Waterlow score of 27 recorded also on 28th February 1999.(p140)

27th February 1999

Admitted from Queen Alexander Hospital for palliative care. It was noted that Mrs Page was withdrawn and anxious. That she would call out frequently and needed reassurance. Also noted was that Mrs Page was on a normal diet and fluids was incontinent of faeces had a catheter for retention of urine and needed help with all hygiene needs.
The transfer form(p146-7) noted that Mrs Page has bio? to red sacrum, an old facial wound from 15th February 1998 after fall (scabs on nose) and swelling inner left eye.
Summary – admitted from Charles Ward for palliative care.
Clinical notes – opiates commenced. **Happy for nursing staff to confirm death.**

28th February 1999

Summary – very distressed, calling for help and saying she is afraid.
Oramorph 2.5mgs given with no relief. Thioridazine given with no effect (p120)

Clinical notes – jerks a lot agitated. Not in pain.

2nd March 1999

Summary – commenced fentanyl 25mgs this am. Very distressed. Seen by Dr Barton to have diamorphine 5mgs IM given at 8.10. Seen by Dr Lord diamorphine 5mgs IM given for syringe driver with diamorphine.
Clinical notes – no improvement. Quieter PM S/C diamorphine. Fentanyl patch started today.
Agitated and calling out even when staff present.
Ct fentanyl patches. Son seen concerned about deterioration today. Explained agitation and drowsiness was probably due in part to diamorphine accepts mother is dying and agrees continue present plan.

3rd March 1999

Summary – rapid deterioration this AM. Neck and left side rigid. Syringe driver commenced at 10.50 with diamorophine 20mgs and midazolan 20mgs. Son stayed all day aware of poor prognosis.
Condition deteriorated died 21.30 for cremation.
Clinical notes – Died peacefully verified by SN Dorrington. Son informed for cremation.

Comment

Mrs Page was admitted fro Queen Alexandra for palliative care. She was agitated and distressed. Diamorphine was given for confusion not pain. No reported pain.
The nurses assessed her care needs on admission and wrote care plans which seemed appropriate.
<u>Administration of medicines.</u>
Mrs Page was given medication for her agitation, she did not complain of pain. Oramorph, Fentanyl and diamorphine were prescribed and administered without question. This was not satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.39 BJC/36 Gwedoline Parr

Code A

Date of admission to GWMH: **31st December 1998**
Date and time of Death: **13.10 hours on 29th January 1999**
Cause of Death:
Post Mortem:
Length of Stay: **30 days**

Mrs Parr's past medical history:-

Dementia.
June 1991 – Heart block - pacemaker
Cholecystectomy
Appendicetomy
Basal cell carcinoma left cheek
1998 – Fracture neck of femur – dynamic hip screw
1998 – Repair umbilical hernia
Insulin dependent diabetic (diet controlled)

Mrs Parr lived alone and had a daughter and a son. Her daughter was her main carer until she was diagnosed with cancer and became unwell. Mrs Parr was admitted to Gosport War Memorial Hospital on 31st December 1998 for gentle rehabilitation after being admitted to Haslar following a fall where she sustained a fracture neck of femur and underwent surgery for dynamic hip screw on 14th December 1998. During her stay at Haslar Mrs Parr developed acute abdominal pain and on 24th December 1998 underwent an umbilical hernia repair.

On admission to Gosport War Memorial Hospital care plans (p34-44) commenced for hygiene, settle at night, catheter care, constipation.
A lifting/handling risk calculator was completed on 31st December 1998 (p46-7) and 17th January 1999 both scoring 10. A handling profile was completed on 1st January 1999 noting that Mrs Parr needed the help of 2 nurses and a hoist, she had dry skin but intact and was to be nursed on a biwave mattress.
A mouth assessment form was completed.
A Barthel ADL index (p48) was completed weekly from 31st December 1998 to 24th January 1999 ranging from 2 at the start and then 1 at the end.
A weekly Waterlow score was taken from 31st December 1998 to 11th January 1999 scoring from 25 to 32. (p50)

31st December 1998

Admitted To Gosport War Memorial Hospital from Haslar following fall on 11th December 1998 and dynamic hip screw surgery on 14th December 1998. Mrs Parr developed acute abdominal pain on 24th December 1998 and later the same day underwent an umbilical hernia repair. Mrs Parr also had been catheterised. She was admitted for gentle rehabilitation. Transfer letter noted (p207) that Mrs Parr needed help with personal care, encouragement to mobilise and her skin was in tact.

Clinical notes – for gentle rehabilitation probably needs long term care either at Dryad Ward or Nursing Home. Left buttock ulcer.

4th January 1999

Summary – right leg remains externally rotated and shortened. Seen by Dr Barton. X-rays taken.

5th January 1999

Summary – seen by Dr Lord to have left knee X-rayed.

6th January 1999

Summary – found sitting on floor in lounge at 21.30 no injuries, not distressed.

18th January 1999

Summary – grand-daughter aware of poor prognosis. Deterioration. Frusemide given and 850 mls urine passed.

23rd January 1999

Summary – general deterioration. Oramorph 5mgs given at 15.00 with little effect. Daughter Margaret very ill, for terminal cancer care. Family will try and bring Margaret in to see Mrs Parr. (p19)

24th January 1999

Summary – remains poorly.

25th January 1999

Summary – syringe driver commenced 19.45 hours diamorphine 20mgs. Fentanyl commenced at 8.40 25mgs removed at 19.00.

27th January 1999

Summary – condition remains ill and deteriorating. Comfortable at present. Dose in syringe driver. 21.35 syringe driver reprimed with 20mgs diamorphine.

28th January 1999

Summary – syringe driver recharged 20.20 diamorphine 20mgs.

29th January 1999

Remains very poorly. Happy for nursing staff to confirm death.
Summary – died peacefully at 13.10 hours. Verified by SN Shaw and Sister Hamblin.

Comment

Mrs Parr was admitted from Haslar after hip surgery and the repair of a hernia. She became agitated and Oramorph was commenced.
The nurses assessed Mrs Parr's care needs and drew up care plans.

<u>Administration of medicines.</u>

Mrs Parr had been prescribed Fentanyl and Oramorph. The nurses failed to question this combination of medication and administered it. This was poor practice.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

Code A

Code A

Code A

6.41 BJC/38 Margaret Queree

Code A

Date of admission to GWMH: **29th July 1994**
Date and time of Death: **12.00 hours on 10th October 1994**
Cause of Death:
Post Mortem:
Length of Stay: **74 days**

Mrs Queree's past medical history:-

Osteoarthritis.
Back pain.
Quinsy.
Heart failure.
Jaundice.
Right hip replacement.
Bilateral leg cellulites.

Mrs Queree was born in Gosport and was a widow. She was the eldest of nine children and had five children of her own. Mrs Queree lived in a warden controlled flat until June 1994 when she was admitted to St Vincent House Residential Home. Her daughter, who lived in Gosport, visited regularly. Mrs Queree was admitted to the Queen Alexander Hospital in May 1994 for constipation and overflow. She underwent surgery for PV discharge and pelvic abscesses. She had a permanent colostomy put in place. She was transferred to Gosport War Memorial Hospital on 29th July 1994 for rehabilitation. It was noted that Mrs Queree's sacral area was very red with a small break on sacrum that she was slow to mobilise and had a catheter in situ.

On admission care plans (p193-214) commenced for poor diet and fluid intake, small sacral sore, incontinent, personal hygiene, mobility, colostomy and to settle at night.
A Waterlow score of 14 (p190) was recorded on 30th August 1994 and 20 on 2nd October 1994.

29th July 1994

Clinical notes transfer to Daedulus Ward for 1 week rehabilitation. Transfers with 2 nurses and a hoist. Reluctant to mobilise and very depressed.

15th August 1994

Clinical notes – mobilising 10 steps. Eating better. Barthel 7. To be discharged to a Nursing Home.

6th September 1994

Nursing report – offensive discharge from vagina. Dr Beasley informed

7th September 1994

Nursing report – no discharge overnight. Seen by Dr Brand leave well alone at present but should discharge return ? for refer back to surgeon.

12th September 1994

Clinical notes – confused episodic, not mobile, oedema.
Nursing report – to be long stay now.

22nd September 1994

Nursing report – swabs taken to check for MRSA.

26th September 1994

Nursing report - carrier of MRSA.

3rd October 1994

Nursing report – commenced MST.(p187-192)

4th October 1994

Nursing report – MST increased to 20mgs. Daughter seen about deteriorating condition. Warned to expect worst

5th October 1994

Clinical notes. (p70) – deteriorated generally, not eating and drinking well. Small dose of opiates (MST) commenced for general distress.

6th October 1994

Nursing report – very agitated and confused. Restless and distressed. Daughter contacted. Syringe driver commenced at 14.10.

7th October 1994

Clinical notes – much more peaceful since S/C analgesia commenced.

10th October 1994

Clinical notes – further deterioration – died peacefully 12.00 midday. Certified by Sister Joines.

Comment

Mrs Queree was admitted from Queen Alexandra Hospital for rehabilitation. She started to deteriorate and was written up for Morphine Sulphate. This helped control the pain.

The nurses assessed her care needs on admission and wrote care plans which seemed appropriate.

Administration of medicines.

Mrs Queree had her dosage of morphine doubled without any apparent reason. There is no evidence that the nurses questioned this decision.

This was not satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.42 BJC/39 Joan Ramsey

Code A

Date of admission to GWMH: **1st June 2001**
Date and time of Death: **Alive**
Cause of Death:
Post Mortem:
Length of Stay:

Mrs Ramsey's past medical history:-

Hiatus Hernia
Ulcerative Colitis
Registered blind
Osteoarthritis – both knees
Right carpal tunnel surgery
Fracture right and left neck of femur
Fracture right colles
Right knee replacement
IHD
MI

Mrs Ramsey was widowed and had 3 daughters and a son. She lived alone in a bungalow. A male friend would spend the day with her and would do all the shopping and cleaning for her. Mrs Ramsey fractured her right neck of femur and was admitted to hospital for a dynamic hip screw. She returned home but was later admitted to Ferndales Rest Home. In June 2000 Mrs Ramsey suffered a fall at the Home where she sustained a left fracture neck of femur and underwent surgery of a dynamic hip screw at the Royal Haslar Hospital. Mrs Ramsey was found to be suffering from confusion and had oozing from her wound. Her rehabilitation was hindered due to a dementing illness. In February 2001 Mrs Ramsey was transferred to Orthopaedics for conversion of her dynamic screw to a Thompson's hemiarthroplasty. The wound became infected and two weeks after the hemiarthroplasty an x-ray confirmed a dislocation and surgery was performed on 1st March 2001. The wound infection included staph aureus needing vacuum pump. In May 2001 Mrs Ramsey developed gallstones and was treated for acute cholecyctitis. Mrs Ramsey was transferred to Gosport War Memorial Hospital on 1st June 2001 for rehabilitation. In August 2001 she was due to have cataract extraction but on assessment it was thought that it would not improve her visual acuity.

On admission a mouth assessment and a health summary assessment of daily living were completed noting that Mrs Ramsey lived in Ferndale Rest Home. She had a daughter who lived in Yorkshire, a daughter who lived in Eastleigh and visited regularly and a son and daughter-in-law who lived in Elson. It also noted that Mrs Ramsey communicated well, wore glasses, had no hearing problems, on regular analgesia due to left hip pain and had short term memory loss. Needed a hoist for transfers, was catheterised, needed encouragement to take fluid, needed a pureed diet and could feed herself and was nursed on a pressure relieving mattress.

A Barthel ADL was taken weekly from 1st June until 19th August all scoring 2 and weekly from 27th August to 18th November 2001 all scoring 1.
A weekly Waterlow was also recorded from 1st June until 19th August and Weekly Waterlow scores were recorded from 27th August and 18th November 2001.
Care plans commenced on 1st June 2001 for constipation due to poor mobility, Night care/sleep, catheter, and hygiene. A care plan commenced on August 2001 for pressure sore – sacrum. Care plans commenced in November 2001 for communication, catheter care, nutrition, hygiene, pain management left fractured neck of femur, wound on left hip, constipation due to poor mobility and dysphagia.
A nutritional screening plan recorded a score of 7 on the 1st June and 24th October 2001.
A handling profile on 1st June 2001noted that Mrs Ramsey's pressure areas were intact, sacral area intact but reddish and nursed on a Pegasus airwave mattress. Mrs Ramsey had a catheter in situ and needed the help of a hoist, glide sheet and 2 nurses for transfers.

1st June 2001

Clinical notes – transferred back from Royal Haslar Hospital after acute cholecyctitis. Plan for urgent discussion with family when can we stop transfers for appropriate diagnosis Mrs Ramsey has not functionally shown a marked improvement.
Summary – transferred to Dryad Ward for continuing care and rehabiliation. Had graze on sacrum but no breaks. Skin flaps on both elbows.
Transfer form – notes fracture right hip 1998, fracture right colles 1998, right knee replacement, fracture left hip June 2000 and DHS June 2000, revision to Thompsons Feb 2001, revision to Girdlestone March 2001, persistent problems with wound infection, hypertension and depression.

4th June 2001

Clinical notes – discussion with family re future. Seen by physio, left leg some evidence of shortening, unable to weight bear and in my opinion this lady will be unable to walk. Other methods of independence need to be explored.

5th June 2001

Clinical notes – better complaining of pain left side.

6th June 2001

Summary – left hip wound weeping a little in centre also surrounding area looks red. No complaints of discomfort here but does have intermittent back and knee pain.

11th June 2001

Clinical notes – prefers being bed bound.

12th June 2001

Clinical notes – reluctant to sit out. Physio opinion not suitable for rehabilitation. Still complaining of back pain. No Pressure sore – hip wound healed but scratched. No hip pain. Barthel 2. Regular analgesia not for CPR. Refer to social services for Nursing Home placement.

15th June 2001

Clinical notes – discussion with daughter – good for family to be involved with current care it cold help to encourage her.

2nd July 2001

Clinical notes – now on sertialine ? reason for change weekend hallucinations trans visual. Daughter looking for Nursing Home.

3rd July 2001

Clinical notes – confused mild dehydration.
Summary – swelling and tenderness side of abdomen.

7th July 2001

Clinical notes – complaining of abdo pain then some nausea, may have gallstones.

9th July 2001

Clinical notes – complaining of visual hallucinations. Awaiting US scan for abdo.

17th July 2001

Clinical notes – US results minimally thickened GB wall clear fluid in it. Kidney slightly small.

20th July 2001

Clinical notes – weepy and emotional.

24th July 2001

Clinical notes – discussion with daughter informed of ultra sound scan – opted not to further pursue the splenomegaly.

9th August 2001

Clinical notes – assessment for cataract extraction.

14th August 2001

Clinical notes – complaining of abdo pain to monitor.
Summary – complaining of abdo pain right upper of abdomen. Surgeon for further assessment.

3rd September 2001

Contact record – full assessment taken for Nursing Home placement.

7th September 2001

Summary – red area of irritation on nose to be photographed.

10th September 2001

Clinical notes – complaining of left knee pain – now better.
Summary – complaining of sore sacrum – reposition ? to try and sit out.

24th September 2001

Letter from GWMH to Social Services stating that Mrs Ramsey has been an inpatient from June 2001 and is now stable not needing specialist care for infection, catheter, constipation, psychiatry intervention, physiotherapy, optithalmologists review and speech and language therapy for swallow. Her Barthel is 2/3 and has remained so for the past 4-6 weeks. Can safely be looked after in the community.

12th October 2001

Clinical notes – right scapular area 5cm lipomatous swelling – observe.

24th October 2001

Summary – eyes very red – rubbing she can see black spots. Complaining of black flies around her eyes.

25th October 2001

Clinical notes – complaining sore eyes – slightly infected.
Summary – eyes swabbed.

26th October 2001

Summary – scratched her abdomen and inner thighs.

5th November 2001

Clinical notes – left leg lateral aspect of thigh red patch from iliac crest to above knee. Possible cause of pyrexia left thigh cellulitis.
Summary – flushed and unwell, left leg red and hot around wound site.

8th November 2001

Clinical notes – complaining of abdo pain. Left thigh cellulitis much better.
Summary – confused, hallucinating and aggressive.

12th November 2001

Clinical notes – funding appears to have been agreed for Home.

13th November 2001

Clinical notes – Nursing Home funding approved and daughter looking for place.

19th November 2001

Clinical notes – urgent call re stridor at lunch. Found patient upright, blue tinge around lips. Chest massage, felt better, chest clear. 3rd episode this week. Full SALT assessment.
Reviewed by SALt a oseophageal dysmolility to supervise intake and a very moist diet. To alternate solids with sips of water. Referral for barium meal.

20th November 2001

Clinical notes – assessed by St Ann Nursing Home, Southampton to be transferred.
Contact record – matron from St Anne's Nursing Home visited to assess for placement.

27th November 2001

Transferred to Nursing Home.

Comment

This was a frail lady who was admitted to Gosport initially for rehabilitation after repair of a fractured neck of femur. It became clear that she was not going to improve and eventually a nursing home bed was found for her and she was transferred there on 27th November 2001
Some aspects of her skin care and nutrition were poor.

<u>Administration of medicines.</u>

The care plans had been drawn up for appropriate problems and needs. I found no evidence of the inappropriate administration of medicines.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

(This is my assessment and has not been discussed with the Clinical team)

6.43 BJC/40 Violet Reeve

Code A

Date of admission to GWMH: **11th November 1996**
Date and time of Death: **22.30 hours on 14th April 1997**
Cause of Death:
Post Mortem: **Burial**
Length of Stay: **5 months**

Miss Reeve's past medical history:-
CVA left hemiparisis
Obesity
Hypertension
Constipation
Glaucoma in family

Miss Reeve was single and the eldest of three sisters. One sister lived in London and the other lived in Gosport. Miss Reeve spent a lot of time abroad and moved to England in 1939, she left in the 1960's to move to Germany and then returned to live in England finally getting a flat in Gosport. Miss Reeve was described as being obese but neatly dressed.
Miss Reeve was admitted to the Queen Alexander Hospital on 18th October 1996 following a right CVA and was transferred to the Gosport War Memorial Hospital on 11th November 1996 for rehabilitation.

On admission care plans commenced for immobility, elimination, hygiene and to settle at night, theses were reviewed on the 9th March 1997 and further care plans for unable to eat or drink commenced on 1st April 1997 and bruised left calf commenced on 1st March 1997.
A Waterlow score of between 25 – 30 (p138) was recorded between the period of 8th November 1996 to 23rd March 1997.
A Barthel ADL index (p139)was completed weekly from 8th November to 5th April 1997 scoring 0.

11th November 1996

Transfer letter – admitted to Daedalus ward after stroke. Suffering from low platelets count, obesity and hypertension. It was noted that she was prone to constipation and transferred with the aid of a hoist.
Summary – admitted from Mary Ward Queen Alexander Hospital. Original CVA 8th October 1996 extension 18th October 1996 for gentle rehabilitation. Needs help with all activities of daily living. Catheterised. Transfers with Wessex hoist. Left arm painful. Barthel 0 Waterlow 25 for MRSA screening.

13th November 1996

Summary – MRSA negative.

27th November 1996

Clinical notes – unhappy painful legs, back and rectum.

16th December 1996

Clinical notes – transfer to long term bed.

21st December 1996

Summary – remains drowsy. Seen by Dr Barton possibly suffered a further stroke.

30th December 1996

Clinical notes – long discussion with sisters and niece and explained not improved much in last 2½ months. Agreed she is very depressed but not confused. Leave flat open for a further month.

2nd January 1997

Summary – slipped to floor in present of S/N Bre? could not prevent from slipping to floor. Assistance of 4 to put back to bed. Accident form completed.

3rd January 1997

Summary – Howling from 9-11am diazepam 5mg given at 10.50.

13th January 1997

Clinical notes – much quieter after 6mgs ?. Still agitated in the evenings. Barthel 0 platelets 66. Prognosis poor.

3rd February 1997

Clinical notes – little more to do except prescribed with antidepressants.

28th February 1997

Summary – poor prognosis and outlook explained.

1st March 1997

Summary – heard to be howling. Left leg caught underneath cot sides despite padding. Bruise mark on lower leg and cream applied, to be observed. Accident form completed.

10th March 1997

Clinical notes – still very distressed. Family also distressed would like second opinion from a neurologist. Neurology referral to Dr Gibb.
Seen by R Viewer EMI, slowly introduce oramorph 2.5 mgs.

11th March 1997

Summary – seen by Dr Viewer try oral diamorphine, to be observed for Parkinsons side effects.

13th March 1997

Clinical notes – further deterioration.

18th March 1997

Clinical notes – review with Dr Gibb – drowsy, eyes closed – agree with plan to control/improve behavior with drugs but avoiding sedatives (day time).
Summary – seen by Dr Gibbs no evidence of brain tumour.

24th March 1997

Clinical notes – Midazolam via syringe driver will eat if fed. Family accepted situation. Oramorph/diamorphine if very distressed if lady dies **nursing staff to confirm death.**

29th March 1997

Summary – distressed throughout morning.

3rd April 1997

Clinical notes – make further swallowing assessment. Seen by SLT swallowing severely reduced.
Summary – seen by SLT at severe risk of aspiration and subsequent chest infection. Nil by mouth.

7th April 1997

Clinical notes – distressed, grimacing and crying out. Floppy left oedematous hand. Blisters breast and sacrum. Add diamorphine to midazolam. Increase dose of diamorphine to keep comfortable. Prognosis poor.
Summary – in view of continues distressed morphine to be added to syringe driver 20mgs.

8th April 1997

Summary – more settled with diamorphine addition to syringe driver.
Deteriorating – family unhappy with care and feeding. S/C fluids commenced.

10th April 1997

Summary – chesty seen by Dr Barton nursed 2 hourly all care.

11th April 1997

Summary – peaceful family staying night. Chesty and bubbly.

13th April 1997

Summary – distressed diamorphine increased to 40mgs via syringe driver with good effect. Nocte – distressed on movement diamorphine increased 50mgs.

14th April 1997

Clinical notes – condition deteriorating 22.30 died peacefully. Pronounced dead by SSN Ray and S/N Markham for burial.
Summary – death confirmed, sister and niece present.
Big violent family argument over execution of will.

Comment

Administration of medicines.
Yvonne Astridge (Nurse) queried Dr Lord medication after neurologist visit. Stopped Medazelam.
Dr banks suggested opiods as a sedative to stop Miss Reeve from howling at night.
When Diamorphine was started at 20 mgms it increased rapidly though 40 and to 50 mgms without an apparent reason. Nurses did not appear to question. This was not satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.44 BJC/41 Gladys Richards

Code A

Date of admission to GWMH: **17th August 1998**
Date and time of Death: **21.20 hours on 22nd August 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **6 days**

Mrs Richards past medical history:-

Deaf in both ears
Cataract operation in both eyes
Six month history of falls
Alzheimers
Hysterectomy

Mrs Richards was a widow and had two daughters. She lived at Glen Heathers Nursing Home. Mrs Richards was allergic to eggs and mackeral. On 30th July 1998 Mrs Richards suffered a fall at the home and fractured her right neck of femur. She was admitted to the Royal Haslar Hospital and underwent a closed relocation of her right hip (hemiarthroplasty) with a canvas knee immobilising splint to discourage any further dislocation and to stay in place for 4 weeks. Mrs Richards was transferred to the Gosport War Memorial Hospital on 11th August 1998 for continuing care.
Mrs Richards was transferred to the accident and emergency department of the Royal Haslar Hospital on 14th August 1998 for reduction of dislocated right hip and was readmitted to the Gosport War Memorial Hospital on 17th August 1998.

On admission care plans (p49-58) commenced for sleep, nutrition, constipation and hygiene.
A Waterlow score of 27 was recorded (p41)on 11th August 1998 as well as a Barthel ADL index with a score of 3. (p40)

11th August 1998

Clinical notes – transferred to Daedulus ward after hemiarthroplasty. Catheter insitu and canvas knee immobilising splint to discourage further dislocation must stay in place for 4 weeks. On examination(p29) frail dementing lady. Not obviously in pain. Please make comfortable. Transfers with hoist. Usually routine, needs help with Activities of Daily living. **Happy for nursing staff to confirm death.**
Summary – admitted from E6 Royal Haslar Hospital for continuing care.

13th August 1998

Contact record – found on floor at 13.30 hours no apparent injuries. 19.30 pain right hip internally rotated.

14th August 1998

Clinical notes – sedation/pain relief has been a problem not controlled by haloperidol but very sensitive to oramorph.

Right hip shorter and internally rotated. Is she well enough for another surgical procedure? Daughter aware and not happy.
Contact record – hip x-rayed dislocated. Daughter seen by Dr Barton for transfer to Haslar accident and emergency department for reduction under sedation.
Transfer to Haslar Hospital for reduction of dislocated right hip.
Contact record – notified that reduction had been done and to stay at Haslar for 48 hours then return to Gosport War Memorial Hospital.

17th August 1998

Clinical notes – transfer to back to Daedulus ward. Readmission from Haslar after reduction under IV sedation. Remained unresponsive for several hours. Now appears peaceful.
Plan: - Haloperidol
-only give oramorph in severe pain.
- see daughter again (p30)
Contact record – returned to Gosport War Memorial Hospital very distressed and in pain. To remain in straight knee split for 4 weeks. Two pillows between legs at night. MRSA negative.
In pain and distress daughters agree oramorph 2.5mgs.
X-ray no dislocation seen. For pain control overnight.

18th August1998

Clinical notes – still in great pain. Suggest S/C diamorphine/haloperidol and midazolam. Please make comfortable.
Summary – reviewed by Dr Barton for pain control via syringe driver. (p46)
Daughters agreed to use syringe driver. Syringe driver 40mgs diamorphine , Haloperidol 5mgms and Medazelam 20 mgms commenced.
Peaceful reacted to pain when being moved.
Daughter upset and angry about mothers condition but happy pain free.
Stayed overnight.
Still unhappy with various aspects of care complaint to be handled officially.

21st August 1998

Clinical notes – much more peaceful. Condition very poor.
Pronounced dead at 21.20 by S/N Griffin. Relatives present. For cremation.
Summary – condition deteriorating.

Comment

Mrs Richards was admitted to Gosport Hospital for continuing care. She dislocated her hip again and had to have it reduced at Haslar. After this she was in pain.
The nurses assessed her care needs and care plans were drawn up. These seemed appropriate for the description of Mrs Richards in the clinical notes. Mrs Richards had been in pain and her daughters agreed for a syringe driver to be used.

<u>Administration of medicines.</u>
Mrs Richards was given medication for her pain. The nurses failed to query the drugs administered by syringe driver.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.45 BJC/42 James Ripley

Code A

Date of admission to GWMH:
Date and time of Death: **Still alive**
Cause of Death:
Post Mortem:
Length of Stay:

Mr Ripley's past medical history:-

Diet controlled diabetes
Osteoarthritis
Gout
Hypertension
Mild chronic renal failure
Possible asbestosis.

In August 2002 Mr Ripley was in Gosport War Memorial Hospital. He had worsening renal function. He was breathless.

Comment

Administration of medicines.
He was prescribed Diclophenac as a drug suitable for his arthritis. Regular creatinine checks should have been done.
I would have expected the nurses to query this in the circumstances.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

Code A

Code A

6.47 BJC/44 Elizabeth Rogers

Code A

Date of admission to GWMH: **30th January 1997**
Date and time of Death: **22.50 hours on 4th February 1997**
Cause of Death:
Post Mortem: **Burial**
Length of Stay: **6 days**

Mrs Rogers past medical history:-
Parkinson's disease

Mrs Rogers had been married twice, her first husband died in 1979. She had 2 daughters and 3 sons, 2 sons and a daughter lived in Wigan and another daughter lived in Gosport. Mrs Rogers moved down to Gosport from Wigan as she was getting no help from her family.
She was admitted into Thatched Cottage Residential Home as she became immobile and had swallowing problems.
From the Home Mrs Rogers was admitted to the Royal Haslar Hospital with a chest infection and urinary tract infection. It was noted that she had a catheter in place, was bed bound, slightly dysphagic, had lost weight and her sacrum was red but intact. Mrs Rogers was transferred to the Gosport War Memorial Hospital for continuing care on 30th January 1997.

On admission care plan commenced for constipation, catheter, personal hygiene, MRSA and sleeping.(P 349-367)
On 30th January 1997 a Barthel ADL(p 363) index was completed scoring 2.
A Waterlow score of 26 was also completed (p365). A mouth assessment was also completed on 31st January 1997.
A handling profile was completed (p13)noting that Mrs Rogers needed the help of 2 nurses and hoist for transfers.

30th January 1997

Transferred to Dryad Ward. Transfer form notes grazed sacrum markings on hip and buttock skin intact.
Summary – admitted from A5 at Haslar after being admitted on 12th January 1997 ***following CVA*** [10]and has end stage Parkinsons. Screened for MRSA.

2nd February 1997

Summary – due to increase in pain and distress oramorph 10mgs given at 09.45.
PM – oramorph 10mgs at 14.00 and 18.00 hours. Extremely stiff when being attended to.

3rd February 1997

Summary – **pain not controlled by oramorph.** Seen by Dr Barton syringe driver commenced at 8.20 hours diamorphine 40mgs midazolam 20mgs and hyoscine 400 mgs. Daughter contacted and grand-daughter also notified of poor condition. Family seen by Dr Barton. Driver still insitu and running to time.

[10] Did not have CVA.

4th February 1997

Summary – further deterioration. Family seen by Dr Barton. Pastor Mary has also visited. Syringe driver renewed at 08.20 hours diamorphine 60mgs midazolam 40mgs and hyoscine 400mcgs remains peacefully.
Died peacefully at 22.30 surrounded by family
Clinical notes – Condition quickly deteriorated appeared comfortable and peaceful. Relatives at bedside death at 22.50 verified by RGN Dorrington.
For burial.

Comment

Mrs Rogers was admitted with end stage Parkinsons. She was immediately prescribed and administered oramorph and soon afterwards progressed to diamorphine. There was no pain assessment, there are no medical notes.
There is no analgesia ladder. Simple analgesia might have worked.
Parkinson's disease is not opiod sensitive.
Notes stated CVA. Mrs Rogers did not have a CVA.
The nurses assessed her care needs on admission and wrote care plans which seemed appropriate.
Administration of medicines.
Mrs Rogers was given medication for her pain and the nurses did not question the fact that she went straight on to morphine without trying milder medication.
This was not satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.48 BJC/45 Enid Spurgin

Code A

Date of admission to GWMH: **26th March 1999**
Date and time of Death: **01.15 hours on 13th April 1999**
Cause of Death:
Post Mortem:
Length of Stay: **19 days**

Mrs Spurgin's past medical history:-
MI
Lyme Disease
Arthritis in back
Paget's disease

Mrs Spurgin was a widow and lived alone. She had lived in her home for 40 years and was a retired teacher. She had a home help who would go in once a week and a gardener would tend her garden. Mrs Spurgin had a nephew who was noted as her next of kin. Mrs Spurgin wore glasses as her eyesight had deteriorated and that meant she also had to give up driving.
Mrs Spurgin was admitted to the Royal Haslar Hospital on 19th March 1999 following a fall and sustaining a fracture neck of femur. The next day Mrs Sprugin underwent surgery for a dynamic hip screw. She was admitted to Gosport War Memorial Hospital on 26th March 1999 after suffering a CVA.

On admission care plans commenced for MRSA screening, sleeping, pain on movement, wound on right elbow and laceration on right calf – skin is fragile, right leg swollen and oedematous, continence, washing and dressing, constipation and a further care plan commenced on 4th April 1999 for wound on hip oozing.
A mouth assessment was completed on 30th March 1999.
A nutritional assessment with a score of 21 was recorded on 26th March 1999/
A Waterlow score of 32 (p89/91)was recorded on 26th March 1999 and another on 10th April 1999 with a score of 31.
A Barthel ADL index (p93) was also completed on 29th March 1999 scoring 6 and on 10th April 1999 scoring 5.
A physio care plan (p95) commenced on 1st April 1999.
A handling profile was completed on 26th March 1999 noting that Mrs Sprugin's communication was good, she had pain in right hip, her skin fragile and was to be nursed on Pegasus biwave mattress and that she needed the help of 2 nurses and a hoist for transfers.

26th March 1999

Transfer form notes skin on lower legs paper thin not to wear TED stockings. Right lower leg swollen, small break on posterior – steristrip.
Clinical notes – transfer to Dryad ward no weight bearing. Plan – sub cut analgesia.

Summary – admitted to Dryad ward for rehabilitation. In a lot of pain oramorph regularly with effect. Skin very dry tissue paper skin, small break on right calf.

31st March 1999

Sleep care plan – commenced on MST 10mg. 13.15 oramorph 2.5mls given not to much effect.

3rd April 1999

Sleep care plan – MST 10mg still complaining of pain.

6th April 1999

Summary – seen by Dr Barton MST increased to 20mgs. Nephew visited. Does not want to go into Nursing Home.

7th April 1999

Clinical notes – still in a lot of pain. MST increased to 20mgs for x-ray to right hip as movement still quite painful, also about 2" shortening right leg.
Summary – fracture sit red and inflamed. Seen by Dr Barton.

8th April 1999

Sleep care plan – MST increased to 20mgs.

9th April 1999

Summary – catheterised.

11th April 1999

Sleep care plan – oramorph 5mg given at 07.15 hours.
Summary – deteriorated Nephew phoned. **Very drowsy and unrousable** at times. Refusing food and drink and asking to be left alone. Right hip looks red and inflamed and is hot. Denies any pan but complaining when moved. To discuss syringe driver with nephew who would like her to be kept comfortable.
Seen by Dr Barton **to commence syringe driver.**

12th April 1999

Clinical notes – now very drowsy (since diamorphine infusion established) reduce to 40mgs/24 hours, if pain reoccurs increased to 60mgs. Ask to move hip but **patient not rousable**.
Sleep care plan – **syringe driver satisfactory** appears in some distress.
Summary – seen by Dr Reid diamorphine decreased to 40mgs if pain reoccurs dose can gradually be increased as and when.

13th April 1999

Clinical notes – 01.15 died peacefully.
Death confirmed Night Sister Walker and S/N Collins.

Comment

Mrs Spurgin was admitted from Haslar after having a dynamic hip. She was started on strong analgesia and became very drowsy.
The nurses were able to adjust dosage of medication as Dr Barton had used a sliding scale. It was a very wide range.
The nurses assessed her care needs on admission and wrote care plans, which seemed appropriate.
<u>Administration of medicines.</u>
There was a very large increase of diamorphine from 40 mgms to 80 mgms. The nurses did not query this. There was inappropriate antibiotic medication. Vancomycin was given for MRSA, should have been Flucloxacillin.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness				

6.49 BJC/46 Jean Stevens

Code A

Date of admission to GWMH: **20th May 1999**
Date and time of Death: **22.30 hours on 22nd May 1999**
Cause of Death:
Post Mortem: **Burial**
Length of Stay: **2 days**

Mrs Stevens past medical history:-

IHD
MI x 2
COPD
Sigmoid resection due to diverticulitis and stricture
Asthma
Pneumonia
Arthritis

Mrs Stevens lived with her husband and had 2 daughters. They managed all their needs and were independent. Mrs Stevens suffered a CVA and was admitted to the Royal Haslar Hospital on 26th April 1999 her recovery was affected when she suffered a Myocardial Infarction on 28th April 1999. Mrs Stevens was transferred to the Gosport War Memorial Hospital on 20th May 1999. She was catheterized, had an NG tube feed and her pressure areas were intact except for a very sore groin area.

On admission an assessment for was completed noting that she had poor hearing in right ear, poor vision wears glasses all the time, her speech was slow and slurred, was complaining of abdominal pain due to bowel problem. Care plans commenced for catheter, personal hygiene, shoulder pain, pressure area care, poor gag reflex, and night care.
Waterlow score 25 was recorded (p28), a Barthel ADL index scored 1.(p30)
An abbreviated mental study was completed scoring 4. (p31)
A handling profile (p40) was completed noting that Mrs Stevens had abdominal pain, skin dry and intact, nursed on pressure relieving mattress and a catheter and NG feeding tube were in place.
A nutritional assessment was completed noting a score of 20. (p42/4)

20th May 1999

Transfer form notes Mrs Stevens has suffered a right CVA dense left hemiplegia unresolved, recovery affected by MI on 28th April 1999 now remains dense left hemiplegia with no swallow, catheterized and faecally incontinent, needs all care, NG feeding, pressure areas intact though very sore groin area.
Clinical notes – transferred needs all help, transfers with hoist. Barthel 0.
Summary – transferred from A6 Haslar. NG feed required due to poor gag reflex. Speech slurred. Alert and aware of surroundings.

21st May 1999

Contact record – AM regular 4 hourly oramorph 10mgs. PM uncomfortable throughout afternoon despite 4 hourly oramorph.

Husband seen and very upset.
Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with medazolam aware of poor outlook but anxious that medication given should not shorten her life. 19.45 commence syringe driver 20mgs diamorphine and midazolam in 24 hours.

22nd May 1999

Summary – condition deteriorated very bubbly 20mgs diamorphine syringe driver. 22.30 died one daughter contacted. Police contacted to try and notify other daughter
Clinical notes – died peacefully at 22.30 hours husband present. For burial. Verified by SSN Tubbritt.

Comment

Mrs Stevens was admitted from Haslar. The nurses made a comprehensive assessment of her condition and drew up care plans, which appear appropriate. There was no assessment that Mrs Stevens was in any pain.
pain.
Mrs Stevens notes ate missing from Haslar.
Administration of medicines.
Mrs Stevens had not complained of pain yet she was written up for oramorph and the diamorphine by syringe driver. (p32/3). There is no evidence that the nurses questioned this decision. This was not satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness				

6.50 BJC/47 Daphne Taylor

Code A

Date of admission to GWMH: **3rd October 1996**
Date and time of Death: **01.25 hours on 20th October 1996**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **18 days**

Mrs Taylor's past medical history:-
Hypertension
Vertigo of central origin
Bilateral visual impairment due to ischaemic retionpathy

Mrs Taylor lived with her husband they had a daughter and a son. Mrs Taylor was a retired sub post office manager. Mrs Taylor was admitted to the Royal Haslar Hospital on 29th September 1996 after suffering a stroke. She was transferred to the Gosport War Memorial Hospital on 3rd October 1996 for rehabilitation.

On admission care plans (p36-58) commenced for sleep, pain right arm left leg, PEG feed, bowels, catheter, personal hygiene, immobile, at risk of developing pressure sores, has scratches on left leg and mouth care.
An assessment form was completed noting that Mrs Taylor wore a hearing aid in her left ear, wears glasses and is blind in left eye, unable to walk, is PEG fed and has been catheterised.
A Barthel ADL index was completed with a score of 0 recorded.(p72)
A Waterlow score of 20 was recorded.(p74)

3rd October 1996

Transfer form – admitted for rehabilitation after CVA, catheterized, drowsy, PEG fed, understands, but has no speech.
Summary (p12)- admitted from A5 Haslar to Daedulus ward with left CVA right hemiplegia. NBM swallowing reflex absent. Seen by Dr Barton medications boarded, chesty and rattly.

7th October 1996

Summary – Seen by Dr Barton appears to be in pain, boarded for Fentanyl patches 25mgs every three days. MRSA swab.
Seen by Dr Lord to be referred to dietician and Speech and Language therapy, seen husband not to be transfused.
Clinical notes – poor prognosis aim to maintain BP.

9th October 1996

Summary – in a great deal of pain boarded for 50mgs Fentanyl patches.(p62)
Clinical notes – condition deteriorated. **Nursing staff may confirm death.**
Would not use antibiotics but make comfortable.

10th October 1996

Summary (p64)– Fentanyl patch renewed as patch applied on 9th fell off.
Authorised by Dr Barton.

11th October 1996

Summary – more settled. MRSA negative.

17th October 1996

Summary – Left arm elbow still very painful on movement. Dr Barton seen X-ray from Haslar has requested repeat X-ray.

18th October 1996

Summary – AM very unsettled night appeared distressed and in pain. Syringe driver set up with 40mgs diamorphine and midazolam 20mgs over 24 hours. Fentanyl patch removed appears more comfortable.
PM appears more peaceful and relaxed, no pain, rousable on turning.
Family seen by Dr Barton and informed of poor prognosis. Feed to continue.
Clinical notes – condition deteriorated last night S/C analgesia commenced.

19th October 1996

Summary – condition deteriorating, chesty very bubbly. Diamorphine 40mgs via syringe driver. Husband contacted still wishes feeding to continue.

20th October 1996

Summary – 01.25 hours died peacefully for cremation. Verifed by SSN Tubbritt and S/N Nelson.

Comment

Mrs Taylor had a severe stroke which left her unable to swallow or speak. She was tube fed. The nurses assessed her care needs and drew up comprehensive plans, which appear, based on the information available, to be appropriate.
Administration of medicines.
Mrs Taylor was prescribed a rapidly escalating amount of analgesia. There is little evidence that she was suffering from pain or that an assessment was made for pain. There is no evidence that the nurses queried the decision to prescribe such high doses and they administered it. This was not satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.51 BJC/48 Sylvia Tiller

Code A

Date of admission to GWMH: **4th December 1995**
Date and time of Death: **07.20 hours on 13th December 1995**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **10 days**

Mrs Tiller's past medical history:-

CCF
Cholecystectomy
Hysterectomy
Arthritis
Mild CVA
Non insulin dependent diabetic
Mastitis
Hypertension

Mrs Tiller lived alone in her own flat. She has 2 daughters and 2 sons. One of her daughters would help for 4-5 hours a day and a grand-daughter would do her laundry. Mrs Tiller was admitted to the Queen Alexander Hospital on 3rd November 1995 after suffering a MI/CCF she was later transferred to Charles Ward suffering from end stage cardiac failure and was transferred to Gosport War Memorial Hospital on 4th December 1995.

On admission to Gosport War Memorial Hospital care plans commenced for non insulin dependent diabetic, sleep, wound on sacrum, at risk of developing pressure sores, elimination, catheterised and personal hygiene.(p172-183)
A Barthel ADL (p184)index score of 0 was recorded on 5th December 1995 as well as a Waterlow score of 28. (p185)
A lifting/handling risk calculator was also completed scoring 25. (p186)

4th December 1995

Transfer form – admitted to Dryad ward suffering end stage cardiac failure, has poor appetite, diamorphine and halperidol both 10mgs via syringe driver, sacrum very red, has had some weight loss and has been catheterized.
Clinical notes – very poorly breaks on sacrum. Family aware of poor prognosis.
Summary – admitted from Charles Ward Queen Alexander Hospital.

5th December 1995

Summary – all care given, seen by Dr Barton.

6th December 1995

Clinical notes – told nursing staff wishes to die. If distressed TLC.
Summary – deteriorating slowly, lower half of body still very oedematous, legs leaking small amounts serous fluid.

8th December 1995

Summary – a little brighter.

9th December 1995

Summary – looks poorly, however quite bright. Family visited.

10th December 1995

Summary – agitated and complaining of pain in legs, oramorph 5mg given at 16.50hours.

11th December 1995

Summary – complaining of central chest pain. Oramorph 5mg given.

12th December 1995

Clinical notes – Further deterioration comfortable on oramorph.
Summary – daughter seen syringe driver discussed. Oramorph 5mgs given. 19.30 complaining of chest pain distressed, syringe driver commenced diamorphine 20mgs over 24 hours. Family visited.

13th December 1995

Summary – condition deteriorated over night died at 07.20 hours grand-daughter present certified by Dr Barton at 07.45.
Clinical notes – died 07.20 hours for cremation.

Comment

Mrs Tiller had end stage renal failure. She had had several previous hospital admissions. The nurses assessed Mrs Tiller's care needs and drew up care plans for her which appear on the information supplied to be appropriate.
Administration of medicines.
Fentanyl was used and a starting dose of 25 mcgms was used. This was high and the nurses did not question the dosage and administered it. Then there was a rapid escalation of morphine. Mrs Tiller was very frail.
This was not satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

Code A

Code A

6.53 BJC/50 Frank Walsh

Code A

Date of admission to GWMH: **9th June 1994**
Date and time of Death: **08.20 hours on 14th June 1994**
Cause of Death:
Post Mortem: **Burial**
Length of Stay: **6 days**

Mr Walsh's past medical history:-
TIA

Mr Walsh lived at home with his wife who was his main carer. They had a large family who rallied round and helped out. They had a son and grandson. Mr Vince was admitted to the Gosport War Memorial Hospital on 9th June 1994 an emergency admission from home after deteriorating and suffering a CVA.

On admission an assessment of activities of daily living was completed noting that Mr Walsh was vague and very slow to respond, he had a poor appetite and had to be fed and that he needed total care.
Care plans commenced on 9th June 1994 for sacrum red and prone to soreness – to be checked daily, spenco mattress in situ, sponge cushion in armchair, needs help to settle, mobility, incontinent and constipation.

9th June 1994

Nursing report – seen by Dr Erskine for assessment and rehabilitation with view to returning home. Incontinent of urine since admission.
Clinical notes – elderly man less mobile pass few days incontinent urine/faeces.
TIA earlier this year confused at times.

12th June 1994

Nursing report – nauseated.
Clinical notes – complaining of abdominal pains.

13th June 1994

Nursing report – taken to bathroom for wash collapsed before he could be put in bath, gasping returned to bed and revived. Visited by Dr Dorrian Cosham.

14th June 1994

Clinical notes – patient had "a turn", on examination apyrexial.
Nursing report – died 08.20 hours. GP and relatives informed.
For burial verified by B Spencer and S Rowlands.

Comment

Mr Walsh was unwell and admitted to Gosport to be assessed, rehabilitated and to return home. The nurses assessed his care needs and wrote care plans which appear appropriate.
Administration of medicines.
This was satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.54 BJC/51 Walter Wellstead

Code A

Date of admission to GWMH: **7th April 1998**
Date and time of Death: **08.30 hours on 13th May 1998**
Cause of Death:
Post Mortem:
Length of Stay:

Mr Wellstead's past medical history:-

Hernia
Depression
Asthmatic
CVA's
Senile dementia
Aortic aneurysm repair

Mr Wellstead lived at Zetland Lodge Nursing Home which was DSS funded. He had a brother and a sister and also had a son and daughter. He was in the Army and later worked in a boat yard. Mr Wellstead was described as having variable deafness, unable to stand straight, suffered with depression and spent a lot of time in his bed. Mr Wellstead was admitted to the Queen Alexander Hospital on 12th March 1998 following a fall in his room where he sustained a fracture of this right hip and underwent dynamic hip screw surgery on 14th March 1998. He was transferred back to the Nursing Home on 20th March 1998. Mr Wellstead was then admitted to the Gosport War Memorial Hospital on 7th April 1998 with dementia and for a full assessment.

On admission a nutritional assessment was completed with a score of 18.
A handling profile was completed noting that Mr Wellstead had limited speech, understands but is un co-operative and aggressive at times, has no complaints of pain, skin is intact and requires the help of 2 nurses and a hoist for transfers.
Care plans commenced on 8th April 1998 for aggressive and verbally abusive, and on 5th May 1998 for increasingly immobile – puts himself on floor.
A Waterlow score of 19 (p83)was recorded on 10th April and 1st May 1998.
A lifting/handling risk calculator score of 28 was recorded on 10th April and 5th May 1998.

7th April 1998

Clinical notes – admitted with increased aggression towards nursing home staff. Some paranoid ideas. Poor mobility due to fracture.

14th April 1998

Clinical notes – want weight bear, poor posture and rigidity of limbs.
Continent in the day incontinent at night. Needs all nursing care.
Nursing notes – fall.

20th April 1998

Clinical notes – x-ray hip not weight bearing, cannot stand alone.

22nd April 1998

Clinical notes – put himself on floor says left hip hurts.

Nursing notes – found on floor checked over by Dr ? no problems found.

23rd April 1998

Nursing notes – had a fall on toilet no apparent injuries. Nocte rolled over and caught right eye on cot side small laceration sustained accident form completed.

24th April 1998

Nursing notes – fall old injury to head reopened no dressing needed accident form completed.

25th April 1998

Clinical notes – complaining of pain in left hip, drowsy.
Nursing notes – complaining of pain left side.

27th April 1998

Clinical notes – restless start diazepam.

28th April 1998

Nursing notes – found on floor in dining room laceration to head.

1st May 1998

Clinical notes – reviewed generally more settled.
Nursing notes – rigid and drowsy.

4th May 1998

Nursing notes – noisy shouting.

5th May 1998

Clinical notes – settled low in mood.

6th May 1998

Clinical notes – appears in pain when moved, drowsy told nurse would like to be left to die. Keep comfortable **set up syringe driver** not for active treatment.
Nursing notes – deteriorated remained in bed turned to right side 2 hourly. Seen by Dr Childs increased pain syringe driver set up at 20.15 hours diamorphine 15mgs.

7th May 1998

Clinical notes – son agreed syringe driver. Syringe driver commenced 15mgs diamorphine.
Nursing notes – syringe driver renewed at 20.05 hours.

8th May 1998

Clinical notes – semi conscious not in pain.

9th May 1998

Nursing notes – 2 hourly turns plus mattress developing pressure sores pillows between knees when nursed on sides.

10th May 1998

Clinical notes – increase diamorphine 30mgs in 24 hours.
Nursing notes – showing signs of pain wincing when turned. Seen by Dr North in pain and also terminal pneumonia 30mgs diamorphine in syringe driver. Son made aware of situation.

11th May 1998

Clinical notes – midazolam added to syringe driver family aware of poor prognosis continues on diamorphine 30mgs.

13th May 1998

Clinical notes – found at 08.30 hours by staff pronounced dead at 09.00 hours by Dr Taylor.

Comment

Mr Wellstead was ill he had been readmitted after being discharged to a nursing home. He was frail and immobile. Nursing care plans were made(p262/4) Mr Wellstead had numerous falls with a minimum amount of injury.

The nurse's notes appear to be satisfactory and seem appropriate.

Administration of medicines.

There was no concern about the medication or administration of it by the nurses.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.55 BJC/52 Alice Wilkie

Code A

Date of admission to GWMH: **6th August 1998**
Date and time of Death: **18.30 hours on 21st August 1998**
Cause of Death:
Post Mortem:
Length of Stay: **16 days**

Mrs Wilkie's past medical history:-
Dementia

Mrs Wilkie lived at Addenbrooke Residential Home a psychogeriatric care home where she needed 24 hour care. Mrs Wilkie had a daughter and granddaughter.
Mrs Wilkie was admitted to the Queen Alexander Hospital on 31st July 1998 with unresolved urinary tract infection, decreased mobility and pyrexia.
She was transferred to Gosport War Memorial Hospital on 6th August 1998 for 4-6 week observation.

On admission care plans commenced for nutrition due to dementia, restricted mobility, pressure area care, constipation, catheter care, hygiene and settle at night.
A handling profile was completed noting that Mrs Wilkie was withdrawn and does not communicate, gets agitated at times, is in pain occasionally, nursed on air mattress, has a pressure relieving cushion in her chair, has been catheterized and needs the assistance of 2 nurses and a hoist for transfers.
A Barthel ADL index score of 1 on 6th August 1998 and 2 on 9th August 1998 were completed. As well as a Waterlow score of 15 on 6th August 1998.
A nutritional assessment score of 22 was also recorded on 6th August 1998.

6th August 1998

Admitted to Daedulus ward, too dependent to return to nursing home for 4-6 weeks observations then decided on placement. Catheter in situ.
Contact records – seen by Dr Peters.

17th August 1998

Contact record – deteriorated over weekend. Daughter seen aware of worsening condition agrees active treatment not appropriate, to use syringe driver if in pain.

21st August 1998

Contact record – condition deteriorating comfortable and pain free. 18.30 death confirmed, family present.

Comment

There were no medical notes. The nurses appeared to assess Mrs Wilkie's care needs and the care plans seemed appropriate. It is not possible to form any opinion about the care without more information.
Administration of medicines.
Need to see medical notes

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B				
Unexplained by Illness				

6.56 BJC/53 Ivy Williamson

Code A

Date of admission to GWMH: **3rd August 2000**
Date and time of Death: **18.20 hours on 1st September 2000**
Cause of Death: **Metastatic Malignant Melanoma**
Post Mortem: **Cremation**
Length of Stay: **19 days**

Mrs Williamson's past medical history:-
Malignant melanoma left maxillary 1994
Pulmonary metastases July 2000
COPD
Osteoarthritis – knees
Leg oedema/cellulites
Asthma

Mrs Williamson lived with her husband in a bungalow. They had 3 sons who lived nearby. Mrs Williamson was her husband's main carer, he had bilateral leg ulcers and was in Royal Haslar Hospital undergoing bilateral knee amputations. Mrs Williamson was blind in her right eye and wore glasses. Mrs Williamson was admitted to Queen Alexander Hospital in July 2000 after suffering a fall. She was diagnosed with cancer and was told that the outlook was poor. It was decided that both Mr and Mrs Williamson would be transferred to the Gosport War Memorial Hospital so that they could be together as Mrs Williamson did not have long to live. Mrs Williamson was transferred on 3rd August 1998.

Care plans were commenced on 3rd August 1998 for hygiene, cellulites in both legs, constipation and help to settle at night.
A nutritional assessment was completed on 3rd August with a score of 9.
A handling profile noted that Mrs Williamson had aching pain in left hip, dry skin, nursed on Pegasus biwave plus mattress, was independent but may need the help of 1 nurse.
A Waterlow score of 11 was recorded on 3rd August 1998 as well as a Barthel ADL index score of 17.

3rd August 2000

Clinical notes – transferred from Queen Alexander Hospital awaiting bronschoscopy.
Summary – admitted to Sultan ward from Phillip ward Queen Alexander Hospital following fall at home. Awaiting bronschoscopy very concerned about husband.

5th August 2000

Summary – pain in left hip.

6th August 2000

Summary – returned from seeing husband at Royal Haslar Hospital on rising from wheelchair banged right lower leg causing blister and bruising incident form completed.

9th August 2000

Clinical notes – bronschoscopy at Royal Haslar Hospital.

10th August 2000

Summary – pain right side upper thorax.

11th August 2000

Clinical notes – for palliative care oramorph or diamorphine if distressed. Happy for transfer to Daedulus ward for palliative care.

Summary – boarded for oramorph 5-10mgs slowly if required.

17th August 2000

Clinical notes – told melanoma has spread from cheek to left lung and this was causing breathlessness. Sons discussed poor prognosis months rather than years.

21st August 2000

Clinical notes – transfer from Sultans ward to Daedulus ward. Walking with wheeled frame. SOB on mild excursion if distressed for oramorph or diamorphine.

Summary – transferred to Daedulus ward seen by Dr Lord to continue with all care for 1 month. Husband to be transferred to Daedulus. If very SOB give oramorph.

25th August 2000

Clinical notes – pain control poor try wonadol instead of cocodemal prescribe oramorph.

27th August 2000

Clinical notes – asked to cough 'off colour' croaky voice. Prescribed antibiotics.

Summary – chesty clammy to touch. Seen by Dr Palmer antibiotics for chest infection.

28th August 2000

Summary – sons visited feel she has deteriorated.

29th August 2000

Clinical notes – asked to see denies pain, breathlessness, feeling down and sleep disturbance, anxious about husband arriving on ward today after leg amputations.

30th August 2000

Clinical notes – unwell for 5 days now pyrexial.

Summary – unwell sudden collapse at 18.45 family informed and visited.

31st August 2000

Clinical notes – looks tired and uncomfortable physically deteriorating denies any pain. Very frail large mets in left lung. Try small doses of oramorph for midazolam if agitated. Diamorphine if in pain and distress. Family are aware. **Nursing staff may certify.**

Summary – catheterised syringe driver commenced at 11.45 hours.

1st September 2000

Clinical notes – death confirmed by S/N Neville at 18.20 hours. Husband present for cremation.

4th September 2000

Clinical notes – certificate issued. Cremation form completed.

Comment

The nursing assessment and care plans seem satisfactory. Mrs Williamson was very ill and her medication and pain seem to have been managed well.

Administration of medicines.

This was satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.57 BJC/54 Jack Williamson

Code A
Date of admission to GWMH: **29th August 2000**
Date and time of Death: **hrs on 18th September 2000**
Cause of Death: **1a Congestive cardiac failure**
b Ischaemic heart disease
2 Peripheral vascular disease leading to bilateral leg amputation MRSA wound infection
Post Mortem: **Cremation**
Length of Stay: **21 days**

Mr Williamson's past medical history:-
Hiatus hernia
Leg ulcers
IHD
Atrial fibrillation
Barett's oesophagus

Mr Williamson lived with his wife in a one bedroom bungalow. His wife was his main carer and they had 3 sons who live locally. Mr Williamson had suffered for many years with leg ulcers and had been admitted to hospital on numerous occasions and had had skin grafts undertaken to improve his legs. Mr Williamson was admitted to the Royal Haslar Hospital with bilateral leg ulcers and cellulites on 30th May 2000. It was decided that Mr Williamson would undergo bilateral below knee amputations on 18th August 2000. Mr Williamson was transferred to the Gosport War Memorial Hospital on 29th August 2000 for rehabilitation and to be with his wife who had been diagnosed with cancer.

On admission care plans commenced for sacrum sores x 2, hygiene, constipation, catheter care, nutrition and night care.
A nutritional screening tool was completed with a score of 9 recorded.
A Barthel ADL index was taken weekly from 29th August to 18th September 2000 scoring from 3-4, 5 and 2.
A Waterlow score of 18 was recorded on admission.
A handling profile was completed noting that Mr Williamson needed the help of 2 nurses and a hoist for transfers, complaining of thigh pain ? phantom, to commence regular analgesia and that he had 2 grade 2 sacral sores, scarum excoriated and was to be nursed on a pressure relieving mattress and cushion for wheelchair and that he was catheterised.

29th August 2000

Transfer form – for rehabilitation and to be with wife who was dying.
Depressed, superficial sore on sacrum with multiple excoriation, extensive sacral and perineal excoriation.
Clinical notes – transferred from B3 Haslar after bilateral through knee amputations, suffering depression, some pain both thighs, phantom pain feels

both toes. 'shattered' regarding his wife's condition of cancer. Sacral sore hurting need regular analgesia. Review wounds and sacral area.
Summary – admitted to Daedulus ward. On arrival complaining some pain in both thighs ? phantom will be prescribed regular analgesia and effects to be monitor. 2 grade 2 pressure sores, granuflex applied. Surrounding areas excoriated. Catheter insitu. Dressings to both stumps clean.

30th August 2000

Summary – screened for MRSA.

31st August 2000

Clinical notes – right stump sloughly, gaping area. Sacral ulceration a bit better. Some phantom limb pain. Very upset about wife.
Summary – Seen by Dr Lord right stump leaking area sloughly. Review on Monday.

4th September 2000

Clinical notes – wife died at weekend – very upset. Pain in right stump oozing today. Left stump broken area buttocks inflammation down if in pain codeine or prescribe oramorph.
Summary – seen by Dr Lord to continue dressings. Refer to physio for upper limb work. Bottom improved.

11th September 2000

Clinical notes – clips removed from stumps. Oozing ++ both stumps. Wife funeral tomorrow. Green discharge right thing and exduate discharge left thigh down.

15th September 2000

Summary – contacted by microbiology Gram+ cocci boarded for fluxlocacillin 500mgs and pen v 50mgs.

16th September 2000

Clinical notes – lab phoned to swab again for MRSA ?
Summary – contacted by microbiology MRSA+ in wound. Antibiotics ineffective feels should be referred to surgical team at Haslar. Dr Knapman contacted no changed in treatment.

17th September 2000

Summary – deterioration in condition.

18th September 2000

Clinical notes – marked deterioration in general condition. MRSA isolated from right stump, very poor oral intake, nausea and oedema ++, sweating and distressed. Very unwell unlikely to survive much longer. Oramorph 2.5mg 4 hourly and PM S/C diamorphine if requiring further doses. For diamorphine via syringe driver. Son seen, aware he is dying.
Prognosis very poor if he dies **nursing staff to confirm.**
21.55 hours died. Family informed and visited for cremation. Coroner's office informed.
Summary – deterioration of condition throughout morning, cold, breathing laboured, uncomfortable. Son notified advised use of syringe driver if required. Seen by Dr Lord 4 hourly oramorph antibiotics stopped for daily review of pain control. 16.50 very uncomfortable diamorphine and hyoscine via syringe driver. 19.50 hours family seen aware of deteriorating condition pain controlled via syringe driver and poor outlook.

21.55 died verified by S/N Nelson.

Comment

Mr Williamson was transferred after an amputation of both legs below the knee. He contracted MRSA and his wounds failed to heal and became infected. His wife died shortly after he was transferred to Gosport. He was very distressed.

His pain was managed by oramorph initially and then a syringe driver was put up.

The nurses assessed his care needs on admission and wrote care plans which seemed appropriate.(p1663-1677)

Administration of medicines.

This was satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.58 BJC/55 Robert Wilson

Code A

Date of admission to GWMH: **14th October 1998**
Date and time of Death: **23.40 hours on 18th October 1998**
Cause of Death:
Post Mortem:
Length of Stay: **5 days**

Mr Wilson's past medical history:-
Early dementia
Alcohol liver disease
Leg oedema

Mr Wilson was born in Ayrshire and lived at home with his second wife in a 2 bedroom council house. Mr Wilson had seven children with his first wife, 3 daughters, 3 sons and 1 adopted child he was close to his 3 sons but they did not get on with his second wife, there was friction. Mr Wilson's second wife had a daughter. Mr Wilson was a large man who was hard of hearing and had a hearing aid and he was a heavy drinker.
Mr Wilson was admitted to Queen Alexander Hospital on 22nd September 1998 after suffering a fall where he fractured his left humerus. His wife was on holiday. He was transferred to the Gosport War Memorial Hospital on 14th October 1998 for continuing care.

On admission a Waterlow score of 23 was recorded, as well as a Barthel ADL index score of 4.
Care plans also commenced for help to settle at night, constipation and hygiene.

14th October 1998

Transfer form – admitted to Dryad ward for continuing care. Still in a lot of pain, on high protein diet, legs very oedematous and at high risk of breakdowns. Will need 24 hour nursing care until his arm has healed.
Clinical notes – transferred to Dryad ward. Barthel 7, needs help with ADL, continent for gentle mobilization.
Summary – Transferred from Dickens Ward Queen Alexander Hospital. Arm in collar and cuff. Long history of heavy drinking. LVF, chronic oedematous legs. Seen by Dr Barton **oramorph 10mgs** given. Continent uses bottles.

15th October 1998

Summary – commenced 10mgs oramorph 4 hourly for pain in left arm. Wife seen and explained condition is poor. Oramorph 20mgs given at midnight. 10mgs given at 06.00 hours.

16th October 1998

Summary – Seen by Dr Knapman as deteriorated overnight. PM very bubbly chest syringe driver commenced 16.30 hours 20mg diamorphine.

17th October 1998

Clinical notes – comfortable but rapid deterioration. **Nursing staff to verify death if necessary.**

Summary – 05.15 hours hyoscine increased to 600mgs secretions increasing overnight. **Diamorphine 20 mgs**. Wife and stepdaughter stayed last night. PM slow deterioration, requiring suction very regularly. Syringe driver renewed at 15.50 hours diamorphine 40mgs wife to remain overnight.

18th October 1998

Summary – further deterioration seen by Dr Peters syringe driver renewed at 14.50 **diamorphine 60mgs** continues to require suction. Children visited. Clinical notes – 23.40 died peacefully verified by S/N Collins.

Comment

Mr Wilson had liver disease and renal failure. The use of opiods is contra indicated for people with poor renal function. The doses of diamorphine were increased.

He retained fluids and gained16 Kgms in weight.

The nurses assessed some care needs on admission and wrote care plans which seemed appropriate.

Administration of medicines.

The nurses should have known the type of patients who should not have opiods and should have questioned the prescribing doctors. This was not satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness				

6.59 BJC/56 Norma Windsor

Code A

Date of admission to GWMH: **27th April 2000**
Date and time of Death: **02.55 hours on 7th May 2000 at SMGH**
Cause of Death:
Post Mortem:
Length of Stay: **10 days**

Mrs Windsor's past medical history:-

Ischaemic heart disease
Anemia
Severe dermatitis
Left axilliary lymphadrapathy
Chronic lymphatic leukemia
MI

Mrs Windsor lived with her husband in a house. They had just sold this and were hoping to move to a bungalow. They had 3 daughters. Mrs Windsor was deaf in her left ear and wore a hearing aid.
Mrs Windsor was admitted to the EWGH for respite care and gastroenteritis after collapsing. She was transferred to the Gosport War Memorial Hospital on 27th April 2000 for 'build up' and was then transferred to the St Mary's General Hospital where she died on 7th May 2000.

27th April 2000

Clinical notes – complaining of weakness and exhaustion and depression also recent bout of diarrhoea and vomiting.

3rd May 2000

Clinical notes – taking lots of analgesia for back.

6th May 2000

Transfer form - transferred to St Mary's General Hospital not eating or drinking. Complaining of back pain, probable sepsis and hypotension. Family seen realise deteriorating and survival very slim.
Summary – family seen explained very sick. Infection present. Family wanted her to be kept comfortable. Family seen by Dr Knighton who state that she had not responded and little else could be done. 0.5 mg diamorphine given.

Comment

Mrs Windsor should have been admitted to an acute hospital for haematological investigation or transferred earlier. The nurses failed to keep the doctor informed about how ill this lady was and how rapidly she was deteriorating.
This was a poor standard of communication and therefore care.

Page was admitted fro Queen Alexandra for palliative care. She was agitated and distressed. Diamorphine was given for confusion not pain. No reported pain.

The nurses assessed her care needs on admission and wrote care plans which seemed appropriate as far as they went but they failed to realise the significance of her condition and inform the doctor. The doctor failed to diagnose and failed to transfer the patient.

Administration of medicines.

It is suggested that Mrs Windsor had a steroid crisis. The nurses should have been aware of this possibility. This was not satisfactory.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A			3A	
Unclear B				
Unexplained by Illness				

6.60 BJC/57 Douglas Midford Millership

Code A

Date of admission to GWMH: **8th July 1999**
Date and time of Death: **09.20 hours on 20th July 1999**
Cause of Death:
Post Mortem:
Length of Stay: **13 days**

Mr Midford Millership's past medical history:-

COPD
CCF
CVA
Basal cell carcinoma (forehead)
Depressed
Panic attacks

Mr Millership lived with his wife in their own flat. It was his second marriage as his first wife had died after 25 years of marriage from cancer. He had a son and 2 daughters. Mr Millership had been in the RAF and had served in the Battle of Britain. He was slightly deaf. Mr Millership was admitted via his GP to the Royal Haslar Hospital after his wife was finding it hard to cope. He was transferred to Gosport War Memorial Hospital on 8th July 1999 for general nursing care.

On admission a Barthel ADL index was completed with a score of 13. A waterlow score of 18 was recorded also.
A nutritional assessment with a score of 13 was completed.
A handling profile was completed noting that Mr Millership had pain on micturition, skin was dry and vulnerable areas in the sacral region, need air mattress, unable to tolerate air mattress so extra vigilance required and he is fully independent.
Care plans commenced for breathlessness, poor skin integrity sacral area, hygiene and help to settle at night.

8th July 1999

Clinical notes – transfer from Haslar Hospital for assessment. Severe COPD, CCF, panic attacks and depression. Episodes of severe SOB, mobilises to toilet independently. ? return home but will need support.
Summary – for assessment wife finding it difficult to cope and would appreciate support especially at night. Use of oxygen via nasal cannlae.
Seen by Dr Banks .

11th July 1999

Summary – seen by Dr Pennells re UTI.

12th July 1999

Summary – seen by Dr Banks to commence on risperidone.

13th July 1999

Clinical notes – settling now. No panic attacks. Sleeping flat on bed no distress at all.

14th July 1999

Summary – MRSA negative.

16th July 1999

Clinical notes – discussion with wife ? cope at home does she feel confident.
Brighter – review next week.

19th July 1999

Summary – 20.45 complaining of feeling cold. 22.50 found on floor by side of bed attempting to go to toilet. No injuries sustained. Accident form completed. Very breathlessness and anxious most of the night.

20th July 1999

Summary – became very breathlessness returned to bed commenced on oxygen via nasal for TLC feeling comfortable. Family informed of poor prognosis.
09.15 further deterioration wife and daughter and son present.
Clinical notes – sudden deterioration CVA/MI review 2-3 hours.
09.20 hours passed away. Death confirmed 11.30.

Comment

The nurses assessed his care needs on admission and wrote care plans which seemed appropriate.
Administration of medicines.
This was satisfactory.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.61 BJC/58 James Corke

Code A

Date of admission to GWMH: **22nd July 1999**
Date and time of Death: **14th August 1999 in Haslar Hospital**
Cause of Death:
Post Mortem:
Length of Stay:

Code A

Mr Corke's past medical history:-
Parkinson's disease

Mr Corke lived with his wife. He liked to watch sport, enjoyed sitting in his garden and was a keen gardener. Mr Corke was admitted to the Royal Haslar Hospital on 8th July 1999 for 1 week respite/holiday care to give his wife a rest. He was readmitted as an emergency to the Gosport War Memorial Hospital on 22nd July 1989 for urinary retention, ankle oedema, constipation and he was confused. He was then transferred back to Haslar Hospital where he died on 14th August 1999.

On admission care plans commenced for maintaining safe environment due to falls – cot sides insitu 26/7, catheter care, constipation, hygiene, settle at night, abdominal discomfort, oedematous legs and ankles.

22nd July 1999
Nursing report – readmitted wife unable to cope, constipated, confused, marked ankle oedema. Seen by Dr Beale found to be in urinary retention. Catheterised.

28th July 1999
Nursing report – seen by Dr Beale, may go home before OT assessment.

31st July 1999
Nursing report – seen by Dr Beale, drowsy but rousable, recatheterised.

2nd August 1999
Nursing report – for discharge on Saturday. 14.30 hours complaining of feeling unwell and abdominal pain.

4th August 1999
Nursing report – seen by Dr Beale antibiotics changed for discharge as planned.

5th August 1999
Nursing report – slightly verbally abusive drowsy but rousable. Discharged.

Comment
The nurses assessed his care needs on admission and wrote care plans which seemed appropriate.
Administration of medicines.
This was satisfactory.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

7.00 Expert's statement of truth

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature_____Date_____

Irene Waters. LL.M., MSc. Public Health, Master of Nursing, RHV, RGN.

APPENDIX 1 PROFESSIONAL PROFILE:- IRENE WATERS

Code A

QUALIFICATIONS: LL.M., MSc., MN, RHV, RGN.

LL.M.(Legal Aspects of Medical Practice) Cardiff Law School. 1999-2000
MSc Public Health, London School of Hygiene and Tropical Medicine 1995-6
MN Master of Nursing Degree, University of Wales, College of Medicine 1984-6.
RHV Diploma in Health Visiting, University of Surrey.
RGN St. Thomas' Hospital, London SE1.

CAREER

A senior health services professional at Director level, now practising as a health services consultant. Clinical, general management and commissioning experience gained with acute, community and primary care and mental health services in England and Wales over 20 years. Proven, experienced and successful expert witness for health care issues in the public and private sector.

Specialist field is nursing and nursing care and formerly Director of Nursing with the Bart's NHS Group with professional responsibility for 1408 nurses working in the hospital and community. **This has included working both as a nurse and a manager assessing and providing nursing and care services for people outside the hospital setting.** Currently employed as a professional adviser, health consultant, non –executive director of Newbury Primary Care Trust and former non-executive director of Berkshire Health Authority.

Recently appointed panel member for due regard of the Professional Conduct Committee of the NMC.

Extensive knowledge of strategic planning, developing, describing and evaluating health care services and predicting manpower and educational requirements.

Commercial and marketing experience in private health care and in the hotel industry.

Excellent track record in managing, leading and facilitating change in a multidisciplinary, multi agency and multiprofessional environment.

I have undertaken relevant training the Expert Witness Institute, the Academy of Expert Witnesses and Bond Solon, and am on the rolls of / member of:-

- Law Society Directory of Expert Witnesses 2001.
- UK Register of Expert Witnesses.
- Expert Witness Institute
- Recognised by the Law Society as a Single Joint Expert in May 1999.
- Medical Experts Database for"Action for Victims of Medical Accidents"(AVMA)

AREAS OF EXPERTISE WITHIN BOTH THE PRIVATE AND PUBLIC SECTOR

1. **General Nursing, Community Nursing, Health Visiting.**
2. **Nursing Career profiles.**
3. **Appropriateness of nursing:- care**
   intervention and outcomes
   manpower and skill levels
   education and training needs
4. **Interfaces with:- hospital, community, professional groups (eg. social services)**
5. **Community Care, Nursing and residential care.**
6. **Management, risk assessment and health and safety issues.**
7. **Child care and development. Children with disabilities. Child Protection**
8. **Quantum Assessment. Past, present and future care needs and costs.**

APPENDIX 2

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United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) now Nursing and Midwifery Council. (NMC)

- Code of Professional Conduct.
- Scope for professional practice
- Guidelines for Records and Record Keeping
- Guidelines for the Administration of Medicines