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2. REVIEW OF EXPERTS (WHERE AVAILABLE)

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CONTENTS OF BOXES TO GENERAL MEDICAL COUNCIL

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Code A		COPIES PAPER RECORDS

BJC/24	**NORAH HALL**	**COPIES OF PAPER RECORDS**
BJC/54	**JACK WILLIAMSON**	**COPY OF PAPER AND MICROFILM RECORDS**
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BJC/11	**Code A**	**COPY OF PAPER RECORDS**
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BJC/33	**DULCIE MIDDLETON**	**COPY OF PAPER AND MICROFILM RECORDS**
BJC/50	**FRANK WALSH**	**COPY OF MICROFILM RECORDS**
BJC/57	**FRANCIS MIDFORD-MILLERSHIP**	**COPY OF PAPER RECORDS**

LILY ATTREE

6.03 BJC/03 Lily Attree

Date of Birth: Code A Age: 79

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.
50mg diamorphine commenced via syringe driver.

21st August 1996
Diamorphine increased to 75mgs.

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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification — **Exhibit number**

LILY ATTREE Code A — BJC-03

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	probably appropriate treatment			
Unclear B				
Unexplained By Illness C				

General Comments

Dying from squamous cell Ca oropharynx/antrum (2nd primary)
Demented in nursing home, MTS 1/10, doubly incontinent, immobile, in pain
'Not for 555' in ?Feb 1994
Deterioration in July (A) Sultan ward 1996-07-26, but walking with 1, 07-29
1996-08-17 Oromorph 20 mg 4 hourly [i.e. 120 mg/day], then
1996-08-20 diamorphine 50 mg/24 h [*BNF* equivalent dose 20 mg morphine sulfate every 4 h = 45 mg diamorphine/d], then 50% increase to
1996-08-21 75mg/24h [*BNF*-appropriate]

Not clear if pain was adequately monitored and dose titrated.

Poor prescriptions earlier, eg
1996-01-30 'Oromorph 2.5-20 mg till pain controlled'

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/03
LILY ATTREE
79
Known to have nasopharyngeal ca invading base of skull

Started oramorph prn	15/8/96	25mg total
	16/8/96	20mg total
	17/8/96	20mg then started 20mg 4 hourly
converted to sc infusion on	20/8/96	50mg/24 hours

slight dose increase from oramorph to driver but probably needed because of pain

increased to 75mg/24 hours on 21/8/96 then kept stable until death on 24/8/96
Terminal disease, dealt with well

PL grading A1

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R10

TO: REF:
STN/DEPT:

FROM: DC Code A REF:
STN/DEPT: MCIT Western TEL/EXT:

SUBJECT: OPERATION ROCHESTER DATE: 30/10/2002

Sir,

At 1200 hours on Wednesday 30th October 2002 (30/10/2002), I visited Gail BRAGGINTON (Nee ATTREE), Code A Code A in relation to her contacting the Gosport War Memorial Hospital information line. Also present was her sister Ann ATTREE Code A Code A

Their concerns involved the treatment of their mother Lily ATTREE (Nee NICHOLLS) Code A (85 yrs) who had been admitted to the hospital sometime in July 1996 from a nursing home called 'Trelill', Anglesea Road, Alverstoke, Gosport (now called Beachcroft).

The circumstances of their mothers admission was that she was suffering with throat cancer and had had a second treatment of radio therapy at St Mary's Hospital during February 1996 and as the prognosis for her was good, she was returned to the nursing home having fully recovered.

At this time their mother was fine, able to feed herself, walking around and generally living a normal life.

Their mothers General Practitioner at this time is believed to have been Dr BARTON and or Dr BANKS at the practice described as being the Health Clinic attached to the War Memorial Hospital.

Sometime in July 1996 their mother had a fall and subsequently was treated at Haslar Hospital where her wound was stitched and she later returned to the nursing home.

The daughters showed concerns about their mothers fall and it was then suggested by the nursing staff that their mother be admitted to the War Memorial Hospital in order for her to receive further care and observations.

Their mother was then admitted to the hospital and placed in an upstairs ward, they not being able to remember the name, other than it was a naval base name from the local area.

Both daughters confirm that this time their mother was walking, eating and not suffering any pain.

Again neither can remember the date, but approximately two weeks after their mothers admission, daughter Gail visited her mother on a Thursday afternoon and found her sat alone in a chair and when she spoke with her noted that her speech was slurred.

On asking a nurse on the ward what had been given to her mother, she was informed that it was Oramorph, at which point Gail demanded that this treatment be withdrawn immediately but as she now knows, this wasn't the case.

On the Saturday that week, her other daughter Ann visited her and found her well and indeed fed her mother whilst she was there and ensured that she was not in any pain.

Ann again visited on the Sunday to see her mother and found that her mother was now receiving drugs

DOCUMENT RECORD PRINT

intravenously and was unconscious in her bed. The following day both Ann and Gail are at the hospital and Ann realising that her mother was still drugged and not receiving water or nourishment, challenged a male doctor in anger and said to him "You are killing my mother, you're filling her with drugs until you kill her".
His reply to this was 'That's your opinion" and he walked off.
They describe this doctor as being in his late 50's, approximately 5'7" tall, of medium build, grey hair and looking rather dapper in a suit.
Both daughters are of the opinion that their mother had more life in her, albeit 2 weeks, 2 months or whatever but her death on 24th August 1996 (24/08/1996) was premature and caused by the over use of drugs. Actual cause of death given as cancer of the tongue and pneumonia.
Both daughters will state that their mother never complained of pain nor were they consulted about her medication.
Attached to this report are a few notes on a single A4 piece of paper written by Gail BRAGGINTON.
Submitted for information.

Expert Review

Lily Attree

No. BJC/03

Date of Birth: Code A

Date of Death: 24 August 1996

Mrs Attree was admitted to Gosport War Memorial Hospital on 26 July 1996 from Queen Alexandra Hospital for palliative care and to recover from Deep X-Ray Therapy. On admission Mrs Attree's notes state she was suffering from depression and was doubly incontinent.

Prior to this Mrs Attree was a widow who lived in a nursing home. She had been diagnosed with cancer of the tongue and at the time of her admission had not been able to feed herself and needed a pureed diet. She had some mobility but needed assistance with washing and dressing.

The experts noted that she was terminally ill with an extremely advanced malignancy and had difficulty swallowing.

Her treatment included opiates, first orally, then intravenously. The conversion to Diamorphine was noted by the experts to have been a high dose but was given with no intent to harm. Since from the medical records the experts perceived a concern to treat pain in a patient with an extensive tumour who may have been unable to verbally report pain because of her primary cancer and mental state.

1. **Lily Attree**

No. BJC/03

Date of Birth: Code A

Although Mrs Attree was noted as 1A by Robin Ferner ("RF"), Peter Lawson ("PL") and Irene Waters ("IW") she was assessed as A2 by Anne Naismith ("AN").

In AN's Assessment Note, she notes that "*The conversion to Diamorphine was probably too high a dose. It is possible that this accelerated the death by some days but probably no more, and as this management was shared by several doctors it seems unlikely there was an intent to harm – it seems more a matter of being unskilled in the management of pain in advanced cancer.*"

In view of the comment that death may have been accelerated by some days I would advise that this case should not be continued to be categorised as 1A.

RONALD CRESDEE

Ronald Cresdee

Date of Birth: Code A Age: **78**
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
RONALD CRESDEE Code A

Exhibit number
BJC-14

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Admitted for terminal care; appropriate dose-escalation			
Unclear B				
Unexplained By Illness C				

General Comments

79-year-old X-butcher
C/a bronchus, oesophageal stricture from this, PEG tube
1996-06-18: Oramorph 10 mg x 5 a day
1996-06-27: Oramorph 20 mg x 5 a day
1996-07-04 (?) syringe driver – diamorphine 50 mg/24 h
1996-07-06 diamorphine up to 100 mg/24 h
1996-07-07 diamorphine up to 150 mg/24 h
1996-07-07 +

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/14
RONALD CRESDEE
78

carcinoma of bronchus with oesophageal obstruction and stent.
Started with prn oramorph then regular oramorph, dose increased and then diamorphine syringe driver. Good dose conversion. Cause of death clear.

PL grading A1

03-DEC-2003 11

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/14	Cresdee, Ronald 1105	Management in the GP ward by a group of GPs. Patient had pain from advanced ca bronchus and was clearly dying – reviewed by consultant in palliative medicine and felt to have no specialist palliative care needs (recommended nursing home). Initially morphine was progressively increased. Possibly developed morphine toxicity after a dose increase, though still at modest dose level. This possibility seems not to have been considered. Increasing agitation, hallucinations and deterioration then managed with sedation and markedly increased diamorphine. Impossible to tell from the notes whether diamorphine was being used as a sedative, or whether the GPs worried that underlying pain which the semi-conscious patient could no longer report was a cause of the agitation. Inevitable death from advanced cancer may have been marginally accelerated by excessive opioid dosages but hard to tell.	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R12B

TO: REF:
STN/DEPT:

FROM: DC Code A REF:
STN/DEPT: MCIT W TEL/EXT:

SUBJECT: ACTION 157 - ELIZABETH MUNDAY DATE: 22/01/2003

Visited MUNDAY and her brother Jack CRESDEE at their H/A on 22/01/03. They had concerns over the deaths of their parents at the GWMH.

Their mother, Olive CRESDEE Code A) was admitted to GWMH in 1990 suffering from brain cancer which was prescribed as being untreatable because this was secondary cancer following breast cancer which she had suffered from a few years earlier.

She passed away on 02/06/1990 within 24 hours of being placed on a syringe driver.

The driver was never explained to them and this is what they are concerned about.

The same thing happened to their father, Ronald CRESDEE Code A he was admitted to the GWMH in 1996 suffering from throat cancer and once again was expected to die.

Prior to going to GWMH he spent sometime at the Haslar Hospital and Southampton General Hospital.

Whilst at the GWMH he was violent on a couple of occasions and had to be sedated.

On 07/07/1996 he passed away a few hours after being placed on a syringe driver.

I explained the principals of the syringe drivers to them and they now feel happier, the confusion appears to be over the dosage etc.

Both their parents were admitted to the GWMH with terminal cancer and expected to die within a few weeks.

Their main concerns appear to be the use of drivers, which was never explained to them and the general standard of care.

The GP for their parents was Doctor ASBRIDGE, Rowner Health Centre, Gosport.

I updated MUNDAY and CRESDEE regarding the enquiry and advised them of the time it would take.

DOCUMENT RECORD PRINT

Details for FLO given to them.

In regard to cause of death for their parents they could not find the death certificates, however they recall that it was recorded as chest infection for both.

Expert Review

Ronald Cresdee

No. BJC/14

Date of Birth: Code A

Date of Death: 7 July 1996

Mr Cresdee was a widower living on his own at home. At the time of his admission to Gosport War Memorial Hospital on 17 June 1996 the district nurse was visiting him twice a week. Mr Cresdee's son had also been on leave from the Navy to look after him as Mr Cresdee was finding it hard to manage on his own.

On admission Mr Cresdee was noted to have carcinoma of the bronchus with oesophageal metastases. He was nauseous, disorientated and had reduced mobility.

The expert review noted that this patient had pain from advanced carcinoma of the bronchus and was clearly dying. On reviewing the medication given to Mr Cresdee it was noted that there was a possibility he may have developed Morphine toxicity after a dose increase, although this was still at a modest dose level. Increasing agitation, hallucination and deterioration were managed with sedation. The notes are not clear as to whether the Diamorphine was being used as a sedative or whether the GPs were worried about the underlying pain.

The experts agreed Mr Cresdee's death was inevitable from advanced cancer.

2. **Ronald Cresdee**

No. BJC/14

Date of Birth: Code A

Mr Cresdee was dying from advanced carcinoma of the bronchus. Having been reviewed by a consultant in palliative medicine he was felt to have no particular palliative care need and was recommended treatment in a nursing home.

One of the experts, AN, noted that the management of this patient included "*markedly increased Diamorphine*" and, moreover, records that "***Inevitable death from advanced cancer may have been marginally accelerated by excessive Opioid dosages ...***".

In view of this comment I would advise that the case should not remain within the categorisation of 1A.

ALBERT HOOPER

Albert Hooper

Date of Birth: Code A Age: **90**
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
ALBERT HOOPER Code A

Exhibit number
BJC-27

Deleted: oo
Deleted: ___

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	90-year old dying slow increase in R.			
Unclear B				
Unexplained By Illness C				

General Comments

Formatted: Bullets and Numbering

90-year-old retired sales manager
previous cholecystectomy and nephrectomy
COPD on LTOT
Macroglobulin gamma uncertain significance
Bloody diarrhoea
Anaemia and vitamin deficiencies
AF + IHD
Gross leg oedema
alb 24 tot prot 85
sacral sore
Re-admitted 2000-08-18 with diarrhoea, then transferred to GWMH 2000-09-12
Pain (L) leg, ? depression, started citalopram + diazepam + amitriptyline

- drowsy
- bronchopneumonia
- death

syringe driver hyoscine 0n 2000-10-06
added diamorphine 10 mg on 2000-10-07
added midazolam 10 mg
then ^ diamorph 20 mg and midazolam ^ 20 mg
DIAZEPAM ± AMITRIPTYLINE ± CITALOPRAM could have contributed
OT assessment, Haslar: Elderly care team
2000-06-09 Gastroenteritis, Anaemia, Multiple myeloma
Endoscopy OK
SO – NO CHANGE

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/27
ALBERT HOOPER
90

Frail with multiple medical problems. Became chesty and was given sc hyoscine to dry his secretions. He continued with pain and required a small sc dose of diamorphine. When it became clearer that he had a chest infection antibiotics were not given but this was probably appropriate. It was decided to treat him palliatively (ie inevitably going to die) and this was done well.

PL grading A1

08-DEC-2003 15:08

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/27	Hooper, Albert	Very old, frail man with multiple pathologies including recurrent anaemia – felt too ill to go back to QAH for transfusion and had not greatly helped before	A1
	[illegible]		
		Longstanding COPD requiring oxygen continuously. Developed chest infection. Treated symptomatically only in view of deteriorating general condition, initially with hyoscine only, then as he c/o pain not relieved by paracetamol given diamorphine 10mg + midazolam 10mg. Doses doubled on day of death because not comfortable being suctioned. Very reasonable care under the overall circumstances. Consultant Dr Reid. Locum Staff Physician who wrote excellent clerking and notes.	

RESTRICTED

DOCUMENT RECORD PRINT

Officer's Report

Number: R11D

TO: | REF:
STN/DEPT:

FROM: DC 2479 YATES | REF:
STN/DEPT: MCIT W | TEL/EXT:

SUBJECT: | DATE: 09/12/2002

Sir

Re: Action 227

I have spoke to Ann Margaret RAY of Code A. She had contacted the police (Message 33) to report her concerns regarding the death of her father at the Gosport War Memorial Hospital on 9th October 2000 (09/10/2000).

The circumstances are as follows. Albert Henry Beville HOOPER Code A lived at Code A Code A His GP was Dr PETERS from the Forton Road Surgery at Gosport. Mr HOOPER was suffering with emphysema and had been for some time.

On 18th August 2000 (18/08/2000) Mr HOOPER was admitted to the Royal Navy Hospital at Haslar with severe Bronchitis. This was treated and on 12th September 2000 (12/09/2000) he was transferred to Dryad Ward at the Gosport War Memorial Hospital for respite care. Mr HOOPER asked to see a solicitor in order that he could give his daughter Mrs RAY Power of Attorney so that she could look after his personal business etc. His health was described as good at this time by his daughter.

On 18th September 2000 (18/09/2000) Mrs RAY noticed a complete change in her father's health and described him as being so heavily sedated that he appeared 'completely out of it' and 'like a zombie'. On 21st September 2000 (21/09/2000) the solicitor attended the hospital but found Mr HOOPER to be so heavily sedated that he was unable to sign the Power of Attorney forms.

On 27th September 2000 (27/09/2000) and again on 3rd October 2000 (03/10/2000) Mrs RAY asked to speak to the Doctor. On both occasions she spoke to Dr BARTON who stated that her father was being sedated as he was in a lot of pain due to bed sores and depression.

On 3rd October 2000 (03/10/2000) Mr HOPPER died. The cause of death on the certificate was given as

RESTRICTED

Bronchial Pneumonia and chronic obstructive pulmonary disease. The certificate was signed by a Dr B WILSON . Mr HOOPER was cremated.

Mrs RAY does not know what medication had been administered to her father nor can she remember if her father was on any form of intravenous medication. Mrs RAY has been told that this is an ongoing police investigation and has been given a contact number for Operation Rochester.

C S YATES

Expert Review

Albert Hooper

No. BJC/27

Date of Birth: Code A

Date of Death: 9 October 2000

Mr Hooper was living alone at his home at the time of his admission on 12 September 2000 at Gosport War Memorial Hospital.

Mr Hooper had previously been admitted to Royal Haslar Hospital on 18 August 2000 with diarrhoea, reduced mobility and an inability to cope at home. He was transferred to Gosport War Memorial Hospital for rehabilitation and continuing care. The transfer form noted that Mr Hooper needed help with all aspects of personal hygiene and dressing, that he was occasionally incontinent and hard of hearing. Clinical notes made reference to his multiple medical problems including chronic obstructive pulmonary disease, ischaemic heart disease and anaemia.

Whilst an inpatient, Mr Hooper developed a chest infection which was treated symptomatically in view of his deteriorating general condition. He was prescribed Hyoscine to begin with and, as he continued to complain of pain, not relieved by paracetamol, Diamorphine 10mgs and Midazolam 10mgs were introduced. The doses were doubled on his day of death because Mr Hooper remained uncomfortable whilst being suctioned.

The experts note that Mr Hooper received very reasonable care under the overall circumstances.

The experts did note that a combination of drugs may have contributed to Mr Hooper appearing sedated. Overall, the nursing input was also commended for appropriately identifying Mr Hooper's care needs and for maintaining good communication with Mr Hooper's family.

Albert Hooper

No. BJC/27

Date of Birth: Code A

Mr Hooper was a ninety year old frail individual with multiple medical problems at the time of his admission to Gosport War Memorial Hospital. He was prescribed Citalopram in addition to the Diazepam and Amitriptyline because of pain in his left leg. He went on to receive Hyoscine together with Diamorphine and Midazolam by syringe driver prior to his death.

RF has noted that the combination of Diazepam, Amitriptyline and Citalopram could have contributed to the deteriorating clinical condition and it was noted by Mr Hooper's family that on 18 September 2000 there was a complete change in Mr Hooper's health with him being described by his family as so heavily sedated that he appeared completely out of it and like a zombie to the extent that he was unable to sign the Power of Attorney forms.

In view of the possible contribution of Citalopram to Mr Hooper's worsening condition I would advise that this case should not remain within the categorisation 1A.

STANLEY MARTIN

Stanley Martin

Date of Birth: Code A Age: 84
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 was completed scoring 2 and a Waterlow score of 29 was recorded.

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.

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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification S. MARTIN **Exhibit number**
MarSta Code A **BJC-32**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	CONSENSUS WAS 1A			
Unclear B		A somewhat high single IM dose (5 mg) in a dying elderly man		
Unexplained By Illness C				

General Comments

84-year-old man - peripheral vascular disease, epilepsy, c/a bladder (D. 1997-06)
1997-01-07 A. Chest infection, CCF
1997-02-22 Dense Right hemi, wheelchair, Barthel 2
1997-03-07 Transferred Daedalus
1997-07-01 discharge home > shared care 6/52 home, 2/52 in
E.g. 1997-07-22 to -08-04; 1997-09-16 to -10-13;
1998-01-06 Last planned admission. Night-time nausea and vomiting ?MI
1998-01-07 Rx dimaorphine 5mg IM
1998-01-08-08-00 'Given 5mg diamorphine IM to assist breathing [365/457]
1998-01-08-08-20 Died

drug chart
discharge prescription

Nothing relevant
SO - NO CHANGE

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/32
STANLEY MARTIN
84

Suffered a dense stroke, deteriorated rapidly because of either a chest infection or myocardial infarction. Small dose of opiate used appropriately.

PL grading A1

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/32	Martin, Stanley n 3256	Very well known to the ward. Admission shortly before death with severe breathing difficulties, probably mixture of CCF and infection. Became anuric. Given single dose of diamorphine 5mg IM to relieve dyspnoea but died 20 minutes later so probably absorbed little if any of it.	A1

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AE

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: MCD E TEL/EXT:

SUBJECT: DATE: 06/12/2003

I visited Mr MARTIN at his home address at 1200 hrs on Tuesday 25th November 2003 (25/11/2003) in relation to his father, Stanley MARTIN Code A as per the policy log.

I outlined the details as per A223 and gave Mr MARTIN a copy of his father's medical records.

Mr MARTIN's additional comments are as follows:

His father didn't like being in hospital and although the food was nice, he always lost weight whilst on his respite break. The family had to feed Mr MARTIN, staff didn't appear to.

Stanley MARTIN appeared healthy and well on Tuesday 6th January 1998 (06/01/1998), the family received a phone call at 0700 am saying that staff were not happy with Stanley MARTIN's condition, by 0720, he arrived at the hospital and by 0820 his father was dead.

Mr MARTIN did not see or hear a syringe driver but he doesn't know his father's cause of death or who certified his death.

He is happy to be notified by way of letter.

Expert Review

Stanley Martin

No. BJC/32

Date of Birth: Code A

Date of Death: 8 January 1998

Mr Martin was an eighty-four year old man who was admitted to Gosport War Memorial Hospital on 6 January 1998. He lived at home with his son and had a shared care arrangement with Gosport War Memorial Hospital.

On admission on 6 January 1998 he had bronchopneumonia.

Mr Martin was nauseated the following day and complaining of a sore abdomen and deteriorated quickly thereafter, becoming anuric. The experts considered his death was probably due to a mixture of congestive cardiac failure and infection. Although he was given a single dose of Diamorphine intramuscularly 5mgs to relieve dyspnoea he died twenty minutes after this and therefore probably absorbed little of it, if any.

4. **Stanley Martin**

No. BJC/32

Date of Birth: Code A

Mr Martin was an eighty-four year old man who was admitted to Gosport War Memorial Hospital on 6 January 1998.

He died two days later and although noted by some experts to have received optimal care prior to his death with severe breathing difficulties, RF notes that he received "*A somewhat high single IM dose of Diamorphine in a dying elderly man*". AN noted he died twenty minutes later "*so probably absorbed little of it*". In view of RF's views that this case fell within the 2B category, and AN's comments, I would advise that it should not remain within the spectrum of 1A cases.

IRENE BRENNAN

Irene Brennan

Date of Birt Code A Age: 87
Date of Admission to GWMH: **10th June 1998**
Date and time of Death: **14.15 hours on 1st July 1998**
Cause of Death:
Post Mortem: cremation
Length of Stay: **21 days**

Mrs Brennan's past medical history:-

- Osteoarthrisit
- Duodenal ulcer 1963
- CVA
- Gastric ulcer 1975
- Colon and rectal signoidoscopy 1982
- Femoral and inguinal hernia 1987
- DVT 1987
- Polymyalgia rheumatica 1988
- Brachial (cervical) neuritis 1988
- Fracture left ankle 1989

Mrs Brennan was a widow. She had two daughters and lived with one of her daughters. Mrs Brennan's daughter was becoming aware of Mrs Brennan increasing dependency and shared care was arranged for her. Mrs Brennan was put on MST on 11th May 1998. Mrs Brennan was admitted to Gosport War Memorial Hospital on 10th June 1998 for management of her pressure sores. She was expected to stay in for a few weeks.

On admission care plans commenced for pressure sore on buttocks/at risk of pressure sores, catheter, bowels and hygiene.
Regular barthel ADL scores and Waterlow scores were recorded fortnightly and then weekly. A handling profile was completed noting that Mrs Brennan needed the help of two nurses and a hoist.

Daily summary

May 1998
Clinical notes – increasing problems with pain. Now on MST. Barthel 0. Family agree not for active treatment. Make comfortable. Family keen to take home.
June 1998
Clinical notes – continues on **MST pain control reasonable**. Allevyn to sacral ulcer. Poor prognosis discussed with patient if she dies could nursing staff please confirm death.

10th June 1998
Contact record – **oramorph 2.5mls** given by daughter. Readmitted to Daedalus ward for management of pressure sores.
15th June 1998
Clinical notes – readmitted stiffness and pressure sores. Pain reasonably controlled on MST. Sacrum extensive superficial ulceration. Very stiff. Continue NHS respite care.
Contact record – seen by Dr Lord to stay in for next few weeks.
18th June 1998
Clinical notes – breakthrough pain increase MST to 50mg.
Contact record – **MST now 50mgs** painful left hand.
20th June 1998
Clinical notes – pain distressed on Fentanyl patch. Still in pain. **Continue fentanyl patches** aware she is dying may need syringe driver.
28th June 1998
Contact record – general discomfort. For **regular oramorph**. Increase MST ask Dr Barton.
29th June 1998
Contact record – MST discontinued – fentanyl patches 25mg prescribed and in situ. In a great deal of pain to commence **60mg diamorphine via syringe driver** over 24 hours.
1st July 1998
Clinical notes – 14.15 hours died family present. For cremation.
Contact record – death confirmed at 14.15 hours. Family present.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
IRENE BRENNAN Code A G49068

Exhibit number
BJC-80

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		Fentanyl + sc diamorph [in high dose] replaced MST + oramorph; poor prescription - diamorph 40-200		
Unclear B				
Unexplained By Illness C				

General Comments

87-year-old lady, whose daughter was an auxillary nurse on the Ward, and who presented with increasing signs of (R) hemi, with scan = infarct; and who had bad arthritis. Long term rehab, with several failed attempts at discharge, known ulcer disease, and a generally sane policy of analgesia, but rapid escalation at the end, with fentanyl + high dose diamorph

1997-10-07	Transfer toDaedalus for long-term rehab.(R) hemi, dysphasia, immobility, falls, UTIs, arthritis, previous DU 1963. Rx co-dydramol
1998-02-02	Home on coproxamol
1998-03-10	A. for shared care – further deterioration Barthel~ 0
1998-04-06	Home
1998-04-28	'Shared care admission – Hemi? with dysphasia & ^ mobility problems'
1998-05-14	'^ing problems of pain & stiffness from O.A.... Barthel was 0'
1998-05-21	'Further deterioration. Comforatble on MST...' –05-11: 10 mg bd; -05-18: 20 mg bd; -05-24: 30mg bd; -06-01:40mg bd; by –06-23: 60 mg MST bd. Then –06-29: fentanyl 25 [≡ morphine 990 mg/day]... also oramorph
1998-05-28	'Family very keen to have Mum home'
1998-06-02	Home with MST 40 mg bd + Oramorph up to 10 mg PRN
1998-06-10	'Readmitted as difficult to cope...'
1998-06-15	^ing stiffness + pressure sores... pain reasonably controlled on MST, catheterised, sacral sore, faecal incontinence, bed-bound, v. stiff
1998-06-18	'Further breakthrough pain ^ to 50 mg MST'
1998-06-29	'In pain & distressed over weekend – on Fentanyl patch...' Diclofenac... dying, may need syringe driver... GIVEN 60 mg diamorph [≡ 90 mg MST bd], then on 30th & 1st given 100 mg [≃ 150 mg MST bd]
1998-07-01-14-15	Dies

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

Final Score:

1B

BJC/80
IRENE LOUISE BRENNAN
87

Previous stroke and pain from osteoarthritis. They identified that the pain was likely to be due to stiffness and OA but continued with opioids. Diclofenac suppositories were written up in the last 2 weeks although I was not convinced they were given. The increase in opioids was to control pain although sometimes there appeared to be dose increases at times when I could not find a record of uncontrolled pain.

PL grading 1A
Group grade 1A

20/08/2004 12: 02089524407

Exhibit No	Patient Identification	Assessment Note	Assessment Score
BJC/80	Brennan, Irene N962.	Very frail lady with severe and very painful OA. Mobility gradually decreased over a number of admissions to GWMH. Eventually progressed from Coproxamol to MST 20mg BD, then slowly increased, always with at least one dose of breakthrough oramorph most days, to 30mg BD, 40mg BD, 50mg BD and finally 60mg BD. On 29/6/98, swallowing appears to have been problematic as she neared death and the MST was not tolerated. In the morning applied fentanyl TTS 25mcg (exact conversion). But at 1600 hrs seen by Dr Lord. In severe pain. S/D started with diamorphine 60mg, ie rather generous conversion but not unacceptable given that the lady was in pain and had just had diamorphine 10mg IM stat. Continued for 24 hours then increased to 100mg (?why – no more breakthrough that I can see) until death the next day. Might quibble with the sharp increase on the penultimate day of life, but I am sure it made no difference at all to the outcome. On the whole, steady and progressive increase in analgesia with breakthrough doses as proof that pain never over controlled. Thought of OA pain and wrote up for diclofenac suppositories at the end of life but in fact never given.	1A

WALTER WELLSTEAD

Walter Wellstead

Date of Birth: Code A Age: 82
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 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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification W. Williams **Exhibit number**
WaWe 1 Code A G097755 **BJC-51**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	CONSENSUS WAS 1A			
Unclear B	Probably reasonable in view of discomfort, failure to respond to treatment, and relatively low doses (but ? too much haloperidol)			
Unexplained By Illness C				

82-year-old widower, ex-Burma, ex-boatyard varnisher, from nursing home, previous Ao aneurysm repair, dementia requiring admissions previously, inguinal hernia
Admitted 1998-03-12 with R#NOF > DHS, but subsequent wound infection
Discharged back to NH –03-20
1998-04-07: admitted to GWMH (?) with increased aggression and poor mobility since #
Developed contractures of knees, noted to be in pain
Paracetamol >
1998-05-06 diamorphine 15 mg/24h + haloperidol; 20 mg
1998-05-10 30 mg/24h + haloperidol;
1998-05-11 30 mg/24h + midazolam
1998-05-13 +

1995, 1997 Nursing notes, etc from Mulberry ward
'6/52 history of agitated behaviour at rest home, with periods of out of character behaviour – recently threw himself downstairs…'
1997- oct to dec: 'Walter put himself on floor in corridor…'

SO – NO CHANGE IN THIS

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/51
WALTER WELLSTEAD
82

Vascular dementia, increasing behavioural problems in NH. Fractured neck of femur earlier in the year. During the final admission he had painful contractures of his legs which required paracetamol. The pain increased on 6/5/98. He was started on a syringe driver of diamorphine at 15mg per day. This is a reasonably low dose which was increased when more pain was documented 4 days later. A low dose of midazolam was added when he became restless.
The syringe driver was set up when it was clear that he had reached the end stages of his physical and mental illnesses. The doses used were not excessive.

PL grading A1

BJC/51	Wellstead, Walter	Readmitted to the psychogeriatric ward because of advanced vascular dementia and severe agitated	A1
	N3337	depression with paranoid features and wandering behaviour. Mobility impaired by recent repair of R	

Exhibit No	Patient Identification	Assessment Note	Assessment score
		#NOF. Multiple falls during the admission. Noted to be in severe pain when moved and had to be put back to bed. (Repeat Xray of R hip during this admission had shown good position of the DHS but separated trochanter ?new injury.) Had severe flexion contractures of both legs. In pain ++ during any attempt to move him. Started on syringe driver with diamorphine 15mg and haloperidol 20mg (reasonable in view of psychiatric history and recent medication). Only quibble is that he is subsequently described as semi-conscious and comfortable, but 4 days later diamorphine was doubled ?why. He subsequently became agitated (?opioid toxic) and haloperidol removed, midazolam 10mg substituted. Died peacefully with a terminal bronchopneumonia.	

DOCUMENT RECORD PRINT

Officer's Report

Number: R7L

TO: REF:
STN/DEPT:

FROM: DC 424 ROBINSON REF:
STN/DEPT: MCIT E TEL/EXT:

SUBJECT: WALTER HENRY VERDON WELLSTEAD DATE: 31/12/2002
Code A 5 - 13/05/1998

I visited Timothy WELLSTEAD at his home address Farthings, Chapel Rd, Swanmore (Tel.01489 894756) in relation to his father, Walter who died in the GWMH on 13th May 1998 (13/08/1998).

Timothy WELLSTEAD will say that his father was a Sgt in the army and upon completing his national service became a grocer and finally a painter in Moody's Boatyard, Swanwick. He was married with two children, Timothy and Geraldine EVERTS (Evertsencann No.3 Breskens 4511XK) and widowed from the age of 55 years. He retired at the age of 65 years.

Around this time he was diagnosed as suffering from Asthma which was believed to have been caused by stress. He was a heavy smoker until the age of around 40 years.

Around 1995 Walter WELLSTEAD suffered a series of mini strokes, he became depressed and was unable to care for himself. He received the support of the Social Services and was moved from his home to live in lodging type accommodation with support from carers.

In January 1996 he was admitted to Mulberry Ward, GWMH in order to be accessed for his depression and to sort out a more appropriate accommodation for him. He remained in hospital for a month and was then discharged to his lodgings. He was then moved around over the next few months until October 1997 when he was readmitted to Mulberry Ward for depression.

In January 1998 Mr WELLSTEAD was discharged to Zetland Lodge in Warsash and two months later he fell and fractured his hip.

He was admitted to the Queen Alexandra Hospital and operated on. The operation was a success. During this time Mr WELLSTEAD was eating and drinking.

On 20th March 1998 (20/03/1998) he was discharged to Zetland Lodge here his mental condition deteriorated and on 1st April 1998 (01/04/1998) he began grabbing at and hurting staff. The home was unable to cope with his behaviour and he was readmitted to the GWMH.

Timothy WELLSTEAD describes him as being extremely unhappy there. He would throw himself on the floor. He was still eating and drinking. Walter WELLSTEAD was then moved beds to the higher

DOCUMENT RECORD PRINT

dependency section.

On Wednesday 6th May 1998 (06/05/1998) Timothy WELLSTEAD received a telephone all from the GWMH. They wanted him to attend the hospital to discuss placing his father on a Diamorphine pump and they needed his permission. He was informed that they wanted to use Diamorphine to calm him down and sedate him, this was because of his physical behaviour.

Timothy WELLSTEAD agreed to the use of Diamorphine and on his next visit discovered that his father had been moved to a single room and that he appeared to be in a deep coma. He was lying in the foetal position and covered with a sheet.

Timothy WELLSTEAD was concerned as to how his father was being nourished and made enquiries with a male member of staff.

This staff member had only arrived on the ward that day and on checking Mr WELLSTEAD's notes informed him that it did not appear that Walter WELLSTEAD had received food or fluids.

On Sunday 10th May 1998 (10/05/1998) whilst Timothy WELLSTEAD visited, his father was turned and his mouth was moistened. He believes that the dose of Diamorphine was increased at this stage. He also states that the member of staff who asked his permission with regards administering Diamorphine told him that his father didn't want to live anymore and that he would be dead within a couple of days.

On 13th May 1998 (13/05/1998) at 0515 Timothy WELLSTEAD received a telephone call from the hospital which advised him that he should come in.

Timothy WELLSTEAD attended and his father died at 0830 hrs.

Walter WELLSTEAD was certified dead and his death certificate shows the cause as dementia. This was done by W A MUNRO MB .

Mr WELLSTEAD was cremated.

Mr Timothy WELLSTEAD's concerns are that his father was prescribed Diamorphine to hasten his death.

Expert Review

Walter Wellstead

No. BJC/51

Date of Birth: Code A

Date of Death: 7 April 1998

Mr Wellstead was admitted to Gosport War Memorial Hospital on 7 April 1998. He had been admitted to Queen Alexandra Hospital on 12 March 1998 following a fall in his room at the nursing home where he lived.

Mr Wellstead underwent surgery on 14 March 1998 and received a dynamic hip screw. On admission to Gosport War Memorial Hospital in April 1998 it was noted that Mr Wellstead had dementia and was uncooperative and aggressive at times. Although he was continent in the day he was incontinent at night and needed full nursing care. His mobility was impaired by his recent operation and he had multiple falls during the admission.

Mr Wellstead was noted to be in severe pain when being moved and was started on a syringe driver with Diamorphine 15mgs and Haloperidol 20mgs. The experts, in view of Mr Wellstead's psychiatric history and recent medication, considered this dosage reasonable. A question was raised as to whether Mr Wellstead's agitation was aggravated by opioid toxicity but the experts concluded that he died peacefully with terminal bronchopneumonia and have rated him as having received optimal care.

5. **Walter Wellstead**

No. BJC/51

Date of Birth: Code A

Mr Wellstead was admitted to Gosport War Memorial Hospital on 7 April 1998. He had developed contractures of the knees and was noted to be in pain.

Criticism is made of this case by two experts. RF questions whether Mr Wellstead was given too much Haloperidol and AN questions why, when Mr Wellstead was described as being semi conscious and comfortable, his Diamorphine dose was doubled four days later.

AN notes Mr Wellstead subsequently became agitated and she questions whether this was due to Opioid toxity.

Although PL notes the doses used were "not excessive", in view of the conflict of expert opinion and RF, in any event, noting this case as 1B my advice is that it should not proceed under the 1A categorisation.

EDITH CHILVERS

Edith Chilvers

Date of Birth Code A Age: **87**
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				

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification | **Exhibit number**
EDITH CHILVERS Code A | BJC-08A

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B				
Unexplained By Illness C				

General Comments

87 (?97) year-old widow, (L) hemiparesis 1988-10
co-proxamol 1989-03-03; MST 1990-04-06; sc diamorphine 150 mg [?] bd 1990-08-10

MISSING: any prescription chart; GP records; relevant nursing notes

Impossible to say whether this represents appropriate treatment without further information.

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/08A
EDITH CHILVERS
87

Dense stroke with severe pain ?thalamic in origin. Only 23 pages of notes and it is difficult to know how the opiates were titrated against the pain. She ended up on a very high dose but it might have been appropriate and I cannot give a grade from the available notes except to say that the description of the stroke suggests it was enough to account for her death.

03-DEC-2003 14:58

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/08A	Chivers, Edith	I find it impossible to make sense of this record. There appear to be large amounts of missing material. I am unclear as to whether she was moved out of Gosport War Memorial to another institution and then later returned, or whether she was continuously an inpatient but the intervening records have been lost. Also, there are NO DRUG CHARTS in the notes. As a result I have no idea how she got from dihydrocodeine 30mg QDS to MST (dose unspecified), or how she then progressed to a syringe driver with diamorphine 150mg in it. Nor can I form any judgement as to whether the opioids contributed to her death.	B1

DOCUMENT RECORD PRINT

Officer's Report

Number: R6R

TO:		REF:	
STN/DEPT:			
FROM:	DETECTIVE INSPECTOR 5723 KENNY	REF:	
STN/DEPT:	MCD - OPERATION ROCHESTER	TEL/EXT:	
SUBJECT:		DATE:	25/11/2004

The case of Edith CHILVERS (BJC/8A) originated from statements of 2 nurses (Code A S26 and TUBBRITT S33) who were interviewed in the early part of the enquiry in respect of general patient care at GWMH . Both of these nurses recalled an elderly patient by the name of Edith CHILVERS being on a syringe driver for several months before dying but neither of the nurses knew anything else about the patient.

Enquiries were made at GWMH and the patient records of Edith CHILVERS were obtained and analysed by the key clinical team. The result of the analysis was 'no score' as there were insufficient records available to categorise the case.

Edith CHILVERS has no known next of kin and all efforts to identify her family have proven negative.

See also R14R of DI NIVEN regarding this and other similar cases.

I therefore recommend that this case be closed.

Code A

Code A

Code A

Code A

Code A

Code A

NORAH HALL

Nora Hall

Date of Birth: Code A Age: **83**
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification — **Exhibit number**

NORA HALL Code A — **BJC-24**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Sought advice from BeeWee Dying from c/a stomach vomiting main problem small doses of opioid			
Unclear B				
Unexplained By Illness C				

General Comments

83-year-old married woman, daughter died of c/a oesophagus aet 41
penicillin allergy
hysterectomy & oophorectomy
varicose veins & thrombophlebitis
NIDDM

1992 Lumpectomy for c/a breast
1997-02-12 abdo pain, ? cholecystitis Settles with a'biotics [wt april 1997 85.3 kg]
1999-04 c/a stomach with palliative gastrectomy
admitted to sultan ward
main problem = vomiting
given co-proxamol
subsequently MST 10 mg bd
subsequently readmitted
diamorphine by sc injection then syringe driver – 10 mg over 24h, increased to 20 mg over 24 h
chart for 19-20th June scrappy (p. 161/322)

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/24
NORA HALL
83

Adenocarcinoma of the pylorus. Pain and vomiting were the issues. Pain control was done very well (with low doses of opiates via syringe driver) and vomiting was addressed but proved difficult to stop.

PL grading A1

08-DEC-2003 15

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/24	Hall, Nora	Excellent palliative care throughout. Frequent consultation with Countess Mountbatten House and reviewed by Bee Wee. Cared for by GPs in Sultan Ward throughout.	A1

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DOCUMENT RECORD PRINT

Officer's Report

Number: R10A

TO:
STN/DEPT:

REF:

FROM: DC Code A
STN/DEPT: MCIT (W)

REF:
TEL/EXT:

SUBJECT: OPERATION ROCHESTER

DATE: 31/10/2002

Sir,

At 1120 hours on Thursday 31st October 2002 (31/10/2002) I visited Leslie Frederick HALL Code A Code A Code A in relation to him contacting the Gosport War Memorial Hospital Information Line.

His concerns were about his mother Norah Catheline HALL (Nee WILTON) Code A 83 years) who at the time of her admission to the Gosport War Memorial Hospital was living with her husband (who has since died) a Code A

The circumstances of his concerns are as followed, his mother was diagnosed with stomach cancer and attended Haslar Hospital for a by-pass operation on her stomach in the words of her consultant for a better quality of life.

He believes that the operation took place on or about the 30th March 1999 (30/03/1999) and on completion she was sent to the War Memorial Hospital for a period of respite, possibly 3 to 4 weeks he thinks, before she was sent home to join her husband.

It would appear that his father was unable to cope with his wife at home, as a result of which after 5 days she was returned to Sultan Ward at Gosport War Memorial Hospital, again his belief is by her General Practitioner, Dr B COLLINS, of Privett Surgery, Privett Road, Gosport.

He would describe his mother at this time as being a woman clearly in her 80's but able to move around on her own.

On his first visit to see his mother with his wife he found his mother to be, in his own words, 'out of it', so he asked a Staff Nurse what was wrong with her and was informed that it was probably due to the drugs.

He stated that he was surprised at this as his mother, being a good Christian, wanted to go when he (God) had decided her time and this was her belief.

Knowing that she had cancer she had told him in the presence of his wife that she had not wanted Morphine to be given.

On another visit a few days later he found that his mother now had a small machine connected to her (now believed to be a syringe driver) and when he asked a Staff Nurse what it was, he was told to monitor her drugs.

He's not sure how long she had been in the hospital, he believes a week or two, when on the 19th June

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1999 (19/06/1999) she died. The cause of death was given as Carcinoma of the stomach.
He cannot understand why his mother was given Morphine against her wishes and why she died so suddenly in that he had received an out patients appointment for his mother to see her consultant on a date in July 1999, so obviously the consultant was not expecting her to suddenly die.
Mr HALL has made a complaint in writing to the hospital, addressed to Ian PIPER (Chief Executive) but to date the only information he has received from the hospital is that Mr PIPER has moved on to another post.
Submitted for information.

RESTRICTED

JACK WILLIAMSON

Jack Williamson

Date of Birth: Code A Age: 80
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
JACK WILLIAMSON   Code A

Exhibit number
BJC-54

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Severe disease with major surgical intervention, and long-term need for opiates			
Unclear B				
Unexplained By Illness C				

General Comments

Frail 81-year-old man, wife dying of metastatic melanoma, with 20-year history of vv eczema, ulcers, previous skin grafts, previous admissions, and previous MI, Barretts, recurrent anaemia, Zimmer frame, difficulties moving
2000-07-05 Ambulance: bleeding from ulcers; osteomyelitis, severe pain, bilateral amputation
2000-08-29 Transferred to Daedalus, having co-cod, tramadol, and oramorph, and phantom pains
2000-09-18 condition deteriorated, MRSA in stumps, collapsed, in pain, laboured breathing: diamorphine 10mg/24h
2000-09-18 dies

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/54
JACK WILLIAMSON
81

This man had severe peripheral vascular disease and ulcers. He required opiates to control his pain up to the operation of amputating both his legs. After the operation they went through the "analgesia ladder" gradually increasing the strength and dose of the analgesics. He appears to have suffered a cardiac event at the end and was given appropriate treatment at appropriate doses.

PL grading A1

09-DEC-2003 15:20

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/54	Williamson, Jack	Had bilateral through knee amputations on a background of known IHD (previous MIs), depression and possible early dementia and polypharmacy. Stumps were oozing when transferred to Daedalus for rehab (and to be with his dying wife, Ivy – BJC/53). Pre-amputation was on MST 40mg BD and needing oramorph 10mg for breakthrough – this was stopped post-op. Stumps got worse. 200mls pus came from R stump and grew MRSA. Deteriorated rapidly, probably mainly MRSA infection exacerbated by worsening CCF and lost will to live after seeing his wife die. Only given tiny doses of analgesia – oramorph 2.5mg once on the afternoon of death, then diamorphine 5mg less than 2 hours before death. Syringe driver set up at that time with diamorphine 10mg, but would have had very little indeed when he died.	A1

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DOCUMENT RECORD PRINT

Officer's Report

Number: R7J

TO: REF:
STN/DEPT:

FROM: DC 424 ROBINSON REF:
STN/DEPT: MCIT E TEL/EXT:

SUBJECT: JACK WILLIAMSON Code A - 18/09/2000 DATE: 18/11/2002
IVY KATHLEEN WILLIAMSON Code A 01/09/2000

I visited Keith WILLIAMSON at his home address, Code A in relation to his parents who both died at the GWMH in September 2002. Also present at the meeting was Ian WILLIAMSON , the eldest son Code A

Keith WILLIAMSON will say that his father Jack was an airframe fitter in the RAF during the war and then went on to work for Fleetlands, Gosport until his retirement at the age of 62 years. He was teetotal but smoked a pipe up until two years prior to his death.

He was married to Ivy Kathleen CLARK and they had four children. They lived at Code A Code A t.

Jack WILLIAMSON suffered from varicose veins, he had the veins stripped in both legs when he joined the Air Force in 1942/1943. He also had a hiatus hernia and suffered from anaemia.

His GP was Dr ANDERSON from the Rowner Health Centre.

Although suffering from dermatitis and ulcers in both lower legs, he was a keen competitive cyclist.

Around 1997/1998 Mr WILLIAMSON suffered a heart attack and was admitted to the ICU at Haslar Hospital, Gosport where he spent 2-3 days and suffered another two heart attacks.

He recovered and was discharged to his home address. It was at this time that his varicose vein leg ulcers progressed into arterial leg ulcers.

These ulcers failed to respond to treatment and required dressing by the district nurse. Mr WILLIAMSON required a frame and an electric buggy in order to get about.

In the Summer of 1998 he was admitted to Haslar Hospital for skin grafts to his lower legs. He remained in hospital for around 3 months.

Approximately five weeks after being discharged he was readmitted to Haslar for clinical depression. The skin grafts had not been successful and Mr WILLIAMSON was in considerable pain. He remained in hospital for the next ten months, being discharged in September/October 1999.

In November 1999 he was admitted to Haslar Hospital for a second attempt to graft skin to his damaged legs and again discharged to his home address.

On July 5th 2000 (05/07/2000) he fell and his legs haemorrhaged, he was taken to Haslar Hospital and in August 2000 he underwent surgery to remove both of his legs at the knee. The operation was successful and some 2-3 weeks later he was discharged to Daedalus Ward at the GWMH, in order to be near to his wife who had been admitted with terminal cancer. He was to undergo rehabilitation and then a place was to be found for him in a nursing home.

It was during this period that he arranged for a ceremony to renew his marriage vows with his wife in Haslar Hospital (photo attached).

Mr WILLIAMSON's wife died on 01/09/2000 at GWMH, he remained on the ward and was lucid and eating and drinking well.

On 12/09/2000 Mr WILLIAMSON was taken out for a visit to a friend, he was eating and drinking and in good spirits.

Mr WILLIAMSON was then diagnosed with MRSA wound infection and all visitors had to be gowned and wear gloves. He was still eating and drinking and spent his time reading.

Throughout this period Mr WILLIAMSON was visited daily by his family.

Around 16/09/2000 his family discovered that he had a drip which went into his stomach. He was unable to drink or feed himself. A member of staff told Keith WILLIAMSON that they were going to "make him more comfortable, like we did your mum".

His family describe him as appearing "as if he'd had a massive stroke". His mouth was bent and he was incoherent.

Mr WILLIAMSON died during the evening of 18th September 2000 (18/09/2000).

His death certificate states that he died from congestive cardiac failure, Ischaemic Heart Disease, Peripheral Vascular Disease leading to bilateral leg amputation at MRSA wound infection.

Death was certified by B WILSON MB and Mr WILLIAMSON was cremated.

Keith WILLIAMSON also spoke of his mother Ivy who was admitted to the GWMH, believed Sultan Ward, with terminal cancer in August 2000.

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DOCUMENT RECORD PRINT

Keith WILLIAMSON will say that his mother was born in Portsmouth in 1922. She lived a full and active life and was fit and healthy. She worked as a line supervisor at the Ultra electrical factory in Gosport and retired from there when she was aged 60 yrs.

When she was aged around 70 years she had a fall at home and banged her face in the process. As a result Mrs WILLIAMSON developed shingles in her face and was treated with a new drug to try and combat this.

Within a year of her fall she was no longer able to breath through her nose and was sent to Haslar to try and discover the cause.

The problem was found to be polyps in her nostrils, these were removed and she returned home.

In 1994 Mrs WILLIAMSON was diagnosed with cancer, having a large melanoma in her face. The growth was removed and Mrs WILLIAMSON underwent major surgery to rebuild the left side of her face. She required many skin grafts and her family say that she never had Diamorphine as a form of pain relief. She had her mouth rebuilt and had an insert which when fitted gave her face a contour.

Mrs WILLIAMSON was discharged from hospital and was required to have three monthly check ups. These dropped off to six month intervals as she recovered.

In July 2000 Mrs WILLIAMSON was found collapsed at her home, it was believed that she had suffered a minor stroke. She appeared to be a bit vague and was admitted to Phillip Ward at the Queen Alexandra Hospital, Cosham where she remained for around ten days.

During that time a biopsy was carried out on tissue from Mrs WILLIAMSON by Dr LORD and as a result Mrs WILLIAMSON bled heavily and become ill. After a few days she recovered and began walking around the ward.

It was decided to move her to the GWMH which was nearer to Haslar Hospital where her husband was admitted.

The family were given the results of the biopsy and were told that Mrs WILLIAMSON was terminally ill, the cancer had returned and was deemed to be incurable and inoperable.

On Saturday 26th August 2000 (26/08/2000), Mrs WILLIAMSON was taken from the hospital to visit her brother, Bob CLARK Code A She is described as being alert and coherent. She was also wearing her wedding ring at this time.

On Sunday 27th August 2000 (27/08/2000) she was taken to visit her husband, Jack, at Haslar Hospital. She wasn't wearing her wedding ring. Her family describe her as being vacant. She wasn't speaking but asked "What's happening to me?". She kept falling asleep and not knowing where she was when she awoke. She found it difficult to swallow and began to hide and hoard her medication.

On Monday 28th August 2000 (28/08/2000) Mrs WILLIAMSON was concise and lucid when visited.

On Thursday 31st August 2000 (31/08/2000) Mrs WILLIAMSON had been moved to a single room, she was unconscious and had been given a syringe driver.

The family do not know what drugs were administered via the driver but Keith WILLIAMSON had requested that his mothers death would be without pain and fear. He wanted his mother made comfortable.

Ivy WILLIAMSON died on September 1st 2000 (01/09/2000) her cause of death was given as Metastatic Malignant Melanoma. The certificate was signed by A LORD FRCP.

Mrs WILLIAMSON was cremated.

Her family's concerns are that she died very quickly after being diagnosed.

EILEEN HILLIER

Eileen Hillier

Date of Birth: Code A Age: **76**
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
EILEEN HILLIER Code A

Exhibit number
BJC-25

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B	Clearly very unwell Not certain if she could have been treated for benign disease. Slow increase in palliation			
Unexplained By Illness C				

General Comments

75-year-old spinster X-schoolmistress, D. C/a breast 1962 – subsequent radiation damage to chest
episodes of depression with psychosis
1995-01 admitted, psychotic depression – ECT
? lump in axilla ? c/a also back pain
D. to nursing home 1995-03-11
1995-05-23 Readmitted to GWMH (?Mulberrry ward) ·
more depression
subsequently – infection of chest wall sinsu, blood loss, decision for palliative care

Co-prox 1995-07-14
MST 10 mg bd 1995-07-21
morphine sulphate 1995-07-21 10 mg qds
ditto tds 1995-07-25
then IM diamorphine 5 mg quds 1995-07-31
+ prn diamorphine 5mg

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/25
EILEEN HILLIER
76

Carcinoma of breast in 1962 treated by mastectomy and radiotherapy. Admitted for treatment of depression. Sinuses on chest wall started discharging and then bleeding. She was physically deteriorating and the consensus opinion was for palliative care. Low doses of opiates were used and the only element I did not like was the administration of diamorphine by intramuscular injection rather than subcutaneously.

PL grading A1

03-DEC-2003 15:55

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/25	Hillier; Eileen	Brief terminal phase so stayed on Mulberry Ward (psychogeriatric). Old ca breast (1962) with massive chest wall damage from RT. Severe haemorrhage recurrently from chronic chest wall sinus ?eroding into main blood vessel. Kept comfortable with modest doses of diamorphine. No syringe driver (though they would – appropriately – have liked to put one up). Modest IM diazepam doses for agitation – had major agitated depression in any case.	A1

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DOCUMENT RECORD PRINT

Officer's Report

Number: R7F

TO:
STN/DEPT:

REF:

FROM: DC 424 ROBINSON
STN/DEPT:

REF:
TEL/EXT:

SUBJECT: OPERATION ROCHESTER
EILEEN MAUDE HILLIER B. Code A

DATE: 14/11/2002

On 1st November 2002 (01/11/2002) I visited Doris RHODES Code A at her home address at Code A Mrs RHODES had contacted police after reading an article in The times relating to the GWMH. Her sister Eileen HILLIER was admitted to the GWMH 07/06/1995 and died there on 01/08/1995. Mrs RHODES will say that her sister had been a teacher having ended her career as the Head of Modern Languages at the Queen Elizabeth Grammar School for Girls in Herts. She took early retirement in order to look after her elderly mother.

Whilst in her late 30's early, 40's Ms HILLIER was diagnosed with breast cancer for which she received radiotherapy. This treatment caused severe burns to her body and was discontinued. Some years later the scar tissue developed ulcers which were dressed by the district nurse.

Around 1979-1980 Ms HILLIER suffered a nervous breakdown and was admitted to Knowle Hospital, Wickham, Hants for treatment. She suffered a further breakdown shortly after her retirement and was again admitted to Knowle Hospital. It is believed she received ECT (Electrical Shock Treatment).

On 21/01/1995 Ms HILLIER was again admitted to Knowle Hospital suffering from depression. She remained at Knowle until 07/06/1995 when she was transferred to the GWMH.

On 15/07/1995 Ms HILLIER was taken from hospital to a family gathering by her nephew Stephen HILLIER , a local GP, where Ms RHODES noticed that her sister was extremely thin and frail.

On 21/07/1995 Mrs RHODES was contacted by her brother Cecil HILLIER Code A Code A and informed that Eileen HILLIER was not expected to live. Mr HILLIER was a regular visitor of his sister whilst she was in hospital.

On 31/07/1995 Mrs RHODES visited her sister with her brother and sister-in-law.

Whilst they were there the nurses came to give Miss HILLIER an injection. Mrs RHODES believes this was Diamorphine. Mrs RHODES states that her sister was resisting and flailing her arms about. After

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the injection she was unable to recognise anyone and although her eyes were open appeared unconscious.

On 01/08/1995 Eileen HILLIER died and was subsequently buried at Fareham Cemetery in Wickham Road, Fareham. Her death certificate gives her cause of death as Cardiac Failure, Haemorrhage Carcinoma of Breast and depression.

The certificate was signed by J RICHBELL.

Mrs RHODES has provided a copy of her diary at the relevant time.

Kathryn ROBINSON

Code A

Code A

Code A

Code A

Code A

Code A

ELLEN BAKER

Ellen Baker

Date of Birth: Code A Age: **80**
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. 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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
ELLEN BAKER Code A

Exhibit number
BJC-06

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Standard R. for LVF post MI			
Unclear B				
Unexplained By Illness C				

80 year old F. with painful venous ulcer, known angina.
Angina x 3, then suddenly worse: central chest pain, dyspnoea
D. LVF ? MI
R. diamorphine 5 mg, frusemide 60 mg, 'salbutamol 2.5 mg via O2'
[Dr Peters]

NO DRUGS CHART
NO INFORMATION ON PRIOR HEALTH
NO GP RECORDS

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/06
ELLEN BAKER
80

sudden deterioration soon after admission. Consistent with acute myocardial infarction and pulmonary oedema. Treated appropriately with oxygen, frusemide (diuretic) and small dose of diamorphine. There are no concerns about this one.

PL grading A1

08-DEC-2003

Exhibit No	Patient Identification	Assessment Note	Assesement score
BJC/06	Baker, Ellen 13161	Frequent episodes of angina. Had acute onset chest pain with breathlessness and wheeze. GP diagnosed LVF secondary to MI and managed it entirely appropriately with IV diamorphine 5mg, oxygen and Nebulised salbutamol, but she died despite his best efforts.	A1

DOCUMENT RECORD PRINT

Officer's Report

Number: R12

TO: REF:
STN/DEPT:

FROM: DC Code A REF:
STN/DEPT: MCIT W TEL/EXT:

SUBJECT: A150 Ann TUFNELL DATE: 19/12/2002

Visited TUFNELL at H/A on 19/12/2002 after she contacted the relatives information line regarding the death of her mother at the GWMH on 09/11/1990.

TUFNELL's mother, Ellen Rose BAKER , was admitted to the hospital on 08/11/90 in order to have proper bed rest. This was due to the fact she had an ulcer on her leg which meant that she was sleeping on a chair at her H/A.

BAKER also suffered from epilepsy and angina.

The following day the hospital contacted TUFNELL to inform her that her mother had died due to heart failure, which was the cause of death recorded on the death certificate.

TUFNELL lived in Fleet at the time and did not visit her mother whilst she was in hospital therefore cannot recall what ward her mother was admitted to.

The concern that TUFNELL has is that her mother was in reasonable health prior to her admittance to hospital and her death was somewhat of a shock.

TUFNELL is unsure of what medication her mother was on for her ailments.

BAKER's DOB is 15/06/1990, her GP was Doctor PETERS at the Forton Road Surgery, Gosport .

I advised TUFNELL regarding current enquiries and promised to maintain contact.

HUBERT CLARKE

Hubert Clarke

Date of Birth: Code A Age: **94**
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification | **Exhibit number**

HUBERT CLARKE Code A / Code A **BJC-10**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Probable infarct ?pneumonia Reasonable doses ?too low for comfort			
Unclear B				
Unexplained By Illness C				

General Comments

94-year-old X-navy widower, small CVA, TIA, falls, calcific aortic valve disease, old TB.
Admitted 2000-04-24, but recovered.
GTN spray.
Well OPD 2000-05-11, then re-admitted 2000-06-05 after fall.
2000-06-08: chest pain (?MI, ? pneumonia)
R. erythromycin + haloperidol
Then diamorph sc 5mg
Then Oramorph 10 mg
Then diamorph 5 mg/24h added
+ 2000-06-17-14-40.

Final Score: [ ]

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/10
HUBERT CLARKE
94

A man with cerebrovascular disease and falls
In his short hospital admission he suffered cardiac chest pain and a pneumonia. He was well looked after with good use of medication via a syringe driver.

PL grading A1

05-DEC-2003 96%

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/10	Clarke, Hubert	Cared for by his own GP, Dr Hamson. Had recurrent ischaemic chest pain and hypoxia with an agitated delirium, history of previous CVAs. Managed with very small doses of haloperidol and latterly diamorphine; fixed doses, no ranges. Good management; natural death.	A1

RESTRICTED

DOCUMENT RECORD PRINT

Officer's Report

Number: R9

TO: REF:
STN/DEPT:

FROM: DC Code A REF:
STN/DEPT: MCIT W TEL/EXT:

SUBJECT: DATE: 22/10/2002

Sir,

This report relates to the death of Hubert Robert Knight CLARKE, DOB Code A who died on 17th June 2002 (17/06/2000 at Gosport War Memorial Hospital. The cause of death is shown as Bronchopneumonia and Cerebrovascular accident.

Mr. CLARKE served in the Navy as a Chief Petty Officer on submarines. He left the Navy in 1947 and became a Civil Servant. He was married and had two daughters. He lived in the Gosport area after leaving the Navy.

His daughter, Mrs. Rosemarie THOMPSON of Code A contacted the authorities after seeing a news item about Gosport War Memorial Hospital. She and the family had been concerned for some time about the treatment of her father prior to his death mainly because of the fact that he was on Diamorphine whilst in Hospital. I visited her at her home address on Tuesday 22nd October, 2002 (22/10/2002).

I was informed that Mr. CLARKE suffered a mild stroke at home Code A in April 2000. He was taken to Queen Alexander Hospital at Portsmouth. After five days he was allowed back home. Although it was discovered that he had a slight hear murmur he seemed quite strong and healthy but the family were warned that more strokes could follow. Mr. CLARKE attended Gosport War Memorial Day Hospital twice a week after that.

On June 5th 2000 (05/06/2000) he had another stroke whilst at home. On this occasion he was taken to Gosport War Memorial hospital. On 7th June 2000 (07/06/2000) he apparently fell over whilst on his way to the toilet. It was thought that this was possibly another stroke. He was seen by his own GP Dr. HARRISON of Bury Road Surgery, Gosport and there was a suggestion that he should be taken to Haslar Hospital for tests but it transpired that these had already been done before so that was left. It was about this time that the family were asked that if Mr. CLARKE had another stroke would they want him to be resuscitated, the family decided no.

RESTRICTED

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DOCUMENT RECORD PRINT

It was noticed on their visits that Mr. CLARKE was getting more and more sleepy and eating less. On 10th June he was moved from the main ward to a room by the Nurses Station apparently so the staff could keep a better eye on him.

On the 10th or 11th June 2000 (10-11/06/2000) the family noticed a syringe driver attached to Mr. CLARKE and saw on the notes that he was being administered Diamorphine. When they asked about this they were told that it was because of the pain in his legs. He at that time was not responding when they spoke to him and on 12th June (12/06/2000) seemed to be in a coma. The family also noticed that he did not appear to be on a drip of any sort but he did not have a catheter fitted.

Mr. CLARKE died at hospital on 17th June 2000 (17/06/2000) as previously stated.

DC Code A

RESTRICTED

RESTRICTED

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AR

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: MCD E TEL/EXT:

SUBJECT: DATE: 27/01/2004

I visited Rose Marie THOMPSON at her home address on 4th December 2003 (04/12/2003) in accordance with the Policy Log.

I outlined the concerns that she had initially expressed within Officers Report R9.

Mrs THOMPSON wished to add that her father was in Sultan Ward. At the time of his admission the family had no reason to suppose that he was not coming home. That he lived alone was mobile and lucid prior to his admittance to Hospital and that whilst he was in Hospital towards the end of his life he received no fluids.

Mrs THOMPSON would be happy to be notified of the Clinical Teams findings by way of a letter.

I provide her with a copy of the medical records in relation to Hubert CLARKE, I explained the format and method of copying to her.

RESTRICTED

MARY GERMAN

Mary (Marie) German

Date of Birth: Code A Age: **78**
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification | **Exhibit number**

Code A MARY GERMAN | BJC-19

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Good pain relief, quiet death at last			
Unclear B				
Unexplained By Illness C				

General Comments

78-year-old widow, c/a lung on bronchoscopy + mets to supraclavicular node and ?rib
Discharged on MST, readmitted unable to cope
R. Diclofenac, Oramorph (carefully calibrated) (15 mg every 4 hours) then appropriate dose of diamorphine (30 mg/day)

BUT bad prescription for oramorph from 24/11: crossings out, inaccurate date...

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/19
MARY GERMAN
78

Lung carcinoma with spinal secondary deposit.
In pain. Controlled by MST. There was a brief period on oramorph before an appropriate conversion to diamorphine via syringe driver. Good use of analgesia.

PL grading A1

08-DEC-2003 17

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/19	German, Mary N246	Already on morphine, diclofenac and carbamazepine on admission for a mixture of primary lung, bone and neuropathic pain. Required several rescue doses, especially at night. Deteriorated with increased secretions. S/D translated straight across from oral requirement to diamorphine equivalent, low dose hyoscine added for secretions. No sedation at all because she was not agitated. Died peacefully.	A1

DOCUMENT RECORD PRINT

Officer's Report

Number: R7H

TO: REF:
STN/DEPT:

FROM: DC 424 ROBINSON REF:
STN/DEPT: Operation Rochester TEL/EXT:

SUBJECT: Marie Josephine GERMAN Code A 03/12/1998 DATE: 31/10/2002

Sir

I visited Marie EARL (nee GERMAN) at her home address Code A Code A in response to her contacting the NHS Helpline over the death of her mother in the GWMH on 03/12/1998.

Mrs EARL will say that her mother had rheumatic fever as a child. She suffered a heart attack in 1967 (47 yrs) and was diagnosed as suffering from angina as a result but was not receiving any treatment/medication for it.

Mrs GERMAN was a heavy smoker, smoking around 20 cigarettes a day. She was prone to suffering from bouts of bronchitis.

She was a widow, her husband Lawrence Joseph GERMAN died in 1995. Mrs GERMAN lived alone at Code A

She described as being of sound mind and fully mobile. She did not require any assistance with walking.

In October 1998, Mrs GERMAN suffered from a bout of bronchitis which did not respond to treatment. She was referred for an x-ray which showed that she had a shadow on her lung. Mrs GERMAN was seen by a specialist at Haslar Hospital, who diagnosed a 'patch' of cancer on her lung and that he considered that 4 doses of radium treatment was sufficient to 'stop' it.

At this time Mrs GERMAN began to suffer from backache which was diagnosed as being sciatica and was prescribed Movolat cream and an analgesic.

On Friday 20 November 1998 (20/11/1998) Mrs GERMAN was admitted to Blendworth 11 Ward at St Mary's Hospital, Portsmouth.

On Monday 23 November 1998 (23/11/1998) she began her course of radium treatment, which concluded on Thursday 26 November 1998 (26/11/1998).

DOCUMENT RECORD PRINT

Mrs GERMAN was discharged on Friday 27 November 1998 (27/11/1998) and taken home. Mrs EARL describes her mother as being tired but in good spirits.

During her first night at home Mrs GERMAN was extremely ill with sickness and diarrhoea, she was visited by her GP, Dr TRAYNOR , who advised a period of recuperation and rest in the GWMH.

Mrs GERMAN was admitted on Saturday 28 November 1998 (28/11/1998) to the GWMH, to an upstairs ward which she shared with 3 other ladies. She was sat in a chair and was fully lucid.

On Sunday 29 November 1998 (28/11/1998) Mrs GERMAN was in bed and extremely weak, she was unable to hold a cup but was still fully lucid.

Mrs EARL was spoken to by the ward sister who told her that there was 'more going on than they knew about as her mother seemed too ill and weak but they didn't have her records as yet'. At this point Mrs GERMAN was still able to walk to the toilet.

On Monday 30 November 1998 (30/11/1998) a specialist spoke with Yvonne JONES (sister of Marie EARL tel 02392510156) she was informed that her mother was terminally ill.

The two sisters then visited mother and found that she had a tube going into her chest, a pump by the side of her bed and a box hanging off the head board. They were told that the box contained pain killer.

Mrs GERMAN was very weak but was still mentally competent. She was taking fluids and food and asked for tea towels from home to protect her bed clothes as she kept spilling her drinks.

On Tuesday 1 December 1998 (01/12/1998) Mrs GERMAN was still fully alert and speaking of family matters, she was still taking fluids.

On Wednesday 2 December 1998 (02/12/1998) Mrs GERMAN was requesting documents from her home, ie her will and building society books.

Mrs EARL left her mother in the evening intending to return with the items the following day. She received a telephone call from the ward, informing her that her mother was restless and that she would be kept informed.

At 2340 hrs Mrs EARL received a further call to advise her that her mother was 'not very well' Mrs EARL arrived at the hospital to discover that her mother had died at 0003 hrs 03/12/1998 and had been moved to a single room prior to her death. This was done because she was restless and it was thought that she would from peace and quiet.

Mary GERMAN's cause of death was given as Small Cell Lung Cancer and was certified by D B TRAYNOR MB.

Mrs GERMAN was cremated in accordance with her wishes.

Mrs EARL's concerns are that she had been led to believe by the Dr at Haslar that her mother would recover from her cancer and in fact she died within 6 days of her final treatment.

KATHLEEN ELLIS

Kathleen Ellis

Date of Birth: Code A Age: 85
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification Code A KATHLEEN ELLIS

Exhibit number BJC-18

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Very frail elderly lady, given sc fluids			
Unclear B				
Unexplained By Illness C				

General Comments

85-year-old widow, living with son
1994 Colles#
1996 fibula #
1997 pubic ramus #
1999-06-23 dehydrated, chest infection, AF 140, faecal and urinary incontinence
Barthel 0/20; Waterlow 30
Transferred to Gosport War Memorial Hospital for assessment 1999-06-24
Became unable to swallow, unsuccessful NGT placement x 4
Died 1999-07-05

BUT – NEGLIGENT PRESCIPTION OF OPIATES: 203/223 1999-06-24

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/18
KATHLENE ELLIS
85

Dementia, stroke developed a chest infection. They tried to feed via a nasogastric tube but could not. Gave thickened fluids, she deteriorated. Care was of a good standard.

PL grading A2

08-DEC-2003 15:05

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/18	Ellis, Kathleen	Advanced dementia with severely impaired swallowing. Had been deteriorating for several months, more so for 6-8 weeks since she fractured her humerus in a fall. Developed further chest infection. Unable to swallow antibiotics, had few doses. Kept on SC fluids. Probably died of recurrent aspiration pneumonia. Had no drugs at all. No evidence of any sub-optimal care.	A1

DOCUMENT RECORD PRINT

Officer's Report

Number: R7G

TO: REF:
STN/DEPT:

FROM: DC 424 ROBINSON REF:
STN/DEPT: OPERATION ROCHESTER TEL/EXT:

SUBJECT: KATHLEEN MELITA ELLIS Code A DATE: 30/10/2002

Sir

On 30th October 2002 (30/10/2002) I visited Graham ELLIS, Code A Code A, in relation to his mother, who died in the GWMH on 05/07/1999.

Mr ELLIS will say that his mother was a frail lady who had moved to a nursing home (1 Merlin Park, 1 Fort Rd, Alverstoke) some 3 months previously due to the fact that she had suffered a fall whilst at home.

Mrs ELLIS had broken her upper arm when she fell. This had been supported, unplastered in a sling and was said to have been healing well.

She also suffered from angina for which she was prescribed coro-nitro (a spray for under the tongue) and had suffered from a severe case of shingles, some years previously, which had resulted in a large area of scar tissue on her back. This wound, though healed, still caused her pain for which she was prescribed Co-proximal.

Mr ELLIS describes his mother as being fully mobile, although she walked with a frame and fully lucid although she could be forgetful at times. He states that she was not senile.

Mr ELLIS states that whilst his mother was in Merlin Park she suffered a stroke and was unable to swallow. As a result of this she became dehydrated and was admitted to the Queen Alexandra Hospital.

She was treated for dehydration and her ability to swallow returned, she was then discharged to the GWMH for rehabilitation. Mr ELLIS cannot remember the name of the ward but recalls that it was on the ground floor.

Mr ELLIS did not travel with his mother in the ambulance but was there when she was admitted. He states that she was behaving as normal and was not complaining of any pain, she appeared well and lucid and was sitting in a chair in the day room.

Mr ELLIS believes that it was the following day that his mother went into what he describes as a 'zombie state'. He states that in order to get her to hear him and reply to him, he would have to position

DOCUMENT RECORD PRINT

himself right in front of her. He states that his mother grew steadily worse over the course of a few days. He said it was if his mother was 'heavily drugged' or 'hypnotised'.

Mr ELLIS states that his recollection of the days and dates is poor but he was never informed of his mother being placed on any medication, nor did he make any enquiry with members of the nursing staff or the medical staff.

His concern is that his mother whilst being admitted for recuperative care, plummeted health wise and died within 4/5 days of being admitted to the GWMH.

I then went to speak with Susan ELLIS (daughter-in-law of Kathleen, married to David ELLIS Code A
Code A

Susan ELLIS is a RGN with some 25 years experience, she had been responsible for helping to care for her mother-in-law and will say, that Kathleen ELLIS was a frail lady who had been looked after at home by her son Gordon and then after his death, her son Graham.

She confirmed that Kathleen ELLIS had suffered a heart attack some years previously, but had not suffered since. She confirmed that Kathleen ELLIS had suffered from shingles and as a result had a large area of scar tissue on her back, Susan ELLIS states that the wound had gone through her back, virtually to the bone.

This scar tissue would cause Kathleen ELLIS pain, for which she was prescribed Co-proximal, Kathleen ELLIS had become increasingly unsteady on her feet and had a number of falls, one of which resulted in her breaking her upper arm.

Susan ELLIS states that her mother in law went into the nursing home because of the regularity of the falls. She states that the broken arm was healing well but Kathleen was unhappy about being 'placed in a home', she began to stop eating and drinking and as a result became dehydrated. She was seen by Dr Janet ANDERSON who upon examining her, stated that she was suffering from an 'erratic pulse' due to dehydration and that was all.

Kathleen ELLIS was admitted to the Queen Alexandra Hospital, Cosham, Hants where she was treated successfully for the dehydration. She began eating and drinking again and was discharged to the GWMH in order to regain her mobility.

Whilst a patient at the QA Hospital, Kathleen ELLIS was not prescribed any pain relief, nor did she complain of being in any pain. She was visited daily by her family and described as being 'lucid'.

Susan ELLIS states that Kathleen was fully alert initially, but became quieter as the days went on. She states that on the day before Kathleen died, she visited her and found her sitting in a chair in the day room. She was rambling, incoherent and appeared 'spaced out'. She said that she had seen her husband (deceased).

She appeared to Susan ELLIS to be bloated and her breathing appeared 'rattily', Susan ELLIS states that she appeared presenting the symptoms of being under the influence of Diamorphine.

The family requested that Kathleen ELLIS be returned to her bed and that they be contacted if there was

any concern about Kathleen.

At 0600 hrs, the following morning (05/07/1999) the hospital rang to inform the family of Kathleen ELLIS death.

Susan ELLIS states that Kathleen ELLIS was fed and given drinks by the family up until the time of her death.

The death certificate gave cause of death as cerebrovascular accident (stroke).

The family is concerned about the suddenness of her demise and that if a pain killer was given, why wasn't anyone told or consulted.

Kathleen ELLIS was interned at St Mary-the-Virgin Church, Gosport.

I submit this report for your information.

Kathryn ROBINSON

IVY WILLIAMSON

Ivy Williamson

Date of Birth Code A Age: **77**
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification IVY WILLIAMSON

Code A

Exhibit number BJC-53

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		Unclear why midazolam alone was given at first; otherwise well managed		
Unclear B				
Unexplained By Illness C				

General Comments

78-year-old woman, diagnosed with malignant melanoma of antrum 1994, resected
2000-07-26 Admitted from dom visit after a fall; had cellulitis; found to have large pulmonary mets
Treated with paracetamol, then 'Kapake'
Transferred Sultan (?) 2000-08-03
At that time, treated with PRN co-codamol (hip and abdo pain)
Bronchoscopy 2000-08-09 confirms they are melanomatous
Transferred Daedalus 2000-08-21
regular co-codamol, swapped to tramadol 2000-08-25
Occasional oramorph 2.5 to 5 mg, or ibuprofen
Treated with midazolam by infusion 2000-08-31 20mg/24h, then same + diamorph 10 mg next day
Dies 2000-09-01

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/53
IVY WILLIAMSON
78

Malignant melanoma with pulmonary metastases. She deteriorated with an exacerbation of COPD but then deteriorated markedly with breathlessness and agitation. She was treated for the breathlessness but also kept free of pain and agitation with appropriate use of diamorphine and midazolam via syringe driver.

PL grading A1

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/53	Williamson, Ivy 11294	Died of advanced metastatic malignant melanoma. Excellent care. Opioids and sedatives only in very small doses, for good indications, and only gradually increased in response to symptoms.	A1

DOCUMENT RECORD PRINT

Officer's Report

Number: R7J

TO: REF:
STN/DEPT:

FROM: DC 424 ROBINSON REF:
STN/DEPT: MCIT E TEL/EXT:

SUBJECT: JACK WILLIAMSON B Code A 18/09/2000 DATE: 18/11/2002
IVY KATHLEEN WILLIAMSON Code A - 01/09/2000

I visited Keith WILLIAMSON at his home address, Code A in relation to his parents who both died at the GWMH in September 2002. Also present at the meeting was Ian WILLIAMSON , the eldest son (Code A).

Keith WILLIAMSON will say that his father Jack was an airframe fitter in the RAF during the war and then went on to work for Fleetlands, Gosport until his retirement at the age of 62 years. He was teetotal but smoked a pipe up until two years prior to his death.

He was married to Ivy Kathleen CLARK and they had four children. They lived at Code A Code A

Jack WILLIAMSON suffered from varicose veins, he had the veins stripped in both legs when he joined the Air Force in 1942/1943. He also had a hiatus hernia and suffered from anaemia.

His GP was Dr ANDERSON from the Rowner Health Centre .

Although suffering from dermatitis and ulcers in both lower legs, he was a keen competitive cyclist.

Around 1997/1998 Mr WILLIAMSON suffered a heart attack and was admitted to the ICU at Haslar Hospital, Gosport where he spent 2-3 days and suffered another two heart attacks.

He recovered and was discharged to his home address. It was at this time that his varicose vein leg ulcers progressed into arterial leg ulcers.

These ulcers failed to respond to treatment and required dressing by the district nurse. Mr WILLIAMSON required a frame and an electric buggy in order to get about.

In the Summer of 1998 he was admitted to Haslar Hospital for skin grafts to his lower legs. He remained in hospital for around 3 months.

Approximately five weeks after being discharged he was readmitted to Haslar for clinical depression. The skin grafts had not been successful and Mr WILLIAMSON was in considerable pain. He remained in hospital for the next ten months, being discharged in September/October 1999.

DOCUMENT RECORD PRINT

In November 1999 he was admitted to Haslar Hospital for a second attempt to graft skin to his damaged legs and again discharged to his home address.

On July 5th 2000 (05/07/2000) he fell and his legs haemorrhaged, he was taken to Haslar Hospital and in August 2000 he underwent surgery to remove both of his legs at the knee. The operation was successful and some 2-3 weeks later he was discharged to Daedalus Ward at the GWMH, in order to be near to his wife who had been admitted with terminal cancer. He was to undergo rehabilitation and then a place was to be found for him in a nursing home.

It was during this period that he arranged for a ceremony to renew his marriage vows with his wife in Haslar Hospital (photo attached).

Mr WILLIAMSON's wife died on 01/09/2000 at GWMH, he remained on the ward and was lucid and eating and drinking well.

On 12/09/2000 Mr WILLIAMSON was taken out for a visit to a friend, he was eating and drinking and in good spirits.

Mr WILLIAMSON was then diagnosed with MRSA wound infection and all visitors had to be gowned and wear gloves. He was still eating and drinking and spent his time reading.

Throughout this period Mr WILLIAMSON was visited daily by his family.

Around 16/09/2000 his family discovered that he had a drip which went into his stomach. He was unable to drink or feed himself. A member of staff told Keith WILLIAMSON that they were going to "make him more comfortable, like we did your mum".

His family describe him as appearing "as if he'd had a massive stroke". His mouth was bent and he was incoherent.

Mr WILLIAMSON died during the evening of 18th September 2000 (18/09/2000).

His death certificate states that he died from congestive cardiac failure, Ischaemic Heart Disease, Peripheral Vascular Disease leading to bilateral leg amputation at MRSA wound infection.

Death was certified by B WILSON MB and Mr WILLIAMSON was cremated.

Keith WILLIAMSON also spoke of his mother Ivy who was admitted to the GWMH, believed Sultan Ward, with terminal cancer in August 2000.

Keith WILLIAMSON will say that his mother was born in Portsmouth in 1922. She lived a full and active life and was fit and healthy. She worked as a line supervisor at the Ultra electrical factory in Gosport and retired from there when she was aged 60 yrs.

When she was aged around 70 years she had a fall at home and banged her face in the process. As a result Mrs WILLIAMSON developed shingles in her face and was treated with a new drug to try and combat this.

DOCUMENT RECORD PRINT

Within a year of her fall she was no longer able to breath through her nose and was sent to Haslar to try and discover the cause.

The problem was found to be polyps in her nostrils, these were removed and she returned home.

In 1994 Mrs WILLIAMSON was diagnosed with cancer, having a large melanoma in her face. The growth was removed and Mrs WILLIAMSON underwent major surgery to rebuild the left side of her face. She required many skin grafts and her family say that she never had Diamorphine as a form of pain relief. She had her mouth rebuilt and had an insert which when fitted gave her face a contour.

Mrs WILLIAMSON was discharged from hospital and was required to have three monthly check ups. These dropped off to six month intervals as she recovered.

In July 2000 Mrs WILLIAMSON was found collapsed at her home, it was believed that she had suffered a minor stroke. She appeared to be a bit vague and was admitted to Phillip Ward at the Queen Alexandra Hospital , Cosham where she remained for around ten days.

During that time a biopsy was carried out on tissue from Mrs WILLIAMSON by Dr LORD and as a result Mrs WILLIAMSON bled heavily and become ill. After a few days she recovered and began walking around the ward.

It was decided to move her to the GWMH which was nearer to Haslar Hospital where her husband was admitted.

The family were given the results of the biopsy and were told that Mrs WILLIAMSON was terminally ill, the cancer had returned and was deemed to be incurable and inoperable.

On Saturday 26th August 2000 (26/08/2000), Mrs WILLIAMSON was taken from the hospital to visit her brother, Bob CLARK (14 Gorin Ave, Gosport). She is described as being alert and coherent. She was also wearing her wedding ring at this time.

On Sunday 27th August 2000 (27/08/2000) she was taken to visit her husband, Jack, at Haslar Hospital. She wasn't wearing her wedding ring. Her family describe her as being vacant. She wasn't speaking but asked "What's happening to me?". She kept falling asleep and not knowing where she was when she awoke. She found it difficult to swallow and began to hide and hoard her medication.

On Monday 28th August 2000 (28/08/2000) Mrs WILLIAMSON was concise and lucid when visited.

On Thursday 31st August 2000 (31/08/2000) Mrs WILLIAMSON had been moved to a single room, she was unconscious and had been given a syringe driver.

The family do not know what drugs were administered via the driver but Keith WILLIAMSON had requested that his mothers death would be without pain and fear. He wanted his mother made comfortable.

Ivy WILLIAMSON died on September 1st 2000 (01/09/2000) her cause of death was given as Metastatic

Malignant Melanoma. The certificate was signed by A LORD FRCP.

Mrs WILLIAMSON was cremated.

Her family's concerns are that she died very quickly after being diagnosed.

DULCIE MIDDLETON

CANNOT GET INTO THIS FILE.

Dulcie Middleton

Date of Birth: Code A Age: **86**
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:-

Lived second floor flat – daughter helpful. PMH:- Hysterectomy and appendicetomy.
6th August 2001 – flexible sigmoidoscopy. Has catheter in situ.

Medical notes
25th May 2001 – for GWMH when bed becomes available.
29th May 2001 – admitted RHH 10th May 2001 – collapse found on floor. CVA left hemi. Dysphasia, pureed diet. On examination – for stroke rehabilitation.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification D. Middleton. **Exhibit number**

DM Code A BJC-33

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Very unwell, abdo pain, ?LVF comfortable and small amounts gradually increased			
Unclear B				
Unexplained By Illness C				

General Comments

85-year-old woman, with angina
2001-05-10 found on floor A. Left hemi
2001-07-04 Episode LVF
2001-08-21 'diamorphine 5 mg Given subcut with good effect...' and several subsequent doses given
2001-08-29 abdo pain inspite of sc morphine diamorphine 20 mg/24h by driver
2001-08-31 diamorphine 30 mg/ 24 h
2001-09-02-13-25 Dies

1977 letter: Dupuytrens & opn for it
2001-05-25 Clinical continuation sheet: 2001-05-31: Barthel 1/20

SO – NO CHANGE

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/33
DULCIE MIDDLETON
85

Suffered a dense stroke requiring feeding through a gastrostomy feeding tube. Developed pneumonia and abdominal pain requiring analgesia. Doses of analgesia were appropriate and she died of natural causes.

PL grading A1

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/33	Middleton, Dulcie	Note this patient died in Petersfield Hospital under Dr Vardon, although she had previously been in Daedalus Ward GWMH for rehab post stroke. Had undiagnosed intra-abdominal catastrophe, with pseudo-obstruction, abdominal distension and abdominal pain. Also had angina and LVF. PEG and SC fluids only; oral route not available. Also had aspiration pneumonia with white out of right lung. Very frail; on continuous oxygen. Begun on diamorphine 2.5-5mg PRN; in fact nurses chose to start at 5mg. Had 1 or 2 doses most days, ie 10mg diamorphine. When pain more severe and continuous S/D with diamorphine 20mg very reasonable. Required 5mg breakthrough 3 days later so increased to 30mg diamorphine and midazolam 20mg added because agitated and distressed. High dose of midazolam but no range.	A1

DOCUMENT RECORD PRINT

Officer's Report

Number: R7K

TO: REF:
STN/DEPT:

FROM: DC 424 ROBINSON REF:
STN/DEPT: MCIT E TEL/EXT:

SUBJECT: DULCIE GRACE MIDDLETON DATE: 09/01/2003
Code A - 02/09/2001

I visited Majorie BULBECK at her home address, 1 Code A in relation to her mother, Dulcie Grace MIDDLETON .

Mrs BULBECK has given details in the past but I obtained the following details.

Dulcie MIDDLETON, nee WILSON, was born in India in Code A returning to this country as a child.

She worked as a nanny up until the point of her marriage to George Joseph MIDDLETON in 1939. They had no natural children and adopted Marjorie from Dulcie's sister.

Dulcie MIDDLETON divorced her husband in the 1980's and lived alone in Gosport, eventually residing at Code A

Mrs BULBECK will say that her mother was fit and active and that in her late years she developed slight angina and high blood pressure for which she took medication.

On May 10th 2001 (10/05/2001) Mrs MIDDLETON suffered a stroke and was admitted to the Queen Alexandra Hospital, Cosham . She was moved to Ward A6 at Haslar Hospital , Gosport, the same day. Mrs MIDDLETON made a good recovery at Haslar. She had to relearn how to swallow but was able to eat and drink with assistance.

On 29th May 2001 (29/05/2001) she was moved to Daedalus Ward, GWMH for rehabilitation and remobilisation. At this time she was out of bed and sitting in a wheelchair. She would have her hair done and was in good spirits. She was receiving physiotherapy, speech therapy and occupational therapy. She did have trouble feeding herself due to immobility in her arm.

Mrs BULBECK noted that food was being left where her mother couldn't reach it and drinks were not being consumed because of conflicting instructions as to the use of straws.

Mrs MIDDLETON's bell was not left in an accessible position. Mrs BULBECK arranged for notices to be put on her mothers headboard and in the fridge drawing attention to the fact that Mrs MIDDLETON required assistance with eating and drinking. It was at this point when Mrs MIDDLETON had become extremely thin and dehydrated and Mrs BULBECK was asked if a feeding tube could be put in place.

DOCUMENT RECORD PRINT

This was done and an intravenous drip was set up to re-hydrate Mrs MIDDLETON.

Mrs MIDDLETON was extremely ill with the feeding tube and appears to have suffered from an 'overload of fluid'. At this time she suffered a further stroke or a slight heart attack which damaged her heart and lungs.

On 31 July 2001 (31/07/2001) Mrs MIDDLETON was taken to Haslar Hospital in order for a stomach peg to be fitted. This was to enable food and fluids to be fed directly into the stomach, she returned to GWMH the same day.

She later had a blockage in her intestine which had to be physically removed which caused her immense discomfort and pain.

By this time Mrs MIDDLETON was bedridden. She never left her bed and was constantly sick. She began to hallucinate and would spend long periods staring ahead.

Mrs BULBECK enquired with staff members as to whether her mother was being sedated but didn't receive an answer either way. Her concerns were raised with Phillip BEAD and Pat WILKINS who were the ward managers at that time.

Mrs MIDDLETON would complain of back ache, something she had never done before.

On 6th August 2001 (06/08/2001) Mrs MIDDLETON was rushed to the Queen Alexandra Hospital with an acute intestinal obstruction but she declined any further treatment saying "Don't let them hurt me anymore".

In view of this it was decided to return Mrs MIDDLETON to GWMH but Mrs BULBECK refused and on 16th August 2001 (16/08/2001) Mrs MIDDLETON was transferred to Petersfield Hospital, Cedar Ward. Mrs BULBECK was asked by the ward sister why her mother had been prescribed Diamorphine. This was the fist time that Mrs BULBECK had been aware of her mother being administered Diamorphine. The Diamorphine was stopped as Mrs MIDDLETON was not in pain. She became more animated but was extremely ill.

On 2nd September 2001 (02/09/2001) Mrs MIDDLETON died and her body was cremated.

The death certificate gives her cause of death as Bronchopneumonia and Cerebrovascular and was signed by A W CAIRNS MB.
Mrs BULBECK is concerned about her mothers death as she feels that poor nursing care hastened her death and she is concerned about the use of Diamorphine.

She has complained to the GMC and the Nursing Council.

She believes that the police have a copy of her file and correspondence. She has a full set of medical notes relating to her mother.

FRANK WALSH

Frank Walsh

Date of Birth: Code A Age: 83
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification | **Exhibit number**

FRAN WALSH Code A BJC-50

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	No evidence of misprescribing			
Unclear B				
Unexplained By Illness C				

General Comments

83-year-old man, earlier TIA,
1994-06-09 admitted for rehab – frail, doubly incontinent
1994-06-13 collapse, pallor, ?URTI Rx cefaclor
1994-06-14 died

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/50
FRANK WALSH
83

Very little to go on in the notes but he had a stroke and developed a chest infection. This was treated with oral antibiotics but he deteriorated and died. Nothing suspicious about his treatment and the cause of death appears clear.

PL grading A1

BJC/50	Walsh, Frank	Emergency admission to Sultan under GP. Loss of mobility, doubly incontinent. PMH TIAs. On aspirin and senna; receiving physio. Collapsed in early morning while vertical ?another TIA. Given antibiotics for chest infection but died shortly afterwards.	A1

DOCUMENT RECORD PRINT

Officer's Report

Number: R7M

TO: REF:
STN/DEPT:

FROM: DC 424 ROBINSON REF:
STN/DEPT: MCIT E TEL/EXT:

SUBJECT: OPERATION ROCHESTER DATE: 04/02/2003

Frank WALSH Code A – 14/06/1994

I visited Roy WALSH at his home address, Code A in relation to his father, Frank WALSH, who died in the Gosport War Memorial Hospital on 14/06/1994.

Roy WALSH will say that his father was born in Birtley, Co Durham. He married Shelia Doris COOPER in the 1930's.

He was a clerk in the Royal Horse Artillery. Upon leaving the Army he worked as a clerk for the Ministry Public Buildings and Works. He retired in 1975 and lived at Code A. He had four children, Barbara RODGERS Code A Allan WALSH (Code A), Shaun WALSH (Code A Code A who is Roy WALSH's twin.

Mr WALSH is described as being fit and healthy throughout his life.

He had appendicitis and required an operation in 1936.

In 1975 he had all of his teeth removed and in 1989 he had an operation for a hernia.

He smoked a pipe throughout his life. Towards the latter part of his life he became increasingly forgetful and confused and began to forget how to do simple basic things. His sons had to shave him.

A couple of weeks before he was admitted to the GWMH, he was suffering from constipation. He became more confused and had become incontinent. His wife was unable to cope and Mr WALSH was admitted to the GWMH for treatment for his constipation and for assessment. He was allocated a bed in Sultan Ward.

Mr WALSH was admitted on Thursday 9th June 1994 (09/06/1994) he was visited by Roy WALSH on Friday 10th June and although he was bright and cheerful, he was talking about seeing his brother further down the ward (his brother had died some years previously).

DOCUMENT RECORD PRINT

Frank WALSH died on Tuesday 14th June 1994 (14/06/1994). His death certificate gives 1a Cerebro-vascular accident and b. Cerebro-vascular atherosclerosis as cause of death. The certificate was signed by D ERSKINE MBBS.

Mr WALSH was buried in the Church of the Virgin Mary, Rowner, Gosport .

Mr WALSH is concerned by the fact that he has seen the media coverage and he is of the opinion that his father was not 'ill' and that he died within six days of entering the hospital.

DOUGLAS MIDFORD-MILLERSHIP

Douglas Midford Millership

Date of Birth: Code A Age: **82**
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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**
DOUGLAS MIDFORD-MILLERSHIP Code A BJC-57

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	No evidence of any misprescribing: apparently natural disease			
Unclear B				
Unexplained By Illness C				

General Comments

82-year-old married man, MI 1988, AF 1989, COPD , polycythaemia,
Admitted Haslar with SoB = treated as infection
Transferred GWMH 1999-07-08
Recovery impeded by anxiety
Treated with risperidone 500 > 1000 micrograms bd
Sore throat, then unwell, then
1999-07-20 Sudden deterioration ?CVA?MI – dilated pupils, unresponsive to pain, died
1999-07-20-11-30

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/57
DOUGLAS MIDFORD MILLERSHIP
82

History of COPD, ischaemic heart disease, heart failure and a stroke. There was a sudden deterioration early morning after 12 days on the ward. The exact cause was not clear but he rapidly deteriorated and died. Medication prescription does not contain any worries. The care seems to have been of a reasonable standard.

PL grading A1

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/57	Midford-Millership, Douglas	Immaculate care, presumably in Sultan. Doing very well. Sudden collapse ?CVA ?MI and died within 3 hours. Had no opioids or sedatives at all.	A1

DOCUMENT RECORD PRINT

Officer's Report

Number: R13F

TO:		REF:	
STN/DEPT:			
FROM:	DC Code A	REF:	
STN/DEPT:	FCU FLEET	TEL/EXT:	
SUBJECT:		DATE:	18/02/2003

On 17th February 2003 (17/02/2003) I went to the home address of Barry MIDFORD-MILLERSHIP on the Isle of Wight.

There he explained the circumstances leading up to the death of his father Douglas Francis MIDFORD-MILLERSHIP born Code A

Prior to his death, his father was living with his partner at Code A He was suffering from Emphysema.

In the mid eighties he suffered from a heart attack but despite this he refused to give up smoking. In June 1999 he was taken into Haslar Hospital for treatment for his condition, as he was getting extremely breathless when walking. The treatment seemed successful and after about three weeks he was transferred to the Gosport War Memorial Hospital for rehabilitation, arriving there on 8th July 1999 (08/07/1999).

Barry visited his father on a number of occasions while he was in the hospital. On all occasions he seemed mentally alert and physically improving.

On 20th July 1999 his father died unexpectedly.

The family have no specific complaints about the treatment of Douglas but since hearing the publicity they seek reassurance that he died of natural causes.