Operation ROCHESTER.

Code A

KEYPOINTS May 2005.

Code A Born Hemel Hempstead **Code A**

Suffered depression/ attempted suicide between 60's and 90's.

During the 2 months prior to death suffered, depression, suicidal, poor mobility shuffling gait, diarrhoea, chest infection, poor fluid/food intake, hypoproteinaemia. He may have been developing cerebrovascular disease and Parkinsons.

1993-1996 Knowle hospital for depression, discharged to Hazledene rest home, then to Gosport War memorial Hospital where he died 24.01 1996. Cause of death Bronchopnemonia.

Medical records examined by Key Clinical team who assessed the care delivered prior to death as negligent and cause of death unclear.

4th January 1996 (20 days before death) Consultant Geriatrician Dr Althea LORD notes severe depression, total dependency, catheterisation, lateral hip pressure sores, and hypoproteinaemia, recommending move to long stay bed at Gosport War Memorial Hospital.(BLACK comments reflects that **Code A** probably terminally ill).

5th January 1996 transferred for long term care TO Gosport War Memorial Hospital.

9th January Dr BARTON suggests Opiates may be appropriate response to physical and mental condition.

10th January medical notes Dr TANDY record that 'TLC' is to be administered and Oramorph prescribed.

15th January syringe driver Diamorphine commenced.

16th January Haloperidol (antipsychotic) added to the syringe driver.

18th January Nozinan administered, the dosage doubled on 20th January.

20th January Dr BRIGG increased Nozinam and discontinued Haloperidol

21st January patient reported as 'settled'.

24th January 1996 - death.

Case assessed by multidisciplinary key clinical team. 2004.

Code A . 82. 5th January 1996 – 24th January 1996. Gosport War Memorial Hospital. He was physically and mentally frail, deteriorating on a mental health ward. Medical notes state pain in flexed right hand. Nursing notes state generalised pain. Arthrotec tried plus oramorph. Syringe driver started five days later with a large dose increase when converting from oramorph to diamorphine. Notes on the 21st January 1996 record a respiratory rate of 6 per minute, likely as a reflection of the dose of opiates ie he was probably opiate toxic but the dose was not reduced. Cause of death unclear, although he was very frail, but opiates could have contributed.

Dr Jane BARTON. From caution interview with police 3.3.2005.

Workplace demands were substantial. A choice to be made between detailed note making or spending more time with patients.

Due to demands of work adopted a policy of pro-active prescribing.

Dr BARTON noted Dr LORDS poor prognosis of Code A on 5th January 1996 and believed that Dr LORD felt that Code A was unlikely to get better and that he was not likely to live for a significant period.

Following admission to GWMH on 5th Jan 1996 Code A placed under the care of Dr Jane TANDY. Assessed by Dr BARTON.

Would have seen Code A every week day Monday to Friday.

Dr BARTON made the note of 9th January 1996, prescribed arthrotec for pain in the hand.

Code A seen by Dr BARTON and Dr TANDY on 10th January.. Dr TANDY noted dementia etc, and wrote that he was for TLC. This indicated to Dr BARTON that Dr TANDY agreed with Dr LORD'S assessment and felt Code A was not appropriate for attempts at rehabilitation but for appropriate nursing care and treatment only. Discussed with Mrs Code A who agreed.

Dr BARTON prescribed Oramorph no doubt as a consequence of liaison with Dr TANDY. This was for relief from pain anxiety and distress. Also proactively wrote prescription for diamorphine upon the basis that Oramorph may be insufficient, and that further medication should be available should he need it.

On Monday 15th January 1996 Dr BARTON would have reviewed all of the patients in the usual way including Code A . Believes she may have been told that his condition had deteriorated over the weekend experienced marked agitation and restlessness and significant pain and distress. Believe assessment was that Code A Code A in terminal decline.

Tried to judge medication as necessary to provide appropriate relief whilst not excessive.

Dosages effectively increased appropriate to increased pain/ distress of patient.

Dr BRIGG examined patient on 20th January, few modifications to drug regime so therefore presumably not inappropriate.

Dr BRIGG examined on 21st January Code A settled. With quiet breathing not distressed.. drug treatment continued therefore not inappropriate.

Expert Dr Andrew WILCOCK (Palliative medicine and Medical Oncology) comments..

- Notes inadequate.
- Pain not appropriately assessed.
- Opioids not appropriate as administered to alleviate anxiety and agitation.
- Not necessary to use syringe driver (unless patient unwilling or unable to take medicines orally)
- Doses of diamorphine 40-120mgs excessive to needs of the patient (far exceeding appropriate starting dose)
- Appropriate dose would be 10-15mgs.
- Little doubt that Code A was naturally coming to the end of his life.
- At best DR BARTON had attempted to allow a peaceful death, albeit with excessive use of diamorphine.
- Opinion that Dr BARTON breached her duty of care, by failing to provide treatment with skill and care, difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs may have contributed more than minimally negligibly or trivially to his death. Dr BARTON leaves herself open to the accusation of gross negligence.
- Given the nature of Code A decline, Bronchopneumonia appears to be the most likely cause of death.

In his assessment of Dr BARTONS prepared statement Dr WILCOCK comments that:-

- According to Dr BARTONS job description she should take part in weekly consultant ward rounds.
- Consultants were responsible for patient care and should have been available to discuss complex patient issues.

- Given patient numbers 44, and admission numbers Dr BARTON should have been able to satisfactory manage in a half post as clinical assistant with regular consultant supervision.
- It is completely unacceptable for the trust to have left Dr BARTON with continuing medical responsibilities without consultant supervision and regular ward rounds, to fail to do so would be a serious failure of responsibility by the trust in its governance of patients.

Expert Dr David BLACK (Geriatrics) reports that Code A was extremely frail and dependent, and at the end of a chronic disease process of depression and drug related side effects spanning 20 or more years.

- Problem in assessing care due to lack of documentation.
- Lack of notes represents poor clinical practice, no written justification for high doses of Diamorphine and Midazolam.
- Drug management afforded to patient is sub-optimal.
- Starting dose of 80mgs of diamorphine is approximately 3 times the dose that conventionally applied.
- Combination of higher than standard doses of drugs, Diamorphine, and Midazolam combined with Nozinan likely to have caused excessive sedation and may have shortened life by a short period of time, hours to days.
- Whilst care is sub-optimal cannot prove to be negligent or criminally culpable.
- Predictions of how long terminally ill patients live are impossible, even palliative care experts show enormous variation.
- Medication likely to have shortened life but not beyond all reasonable doubt.

Other key witnesses.

Daughter Linda WILES (also a retired registered metal nurse) understood that Code A Code A was transferred to GWMH for terminal care. She watched her father die through self neglect. He had become extremely frail and had lost the will to live. She was not alarmed that her father was given morphine, she considered it appropriate care.

Code A GP Dr Martin ASHBRIDGE, comments that he suffered chronic intractable depression for which he received continual treatment. It was apparent that in the 5 months prior to his death his physical condition has begun to deteriorate.

Dr Althea LORD employed as Consultant Geriatrician at GWMH, Queen Alexandra Hospital and St Mary's Hospital Portsmouth between March 1992 and June 2004. Consultant for all patients over 65yrs requiring specialist care for their physical health. Assessed Code A prognosis as poor (ie patients chances of survival were slim and unlikely to survive for long) on 4th January 1996, transfer to GWMH

Dryad ward in order to address patients physical and psychiatric needs. Not intended to be a comprehensive care plan.

Dr Jane TANDY employed by East Hants Primary Care trust as Consultant Geriatrician in elderly medicine since 1994, covered Dryad ward until late 1996. On 10th January 1996 DR TANDY had overall medical responsibility of the ward. Dryad was a long term care ward containing frail and elderly patients difficult to manage due to medical or nursing requirements. There was no resident doctor on the ward which was covered by local GP Dr BARTON. Dr TANDY's responsibilities included a ward round once fortnightly. No requirement for a GP to notify Dr TANDY of every change to drugs prescribed to patients, unless her advice was sought by the GP, this occurred infrequently.
On 10th January 1996, Dr TANDY conducted a ward round with Dr BARTON and Sister HAMBLIN and prescribed 5mg Oramorph to alleviate pain and distress. Thereafter Dr TANDY recites the drugs prescribed by Dr BARTON, and comments that she would have used lower dosage of Diamorphine and Midazalam (than prescribed by Dr BARTON) her practice was to use the lowest dose to achieve the desired outcome diminishing adverse effects. There was no resident doctor to review the medication.

Dr Michael BRIGG a Gosport general practitioner. On 20th January 1996 responding to nursing concerns as to the patients clinical response to Haloperidol, Dr BRIGG stopped the dose and increased dose of Nozinan. He did not see the patient at the time but visited later.

Nurse Gillian HAMBLIN. Consultants attended once fortnightly on Mondays unless on leave when it would be monthly. Her practice was to challenge Dr BARTON if she did not feel levels of drugs prescribed were appropriate. Syringe drivers used once a patient becomes incapable of swallowing. The term TLC means that a patient was very likely to die. Nurse HAMBLIN commenced the syringe driver diamorphine on 15.1.1996., and an increased dosage on 18.01.1996. There no policy or protocol regarding the use of syringe drivers prior to 2000.

Nurse Lynne BARRATT administered Diamorphine to **Code A** on the 16th and 23rd January 1996.

Nurse Freda SHAW administered Diamorphine to **Code A** 17.1.1996.

Nurse Bridget AYLING in accordance with policy witnessed the accurate recording of Diamorphine prescribed, and recorded on drug charts.

Nurse Sharon RING re - charged the syringe driver with Diamorphine on 21.1.1996, and witnesses and recorded the withdrawal of Diamorphine for the patient on 4 other occasions.

Nurse Fiona WALKER witnesses withdrawal of drugs for **Code A** on 3 occasions.

Nurse Mary MARTIN variously administered ORAMORPH and verified the death of Code A **Code A** 24.10.1996.