Operation ROCHESTER.

Key points July 2006.

Helena SERVICE born **Code A**

Helena SERVICE was 99years of age when she died at Gosport War Memorial Hospital on the 5th June 1997 two days after her admission.

Born in Watford, Helena married in 1929 and moved to the Stubbington area of Hampshire upon her husband's retirement.

~~Following her husbands death shortly after his retirement~~ Mrs SERVICE lived alone (she had no children) until 1993 when she moved to a nursing home.

She had suffered gastric ulcers in 1981 a stroke in 1984 and fractured ribs following a fall in 1989. During the 80's and 90's she is recorded as suffering increasing heart problems and gout for which she was admitted to hospital both in January 1995 and January 1996.

During 1997 Mrs SERVICE became very unwell at the nursing home suffering back pain, a bed sore and a chest infection and was admitted to the Queen Alexandra Hospital, COSHAM on the 17th May 1997 confused, disorientated and most likely suffering a chest infection precipitating worsening of cardiac failure. She was very deaf, and because of this it was impossible to take a history from Mrs SERVICE herself, this was provided by way of a GP referral letter.

Initially Mrs SERVICE was appropriately assessed and managed by hospital staff resulting in an improvement in her condition, she was more alert and her heart rate improved as did her renal function. However she was suffering left ventricular failure, a failure of the left side of the heart to pump properly, causing a build up of pressure in the veins in the lungs and fluid on the lungs.

Nursing notes between the 21st May 1987 and 2nd June 1997 indicate that Mrs SERVICE was 'breathless on exertion' and variously describe her as demanding and confused,

On the 26th May 1997 it is likely that Mrs SERVICE suffered a stroke, as a result she became more dependant and was unable to return to her nursing home.

On the 28th May 1997 Mrs SERVICE was referred to geriatricians for 'continuing care'.

On 29th May Consultant Geriatrician Dr ASHBAL examined Mrs SERVICE reporting her longstanding cardiac failure breathlessness and deafness. He reported improvement that 'clinically she was better but in a degree of heart failure'.

Entries in medical notes for 30th May and 2nd June 1997 report that she was well and her condition unchanged. The nursing notes comment that she was 'not confused but quite agitated at times' Mrs SERVICE is recorded as being 'very demanding and shouting constantly overnight' on 2nd June 1997.

On 3rd June 1997 she was seen by consultant Dr MILLER who noted her to be 'well' and due for transfer to Dryad Ward at Gosport War Memorial hospital that day.

The nursing transfer letter summarised that Mrs SERVICE had been admitted with atrial fibrillation, confusion a chest infection and was very deaf.

She had received intravenous fluids and antibiotics, oxygen therapy and digoxin. Treatment was listed as thioridazine 25mg at night, lisinopril 2.5mg twice a day, bumetamide 1 mg once a day, aspirin 75mg once a day. Allopurinol 100mg at night, and digoxin 125 microgram once a day.

Dr Jane BARTON conducted the admission assessment of Mrs SERVICE on the 3rd of June 1997. She described her as no longer able to mobilise, ie 'off her legs' and was confused. Dr BARTON recorded that she was a non – insulin dependent diabetic and that she had upper respiratory tract infection and congestive cardiac failure. Under examination Mrs SERVICE was 'breathless and plethoric' this meaning that she was of purple/blue colour to the extremities indicating cyanosis consequent on the heart failure. Dr BARTON listened to her heart concluding that it was struggling to cope and that she was clearly in heart failure was very unwell and was probably dying.

Dr BARTON reports that Mrs SERVICE had deteriorated upon transfer and prescribed opiate analgesia.

On assessment at Dryad Ward Mrs SERVICE was prescribed diamorphine hyoscine and midazolam and administered in increasing doses over the first two days.

Midazolam was commenced at 20mg subcutaneously over the first 24 hours upon the basis that she was failing to settle during her first night at the hospital.

The following day the 4th June 1997 she was administered double the amount of midazolam and additionally 20 mg diamorphine per 24ours via syringe driver, Dr BARTON considering that it would have the effect of relieving pulmonary oedema and the significant anxiety and distress produced from that sensation.

The Hyoscine was to be available to dry the chest secretions.

The terminal prognosis was not consistent however with the results of blood tests carried out the same day (according to consultant palliative care expert Dr WILCOCK)

A Bartel assessment carried out on the 3rd June revealed a 'zero score' meaning that Mrs SERVICE was totally dependent.

Mrs SERVICE continued to deteriorate and passed away at 3.45am on the morning of the 5th June 1997. Her cause of death was recorded by Dr BARTON as congestive cardiac failure.

Clinical Team assessment.

Mrs SERVICE was very old, and had many medical problems including diabetes, heart failure, confusion and sore skin.

She was 'agitated' in the Queen Alexandra hospital but they accepted it and used thioridazine orally. Upon transfer to Gosport War Memorial Hospital, she was placed on sedation via a syringe driver at night. She became less well the next day and diamorphine was added to the driver (she had not required analgesia other than paracetomal at the Q.A.H). Mrs SERVICE died the following day.

Medication could have contributed towards her death, the need for such medication was not clear.

Account Dr Jane BARTON from interview with police 27th October 2005.

Within a prepared statement Dr BARTON commented that by 1997 there had been a significant increase in dependency, increase in bed occupancy and consequent decrease in the ability to make notes of each and every assessment and review of a patient these difficulties applying at the time of her care of Mrs SERVICE.

Dr BARTON reported Mrs SERVICE'S medical history in particular her heart problems and her GP Dr REES recording on 12th May 1997 that she had been diagnosed as being in heart failure.

Dr BARTON summarised Mrs SERVICE'S treatment at the Queen Alexandra hospital following her admission and that a senior registrar confirmed left ventricular failure and that her condition was not suitable for resuscitation.

Dr ASHBAL noted on 29th May that he was to transfer her to Gosport war memorial hospital. That it was not done immediately was probably an indication that there was high bed occupancy at the time, confirmed in notes of 2nd June indicating that a bed was still awaited.

On transfer on 3rd June 1997 Dr BARTON carried out an assessment Mrs SERVICE was clearly in heart failure and very unwell and probably dying. She had probably reached 'multi-system' failure. Care would have been more appropriate at Queen Alexandra hospital but a transfer by ambulance would not have been in her best interests.

Dr BARTON prescribed medication including diamorphine, hyoscine and midazolam.

A barthel score of zero on 3rd June indicated total dependency.

Mrs SERVICE was administered the opiates but continued to deteriorate and her nephew was contacted to inform him of her poorly condition.

She was suffering terminal heart failure and was distressed and agitated as a consequence.

The diamorphine and midazolam were prescribed and administered solely with the intention of relieving Mrs SERVICES agitation and distress with the diamorphine having the additional affect of treating the pulmonary oedema from her heart failure.

At no time was any medication provided with the intention of hastening her death.

Expert Witness Dr Andrew WILCOCK (Palliative medicine and medical oncology) comments:-

Mrs SERVICE was a 99year old woman who was admitted to the Queen Alexandra Hospital on the 17th May 1997 confused and disorientated most likely as a result of a chest infection, and a fast irregular pulse precipitating a worsening of her cardiac failure.

She was appropriately assessed investigated and managed and her condition improved relatively quickly, she was more alert, her heart rate was controlled and her renal function improved. She remained confused at times and noisy at night.

On 26th May it is likely she suffered a stroke affecting the left side of her body.

She was seen by Dr ASHBAL who agreed to take her to Gosport War memorial hospital for assessment with regards to continuing care.

On the day of her transfer she was described as 'well' by Consultant Physician Dr MILLER.

Her behaviour remained challenging particularly at night however apart from the regular use of thioridazine as a night time sedative Mrs SERVICE's behaviour was managed by the nursing staff using non-drug means.

On Dryad Ward there was an inadequate assessment of Mrs SERVICE's current symptoms and cardiovascular status. Her medication continued mostly unchanged other than the thioridazine.

She was prescribed diamorphine, midazolam and hyoscine with inadequate justification for the dosage.

Dr BARTON reports that in her view Mrs SERVICE was terminally ill with heart failure, however blood tests were taken from her on the same day and these would not be indicated in patients who were imminently dying and the fact that they were carried out suggests that doubt existed.

The blood test confirmed renal impairment and low potassium possibly due to her medication and/or inadequate fluid intake. These could have contributed towards a worsening condition and were potentially reversible with appropriate treatment.

If it were that Mrs SERVICE was not actively dying as the notes on her transfer to Dryad Ward suggest then the failure to re-hydrate her together with the use of midazolam and diamorphine could have contributed more than minimally negligibly or trivially to her death.

If it were considered that Mrs SERVICE were actively dying then it would have been reasonable not to have re-hydrated her and the use of midazolam and diamorphine could have been justified.

However, in the opinion of Dr WILCOCK the starting dose of diamorphine was likely to be excessive to her requirements and access to smaller doses would have been a more appropriate way of initially dealing with her symptoms.

Given that elderly frail patients of significant morbidity can deteriorate with little or sometimes no warning it could be argued that it is difficult to distinguish with complete confidence which of the above scenarios was the most likely for Mrs SERVICE.

The opinion of a cardiologist should be sought on Mrs Service's likely prognosis, scope for optimising her heart failure therapy and the role of opioids in chronic heart failure in 1997.

Expert Witness Dr Michael Charles PETCH Consultant Cardiologist:-

Dr PETCH reported that Mrs SERVICE at the time of her death had a long medical history with evidence of heart disease by 1989 and heart failure by 1995. The average survival of patients with this sort of heart failure is 2 years

hence her terminal decline in 1997 was not unexpected. Once the decision had been made that she was not for resuscitation as it was in the Queen Alexandra hospital in May 1997, then the palliative care with increasing doses of diamorphine and midazolam was appropriate. These drugs were administered in accordance with cardiological practice in 1997.

Mrs SERVICE remained unwell despite corrective treatment (at Queen Alexandra hospital). Opiates, notably diamorphine are standard drugs for the alleviation of shortness of breath and distress associated with pulmonary oedema and are particularly helpful at night. The administration of diamorphine has been standard practice for cardiologists for decades.

Mrs SERVICES prognosis was hopeless. The administration of diamorphine together with midazolam was reasonable given the circumstances as described by Dr BARTON.

Expert Witness Dr David BLACK (Geriatrics) comments:-

Mr SERVICE was admitted to Queen Alexandra Hospital on 17th May 1997 at the age of 99 at the request of her GP to hospital with confusion, disorientation and progressive failure for the rest home to be able to cope with.

She had been progressively failing in the residential care home, unlikely that this was dramatic change in function but the end point of slow deterioration of her multiple illnesses including her progressive heart disease, her cerebro – vascular disease and the physiological frailty of an age of 99 years.

She was diagnosed to have a combination of dehydration and left ventricular failure and recorded as having long standing congestive cardiac failure.

On the basis of her nursing notes she makes very little improvement in her confusion or her breathlessness and indeed things take a turn for the worse when she probably has a new stroke on 26th May, she remains totally dependent after this.

She is seen by a locum consultant geriatrician Dr ASHBAL on the 29th May his assessment is that she will not return to her residential nursing home and that he is transferring her to Gosport with a view to considering continuing care. By this he probably means an assessment as to whether this lady is dying or perhaps to simply remain in an NHS continuing care bed until she does die.

By the 2nd June Mrs SERVICE is deteriorating, she is very demanding overnight shouting continuously suggesting that she is acutely delirious and so breathless that she has to sit up all night on the 2nd June.

I believe that this lady is now physically deteriorating but it is impossible to tell if this is progression of heart failure, a pulmonary embolus, or chest infection

on top of her other problems. I have little doubt that she was entering a terminal phase of her illness.

Mrs SERVICE was transferred to Gosport War Memorial Hospital on 3rd June where she is noted to have a buttock bedsore. The recorded medical assessment is brief but does include an examination which although notes that she had tachycardia and is very breathless, fails to give an overall impression of her status and whether this is acute, chronic or acute on chronic and fails to record her pulse and blood pressure.

A thorough objective assessment of this lady's clinical status is not possible from the notes made on admission and would appear to be below an acceptable standard of good medical practice.

The cause of death in the view of the expert was 'multi-factorial'. The dose of 20mg of diamorphine combined with the 40mg dose of midazolam was higher than necessary in this very elderly and frail lady's terminal care and the medication may have slightly shortened life although this opinion did not reach the standard of proof of beyond all reasonable doubt. The expert would have expected a difference (of survival) of at most no more than a few hours or days had a lower dose been used.

Evidence of other key witnesses.

Code A (Nephew of deceased) General family and medical background as relates to Mrs SERVICE, speaks of her developing a bad cough in 1997 leaving her frail and weak.

Code A Details family history. Although unwell at the age of 99 the family expected her to recover.

Code A Visited Mrs SERVICE four times at Queen Alexandra Hospital. She seemed to be recovering, was chatty and cheerful. Also visited at Gosport War Memorial Hospital, she was very 'dopey' and did not realise that Mrs TUFFEY was there, surprised at her death.

Code A (Personal friend of deceased) Close detail of her recent medical history and increasing dizzy spells precipitating her admission to 'willow cottage' rest home. Admitted to Q.A.H following a cough and seemed to be improving. Transferred to GWMH visited on 4th June 1997, seemed to be unconscious.

Code A (home help and friend) Post 1991 describes Mrs SERVICE as very sound in mind but of frail body. Describes Mrs SERVICE as alert bright and witty at Q.A.H and was shocked at her condition at G.W.M.H. She was told by a nurse that 'she had to be given something to make the journey more comfortable'.

Code A (Proprietor Willow Cottage Guest house) describes her medication and care plan for 1997. Mrs SERVICE was diagnosed by Dr REESE as being in heart failure on 12th May 1997 her next of kin were informed.

Code A (Co-proprietor) information as above. Describes how Mrs SERVICE became increasingly frail over the years. In May 1997 she was diagnosed with heart failure, became breathless and poorly.

Judith REES (General practitioner) Details medical history and the fact that Mrs SERVICE had suffered heart problems since 1984. Dr REES details considerable visits during the 1990's. On 12th May her drowsiness had increased she had ankle swelling and her chest infection appeared to have exacerbated her heart failure symptoms. She was very unwell and in her judgement was dying.

James MILLAR (Consultant general medicine) Conducted ward round at Q.A.H on 18th May 1997. Noted Mrs SERVICE temperature normal but she was mildly dehydrated. Her clear chest sounds suggested an improvement in the function of her heart. X-rays showed classic indications of left heart failure. Subsequent examinations showed improvements in heart and breathing functions but attempts to mobilise her proved difficult. On 28th May 1997 he referred her to the elderly care medical team at G.W.M.H asking for continuation of the measures for continuing care. His final assessment of 3rd June 1997 was that she was well.

James MILLAR (Further statement) Describes medication and rational for prescription.

Grant HEATLIE (Consultant Cardiologist) In 1997 a senior house officer at Q.A.H. His role to see new admissions. Jointly examined Mrs SERVICE with Dr MEEKING. Her ECG and X-ray showed heart failure, not reversible. Noted condition improving by 21st May 1997, and wrote referral letter on 28th May for considering continuing care.

Aureol HART (Nurse Q.A.H) Explains nursing note entries between 17th and 30th May 1997.

Julie BARTON (Nurse Q.A.H) Explains her nursing note entries in particular a nursing transfer note to G.W.M.H.

Al-Ashbal Saleh (Consultant Physician) specifically assessed Mrs SERVICE whilst at Q.A.H for continuing care and wrote transfer letter.

Patricia SHAW (Nurse Dryad Ward G.W.M.H) The admitting nurse at G.W.M.H on 3rd June 1997.. describes as a pleasant lady normal diet but needed assistance with meals, faecally incontinent, buttocks red and sore and skin broken, skin quite dry superficial grazes on spine and skin on lower arms discoloured.

Sharon RAY (Senior staff night nurse G.W.M.H) Explains nursing entries overnight 3rd June 1997 including that she had failed to settle and was very restless and agitated, as a consequence 20mgs of Midazolam administered at 0200hrs over 24hrs via syringe driver.

Sharon RING (Staff nurse Dryad Ward G.W.M.H) Wrote patient summary on 4th June 1997 'condition appears to have deteriorated overnight, remains restless. Seen by Dr BARTON. Driver re-charged with diamorphine 20mgs midazolam 40mgs in 50 millimols hourly. Rang Mr TUFFEY (nephew) to inform him of poorly condition. Nurse RING confirms that she administered the midazolam and diamorphine.

Freda SHAW (Nurse G.W.M.H) Catheterised Mrs SERVICE on 4th June 1997 and explains associated nursing notes.

Irene DORRINGTON (Nurse G.W.M.H) at 0440hrs on 5th June 1997 wrote on the nursing notes that Mrs SERVICE had died peacefully at 0345hrs.

~~Janice HOGGARTH (Social worker) re-referral summary.~~

Natalie LISTER (House physician Q.A.H) spoke to referring GP on 17th May 1997.. and conducted initial examination of Mrs SERVICE..explains detailed notes made between 17th and 23rd May 1997.

Darryl MEEKING (Senior registrar) completed admissions entry on 17th May 1997. ECG and X-ray indicated findings of heart failure. Dr MEEKING instructed that Mrs SERVICE should be resuscitated if her heart was to stop beating given that the probability of success was remote due to her age, history and heart disease.

Jason HEWETT (Locum house officer Q.A.H) examined Mrs SERVICE on 26/27th May 1997.. suffered a small stroke.

Detective Constables YATES and QUADE. Interviewed Dr BARTON on 27th October 2005 and received from her a prepared statement ID ref: JB/PS/10.

Code A

D.M.WILLIAMS
Detective Superintendent 7227.
19th July 2006.