4 CASES PRIORITY.

OP ROCHESTER. June 2004.

CONFIDENTIAL. Detail of individual cases not to be released without the authority of SIO or Deputy.

Subject Areas for discussion.

- Ongoing work of the clinical assessment team prioritising the nine, 3b category cases ie 'negligent care that is to day outside the bounds of acceptable clinical practice, and cause of death unclear.'

- 3b Cases are :-

1. Arthur CUNNINGHAM. 79. 21st September 1998 – 26th September 1998. Gosport War Memorial Hospital. Parkinson's disease, dementia, myelodysplasia, admitted from a nursing home with difficult behaviour. In June 1998 he was using a mobile telephone, and taking a taxi journey. Admitted from day hospital with a large necrotic sacral sore. The sore would have been painful but the reasons quoted for starting the diamorphine/midazolam infusion were related to behaviour. No mention of pain on the 25th and 26th September but the dose of diamorphine was increased on both days. Cause of death was bronchopneumonia although the medication might have contributed to it. Several Doctors involved in care. Rapid escalation of Diamorphine and High doses of Midazolam.

2. Elsie DEVINE. 88. 21st October 1999 – 21st November 1999. Gosport War Memorial Hospital. Multi-Infarct dementia. Moderate/Chronic renal failure, paraproteinaemia. Occassionally aggressive and restless. Prescribed thioridazine for this. When she became more agitated, she was started on fentanyl, and then converted to large doses of diamorphine and midazolam via a syringe driver. Pain was not raised as an issue. Cause of death is not clear and the use of opiods questionable, especially when considering doses. Issue over whether or not she was dying before given Fentanyl, which was inappropriately prescribed for sedation.

3. Sheila GREGORY. 91. 3rd September 1999 - 22nd November 1999. Gosport War Memorial Hospital. Fractured neck of the femur and other medical problems. The original aim was rehabilitation, but there was an early entry about keeping her comfortable. There was a suggestion of a stroke early in her stay, at GWMH and she deteriorated. The decision was made to refer her to Nursing Home for care because she was unlikely to improve further. She then deteriorated with distress and breathlessness. The staff wondered about a chest infection but did not start antibiotics. Oromorph helped the distress and breathlessness, so she was started on a reasonably low dose of diamorphine

through a syringe driver. Frusemide as a diuretic was given in case the breathlessness was due to fluid on the lungs. In the end the cause of death was not entirely clear. Should they have tried antibiotics or explained why they were not used? She probably would have died whatever was done from 15.11.1999.

4. Elsie LAVENDER. 83. 22nd February 1996 – 6th March 1996. Head Injury or brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. It was possibly musculoskeletal pain from a fall downstairs. Other forms of analgesia such as anti-inflammatory drugs or hot/cold packs might have worked. The most worrying aspect is the large dose escalation when converting Morphine to diamorphine via syringe driver (Five fold increase). The cause of death is unclear and the dose escalation might have contributed.

5. Enid SPURGIN.92. 26th March 1999 – 12th April 1999. Gosport War memorial hospital. Had suffered a fractured hip repaired with a dynamic hip screw. She could get from a bed to a chair with the help of 2 nurses before the transfer, and had paracetomal as required for pain relief. Pain became an issue as soon as she arrived at Dryad. Analgesia started with Oramorph regularly and then regular codydramol and then MST at low dose. The dose was increased after continued pain was noted. She had deteriorated on the day a syringe driver was started, but she is reported as denying pain. Diamorphine was started at 80mg per 24hrs via a syringe driver. This is a very high dose 5-6 fold increase. It is not clear who chose this dose but the way the drug was prescribed the nurses could have used a dose anywhere between 20 to 200 M/G a day. It had to be reduced, because she was too drowsy and it probably contributed to her death. No evidence of consultation with appropriate specialist over management of her operation wound infection. Rapid escalation of opiate dose. Poor drug prescription when diamorphine infusion was commenced, nurse could have set up anything from a dose of 20-200 mg per day and still been in compliance.

6. Jean STEVENS. 73. 20th May 1999 – 22nd May 1999. Gosport War Memorial Hospital. This woman had suffered a stroke with marked weakness of the left side complicated by a myocardial infarction and aspiration pneumonia. On the day of transfer she had suffered chest pain all day. But had not told anyone. A strange decision was made to stop her prophylactic anti-anginal treatment, and use the GTN as required and oramorph. She was reported to be uncomfortable on the day of conversion to diamorphine via syringe driver. She then deteriorated rapidly. The pain was likely to be cardiac, and specific angina treatment should have been tried before resorting to regular opiates. The use of opiates was overdone. Pain not mentioned in initial clerking. Alert on admission. Immediately started on Morphine with a rapid dose escalation.

7. Robert WILSON. 74. 22nd September 1998 – 18th October 1998. Gosport War memorial Hospital. Recorded as having a high alcohol intake and poor nutritional status. He was admitted with a left humerus fracture. During his

last days on dickens ward, he was on regular paracetomal, and codeine as required needing one dose of codeine most days. On transfer to dryad, he received 2 doses of oramorph and was then put on a moderate dose of oramorph every 4 hours with paracetomal as required. Liver and kidney problems make the body more sensitive to the effects of oramorph. He had both of these problems. He deteriorated, and was converted to a syringe driver at a dose, which was a close conversion from the oramorph dose. Over the next 2 days the dose was increased without obvious indication. Death was presumably from overdose of opiates, in a man with a poor opiate metabolism, and reduced tolerance. Unless the decision had been taken to treat pain regardless then this was negligent. Initial dose of Morphine inappropriate in a person with known alcoholic liver disease. Rapid increase in body weight documented in notes, with no apparent clinical response.

8. Leslie PITTOCK. 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.

9. Helena SERVICE. 99. 2ND June 1997 – 5th June 1997.Gosport war memorial hospital. This lady was very old, and had many medical problems, eg diabetes, heart failure, confusion and sore skin. She was agitated in the Queen Alexandra hospital but they accepted it and used thioridazine orally. On transfer to Gosport War Memorial Hospital, they put her on sedation via a syringe driver at night. She was 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). She died the next day. Medication could have contributed towards her death. Need for such medication not clear.

- As agreed by SIO WATTS, 4 Four of these cases are to be prioritised and fast -tracked to CPS, with a view to an early decision to be taken on the sufficiency of evidence to support continuing investigation/prosecution. This strategy will also have the effect of engaging counsel early into the process. It is hoped that the first cases will be forwarded to CPS by September 2004.

- Liaison with the Fareham and Gosport primary healthcare trust is ongoing. It is anticipated that the witness interview of 30 or so healthcare professionals in respect of the DEVINE case should commence from Thursday 17th June 2004 under the supervision of DS STEPHENSON. Potential media issues arising are currently being considered by relevant stakeholders.

- Dr Andrew WILCOCK (Nottingham University) has been commissioned to provide the relevant expert evidence commencing with the priority cases from late July 2004.

- Once Dr WILCOCK'S expert evidence is available then having regard to his professional opinion, Healthcare professionals may be interviewed under caution in respect of allegations of Gross negligence manslaughter.

- Liaison continues with the Crown Prosecution Service, Anne ALEXANDER solicitor representing 43 families, and the Chief Medical officer and General Medical Council in respect of ongoing investigation.

- Priority is to be given to the appointment of a police family Liaison co-ordinator DI BISSELL.

- One significant issue to be addressed is informing the families of 16 deceased named as 'cases of concern' in the Baker report commissioned by the CMO. Two of these cases, PITTOCK and SERVICE identified through the independent work of Professor BAKER have been assessed as 3b's by the experts commissioned through the police investigation.

- Mathew LOHN (Field Fisher Waterhouse) indicated on the 9th June 2004 that he required 10 days to complete his quality assurance work on the 54 cases categorised as 2's ie.. care assessed as sub optimal but not negligent, ie outside the bounds of acceptable clinical practice.

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