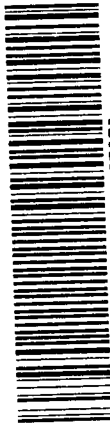

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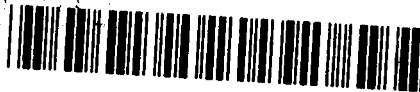
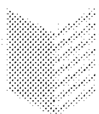
Date Created	02/12/2002





Code A

EM205 RET 1180192444—000003 RT ID: 12

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SKP:333303155—00003 CUST:W333303155

Srv 01/05 5:00pm BST For: FTP UTIL KATHRYN DZIUBAK

HALF

R

Code A

Code A

2000/2047

GMC reg: 1587920

SAP Back Scan Exercise

Case File Number 2000/2047

Doctor Number 1587920

Date Sent to DV

Booked Out By

Code A

Date Returned from DV

Booked in By

Comments

GMC101224-0004

CPT FILE
(Lon)

CPT DOCUMENTS BEGIN

RECEIVED FROM HAMPSHIRE CONSTABULARY

THREE BOXES CONTAINING FILES AS LISTED

TWO FILES CONTAINING PAPERS/REVIEWS OF THE EXPERTS

**IRENE WATERS, ROBIN FERNER
PETER LAWSON, ANNE NAYSMITH
AND MATTHEW LOHN**

POLICE OFFICERS REPORTS AS ENCLOSED WITHIN THE TWO FILES

SIGNED

FORMAT OF FILE CONTENTS

1. DOCUMENT LISTING THE CONTENTS OF THREE BOXES DELIVERED TO G.M.C 10 09 2004

2 REVIEW OF EXPERTS

   A. IRENE WATERS
   B. ROBIN FERNER
   C. PETER LAWSON
   D. ANNE NAYSMITH

3. POLICE OFFICER'S REPORT

4. CASE REVIEWS BY MATTHEW LOHN

CONTENTS OF BOXES TO G.M.C. 10 09 2004

REF.	NAME	FILE CONTENT
BJC/1A	VICTOR ABBATT	COPY OF MICROFILM PAPERS
BJC/2	DENNIS AMEY	COPY OF MICROFILM PAPERS
BJC/6A	CHARLES BATTY	COPIES OF TWO SETS OF MICROFILM PAPERS
BJC/6B	DENNIS BRICKWOOD	COPY OF PAPER RECORDS
BJC/9	SYDNEY CHIVERS	COPIES OF TWO SETS OF PAPER RECORDS
BJC/17	CYRIL DICKS	COPIES OF TWO SETS OF PAPER RECORDS AND COPY OF MICROFILM PAPERS
BJC/23	CHARLES HALL	COPY OF PAPER RECORDS AND COPIES OF TWO SETS OF MICROFILM RECORDS
BJC/31	CATHERINE LEE	COPIES OF TWO SETS OF PAPER RECORDS
BJC/7	STANLEY CARBY	COPIES OF TWO SETS OF PAPER RECORDS
BLC/12	WALTER CLISSOLD	COPY OF PAPER RECORDS

BJC/22 & JR/1	**HARRY HADLEY**	**COPIES OF TWO SETS OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS**
BJC/26	**ALAN HOBDAY**	**COPY OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS**
BJC/35	**EVA PAGE**	**COPY OF PAPER RECORDS**
JC/36	**GWENDOLINE PARR**	**COPY OF PAPER RECORDS**
BJC/37	**EDNA PURNELL**	**COPIES OF TWO SETS OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS**
BJC/38	**MARGARET QUEREE**	**COPY OF PAPER RECORDS AND COPIES OF TWO MICROFILM PAPERS**
BJC/40	**VIOLET REEVE**	**COPY OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS**
BJC/42	**JAMES RIPLEY**	**COPIES OF TWO SETS OF PAPER RECORDS**
BJC/47	**DAPHNE TAYLOR**	**COPY OF MCROFILM PAPERS**

GMC101224-0010

VICTOR ABBATT

VICTOR ABBATT

Victor Abbatt

Date of Birth: **26th June 1912** Age: **77**
Date of Admission to GWMH: **29th May 1990**
Date and time of Death: **00.05hours on 30th May 1990**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **1 day**

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

Code A

BJC/01A
VICTOR ABBATT
77
Admitted with bronchopneumonia
Was cyanosed at time of admission
Given temazepam 10mg at 2215
Died at 0005

Bad medicine to prescribe and give temazepam to someone with breathing difficulties
But already very unwell
PL grading A2

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/01A	Code A	Very brief admission – admitted Code A and died at 0500 hours Code A. Admission diagnosis was chest infection and mild heart failure. Noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on Code A – and they then administered the Temazepam 10mg apparently written up for him. NO DRUG CHART WITH THE NOTES RECORDED. So unable to comment on whether any drug written up or administered might have contributed to the apparently sudden development of cyanosis and/or subsequent death.	B2

GMC101224-0019

DOCUMENT RECORD PRINT

Officer's Report

Number: R7E

TO: REF:
STN/DEPT:

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

SUBJECT: OPERATION ROCHESTER DATE: 13/11/2002
VICTOR JOHN ABBOTT B.

On 10th November 2002 (10/11/2002) I visited Pauline GILMORE (nee ABBOTT) and John Richard ABBOTT Code A at Paulines home address of Code A Code A

They had contacted the Health Authority in relation to the death of their father, Victor (Vic) ABBOTT who had died GWMH on 30/05/1990, after seeing media reports on the hospital.

Victor ABBOTT lived at Code A with his wife Doris Rose ABBOTT .

He worked as a stevedore for the MOD and is described as being very fit.

He suffered from arthritis and the ...... but was not taking any medication for them. He was a life long smoker and had a chesty cough.

Around April 1990, Victor ABBOTT had a chest infection for which he was prescribed antibiotics. He was visited by his wife's GP, Dr PETERS , as he was not on a doctors list. The infection left him very weak and unwell but he was not admitted to hospital, he did attend GWMH for an x-ray which confirmed the diagnosis of chest infection.

At this point he was sleeping a great deal and was suffering from hallucinations due to the lack of oxygen getting to his brain. This was directly attributable to the infection and stopped as he began to recover. They are described as 'brief' and 'temporary'.

Dr PETERS oversaw his treatment which did not include any pain killers, just the antibiotics.

Throughout this period, Mr ABBOTT remained alert and able minded, he was however left very weak and required help to reach the bathroom. Because of this his wife became very tired and worn down and it was suggested that Mr ABBOTT be admitted to the GWMH mainly for him to regain his strength and as a respite for Mrs ABBOTT.

Mr ABBOTT didn't wish to be admitted but recognised that his wife needed a rest. He was admitted to a mens surgical ward on the ground floor of the GWMH and 1930 hrs on 30/05/1990 and settled into a chair, the family left him as he was about to taken to the day room to have a cigarette. The staff

informed them that he would 'be made comfortable' and that they could 'come and see him in the morning'.

Around midnight the hospital contacted the family to inform them that John ABBOTT had died.

The family are concerned that their father was given medication that was too strong and as a result he died.

Mr ABBOTT was cremated.

Kathryn ROBINSON

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AX

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 01/12/2003

I attended the home address of Mrs GILMORE at 1000 hrs on Thursday 27th November 2003 (23/11/2003) in relation to her father, Victor ABBOTT , as per the policy log. Also present were her husband and brother.

I discussed the nature of the family's initial concerns as per officers report 7E.

They felt that all of the relevant points had been covered and were given a copy of their father's medical records.

The family is happy to be notified by letter in 'layman's terms' but would like to have the opportunity for a follow up visit if they feel they have questions.

GMC101224-0023

Expert Review

Victor Abbatt

No. BJC/01A

Date of Birth: Code A

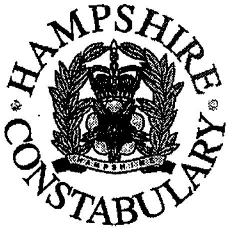
Date of Death: 30 May 1990

Mr Abbatt was admitted to the Gosport War Memorial Hospital on 29 May 1990 as an emergency. Dr Barton requested this as his wife could no longer cope with him at home.

On admission he was diagnosed as having a chest infection with mild heart failure. He was noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on the day of admission. He was then administered 10mgs Temazepam apparently which had been written up for him.[VA1]

The experts criticised the use of a small dose of Temazepam in a patient who is cyanosed. They note, though, that Mr Abbatt was already very unwell.

GMC101224-0025



DENNIS AMEY

Code A

Dennis Amey

Date of Birth: Code A Age: **62**
Date of Admission to GWMH: **14th November 1990**
Date and time of Death: **16.30 hours on 20th December 1990**
Cause of Death:
Post Mortem:
Length of Stay: **38 days**

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

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

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

Code A

BJC/02
DENIS AMEY
62
There are no drug cards or relevant nursing notes
Severe PD
Developed gangrenous – decided on conservative treatment

Started on morphine elixir on 11/12/90
On 120mg diamorphine sc per 24 hours by 19/12/90

This is a huge dose but might have been appropriate
There is not enough detail in the notes to be sure of what the opiate requirements were

- probably some medication cards and casenotes missing

He was clearly very unwell and in pain
However the dose of opiate might have contributed to his death
PL grading B but difficult to give a number

BJC/02	Code A	Admitted for terminal care (long term) because Code A no longer able to cope. Very severe Parkinson's. Had long term catheter. Treated with Septrin for presumed UTI but then developed pyuria and oliguria, succeeded by scrotal gangrene. Surgical opinion requested but in view of very severe Parkinson's surgery not offered (not clear whether thought unsafe or just inappropriate). Managed with opioid pain relief, apparently by diamorphine via syringe driver. At one point from notes was on 120mg diamorphine/day. NO DRUG CHART IN NOTES RECORDED. It is therefore unclear, and cannot be determined from the evidence available to me at this time, whether the doses of diamorphine administered were escalated only in response to uncontrolled pain and indeed what those doses were.	B2

99%

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BD

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 06/12/2003

I attended the home address of Lesley LOWE , the daughter of Denis George AMEY Code A at 1000 hrs on Thursday 27th November 2003 (27/11/2003). Also present was her sister, Susan MAY , Code A . The visit was as per the policy log, a set of their father's medical records were provided.

I outlined their concerns as per officers report 8C and they felt that they had nothing further to add in relation to their father, however they wished to bring to our attention concerns they have in relation to their mother, Freda AMEY , b. Code A who currently lives in a warden controlled complex.

Mrs AMEY has been a diabetic since her late 50's, early 60's. She suffered from Osteoporosis and her diabetes is now insulin driven.

Mrs AMEY was being treated by her GP, Dr BARTON and was being prescribed pain killers.

On one occasion Mrs AMEY had to see Dr KNAPMAN , a partner in Dr BARTON's surgery. Dr KNAPMAN said to Mrs AMEY "Why are you on morphine, you'll end up at ..." and said the name of a local undertakers. He took her off the morphine.

Some years later, around 1999, Mrs AMEY was suffering from back pain. Dr BARTON visited and gave her an injection. She was admitted to the GWMH t o be assessed for her diet and diabetes.

After a couple of days after being admitted Mrs AMEY is described as being "out of her head", incoherent and slurring her words. Her tongue appeared swollen.

The family removed Mrs AMEY from hospital and after a couple of days she appeared to be her normal self.

Dr BARTON felt that Mrs AMEY should then have gone into a nursing home and she took Mrs AMEY off her patient list. Mrs AMEY now attends the Bridgemary Surgery and is under Dr EVSKIN .

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The family are happy to be notified by letter.

Expert Review

Dennis Amey

No. BJC/02

Date of Birth: Code A

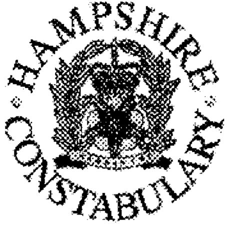
Date of Death: 20 December 1990

Mr Amey was admitted to Gosport War Memorial Hospital on 14 November 1990 following a request from Mrs Amey. Mr Amey at that time had problems with his catheter, he was incontinent and was having spasms. Mr Amey had very severe Parkinson's disease. He was admitted for terminal care.[DA1]

Mr Amey was started on Morphine elixir on 11 December 1990 and by the time of his death on 19 December 1990 he was on 120mgs of Diamorphine subcutaneously per twenty-four hours. Dr Lawson notes that Mr Amey was very unwell and in pain.

The experts have determined that this dose of Morphine was high and possibly sub optimal but without additional documentary evidence cannot be clear as to whether the doses of Diamorphine was escalated only in response to uncontrolled pain.

CHARLES BATTY



Code A

Charles Batty

Date of Birth: Code A Age: **80**
Date of Admission to GWMH: **September 1990**
Date and time of Death: **10.55 hrs on 2nd January 1994**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **3 years 3 months**

Mr Batty's past medical history states that she suffered from:-
1969 – Menieres
1973 – Partial gastrectscomy
1975 - Gastrectomy
1976 – Cervical spondylosis
1981 – Epilepsy
1984 – Prostatectomy benign
1989 – Colostomy – CA descending colon
Parkinson's Disease
History of depression.

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

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

20th December 1993
Seen by Dr Lord – no change.

28th December 1993
Complaining of generalised pain. Seen by Dr Barton. **Oramorph 10mg 6 hourly.**

30th December 1993
Nightmare end of last week disturbed and agitated. Quick and complete recovery.
Appears in pain **Oramorph increased** 10mg 4 hourly and 20mg nocte. ? whether pain is being controlled, difficulty taking oral medication. Discussed with Carol/Rhonda happy to put syringe driver.
11.30 hours syringe driver commenced **Diamorphine 40mgs.**

Code A

31st December 1993

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

1st January 1994

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

2nd January 1994

Mr Batty died at 10.55 hours. Next of kin informed. For cremation.

GMC101224-0043

Code A

GMC101224-0045

BJC/06A
CHARLES BATTY
80

History of Parkinson's Disease, epilepsy and Meniere's
Lengthy stay in hospital, condition appeared stable with agitation and difficult behaviour. This was initially treated with lorazepam and thioridazine.
Pain mentioned in nursing notes on 28/12/93 not mentioned in available medical notes. Cause of pain not clear. Went from little analgesia to oramorph 60mg in 24 hours. Within 8 hours converted to syringe driver with an increase in dose. Dose kept stable for next 3 days up to his death.

Cause of pain unclear. Large opiate dose without other forms of pain relief and rapid change to driver. Cause of death is unclear.

PL grading B2

BJC/06A	Batty, Charles	On coproxamol regularly for a period of years for generalised pain, not clear where, though recurrent fungal infections of the groins and scrotum appeared to be part of it and also, latterly, had pressure area problems. As soon as he began to complain of generalised pain he was started on Oramorph and the dose escalated, then when he had difficulty swallowing changed to syringe driver with a further dose escalation. Clearly difficult to assess his pain because of his dementia. But it did not appear that his	C2

GMC101224-0049

Expert Review

Charles Batty

No. BJC/06A

Date of Birth: Code A

Date of Death: 2 January 1994

Mr Batty was admitted to Gosport War Memorial Hospital in September 1990 for long stay care. He had a previous history of Parkinson's disease, epilepsy and Ménières.

He was treated with Coproxamol regularly for a period of years for pain although its origin was not clear.

In December 1993 he was complaining of generalised pain and started on Oramorph. Dr Lawson notes that Mr Batty went from little analgesia to Oramorph 60mgs in twenty-four hours. The dose was gradually increased and when he had difficulty swallowing it was changed to a syringe driver. It was difficult to assess his pain because of his dementia but it is not clear on the face of the notes whether his condition was deteriorating prior to starting opiate treatment.

The experts review has determined that the treatment was sub optimal due to the high doses, especially Midazolam. Cause of death was felt to be unclear by the expert team.

DENNIS BRICKWOOD

DENNIS BRICKWOOD

Dennis Brickwood

Date of Birth: Code A Age: **80**
Date of Admission to GWMH: **3rd February 1998**
Date and time of Death: **21.15 hrs on 12th June 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **19 weeks**

Mr Brickwood's past medical history:-

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

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

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

15th January 1998
Admitted to Hospital after fall where he sustained a fracture to the neck of femur on the right side.
20th January 1998
Operation dynamic hip screw.

3rd February 1998
Transfer to Gosport War Memorial Hospital for rehabilitation. He was nursed in a side room because he tested positive for MRSA. He was nursed on a Pegasus biwave mattress and needed the help of two nurses for transfers.
March 1998
OT assessment.

5th March 1998
Clinical notes state GP contact by nursing staff. Gets **drowsy with small amount of morphine.** Need to be cautious previously been on MST.
6th April 1998
Unsuccessful home visit.
14th May 1998
Sore heels noted. Skin intact.
24th May 1998
Complained of excessive chest pain. Impression musculoskeletal pain.
4th June 1998
No improvement. Chesty very rattly. **For morphine**. Family happy with care and **syringe driver discussed.**
5th June 1998
Higher dose of oramorph given.
9th June 1998
Changed oramorph to MST. Complaining of chest pain.
10th June 1998
Taking MST/oramorph. For syringe driver is pain not adequately controlled.
11th June 1998
Painful back- swallow and appetite poor. Seen by Dr Knapman syringe driver commenced. Family informed.
12th June 1998
Deteriorating pronounced dead by S/N Giffin at 21.15 hours. Relatives present.
15th June 1998
Death certified. For cremation

GMC101224-0055

Code A

BJC/06B
DENNIS BRICKWOOD
80

Hip fracture, carcinoma of prostate, osteoporosis with vertebral fractures, myeloma. Aiming for home but had an unsuccessful home visit.
Developed musculoskeletal chest pain and chest infection. Chest xray suggested anterior rib fracture. Codydramol ineffective. Converted to oramorph then dose increase to MST then large dose increase to syringe driver. Died 24 hours after starting driver. No other analgesics tried ?would have responded to NSAID or heat packs.

Cause of death unclear and use of analgesia was not ideal

PL grading B2

08-DEC-2003 14:57

Exhibit No	Patient Identification	Assessment Note	Assessment score
		condition was deteriorating prior to starting opioids.	
BJC/06B	Brickwood, Dennis	Patient was being actively prepared for discharge against his and his family's will (because they did not wish to pay for residential care) when he developed a chest infection which did not respond to antibiotics, despite a change of antibiotic. Opioids not started until he was failing on the second antibiotic. Clear complaints of pain from the patient. Excellent reasons for pain (vertebral fractures and cracked rib). My quibble is with the speed at which the dose of morphine/diamorphine was escalated and the large amount of hyoscine and midazolam added to the syringe driver. But I suspect death was accelerated little if at all – the doses were just a little unnecessary	A2

GMC101224-0061

DOCUMENT RECORD PRINT

Officer's Report

Number: R13D

TO: REF:
STN/DEPT:

FROM: Code A REF:
STN/DEPT: FCU FLEET TEL/EXT:

SUBJECT: DATE: 14/02/2003

On Wednesday 29th January 2003 (29/01/2003) I went to the home of Mr Anthony BRICKWOOD concerning the death of his father Dennis John BRICKWOOD , Code A

Prior to his death, his father lived with his wife in Gosport. Sometime before his death his father was diagnosed with Prostate Cancer. It was caught fairly early and was not deemed to be terminal. He went into Haslar Hospital for chemotherapy treatment in tablet form. This treatment was successful and he was transferred to the Gosport War Memorial Hospital for rehabilitation.

A few weeks before his fathers death Mr Anthony BRICKWOOD was approached by staff. They requested that he look for a nursing home for his father as he could not stay there indefinitely. Mr BRICKWOOD states that his father was very alert and vocal. He had made a friend called Terry . Mr BRICKWOOD recalls that the two of them used to complain about the nurses who did not appear to be looking after the older and more frail patients properly.

Dennis BRICKWOOD would often tell his son that the nurses would just place food in front of patients who were clearly unable to feed themselves then an hour or so later would just take it away again without attempting to help them eat.

Mr Anthony BRICKWOOD recalls a senior nurse named Phillip who appeared to be running the ward. He seemed to have a lot of authority and was making decisions that would normally be associated with a doctor.

The evening before his fathers death Anthony had gone to visit his father after work. He found his father in good spirits, talking about the football results. Anthony's brother was also there with his son Thomas. Dennis BRICKWOOD was asking about Thomas' homework and asked him to come back tomorrow to tell him about it. At about 7.00pm (1900) the family left. About an hour later Anthony received a call from the hospital saying his father had taken a turn for the worse. He immediately went to the hospital to find his father unconscious, he noticed that he had been fitted with a syringe driver and was receiving Diamorphine. His father never regained consciousness and died the next day. As far as Mr Anthony BRICKWOOD was concerned there was no doctor on duty over that period.

The two main questions that the family are seeking answers to are:

DOCUMENT RECORD PRINT

What sort of emergency occurred shortly after they left that evening?
Who attended Code A and who authorised that he should be put on such large doses of Diamorphine?

Code A was cremated. The family is represented by Code A.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BA

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 06/12/2003

I visited Mr Antony BRICKWOOD at 2000 hrs on Tuesday 25th November 2003 (25/11/2003) at his home address, Mr Dennis BRICKWOOD was also present (brother).

The meeting was in relation to their father Dennis BRICKWOOD Code A and as per the policy log.

I outlined the concerns as noted in officers report 13D and noted the further comments of Antony BRICKWOOD as;

At the time of his fathers deterioration the family had been searching for a suitable rest home for him to move to.

His father was in the hospital for rehabilitation after a hip replacement. He had come through six weeks of isolation for a super bug.

Mr BRICKWOOD wishes to know:

1. Why the family were not consulted prior to the treatment being commenced?
2. Who took the decision and why?
3. Who administered the drug?
4. In what quantity?
5. And what was actually given to their father?

The BRICKWOOD family is happy to be informed by way of a letter, they have been given a copy of the medical records.

Antony BRICKWOOD was agitated during the meeting but he suffered the loss of his Sensitive Sensitive personal data.

Expert Review

Code A

No. BJC/06B

Date of Birth: Code A

Date of Death: 12 June 1998

Mr Brickwood was admitted to hospital on 15 January 1998 after a fall where he sustained a fracture to his neck of femur.

On 3 February 1998 he was transferred to Gosport War Memorial Hospital for rehabilitation. His medical history included carcinoma of the prostate, osteoporosis and myoma.

He was assessed in March 1998 with a view to being discharged home but, following a trial visit on 6 April 1998, this was not considered a possibility.

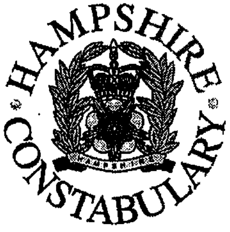
In May 1998 he developed musculoskeletal chest pain together with a chest infection.

The infection did not respond to antibiotics despite a change in treatment.[DB1]

Opioids were started when Mr Brickwood's condition was failing on the second antibiotic tried.

The experts note that the Morphine/Diamorphine was escalated and a large amount of Hyoscine and Midazolam added to the syringe driver although it was not felt death was accelerated as a result of this treatment.

GMC101224-0067



SYDNEY CHIVERS

SIDNEY CHIVERS

Sidney Chivers

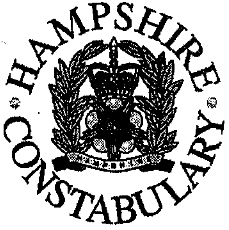
Date of Birth: Code A Age: **79**
Date of admission to GWMH: **11th May 1999**
Date and time of Death: **19.10 hrs on 20th June 1999**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **40 days**

Mr Chivers past medical history:-

CCF
Confusion
Hypertension
Register partial sighted
IHD
Varicose veins
Hallucinations

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

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



11th May 1999

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

14th May 1999

Complaining of increased pain – feeling unwell.

17th May 1999

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

21st May 1999

Brain scan – CVA at Haslar.

24th May 1999

Walking unaided.

2nd June 1999

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

7th June 1999

Hallucinating/distressed.

15th June 1999

Catherised – complaining of feeling weak and pain. Had to be fed. Oramorph commenced 5mgs. ? Lewi body disease.

To be discharged to rest home not for home.

16th June 1999

Fentanyl commenced 25mgs plus oramorph 5mgs.

17th June 1999

Slept long periods.

18th June 1999

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

Deteriorating.

19th June 1999

Seen by Dr Brooks syringe driver commenced 40mgs diamorphine.

20th June 1999

Deteriorated. Bronchopneumonia on S/C analgesia. Syringe driver (2 drivers) reprimed diamorphine 60mgs.

19.10 hours died. Death confirmed S/N [Code A] and Nurse [Code A]

For cremation.

Code A

GMC101224-0073

BJC/09
SIDNEY CHIVERS
80

Had a stroke. Initially doing fairly well but it became clear he was not going to make it home. There was a suspicion of Lewy Body Dementia for which traditional antipsychotics should be avoided; his dose of risperidone was increased (risperidone is a new antipsychotic which should have been OK). He deteriorated soon after the dose increase with pain in his hands and also abdominal pain. Treated with opioids and then large dose of midazolam.

I am not sure what his pain was caused by although stiffness and pain could have been due to risperidone and abdominal pain due to constipation. After starting with oramorph the opioid dose was escalated through fentanyl 25mcg to diamorphine driver 60mg and 80mg midazolam in 3 days.

Cause of death unclear and opioids escalated without trying other ways of stopping the pains.

PL grading B2

GMC101224-0075

BJC/09	Chivers, Sydney	Patient had multiple problems, possibly all cerebrovascular, possibly complicated by Lewy body dementia. Medical notes too brief to allow of full understanding of the process of final deterioration, but it may have been precipitated by increased risperidone to treat his distressing visual hallucinations. Contemporaneously with that increase, and possibly caused by it, his mobility decreased noticeably. He then began to complain of generalised discomfort ?simply due to immobility and stiffness in an elderly man with a CVA. Notable that he was treated by 3 different doctors, according to my reading of the handwriting in the nurses' notes, in his last 2 days. So starting opioids, and initially moving to a syringe driver, were done by 2 other doctors and only the final dose increases, in his agonal hours, were determined by Dr Barton. But the starting doses – 40mg each of diamorphine and midazolam – were similar to those seen in other patients at the end of life and seem not to be determined by the preceding dose of oral opioids, which never exceeded 50mg in 24 hours (=17mg diamorphine).	B2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AZ

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 02/12/2003

I attended the home address of Martin CHIVERS at 1845 hrs on Monday 1st December 2003 (01/12/2003) as per the policy log in relation to his father, Sidney CHIVERS .

I outlined the concerns of his family as per OR71. These were agreed with the added concerns that the family are now aware that diamorphine was administered at the same time as a fentenol patch was being used and that the amount of diamorphine administered was 'not safe'.

The CHIVERS family have a pharmacist and a nurse within their family and both parties have had access to Martin CHIVERS copy of his fathers medical records. I provided him with a copy of our records.

The CHIVERS family would like a letter detailing the clinical teams findings with a 'follow up' visit to enable them to ask any questions. They suggest that provision is made for some form of counselling for those who require it at the time of notification.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7I

TO: REF:
STN/DEPT:

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

SUBJECT: SIDNEY FRANCIS CHIVERS Code A DATE: 09/12/2002

At 1000 on 31st October 2002 (31/10/2002) I visited Martin Keith CHIVERS (Code A Code A in relation to his father, Sidney.

Mr CHIVERS will say that Sidney CHIVERS had been an artillery man in the army, upon leaving he became a builder and pipe layer. It was whilst he was in the building trade that he was involved in an accident and lost the sight in one eye. He was registered disabled by virtue of his partial sightedness and issued a green card.

He then went on to work for British Rail as a porter and finally became a bus conductor up until his retirement.

He was initially married to Mary Patricia Joan CHIVERS nee SKITTLETHORPE and divorced her some years later. He subsequently married Susan MEAD who died around 1996 at Haslar Hospital.

Mr CHIVERS lived alone at Code A.

He was mobile although suffered from water retention on his ankles and was in full control of his faculties. He had daily callers and used the services of meals on wheels.

Around three months prior to his death, (approximately April 1999) Mr CHIVERS was found at his home address collapsed.

He was taken to the Queen Alexandra Hospital, Cosham, where it was discovered that he was suffering from a kidney infection. He remained at the QA for a couple of weeks before being discharged to the GWMH, Dryad Ward for rehabilitation prior to being sent home.

At this point he is described as being mobile, cheerful and fully alert. He had been successfully treated at the QA and it was felt that he required a little more support at home and arrangements were made for Mr CHIVERS to visit three prospective accommodation. He was not in any pain nor was he receiving any painkillers. He is described as being quite capable of complaining if he was in any discomfort.

Two days prior to his discharge date Martin CHIVERS was informed by a member of staff that that his father was in pain, Mr CHIVERS was in bed and he informed his son that he had to stay in bed and that

he was having injections.

Martin CHIVERS spoke with staff who informed him that his father was suffering from headaches and was being given painkillers.

From this moment Sidney CHIVERS didn't get out of bed again. He was still compos mentus and looking forward to going home.

His condition deteriorated over the cause of the week and Martin CHIVERS was spoken to by a senior nurse and the duty consultant. He was informed that his father was extremely ill, his vital organs were failing and that they were not sure how long he would live. He was being administered Diamorphine.

Martin CHIVERS found that his father had been moved to a single room. He could not feed himself or take fluids. He was catheritorised. He was lying in the foetal position. His eyes were closed and he was breathing noisily through his mouth. Mr CHIVERS remained in this condition for about a week.

Martin CHIVERS states that on the day his father died, he was sick. He describes the vomit like thick black tar.

His concerns over his fathers death are that two days prior to his release his father was suffering from headaches and within two weeks he was dead.

Sidney CHIVERS died on 20th June 1999 (20/06/1999). His cause of death is given as Bronchopneumonia and the Dr who certified his death was J A BARTON BM .

Kathryn ROBINSON

GMC101224-0081

Expert Review

Sydney Chivers

No. BJC/09

Date of Birth: Code A

Date of Death: 20 June 1999

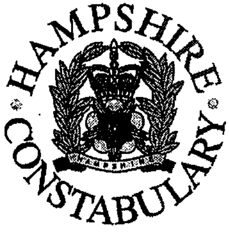
Mr Chivers was admitted in May 1999 to the Gosport War Memorial Hospital from the Queen Alexander Hospital for rehabilitation after suffering a cerebrovascular accident as well as being treated for congestive cardiac failure and a chest infection.

In early June 1999, Mr Chivers' condition deteriorated and he complained of a pain in his hands and also abdominal pain. Soon after this he was commenced on Fentanyl together with Oramorph and on 19 June, having been seen by Dr Brooks, a syringe driver was commenced.

The experts felt that cause of death was probably unclear and noted the opioids were escalated without trying other ways of stopping the pain but did not feel the treatment was negligent.

GMC101224-0083

IMPECA
Budget
1 495 005



CYRIL DICKS

CYRIL DICKS

Cyril Dicks

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

Mr Dicks' past medical history:

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

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

On admission a Barthel ADL index was completed from 29th December 1998 scoring 2 to 14th May 1999 also scoring 2 the scores reached no higher that 4. An abbreviated mental study was completed on 29th December 1998 with a score of 3 recorded.

A Waterlow score of 14 was recorded on 29th December 1998. With a handling profile also completed on that day noting that Mr Dicks skin was intact need a pressure relieving cushion and 2 nurses and a hoist to help transfer.
Care plans for confusion, reduce mobility, retention of urine – catheterised size 12 and help to settle at night were completed starting on 29th December 1998.

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

28th December 1998
Admitted from Haslar with pneumonia that had been treated with IV and oral antibiotics, confusion, he was doubly incontinent and had a urinary tract infection and had been catheterised.

4th January 1999
Remains poorly not eating or drinking well. Please make comfortable.
Happy for nursing staff to confirm death.

11th January 1999
Daedalus ward/NHS continuing care. Barthel 4/20 – reluctant to do much not eating or drinking. Prefers to be in bed. Plan:- to give up Pier House for Nursing Home if stable in early February 1999.

15th January 1999
Contact record – found on floor in lounge PM, examined small grazes on left hand – reassured and put to bed. Son informed.

17th January 1999
Contact record - found on floor in lounge- no apparent injury. Behaviour very irrational PM.

18th January 1999
Did not wake up this morning, stiff unrousable, not in pain – please make comfortable. **Happy for nursing staff to confirm death.**
Contact record – reviewed by Dr Barton. Extremely sleepy. Family wish Dad to be made more comfortable.

19th January 1999
Remains poorly – unresponsive. Family aware – no active treatment required not for any fluid replace. Use S/C analgesia if necessary.

20th January 1999
Catheterisation due to urinary retention.

22nd January 1999
Contact record – Mr Dicks got off commode and sat on floor. Accident form completed.

25th January 1999
Spent a lot of time in bed. Can transfer unaided. Barthel 3/20 – aggression short lived.

Daughter seen – aware very unwell and may not survive. Agreed not for NG feeds, not for antibiotic if pyrexial and NHS continuing care until early March 1999.
Contact record – seen by Dr Lord – daughter seen and is aware of prognosis in event of change of condition or chest infection to be kept comfortable.

8th February 1999
Small black spot on left heel.

15th February 1999
A bit better – eating more. Barthel 1-2/20.

1st March 1999
Not drinking much. Barthel 1/20 – no new medical problems. Heels vulnerable.

2nd March 1999
Contact record – found on floor by chair, cut to upper lip, contusion to left eye.

3rd March 1999
Podiatry – left 1st lat side toe red and inflammed.

5th March 1999
Podiatry – sat in chair. Right 2nd toe red medical side. Left 1st still red.

8th March 1999
Fall – left perior? Bruising + upper limb. Barthel 2/20. Review end of month.

9th March 1999
Contact record – seen by Dr Lord – no change.

10th March 1999
Podiatry – left 1st much improved virtually healed. Right 2nd also improved.

13th March 1999
Contact record – found on floor by side of bed. Checked for injuries.

15th March 1999
No great change. Barthel 2/20.

16th March 1999
Contact record – fell to floor in lounge. Abrasion right eye. Accident form completed.

18th March 1999
Contact record – bruising also noted on right side hip.

20th March 1999
Not so well – in pain when being moved in bed. Generalised twitching and distressed.

22nd March 1999
Marked deterioration over weekend. Family happy with treatment. Died at 22.00 hours found by S/N Basher. Death confirmed at 23.10 hours by SSN Farrell.
Contact record – 22.00 hours found in bed dead. Daughter informed does not want to see.

Code A

GMC101224-0090

BJC/17
CYRIL DICKS
85

Dementia, incontinent, very dependent.
Deteriorating gradually then rapidly over the weekend of 20-21/3/99. One nursing record states sc analgesia and midazolam started on 20/3/99. There is no record of this on the available medication cards or in the medical notes. Elsewhere in GWMH notes the nurses write diamorphine doses given via syringe driver in the notes in red. This is not done here. I do not know if he was given diamorphine.

Cause of death is not clear anyway but if diamorphine was not given it was natural. Care reasonable but fell on the ward and they were prepared to use diamorphine where it was not clearly indicated.

PL grading A2

BJC/17	Dicks, Cyril	Appears to have been dying slowly, but in an expected manner, from longstanding dementia complicated by an acute ?cerebrovascular complication in January. He appeared to be in pain, and was certainly agitated, in the later stages and was probably treated with subcutaneous diamorphine and midazolam, according to the nursing note. But no doses are stated (unusually – in other cases the nurses have written the doses in their notes) and at present I cannot trace an administration record in the drug charts to show that the drugs were ever given, or in what dose. I am sure he would have died, no matter how well he was cared for. It is possible that his death was marginally accelerated by sedation, but I cannot at present adduce any hard evidence for that.	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BP

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 21/01/2004

I visited Mrs Sandra TAYLOR at her home address at 2000 hrs, 21st November 2003 (21/11/2003). Also present was her husband and brother, Leslie DICKS and his wife. I outlined the purpose of my visit as per the policy log and gave the family a set of the medical records relating to their father, Cyril Aubrey DICKS , 17/03/1914 - 22/03/1999.

I went through the family's concerns as recorded in officers report 11E.

They further wished to add that whilst their father was in Haslar Hospital he had been 'picky' with is food, this was normal. He hadn't complained of being in any pain but then he probably would not have mentioned it and that whilst he was moody, he was lucid and talking and was able to walk with the aid of a stick. He had never suffered from ill health apart from having a small hernia.

The family state that Mr DICKS was admitted to the GWMH for recuperation in order to get his strength back.

Upon admission he is described as being in good spirits with no complaints of pain. The family members between them visited him daily.

Approximately two weeks after being admitted the family were told that Mr DICKS had suffered a massive stroke, the following day they were informed that he was 'getting better', then they were told that he was 'failing'.

When the family turned up to visit Mr DICKS on his birthday he was sat up in bed awaiting his presents. They describe him as being 'perky and happy'. They describe his condition as being variable. When he was in bed with his eyes closed he appeared to be asleep on other occasions he would appear to be 'awake' and chirpy with his eyes open.

Mr DICKS was placed in his own room and during the last couple of days of his life he was placed on a syringe driver and diamorphine was administered. The family were not told why, nor did they see a doctor.

At this point Mr DICKS was bed bound.

DOCUMENT RECORD PRINT

On the day of his death Code A didn't wake up. The family stayed with him until 2200. They left to travel to their nearby homes and a few minutes after arriving were notified by the hospital that Code A Code A had died.

The family wish to be notified by letter followed by a visit to provide more detail if required.

DOCUMENT RECORD PRINT

Officer's Report

Number: R11E

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 18/12/2002

Sir

Re. Action 205.

I visited Mrs. Sandra TAYLOR of Code A on Tuesday, 17th December 2002 (17/12/2002). Mrs. TAYLOR has given her contact numbers as Code A and Code A Mrs. TAYLOR stated that she had contacted the police regarding the death of her father at the Gosport War Memorial Hospital in 1999 after hearing of the investigation in the media. She also stated that her younger brother, Leslie DICKS of Code A had attended a meeting at Whiteley, Fareham along with other concerned relatives.

Mrs. TAYLOR gave the circumstances as follows. Her father, Cyril Aubrey DICKS Code A was a retired painter and decorator living in Pier House Residential Home, Lee on Solent. His GP was from the Lee on Solent Practice in Manor Way, Lee on Solent. Mr. DICKS was admitted to the Royal Navy Hospital Haslar around the 14th December 1998 (14/12/1998) suffering with a chest infection. Mr. DICKS was transferred to Daedelus Ward at the Gosport War Memorial Hospital about two weeks later for recuperation. At this time Mr. DICKS appeared to be making a full recovery.

Within a few days Mr. DICKS appeared to be heavily sedated and did not recognise his relatives during visits. Mrs. TAYLOR is not aware what medication if any her father had been administered but cannot remember seeing any drips until the last few days of his life. Mrs. TAYLOR did question staff at the hospital as to why her father was so sedated and was told words to the effect of, "Oh, he is just not so good today." During the first few weeks at the Gosport War Memorial Hospital relatives noticed that although heavily sedated he would often be sat in a chair, but after this he was always just lying in bed.

On the 22nd March 1999 (22/03/1999) Mr. DICKS died, the cause of death was given as Bronchial Pneumonia and the death certificate was signed by Dr. BARTON. Mr. DICKS was cremated.

Mrs. TAYLOR and the rest of the family thought the circumstances of her father's death strange but had absolute trust and confidence in the hospital. It was not until the media coverage that they doubted the hospital and came forward.

I have informed Mrs. TAYLOR that this is an on going and probably long term investigation and I gave

her a contact number for Operation Rochester at Hulse Road.

C YATES

Expert Review

Code A

No. BJC/17

Date of Birth: Code A

Date of Birth: 22 March 1999

Mr Dicks was admitted to the Gosport War Memorial Hospital on 28 December 1998. On admission he was doubly incontinent with a urinary tract infection and had a indwelling catheter.

It is recorded in the Medical Notes that he had a number of falls where he only sustained minor cuts and bruising whilst at Gosport War Memorial Hospital.

The Notes recall on 4 January 1999 that he remained poorly and was not eating or drinking well.

The expert review notes that Mr Dicks was deteriorating gradually following admission and then rapidly over the weekend of 20/21 March 1999.

Although there is no record available in the medication cards or in the medical notes one nursing record states that subcutaneous analgesia and Midazolam was started on 20 March 1999.

The experts conclude the care on the ward was reasonable and that it was likely that Mr Dicks would have died no matter how well he was cared for.

CHARLES HALL

CHARLES HALL

Charles Hall

Date of Birth: Code A Age: **89**
Date of admission to GWMH: **5th July 1993**
Date and time of Death: **11.25 hours on 6th August 1993**
Cause of Death:
Post Mortem:
Length of Stay: **32 days**

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

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

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

5th July 1993

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

10th July 1993

Clinical notes state vomited x 3 brown fluid.

Nursing report – vomited x3 complaining of pain in abdomen. Fainted at lunchtime when stood up.

15.10 hours fall getting off commode. Accident form completed.

13th July 1993

Clinical notes state waiting physio and OT assessments. Abdomen soft.

14th July 1993

Clinical notes state Mr Hall was in renal failure.

15th July 1993

Clinical notes discussion with wife re poor prognosis.

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

19th July 1993

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

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

22nd July 1993

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

23rd July 1993

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

28th July 1993

Clinical notes state has necrotic heel – gradually improving.

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

29th July 1993

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

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

2nd August 1993

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

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

5th August 1993

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

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

6th August 1993

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

Code A

BJC/23
CHARLES HALL
89

Had recently been through major abdominal surgery. Past history of peripheral vascular disease and surgery for it. He was deteriorating before he arrived on Daedalus. The main problem seemed to be the vascular disease and the deteriorating heel ulcer causing pain. In July he had 2 dose of morphine elixir. On 5/8/93 he had 10mg of oramorph at 09.15 and was then put on 40mg of diamorphine via syringe driver at 17.00. He died the following morning.
He undoubtedly had very severe underlying disease and would have died but I consider the move from one dose of oramorph to 40mg to be excessive.

PL grading B3

BJC/23	Hall, Charles	Very frail and terminally ill when transferred to Daedalus. Poor prognosis had already been discussed prior to transfer. Given a single dose of oramorph 10mg. This relieved symptoms and made him comfortable. If he were not in renal failure, the diamorphine equivalent would have been 20mg/24hrs. Since he was, he probably only needed 10mg/24hrs. In fact was given diamorphine 40mg/24hrs as starting dose, and died within 24 hours. Nothing to suggest intent, only that there was a lack of understanding of how to go from oral to SC and how to allow for the effect of his renal failure	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7A

TO: REF:
STN/DEPT:

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

SUBJECT: Charles Sydney HALL b Code A DATE: 28/10/2002

Sir,
I visited Diane HARCOURT, at her home address, 1 Code A in response to her letter dated 16/10/2002. This concerned her late father (details above) and the time he spent at the GWMH.
Ms. HARCOURT will say that her father was a fit and active man. He had been a gunner in the Royal Artillary before leaving to become a diver's assistant and subsequently a publican.
He had undergone surgery for poor circulation in his foot around 1978, whereby he had a new vein inserted into his leg. He suffered no further problems with his leg but was diagnosed as a 'late onset diabetic'
Mr. HALL was admitted to Royal Hospital Haslar some time around May/June1993. This was due to him feeling unwell and being sick. He was diagnosed as suffering from a ruptured gall bladder, he underwent surgery for the removal of his gall bladder and the fitting of a colostomy bag.
Mr HALL made a full recovery and was discharged from Haslar some three weeks later to the care of his family.
He then returned home Code A be cared or by his wife, Violet Ethel HALL, b. 02/12/1904.
At this point in time Mr.HALL was up and dressed every day, he never remain in bed and was recouperating well,however, his elderly wife had suffered as a result of all the stress and worry of his illness and his operation and it was suggested by the district nurse that Mr. HALL be admitted to the GWMH,in order for his wife to have some respite.
Mr.HALL was initially put into a ward on the first floor, Mrs. HARCOURT cannot recall the ward name.
She states that her father was up and dressed every day, he never remained in bed. He was unhappy with the fact that he had to return to hospital when there was nothing wrong with him. He was eating normally and generally moaning and being grumpy with the staff. He spent his time listening to music and studying the racing form in his daily paper. He was in full use of all his facualties.
At this time he had a small bed sore on the heel of his foot but this did not cause him any real discomfort and to her knowlage he didn't require any special treatment for it.
Mrs. HARCOURT states that had her father been in pain then he would have moaned about it and everyone would have been aware of it.
Approximatly a week later, her father was moved to Dryad Ward on the ground floor so that he could access the garden area.
Mrs. HARCOURT belived that her father was being moved so that he could receive some rehabilitation type care. She states that when he was admitted to the ward, he was dressed and fully mobile.

DOCUMENT RECORD PRINT

Mrs. HARCOURT has given the following information in relation to the last week of her fathers life.
Sunday 1st August 1993 (01/08/1993). Mrs HARCOURT visited her father, he was sat in the day room listening to music on the radio, he was fully clothed in his suit. He told her that he didn't like it in the new ward and that he'd been dreaming about rabbits.
Mrs.HARCOURT spoke to a nurse about her father because she thought that he had not been taking his diabetic medication. The nurse informed her that Mr. HALL had 'kidney problems' and this was the reason for him appearing strange.
On Mrs.HARCOURT's next visit she was called in to the nurses office and asked if they could put her father on Morphine, when she asked why she was told that it would make him more comfortable. She states that she was told that Dr BARTON had said that she wanted him on Morphine.
Mrs. HARCOURT refused to give her consent and suggested that they ask her mother, who was his legal next of kin. At the time of this visit her father was up, dressed and appeared well.
Mrs.HARCOURT states that her father never complained to her or her mother of any pain.
Thursday 5th August 1993 (05/08/1993)
Mrs.HARCOURT visited her father with her husband. Mr. HALL was in bed and was able to have a normal conversation with them. She did not notice any sort of apparatus around her father which could have been used for administering drugs.
Friday 6th August 1993 (06/08/1993)
Mr. HALL was visited around 0900/1000 hrs by his wife and a neighbour. He was described as sleeping peacefully.
Around midday, the hospital contacted Mrs. HARCOURT to inform her that her father had died.
Monday 9th August 1993 (09/08/1993)
Mrs HARCOURT took her mother to the GWMH in order to collect her fathers belongings and his death certificate.
They were concerned and distressed to see that the cause of death had been given as Bronchopneumonia and Senile Dementia. The certificate was certified by Dr.BARTON.
Mrs. HARCOURT states that her father never displayed any symptoms of dementia nor was it ever discussed with her family whilst he was in hospital.
She was also concerned that there was nothing that related to her fathers 'kidney problem'.
She states that her family didn't want to query the certificate because her mother was extremely upset and as she said 'it wouldn't bring him back'
Mr. HALL was cremated in accordance with his long held wishes, there was no post mortem.
Mr.HALL's GP was Dr. LYNCH, Stakes Rd Surgery, Gosport.

Expert Review

Charles Hall

No. BJC/23

Date of Birth: Code A

Date of Death: 6 August 1993

Mr Hall was admitted to Gosport War Memorial Hospital on 5 July 1993 after he had undergone a sigmoid colectomy and colostomy following diverticulitis and a gangrenous gall bladder.

On admission, in addition to the rehabilitation issues following his abdominal surgery, he was suffering pain in his left foot which was associated with vascular disease.

He was started in August on oral Morphine which was converted to Diamorphine via a syringe driver on 5 August 1993.

The experts note that although he undoubtedly had severe underlying disease the acceleration from one dose of Oramorph to 40mgs of Diamorphine was sub optimal treatment.

CATHERINE LEE

CATHERINE LEE

Catherine Lee

Date of Birth: Code A Age: **92**
Date of admission to GWMH: **14th April 1998**
Date and time of Death: **14.45 hours on 27th May 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **44 days**

Mrs Lee's past medical history:-

1998 Fracture neck of femur
1998 TIA
IHD
Glaucoma
Rectal prolapse

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

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

14th April 1998

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

Summary – Cold on arrival on Dryad Ward, been sick in ambulance. Settle on ward and given 2.5ml oramorph. Nursed on Pegusus airwave mattress.

15th April 1998

Summary – oramorph 5mgs 4 hourly.

17th April 1998

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

18th April 1998

Summary – oramorph 5mgs 4 hourly.

23rd April 1998

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

24th April 1998

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

27th April 1998

Clinical notes – gentle rehabilitation here for next 4-6 weeks probably for Nursing home on discharge.

Pleased with progress agree Nursing Home would be best option.

11th May 1998

Pain in left chest.

15th May 1998

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

18th May 1998

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

20th May 1998

Summary – visited by daughter. For cremation.

21st May 1998

Clinical notes – further deterioration uncomfortable and restless. Needs S/C analgesia. **Happy for nursing staff to confirm death.**

Summary – restless, agitated. Seen by Dr Barton. Syringe driver commenced diamorphine 20mgs at 09.40. Fentanyl patch 25mgs removed at 13.30.

22nd May 1998

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

23rd May 1998

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

25th May 1998

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

26th May 1998

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

Code A

BJC/31
CATHERINE LEE
92

Severe dementia and hip fracture. Required oramorph on admission to GWMH. Described as being uncomfortable but better on oramorph. The dose of opiates was converted well from oral to subcutaneous. She had medical problems with a poor outlook but the main descriptions in the notes are of restlessness and agitation rather than pain. The final cause of death is not clear although the medical problems were probably enough. Indication for the opiates is not entirely clear.

PL grading B2

BJC/31	Lee, Catherine	Severe dementia. Transferred for rehab after NOF. Had needed no analgesia in 24 hours prior to transfer. Started on oramorph 5mg 4 hourly from day of admission ?why. Increasingly sleepy, agitated and apparently distressed. Ate and drank less and less as became more sedated. Given diazepam as well for 2 days. Also given Fentanyl 25mcg/hour as well for 3 days. Oramorph progressively titrated upwards then changed to syringe driver. Change was actually at equivalent dose (oramorph 60mg/24 hours changed to diamorphine 20mg) but midazolam 40mg added!	B3

DOCUMENT RECORD PRINT

Officer's Report

Number: R11

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 12/11/2002

Sir
Re Action 193. I have spoken to Marie CAINE of Code A
Code A. Mrs CAINE states that her elderly mother Catherine LEE, nee JONES 92 years
Code A died at the Gosport War Memorial Hospital on 26th May 1998 (26/05/1998).
The circumstances are as follows:
Mrs LEE was a very lively elderly lady who was suffering from senile dementia, apart from this she was a very healthy lady who had not visited her GP for many years and enjoyed an active life, walking for miles a day. Mrs LEE was being cared for at home by her family and at the beginning of May 1998 the family were offered the chance of respite care to give them a break. Mrs LEE was placed at Addenbrook for a period of care but on the first night fell three times and broke her hip. The family were unable to ascertain whether Mrs LEE had actually got out of bed and fallen or had fallen out of bed.
Mrs LEE was transferred to the Royal Naval Haslar Hospital where key hole surgery was performed on her hip. She remained at Haslar for 5 days during which time her family describe her as being as bright as a button including the day of the operation almost immediately after she came round from the anaesthetic.
After 5 days she was transferred to Dryad Ward at the Gosport War Memorial Hospital where she was immediately always sleepy. By three days Mrs LEE was never placed in a chair and remained in bed asleep. The family queried what the staff were doing to get her walking again but were told that she was in pain and required Morphine which was administered by way of a syringe driver. Whenever Marie visited her mother she was asleep and was told just to sit by the bed and hold her hand stating that Catherine would know that she was there. On one occasion Catherine's granddaughter visited during which time Catherine was distressed and waving her hands about. This upset the granddaughter who told her mother that she would rather not visit again. This was the only time that any member of the family had seen Catherine do anything other than sleep.
On 26th May 1998 Catherine died, the death certificate was signed by Dr Jane BARTON giving the cause as Bronchial Pneumonia.
Catherine's GP was Dr KNAPMAN of the Forton Road Surgery one of the other partners was Dr BARTON.
I have explained to Marie CAINE that Operation Rochester is an ongoing enquiry into the events at the Gosport War Memorial Hospital and that there would not be any immediate answers to her query. Mrs CAINE is happy with this action and has been given a contact number for Operation Rochester.

Expert Review

Catherine Lee

No. BJC/31

Date of Birth: 5 May 1906

Date of Death: Code A

Catherine Lee was admitted to Gosport War Memorial Hospital on 14 April 1998 from the Royal Haslar Hospital where she had been admitted for surgery to repair a fractured neck of femur.

On admission, it was noted that Mrs Lee had poor mobility, was confused at times and needed full assistance with eating and drinking due to poor eyesight and that she had a poor appetite. She needed care for hygiene and dressing.

On admission she was settled on the ward and given oral Morphine.

This was gradually increased during her stay on 5mgs four times a day to 10 mgs by 18 May.

She was transferred to subcutaneous analgesia on 21 May when she was started on Diamorphine and Midazolam.

The experts have raised a question as to whether the indication for Opiates was clear but note that the medical problems were probably enough to account for the final cause of death.

STANLEY CARBY

STANLEY CARBY

Stanley Carby

Date of Birth: Code A Age: **65**
Date of Admission to GWMH: **26th April 1999**
Date and time of Death: **13.00 hrs on 27th April 1999**
Cause of Death:
Post Mortem:
Length of Stay: **1 day**

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

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

Mr Carby was married and lived at home with his wife. They had five children. Mr Carby was more or less housebound and had been for sometime. Mr Carby was transferred to Daedalus Ward after suffering a CVA. He had undergone a CT scan which showed a right parietal infarct and an old infarct. His speech was slurred and he transferred using a hoist. He was eating and drinking with assistance.
A handling evaluation was completed noting a pressure relieving mattress was in place and his skin intact. It was noted that Mr Carby needed 2 nurses and a hoist for transfers.
On 26th April 1999 a Barthel ADL index was completed and scored 1, a Waterlow score of 23 was recorded noting Mr Carby to be at very high risk of developing pressure sores. A nutritional assessment was also completed with a score of 15 recorded.
Numerous care plans were started on 26th April 1999 including personal hygiene, constipation due to mobility, swallowing, left shoulder pain, pressure sore noting Waterlow score, air mattress pressure relieving cushion and no pressure noted but unable to move to observe all areas, dysplasia, incontinent catheter insitu and assistance to sleep.

26th April 1999

Admitted to Gosport War Memorial Hospital. Daedalus ward for rehabilitation.
Clinical notes state more than happy for nursing staff to confirm death.

27th April 1999

Contact record states Mr Carby is very agitated when family left, unable to get to swallow. Referred to speech and language therapist.
Breath very shallow – colour poor.
Dr Barton contacted and will attend. Seen by Dr Barton and family spoken to.
Cyanosed and clammy. Wife thinks he will not survive.
Dr said **"I will make him comfortable".**
Subcutaneous analgesia commenced.

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

Code A

GMC101224-0137

BJC/07
STANLEY CARBY
65

Admitted with a severe stroke, rapidly deteriorated and died.
When he deteriorated he was prescribed a large dose of diamorphine via driver. However he died within 45 minutes of it being started ie too soon for it to have a significant effect.

Cause of death was the extension of stroke. The large dose of diamorphine makes care sub-optimal but it no effect on his death.

PL grading A2

BJC/07	Carby, Stanley	Patient experienced what was clinically felt to be extension of an already dense CVA. Blood glucose checked and OK. Although syringe driver set up with inappropriately high doses of diamorphine and midazolam (40mg of each) he died 45 minutes later. He therefore could not have received more than 1.25mg of each drug, not enough to have influenced his survival. He might well have received less, since he had a BP of 90/60 and was peripherally cyanosed, slowing the rate of absorption from the subcutaneous route. Although the notes record that Dr Lord recommended a stat of midazolam 2.5mg earlier in the morning, I cannot see evidence in the drug chart that that was actually given. Even if it were, the total midazolam dosage would not have exceeded 3.75mg and it has a short half life, so the earlier 2.5mg, if it were given, would have been metabolised before the syringe driver was set up. This appears to have been an entirely natural death.	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R8J

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 20/11/2002

Sir,

With regard to Actions 216, 217 & 203 I spoke with Mrs Rita CARBY and her two daughters Lucinda CARBY and Deborah McKAY in respect of the death of Stanley CARBY Code A 3 DOD 27/04/1999.

Mr CARBY joined the Royal Navy aged 13 and served for about 12 years. He left the Navy and joined the MOD as a driver. He married Rita in 1957 and had five children 2 boys and 3 girls. He was medically retired aged 58 suffering from diabetics and high blood pressure.

On about the 13/04/1999 Mr CARBY suffered a stroke and was taken to Haslar Hospital. The stroke affected the left hand side of his body and Mr CARBY required help with eating and drinking. He was however quite conversant and seemed happy and pain free. On the 26/04/1999 Mr CARBY was transferred to the GWMH he arrived at about midday.

Mr CARBY was in a small ward by his wife and Deborah during the afternoon. He seemed well and asked his daughter to place a bet on a horse. Mrs CARBY was concerned that her husbands' medical notes had not arrived and informed staff that her husband was a diabetic and needed assistance with eating and drinking. She left with her daughter at about 1645 on the 26/04/1999.

Mr CARBY was visited at about 1800 hours by his son Paul and also by his sister-in-law. He had been moved to a single room and seemed "a bit out of it." On the 27/04/1999 Mr CARBY was unable to talk and was seen by his wife and daughters. The family disagree with the medical notes they have seen, in that Dr BARTON states she informed them he might die. They also note that the drug chart shows that diamorphine commenced at 1215 hours on the 26/04/1999 whereas the start date for this particular drug was shown as the 27/04/1999.

Cause of death was shown as Cerebrovascular accident (stroke) and was certified by Dr BARTON. There was no PM and Mr CARBY was cremated.

DC 2403 Tenison

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AW

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 26/11/2003

I visited Mrs Rita CARBY at her home address at 1245 hrs Wednesday 26th November 2003 (26/11/2003). Also present were her daughters Cindy GRANT and Debbie McKAY. The visit was in accordance with the policy log.

I gave Cindy GRANT a copy of the medical records relating to Stanley Eric CARBY [Code A] 27/04/1999 and I went through the concerns as noted in officers report 8J. The family wished the following points to be noted.

That upon his admission to the GWMH, the family told the nursing staff about their fathers needs, these being, his blood pressure tablets, he required a diabetic diet, due to problems after his stroke, required a beaker to drink with, pureed food, feeding and help with his drinking. This information was given to Phillip BEAD.

Mr CARBY was then settled into bed (which had joists above) where he studied the racing form.

A family member asked for a drink for Mr CARBY which was given in a cup (not a beaker) the family got a beaker.

The family commented on S.N. JOYCE. They didn't like her manner, they formed the impression that she didn't like the size of their father who was a 'big man'.

They state that Mr CARBY's drinks were left where he couldn't reach them.

They state that their father was in good spirits, he was laughing and joking and lucid.

The family made a point of telling Phillip BEAD that they were to be informed of any change in Mr CARBY's condition. Mrs GRANT showed the note made in her father's records on pg 38.

They stated that the point in the original O/R stating that at 1800 hrs on 26/04/1999 when their brother visited, their father was still in the main ward at this time but had been moved to his own room later that evening when a family member called 'Connie' visited. At this point he is described as being tired and mumbly but still lucid and could recognise his family.

DOCUMENT RECORD PRINT

That at 1000 27/04/1999 they received a call from Phillip BEAD telling them to come straight away to the hospital.

When the family arrived Mr CARBY was totally unconscious and they were informed that he had taken 'a turn for the worse in the early hours'. The family want to know why they were not called straight away, at the time, as per request as page 38.

The family state they had to wait to see Dr BARTON who was 1½ hrs late. They state that Phillip BEAD told them that their father had suffered another stroke.

The family then sat with Mr CARBY who was lying in bed on his back, propped up and leaning to the right. The sides of the bed were up to prevent him rolling out.

His breathing sounded phlegmy so they propped him further to ease his airway. At this point they saw a tube in the area of his shoulder blades. They describe the tube as 'thin' and there were sticking plaster marks in the same area.

Mrs McKAY enquired if she should contact her brothers at this time and was told that there was plenty of time and to wait for the Dr to visit.

At this point Mr CARBY is described as being unable to open his eyes or speak. He moaned or grumbled when moved and his breathing became worse. He was able to squeeze his wife and grandson's hand.

The family notified other family members and then Dr BARTON arrived.

Cindy GRANT asked Dr BARTON if her father was going to die and was told "You've got to let nature take its course".

The family then asked Dr BARTON exactly what was happening and they asked if Mr CARBY was squeezing their hands because he was in pain. Dr BARTON then examined Mr CARBY and said that she could give him something to make him comfortable.

The family left the room whilst nurses attended to Mr CARBY. When they returned he was propped up in bed with a fan directed on him, he was cold and turning blue so the family turned the fan off and covered him up.

Approximately 10 minutes later Mr CARBY died.

The family further wish to mention the following:

When did Mr CARBY begin to deteriorate as he died so quickly between 1000.

When he had his stroke at home he was able to walk to the ambulance.

Why was he not removed back to Haslar when he suffered the second stroke.

On page 70 he was asking for a drink am 27/4 to not responding at all (entry S.N. JOYCE).

DOCUMENT RECORD PRINT

On page 68 there is no pressure sores, her father would have to have been moved in order for them to have been seen.

On page 60 Mr CARBY is sat out in chair early am, after having a blanket bath, the family were with him since 10000 how early is early?

On page 64 he was given fluids and referred to speech and language therapist, this is on the day he died.

On page 72 (27/04/1999) his urine is described as concentrated, the family described him as drinking a lot normally.

On page 48 (27/04/1999) Dr LORD has made an entry ref sub fluids. This was not in place when the family attended on 27/4 and it is not indicated or referred to in the nursing notes.

All of the above entries were made in the medical notes prior to 1000 hrs.

The family has concerns about the type of drugs and the manner in which they were administered.

The family are also concern that when Mr CARBY died Cindy became extremely upset and the nursing staff asked the family to calm her down. As this appeared to be taking some time the nurses informed her brother that they would give her an injection to clam her. They thought this inappropriate without knowing Cindy GRANT's medical history. They do not know what drug the injection would contain.

The family wish to be notified personally in a family group.

I went back through the additional concerns to clarify all points and the family confirmed the contents of my notes.

Mrs CARBY is concerned that notification may take place whilst she is out of the country visiting family.

She will probably travel in March/April time and would like to be advised if this would be around the time of notification.

Expert Review

Stanley Carby

No. BJC/07

Date of Birth: 31 December 1933

Date of Death: 27 April 1999

Mr Carby was admitted to Gosport War Memorial Hospital on 26 April 1999 for rehabilitation. He was transferred from the Royal Haslar Hospital where he had been admitted in April 1999 suffering a stroke. The stroke affected the left hand side of his body, this required Mr Carby to have assistance with eating and drinking.

On 27 April 1999 Mr Carby suddenly deteriorated becoming cyanosed dyspnoeic. This clinically appeared to be an extension of his previous stroke.

A syringe driver was set up with a high dose of Diamorphine and Midazolam. Mr Carby died forty-five minutes later. All the experts agree that he would not have received enough of either drug to have influenced his survival. Dr Naysmith noted that he may well have received less than normal since he had low blood pressure and was peripherally cyanosed.

The cause of death was shown as cerebral vascular accident and was certified by Dr Barton. Mr Carby was cremated.

The large dose of Diamorphine makes the care sub optimal but it had no effect on Mr Carby's prognosis.