Other Document Form

Number D1707

Title SCREENING FORM NAYSMITH - GONELLA - 2C

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No COPY TO DC ROBINSON FOR LETTER TO FORM

Document registered / indexed as indicated

No(s) of actions raised A2168

Statement readers instructions

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Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Gonella, Nathaniel** **Exhibit number BJC/93**

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

General Comments

Transferred 30.7.98 for rehab following #olecranon, wired. Cognitively impaired with intermittent confusion, unsteady on his feet. Lot of doubt that he would get home – had failed OT home visit from Haslar. But reasonably OK in himself. One episode chest pain (known valvular cardiac disease and angina) on 3.8.98. Given diamorphine (why not GTN?). Then queried he might need regular morphine – why? No indication he was having a lot of chest pain – had had PRN GTN on 30.7.98 (his first night at Gosport) but not since. And Dr Barton stated he was to be kept comfortable, and she was happy for nursing staff to confirm death!

Between 3.8 and 5.8, I cannot trace that he required any analgesia at all – PRN Oramorph was written up, but not given, and PRN codydramol was written up, but not given. There are no medical notes, apart from an entry documenting catheterisation. But the nursing notes record that he was distressed by faecal incontinence and restless at times. He had received diazepam 2mg PRN since admission; one dose on 31.7, one on 1.8, one on 2.8 and one on 3.8. But on 4.8.98 he was given 3 doses, and nursing notes record it was ineffective. On 5.8.98 nursing notes record that he was agitated and confused and his general condition was deteriorating. A syringe driver was started with diamorphine 20mg, midazolam 20mg and hyoscine 400mcg. These doses are far too high for a man who was essentially opioid naïve. Even admitting that diazepam 6mg in a day had not been effective, midazolam 20mg is equivalent to about diazepam 80mg – so a huge increase! He died on 6.9.98 at 22.10hrs.

He was frail and demented, and was unlikely to get home. He might not even have lived to get to a nursing home. But I strongly suspect that, with better medical management and a less enthusiastic attitude to giving opioids to someone who was not even reported as having pain and sedatives to a man with dementia, he would have lived longer, though I cannot say how much longer. I do not think this was good medical management.

Final Score: 2C

Screeners Name: **Dr Anne Naysmith**
Date Of Screening: **15.5.06**

Signature