Other Document Form

Number D1703.

Title SCREENING FORM LAWSON RE LEE BTC/91 ZB

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

COPY TO N. ROBINSON FOR LETTER TO FGM

Document registered / indexed as indicated

No(s) of actions raised A2166.

Statement readers instructions

Indexed as indicated

No(s) of actions raised

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 **Alfred LEE** **Exhibit number** **BJC 91**

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

An 88 year old male, date of birth 21/10/07, transferred to Daedalus 7/5/96 from QAH. Admitted to QAH 2 months before with 5% burns to his perineum. Said to have a variable mental state. Had an indwelling urinary catheter and was faecally incontinent. He had also experienced short lasting episodes of unresponsiveness which were thought to be vasovagal episodes.

Within 2 days his condition had deteriorated. He was not taking medicines, fluid or diet. At 09.15 on 9/5/96 there was a conversation with his wife and it was agreed to make him comfortable (although I could find no record of him being in pain or distress). A syringe driver of diamorphine 40mg and midazolam was set up. About 8 hours later he died (ie about 13mg diamorphine which is not a large amount).

Grading 2B
2 because I could not find a clear indication for using the sc infusion and it was a high starting dose especially when his renal impairment is taken into account. However he was clearly unwell and the syringe driver appears to have followed an acknowledgement that his condition was terminal.
B because I could not find a clear cause for his death but I felt the contents of the infusion had probably not had long enough to significantly contribute to his death (at least the diamorphine although I suppose the midazolam could have had an effect)

Final Score: 2B

Screeners Name: **Dr Peter Lawson**
Date Of Final Screening: **13.06.05**

Signature

BJC/94 and JSW/1
DOB 25/10/19 died 25/9/98 aged 78 years

Admitted Daedalus ward 16/7/98

22/7/98
Physio records page 5
admitted to Haslar 13/7/98 with right hemiplegia, dysarthria and expressive dysphasia
CT showed ischaemic left side of pons
Barthel 2

Page 6
no active movement right side, tone increased
leans to left, pushes to right
supine to sitting with 1

Pages 6 – 13
Good records of physio progress including pain in wrist, shoulder and knee
Decision to withdraw active treatment recorded on page 13, date 25/8/98

Page 15
SALT report, dated 17/9/98 (following referral for possible stroke extension on 3/9/98)
mild dysphagia
soft, moist, mashed diet with small sips of warm and cold fluids

Page 17
Dr Lord's letter
Recommended slow stream stroke rehabilitation

Pages 23 – 31
Medical notes at GWMH

Page 24
SALT assessment 16/7/98
thickened fluids (syrup consistency)
moderate dysarthria
Barthel 4/20
Good review of medical condition, power 0 in RUL and 1 in RLL
Fed up – continue trazadone

Page 26
30/7/98 painful right wrist – try ibuprofen syrup
6/8/98 "chesty", apyrexial, wait and see

Page 27
13/8/98 Barthel 2/20

right wrist and shoulder painful – try diclofenac and co-dydramol, stop MST (*first mention of this – look up when it was started*)

Page 28
27/8/98 Pain limiting progress with therapy
regular diclofenac, MST 10mg bd plus prn oramorph
increase amitriptyline to 50mg nocte
if ineffective, try carbamazepine

Page 29
Deterioration discussed with family, may not survive, not for iv fluids or iv antibiotics

Page 30
7/9/98 Very poorly today
10/9/98 Remains very unwell, continue MST 40mg bd
21/9/98 Pain in right shoulder, try ibugel topically

Page 31
25/9/98 not so well overnight
extended stroke
family aware
please make comfortable I am happy for nursing staff to confirm death

25/9/98 died peacefully at 22.50 (1 hour)

Page 46 Medication card
MST 10mg bd started on 12/8/98 after already on ibuprofen 400mg tds and co-codamol prn. MST stopped on 13/8/98 and with ibuprofen it was replaced by diclofenac retard.

Page 58 is next medication card
MST 10mg restarted on 27/8/98 and increased to 20mg bd on 1/9/98
PRN oramorph also prescribed (10mg given on 1/3/4th sept)

Page 64 Nursing records

Page 78 – details of Dr Lord's ward round on 3/9/98 after he had deteriorated
6/9/98 S/B Dr Beasley at 11.35am MST increased to 60mg BD
7/9/98 increase in MST thought to be too high. Reduced to 40mg

Page 79 24/9/98 at night Harry agitated, distressed ?in pain. Syringe driver commenced at 23.30 80mg diamorphine, 400mcg hyoscine, 20mg midazolam
No other nursing comments about his pain or distress
died at 22.50 on 25/9/98

Page 127 onwards
MST 30mg bd started 4/9/98
MST 60mg bd started 6/9/98
MST 40mg bd started 7/9/98
MST 60mg bd started 24/9/98
Syringe driver started 24/9/98 diamorphine 80mg per 24 hours plus midazolam 20mg and hyoscine – repeat at 22.25 on 25/9/98.

JSW/1
Nothing contributory in these notes other than confirming the severity of the stroke and the CT report written in the notes

Impression of this case
This was a severe stroke producing marked loss of function
He did not make much of a recovery and the risk of early death was always high
He had pain in the shoulder and wrist on the right
They tried paracetamol, codeine, NSAIDs and then MST to control it but it remained a problem and he was clearly dying.
The conversion from MST would be about 40mg sc diamorphine to gain equivalence, so it could be argued that the starting dose was excessive although it was clear he was distressed and needed a dose increase

Overall, I think he died because of the stroke. Care was marginally suboptimal because of the large opiate dose increase.

Scoring 2A