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Officer's Report

Number: R6N

TO:
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REF:

FROM: Code A
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 08/04/2004

At 1000 hours on Thursday 8th April 2004 (08/04/2004), I visited Mrs **Dorcas GRAHAM** N390 at her home in Porchester in order to establish her concerns regarding the expert review into the death of her husband, **Leonard GRAHAM** N242, at **GWMH** C44 and to further explain the remit of Operation ROCHESTER.

Mrs GRAHAM'S main concern is her belief that the clinical team took no account of her record of events as provided to Code A 326 (R11H refers) when analysing her husbands notes. Her belief was strengthened by the review report which was flawed in a number of ways. The review report contained wrong dates and an inaccurate sequence of events.

I explained to Mrs GRAHAM the clinical review process and the quality assurance process, during which account would be taken of her record of events. I also took her through the relevant sections of Code A report which she agreed is factually correct and what she wanted the clinical team to take account of.

I assured Mrs GRAHAM that her husbands medical records were analysed by the clinical team, individually and holistically, and were quality assured by a medical/legal advisor who took account of the report of Code A

Mrs GRAHAM strongly suspects that the dose of **diamorphine** C64 administered to her husband just prior to his death was in excess of the stated dose of 2.5mg as he died so quickly afterwards. She accepts that there is no evidence to support her view and she regrets having her husband cremated.

I assured Mrs GRAHAM that I would look into the issues raised by her in respect of the review report.