STANLEY CARBY

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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.

HAMPSHIRE CONSTABULARY

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.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
SC Code A

Exhibit number
BJC/07

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		Moribund, distressed, but high doses of diamorphine, midazolam		
Unclear B				
Unexplained By Illness C				

General Comments

65-year-old man, 118kg, NIDDM, LVF, with dense (L) hemi
Admitted for re-hab 1999-04-26; sudden deterioration next day – cyanosed, dyspnoeic, in pain, given:
diamorphine 40 mg/24 h ≡ 14 microg/kg/h
midazolam 40 mg/24 h ≡
Died within 45'

MISSING: any Haslar notes, any GP notes

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

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 Code A Code A in respect of the death of Stanley CARBY DOB Code A 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:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 26/11/2003

I Code A at her home address at 1245 hrs Wednesday 26th November 2003 (26/11/2003). Also present were her daughters Code A The visit was in accordance with the policy log.

I gave Code A a copy of the medical records relating to Stanley Eric CARBY b 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.

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).

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: Code A

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.