Code A

Code A

Walter Clissold

Date of Birth: Code A Age: **90**
Date of Admission to GWMH: **3rd August 1999**
Date of Death: **23.55 hours on 8th September 1999**
Cause of Death:
Post Mortem:
Length of Stay: **37 days**

Mr Code A past medical history:

1987 – CA bladder/bowel
1992 - MI
1999 - Cystoscopy
1999 - Prostatectomy
Hypertension
CCF heart
CRF Kidneys
COPD pulmonary.

Mr Code A was living independently at home. He had a home help and his neighbour would do the shopping for him. Mr Code A had slightly impaired hearing but managed quite well. Mr Code A had no family and his neighbour was noted as his next of kin. He was admitted to Haslar Hospital on 21st June 1999 with shortness of breath and underwent a transurethural resection of prostate and bladder biopsy. He was transferred to the Gosport War Memorial Hospital on 3rd August 1999 for rehabilitation.

On admission a handling profile was completed noting Mr Code A needed the help of 1 to 2 nurses and a hoist for transfers. It also noted that he was nursed on a biwave plus mattress to prevent pressure damage.
A mouth assessment was undertaken as well as care plans for constipation, long term urinary catheter, hygiene and to settle at night.
A Waterlow score of 19-23 was recorded between August and September. As well as a Barthel ADL index for the same period with a score of between 6-3.
A nutritional assessment was completed in August with a score of 18 recorded.

3rd August 1999

Admitted to Gosport War Memorial Hospital from Haslar Hospital for rehabilitation. Pressure area were noted to be intact and that Mr Code A had CA bladder he was in renal failure and that his mobilisation was not good.

16th August 1999

Not in pain. Reluctant to do much.

27th August 1999

Abdominal pain noted.

1st September 1999

Small sacral sore. 2 nurses and a hoist to transfer.

6th September 1999

Small split sacrum. Going downhill. Abdominal pain. Fentanyl given more comfortable.

8th September 1999

Anxious – will have to have syringe driver. Syringe driver satisfactory 20mgs diamorphine.

17.30 hours – very rigid, very bubbly, deteriorated. **Syringe driver recharged with 50 mgs diamorphine.**

23.55 hours – died. Verified S/N Collins.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
Code A

Exhibit number
BJC-12

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		No drugs chart. Weak, Ca bladder, Oramorph		
Unexplained By Illness C				

General Comments

91-year-old man, living alone, with transitional cell Ca bladder, pleural effusion, fistulae, old MI, previous Ca colon, hard of hearing.

Transferred to Dryad 1999-08-03; ESR 76, Hb 9.3 1999-08-05; 'not in pain' 1999-08-16;
'going downhill – on fentanyl' 1999-09-06;
'Syringe driver 50 mg diamorphine, 20 mg midazolam' 1999-09-08 > 40 mg midazolam > +

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/12

Code A

91

Unwell with advanced transitional cell carcinoma of the bladder. But originally aiming for home with support. Low in spirits and abilities declined.
Not required any prn analgesia from 3/8/99 up to his death according to the available medication card. Said to be on fentanyl on 6/9/99 but this was not on medication card and not recorded by nurses.
Deteriorating 6/9/99, comfortable night 7/9/99, big dose of diamorphine on 8/9/99 although I cannot find the medication card for this. But the case records do not appear to justify such a high starting dose.

Cause of death probably bronchopneumonia but the diamorphine dose could have contributed.

PL grading B2

	BJC/12	Clissold, Walter	This man was clearly terminally ill when he was transferred from Haslar to GWM, although nobody at Haslar seems to have been explicit about that, and he himself seems to have been unaware of how short his prognosis was. This may have been because he had survived an unexpectedly long time following the diagnosis of locally advanced bladder carcinoma. During his admission to GWM he seems to have realised himself that he was not going to return to independent living (and may have realised he was dying, but there is no mention of any discussion) and to have given his financial affairs into the hands of a close friend, with instructions to ask his solicitor to make a ward visit. Important parts of the record, particularly a second drug chart, are missing from the recording (and therefore from the original file). Without them, it is impossible to make an accurate reconstruction of the sequence of drug escalation. The only analgesic recorded on the drug chart which is preserved is paracetamol. There is a notes entry on 6.9.99 that he was now more comfortable on fentanyl. It seems likely, therefore, that his analgesia was taken straight from paracetamol PRN to fentanyl, presumably at 25mcg/hr, although again one cannot be certain. There are occasional mentions of intermittent abdominal pain, although the cause is not clear (and was not clear to the team caring for him). This does not seem to have been diagnosed at the time as necessarily cancer pain, and does not seem to have been severe enough to keep him awake. But it does seem to have been positional – he is recorded as "very uncomfortable if out of bed for any length of time". It is not clear, in the absence of the relevant drug chart, whether the deterioration noted between 1.9.99 and 6.9.99 antedated or followed the administration of fentanyl, so a causal relationship cannot be inferred. On the day of his death, a syringe driver was set up containing diamorphine 50mg and ..... midazolam 20mg. Again, it is not clear why, given that fentanyl is transdermal, he was now felt to need diamorphine, nor why at least a 25% increase in opioid dosage was prescribed. The midazolam was doubled later that day. He deteriorated rapidly and died. I would be concerned that the drugs administered via syringe driver accelerated his inevitable death.	B3

Expert Review

Code A

No. BJC/12

Date of Birth: Code A

Date of Death: 8 September 1999

Mr Code A was admitted to Gosport War Memorial on 3 August 1999 following a resection of his prostate and a bladder biopsy at the Royal Haslar Hospital.

Although the original intention was that Mr Code A would be transferred home with support, his condition deteriorated.

This case is made more difficult to analyse in the absence of a drug chart but it would appear that Mr Code A analgesia was advanced from Paracetamol to Fentanyl.

By 6 September 1999 Mr Code A was deteriorating. In the absence of a drug chart it is not possible to draw any conclusions as to whether this was related to his medication. On the day of Mr Code A death, on 8 September 1999, a syringe driver was set up containing 50mgs of Diamorphine and 20mgs of Midazolam. The Midazolam was doubled later that day.

Mr Code A deteriorated rapidly and died and Dr Naysmith raised concerns that the drugs administered via the syringe driver accelerated Mr Clissold's albeit inevitable death. Dr Naysmith was the only expert that rated this case as negligent. In the absence of the drug chart, it is not possible to draw firm conclusions as to any liabilities in this case and no further investigation is advised.