ALAN HOBDAY

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Alan Hobday

Date of Birth: Code A Age: **75**
Date of admission to GWMH: **24th July 1998**
Date and time of Death: **22.45 hours on 11th September 1998**
Cause of Death:
Post Mortem:
Length of Stay: **50 days**

Mr Hobday's past medical history:-
1990 – TURProstatectomy

Mr Hobday lived with his wife in a bungalow. They had a son and daughter and very supportive family. Mr Hobday was a very well man prior to his collapse. He was allergic to penicillin.
Mr Hobday collapsed while out eating and was taken by ambulance to St Mary's Hospital and diagnosed with suffering a left CVA and right hemiplegia. Mr Hobday was admitted to Gosport War Memorial Hospital on 24th July 1998.

On admission care plans commenced on 25th July 1998 for sleep, catheter, shoulder pain, dysphagia, elimination, hygiene and communication.
A lifting/handling risk calculator was taken on 24th July 1998 scoring 23. So a handling profile was completed on 25th July 1998 noting that Mr Hobday needed the assistance of 2 nurses and a hoist, that his skin was intact and that he was to be nursed on a Pegasus biwave plus mattress.
A nutritional assessment plan was completed on 4th September 1998 with a score of 12 recorded.
An assessment sheet was completed noting that Mr Hobday was unable to communicate,
A Waterlow score of 25 was recorded on 24th July 1998.
A Barthel ADL index wad recorded weekly starting on 24th July 1998 scoring 0 and the last one recorded on 9th September 1998 also scoring 0.

24th July 1998

Clinical notes admitted to Daedulus ward. Barthel 0 needs all help with ADL. In view of poor prognosis please make comfortable. **Happy for nursing staff to confirm death.**

25th July 1998

Contact record – wife and daughter seen aware of condition and prognosis and recovery will be limited.

30th July 1998

Clinical notes state catheterised. Pulling out S/C fluids does not want NG feed. Prognosis poor. Wife and daughter seen they feel he has settled and improved from a week ago. Poor swallow, aspiration and possible chest infection. Diamorphine/haloperidol PM if distressed.

31st July 1998

Clinical notes seen by SLT continue with puree diet and thickened fluids.

3rd August 1998

Clinical notes remains poorly.

6th August 1998

Contact record – found on floor in lounge. No injury apparent. Accident form completed.

12th August 1998

Clinical notes has made some progress. Family seem realistic about future.
Contact record – discussion with wife and daughter definite improvement made with physical condition. Discussed future care they seem realistic about his capabilities.

16th August 1998

Contact record – found on floor in day room. Put back to bed. Accident form completed. Wife informed.

17th August 1998

Clinical notes very agitated at times. Suggest S/C haloperidol.

20th August 1998

Clinical notes seen by dietician continue on puree diet and thickened fluids.
Slow progress can push himself out of chair.

22nd August 1998

Contact record – found on floor in day room. No apparent injury. Hoisted into bed. Accident form completed.

7th September 1998

Contact record – twitching (facial) complaining of not feeling well. Dr Barton and wife informed.
Seen by Dr Barton commence **diamorphine 20mgs via syringe driver.** Wife and daughter seem to understand may deteriorate.

9th September 1998

Contact record – **diamorphine increased 40mgs** became very restless and appeared in discomfort.

10th September 1998

Clinical notes extended stroke on 6th September 1998 with facial seizures affecting right side of face. Now on syringe driver secretions +++ but seems comfortable. He's dying, family aware.
Contact record – seen by Dr Lord coughing and bubbling chest. Move to continuing care bed.

11th September 1998

Contact record – syringe driver renewed at 9.45 diamorphine 40mgs.
Clinical notes condition deteriorated rapidly.
Pronounced dead at 22.45 hours by S/N Roberts relatives present.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
AH 1922-12-05 q699624

Exhibit number
BJC-26

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		Bad stroke Rehab Extension BUT high doses		
Unclear B				
Unexplained By Illness C				

General Comments

75-year-old Previous TUR, otherwise well
1998-07-02 stroke: Severe dysphasia + right hemi, prognosis guarded: DNR
1998-07-24 transferred to Daedalus, Barthel 1
slow progress
1998-09-06 extended stroke, seizures, unwell
1998-09-07 diamorph 20 mg in 24h
1998-09-11 diamorph 40 mg, midazolam 40 mg in 24h

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/26
ALAN HOBDAY
75

He had a severe stroke followed by an extension of the stroke. There were feeding difficulties but he made some progress. On 7/9/98 he developed focal seizures and increased pain in his arm. Diamorphine via syringe driver started and the dose needed increasing because of ongoing discomfort. I would have started at 10mg rather than 20mg over 24 hours (hence grade 2) but otherwise the analgesia was appropriate and well controlled. Cause of death was the stroke.

PL grading A2

BJC/26	Hobday, Alan	Written up for diamorphine soon after admission – not clear why, but not needed and not given. Looks as if there were an expectation that he would die, although he seemed to be at least stable, and possibly improving, from his CVA. Extended his CVA on 7.9.98 with fits. Immediately put on a substantial diamorphine dose in S/D. Midazolam also given but that was logical and appropriate because he was having multiple fits, was unable to take an oral anti-epileptic and IV access was not available in GWMH.	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BB

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 16/12/2003

I visited Michael HOBDAY at 1600 hrs on Tuesday 16th December 2003 (16/12/2003) in accordance with the policy log.

I introduced myself and explained my role as FLO, provided Mr HOBDAY with a set of medical records in relation to his father, Alan William HOBDAY , B. Code A 11/09/1998.

I outlined his concerns as given in A194 and M24. He further elaborated stating that his father suffered a stroke in July 1998 and was admitted to the Queen Alexandra Hospital where he began to recover and was transferred to the GWMH where he continued to improve.

On 4th September 1998 (04/09/1998) the family were told that Mr HOBDAY had suffered a further stroke and that it was unlikely that he would survive. From that point he was placed on a syringe driver and he died on 11/09/1998.

Mr HOBDAY is acting as spokesman for the family and his mother has made some handwritten notes relating to her husbands death (attached).

Mr HOBDAY is happy to be notified by way of letter, with the opportunity to be able to raise any queries at a later date.

Expert Review

Alan Hobday

No. BJC/26

Date of Birth: Code A

Date of Death: 11 September 1998

Mr Hobday had suffered a stroke in July 1998 and was admitted to hospital. He was transferred to Gosport War Memorial Hospital on 24 July 1998 for further rehabilitation.[AH1]

On the clinical notes it would appear that he extended his stroke on 6 September 1998 and thereafter developed focal seizures with increased pain in his arm.

Diamorphine was started via a syringe driver and Mr Hobday died on 11 September 1998.

The expert report confirmed that although higher doses of opiates were used than may have been necessary, Mr Hobday's cause of death was due to his stroke.
