Code A

Code A

Edna Purnell

Date of Birth: Code A Age: **90**
Date of admission to GWMH: **11th November 1998**
Date and time of Death: **11.30 hours on 3rd December 1998**
Cause of Death:
Post Mortem:
Length of Stay: **23 days**

Mrs Code A past medical history:-
Dementia
TIA
Vaginal wall prolapse

Mrs Code A lived at Addenbrooke Residential Home. She had a son. Mrs Code A was admitted to Royal Haslar Hospital after sustaining a fracture neck of femur. She underwent surgery on 26th October 1998 of a dynamic hip screw and was then admitted to Gosport War Memorial Hospital on 11th November 1998 for rehabilitation. On admission it was noted that Mrs Code A had problem dependant oedema affecting her lower limbs and left upper limb. She was also suffering from bronchopneumonia, severe dementia and had been catheterised.

On admission care plans commenced for hygiene, confusion, urine and bowel incontinence, settle at night, graze on right elbow and both heels have pressure sores.
A handling profile was completed on admission noting that Mrs Code A was slow to communicate, was in pain, had dry papery and broken skin, was to be nursed on a Pegasus air mattress, had a catheter in situ and needed the help with transfers using a hoist.
A mouth assessment was completed on 11th November 1998.
A Waterlow score of 24 was recorded on 11th November 1998 and 23rd November 1999.
A Barthel ADL index was recorded on 11th November 1998 scoring 2 and on 23rd November 1998 scoring 1.

11th November 1998

Transfer letter notes Mrs Code A is catheterised, has bilateral pressure sores on her heels, is eating well but has poor fluid intake. She is to be admitted for rehabilitation but this could be difficult due to her mental state and pressure sores. She is to be admitted for one month initially and unless there is any improvement then she may need to be admitted to a Nursing Home for continuing care.

Clinical notes – transfer from Haslar with senile dementia, pressure sore on heels and oedema of leg. Family aware of poor prognosis.
Summary – admitted from E3 Haslar.

12th November 1998

Clinical notes – In pain despite co-codamol and oramorph.
Summary – complaining of a great deal of pain. Oramorph 5mg given at 14.10 and to be given on regular basis for 24/48 hours.

13th November 1998

Summary – oramorph 10mgs given at 10.25.

14th November 1998

Summary – son concerned very sedated. He is aware of poor condition and that opiates may be needed to control pain.

17th November 1998

Clinical notes – son seen very angry feels his mother is not being cared for adequately and accusing nursing staff of murdering his mother by giving her oramorph. Has been verbally abusive to nursing staff and doctor. On examination Mrs Code A was semi-conscious and appears to be in distress when moved. Son not happy for any analgesia.
Need to keep comfortable and pain free. Discussion with Dr Lord for IL S/C fluid over 24 hours. Dr Reid coming in to assess situation.
Review by Dr Reid – son has left ward indicating he will complain about his mothers condition. Need to be relieved of pain (despite sons wishes). Nursing staff report choking on food and fluids. Son trying to push food and fluids into mother which she tries to push out with her tongue. (Police should be called if happens again and also if nursing staff are being intimidated.)
Summary – son angry and abusive physically grabbing nurse. Police contacted and incident form completed. Oramorph 10mgs given with good effect.

18th November 1998

Clincial notes – less well, drowsy. Prognosis poor tried to inform son.
Summary – Cheyne stroke respirations feeding inappropriate at present.

20th November 1998

Clinical notes – comfortable – oramorph. **Happy for nursing staff to confirm death.**
Summary – sleepy had been in pain and distress. 15mgs oramorph given.

23rd November 1998

Clinical notes – groaning in pain. Heels thickened skin bilatually, sacrum red but intact on Pegasus airwave mattress and cushions for cot sides. S/C fluid in progress. Hospital manager has had a called from sons solicitors requesting that he visit at 2.00pm.
Use oramorph/diamorphine to keep comfortable if more than 1 injection of diamorphine is required for syringe driver. Feel she is dying – keep free of pain and distress.
Son did not arrive – solicitor informed of condition.

Summary – agitated. Oramorph 10mgs given at 23.40 repositioned 2-3 hourly. Seen by Dr Lord boarded for diamorphine if have more that 1 injection syringe driver to commence.

24th November 1998

Summary – deteriorating syringe driver commenced 20mgs diamorphine.

25th November 1998

Summary – syringe driver recharged 20mgs.

26th November 1998

Summary – syringe driver recharged 20mgs. Son visited PM.

28th November 1998

Clinical notes – further deterioration.

Summary – syringe driver recharged 20mgs.

29th December 1998

Summary – syringe driver recharged 20mgs.

1st December 1998

Clinical notes – remains comfortable.

3rd December 1998

Clinical notes – died 11.30 hours verified by RGN Shaw and Burke.

4th December 1998

Clinical notes – coroners office confirm diagnosis of bronchopneumonia and senile dementia. Certificate issued.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
Code A

Exhibit number
BJC-37

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		Clearly very frail, and in pain at times. Not clear why dose was escalated in last few days? ?Symptom driven		
Unclear B				
Unexplained By Illness C				

General Comments

91-year-old widow, Nursing Home Resident with dementia, left ventricular hypertrophy, tremor

1995-11-03 MTS 5/10, but active
1996-06-12 'Fall – broken arm...'
1997-09-02 '# R. thumb'
1998-10-25 #NOF after fall
1998-10-26 Dynamic hip screw
Labelled NOT FOR ACTIVE RESUSCITATION on E3 Haslar
1998-11-11 Transferred to GWMH
co-
diclofenac suppository
oramorph
diamorphine injection
1998-11-24 diamorphine 20 mg, midazolam 20 mg/24h
1998-11-26 ^ midazolam 40 mg/24h
1998-12-01 ^ diamorphine 30 mg/24h
1998-12-02 chest bubbly ^ diamorphine 40 mg/24h + hyoscine 200 microgram
1998-12-03-11-30 Died

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

RIC/37

Code A

91

Dementia and fractured neck of femur. In pain and distressed hence the use of opiates. It is difficult to know if the dose of diamorphine via syringe driver needed increasing in the last 24 hours but overall the use of opiates appears appropriate. Would have died without opiates being used.

PL grading A2

BJC/37	Purnell, Edna	This lady was demented but mobile and independent prior to her #NOF. She had a poor post-operative course with minimal recovery of function and was reluctant to drink, so that rehab potential was felt to be low to non-existent and she was likely to need long term care. But, given that she was mobile pre-NOF, it is not entirely clear why she should die at this point. However, there is an appreciable mortality from #NOF and her marked dementia must have put her at risk. At GWMH there seems to have been a readiness to move quickly from a single dose of PRN co-codamol to oramorph in doses of 5-10mg PRN, given twice most days. Clearly she had pain. It was probably bone and joint type, related to her recent surgery and to immobility, and so unlikely to have been fully opioid sensitive. And such doses of opioid in a lady with dementia would be likely to cause mental state problems very easily. There seems to have been no intent to try regular dosing rather than PRN at Step 1, to try regular paracetamol as an adjunct or to give Step 2 drugs a fair trial before moving to oramorph. She became very drowsy on oramorph, and then dry, and from that point her renal function seems to have diminished despite SC fluids. Death from that point would have been inevitable. With poor renal function she would have been accumulating active metabolites. On oral medication to some extent that was allowed for, in that it was given PRN when she appeared to be in pain and therefore at long intervals. Typically she was receiving 20mg morphine orally/24 hours. But the syringe driver was started at 20mg diamorphine, ie 3 times that dose, and a high dose of midazolam added. She then appeared comfortable, though semi-conscious. There are no mentions of pain or distress in the nursing notes from that point forward, apart from the reference in the last 3 days of life to a bubbly chest. But the doses of both diamorphine and midazolam were increased, and it is not entirely clear why.	B2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7CZ

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: OP ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 13/04/2004

I visited Code A at his home address on Saturday 9th January 2004 (09/01/2004) in relation to his mother Code A b. Code A, d.03/12/1998 in accordance with the policy log. I provided Code A with a copy of his mothers medical records and outlined his concerns as per Officers Report 13G.

Code A made these additional comments.

In relation to his mothers mobility she needed assistance even when walking with a frame. In relation to her feeding herself, her hands were a bit shaky but she could feed herself. She used to drink using a straw.

When his mother was placed in a single room, she was kept in darkness whereas she liked to be in the light.

When he was spoken to in relation to 'feeding his mother' and the medical notes show that a comment "arrest him on a technical charge" was made. This relates to him feeding his mother a sandwich, which she ate!

The charts relating to his mothers intake of food and fluids were 'destroyed' in April 1999 but he had already begun his complaint with the hospital in February 1999 and had attended a meeting with them.

Code A had wanted to transfer his mother into a BUPA hospital but was informed by a nurse whom he describes as 'massive' that he couldn't as it was "nothing to do with you, you know".

Code A has prepared a chronological list of events (submitted) which he commenced on 17/02/1999.

He visited Chilworths Solicitors in Gosport the following day and spoke with Mr CHILWORTH who rang the hospital in his presence and told them to make sure that all of Mrs Code A records were up to date and unaltered.

Code A was not charged for this consultation.

Code A also notes from his copy of his mothers medical records that the drip which he insisted they set up was taken down the day after he told them he was not returning to the hospital.

He also notes that on 20/11/1998 Dr BARTON has written up that she was happy for the nursing staff to confirm death.

Code A is happy to receive a letter notifying him of his mothers classification.

DOCUMENT RECORD PRINT

Officer's Report

Number: R13G

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: FCU FLEET

REF:
TEL/EXT:

SUBJECT:

DATE: 18/12/2002

Death of Code A at Gosport War Memorial Hospital 3rd December 1998 (03/12/1998).

On Monday 16th December 2002 (16/12/2002) I visited M Code A who is the son of Code A born Code A . I Code A who is not in good health welcomed me into his home and was eager to tell me his story.

He started by explaining to me his own health problems, which he believes, have been exacerbated by the stress he has been under, concerning the circumstances of his mothers death. He is suffering from a heart complaint affecting the main valves and the aorta artery itself.

In the near future he is facing a major heart operation which has a success rate of only about 60%. However this rate is dropping the longer the condition is left. His wife or partner was very concerned that my visit did not over stress him as this is often a trigger for an attack.

Code A tells me that on 26th October 1998 (26/10/1998) his mother fell and broke her hip and was taken into The Royal Hospital Haslar . Prior to this fall his mother, although 91, was sprightly and had all her wits about her.

After a successful operation Mrs Code A made a good recovery and at the time of her transfer to the War Memorial Hospital on the 11th November 1998 (11/11/1998) she was eating and drinking unaided. She was able to walk with the aid of a frame and was able to take herself to the toilet but was accompanied for safety reasons.

Code A clearly remembers that his mother had refused pain killers in Haslar and had told him that she was relatively pain free.

At this time even though his mother was old, he was very optimistic that she would make a full recovery. He describes his mother as physically improving and mentally aware.

On the 12th November 1998 (12/11/1998) his mother was given oral morphine allegedly for pain relief. At the time Code A N complained, and questioned the use of the pain killers, when clearly his mother did not require them.

DOCUMENT RECORD PRINT

On 17th November 1998 (17/11/1998) Code A again complained that his mother was being sedated and left in the dark permanently. She was clearly dehydrating and to Code A knowledge she was not being fed.
Code A read in his mothers notes that Dr REED had recorded 'giving her fluids would only prolong her life.'

Code A complained so bitterly that staff called security and he was asked to leave. However after this incident his mother was provided with what looked like a saline drip.

On the 3rd December 1998 (03/12/1998) Code A died Code A believes that the cause of death recorded was bronchial pneumonia. Code A believes that his mother was starved of not only fluids and food, but was given excessive pain killers which had the effect of suppressing her immune system and thus hastened her death.

Code A is not represented and has no wish to try and claim compensation. However he is passionate that justice needs to be seen to be done even though he quite openly admits that it is not clear what has gone wrong with the system.

Code A was very thankful to be able to get the full story off his chest. He tells me that his biggest frustration is that in the past no one has been willing to listen to his complaint.

Expert Review

Code A

No. BJC/37

Date of Birth: Code A

Date of Death: 3 December 1998

Mrs Code A lived at Addenbroke Residential Home at the time of her admission to the Royal Haslar Hospital to undergo surgery for a fractured neck of femur.

Following the operation on 26 October 1998 and the insertion of a dynamic hip screw, she was admitted to Gosport War Memorial Hospital for rehabilitation on 11 November 1998.

At Gosport War Memorial Hospital Dr Naysmith noted there was a readiness to move quickly from a single dose of Co-codamol to Oramorph in doses of 5 to 10mgs which was given twice most days. Mrs Code A became very drowsy on Oramorph and from that point her renal functions seem to have diminished.

The syringe driver was started with 20mgs of Diamorphine which was three times the dose Mrs Code A was receiving orally. At this point she appeared comfortable although semi conscious.

The experts have considered this case to be a natural death albeit that the treatment was sub optimal and that the dose of opioids was markedly escalated in her final few days.

Dr Lawson notes that in his opinion Mrs Code A would have died in any event without opiates being used. The medical records make note of the concerns expressed by Mrs Code A son as to the treatment that was being provided to his mother.