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ADDITIONAL REPORT
No. 3

SPECIALIST FIELD:- NURSING CARE

REVIEW OF ADDITIONAL NOTES AND NURSING CARE GIVEN TO AN ADDITIONAL 3 PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL

REPORT PREPARED BY:- IRENE WATERS LL.M, M.Sc, M.N.,R.H.V., R.G.N.

DATED:- JULY 2004

ON THE INSTRUCTIONS OF:-

DETECTIVE CHIEF INSPECTOR NIGEL NIVEN
HAMPSHIRE CONSTABULARY
POLICE HEADQUARTERS
WINCHESTER
HAMPSHIRE
SO22 5DB

SUBJECT MATTER:-

This report addresses the appropriateness of the nursing care given to another 3 former patients of Gosport War Memorial Hospital who died during the period 1989 and 2001and whether the nursing care fell below a standard that would be expected from reasonably competent nurses. Also included in this report a review of additional notes for 29 patients that were included in the first/second report.

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CASES BJC 84,85,86

CONTENTS:

Appendices:

CASES BJC 84,85,86

Synopsis

Thank you for seeking about the standard and appropriateness of the nursing care given to another 3 former patients, of the Gosport War Memorial Hospital, who died from the period of 1989 and also the additional notes from 29 previous patients.

1. Introduction.

1.01 The writer

I am Irene Waters. My specialist field is nursing and nursing care. I am a registered general nurse and hold a community nursing qualification. I have a Master of Nursing degree and was formerly Director of Nursing, responsible for 1408 nursing staff, with the Bart's NHS Group, this included a general acute Hospital and a Community Health Services Unit. I have worked in Nursing Homes, been part of the inspection process and am a regular panel member for due regard on the Professional Conduct Committee for the Nursing and Midwifery Council NMC. I am currently employed as a clinical and professional adviser, health consultant and expert witness. Full details of my qualifications and experiences are in appendix 1.

6.00 Summary Review of the facts surrounding the care of the 23 additional patients notes and 3 new cases.

All from photocopied inserts.

BJC04 Edith Aubrey
Nothing new to report.

BJC05 Henry Aubrey
Nothing new to report.

BJC06B Dennis Brickwood
Nothing new to report.

BJC07 Stanley Carby
Nothing new to report.

BJC09 Sidney Chivers
Nothing new to report.

BJC1 Code A
Nothing new to report

BJC13 Code A
Care plans for admission and for recovery and post op on 2nd June 1997 for right inguinal hernia.
Also handling profile dated **13th August 1999** which shows that Mrs Cox had poor communication was apathetic, **she was not complaining and had no pain.** It noted that she had dry skin and was incontinent of urine. It also noted that she needed the help of 1 nurse and was depressed and needed lots of encouragement and prompting.

BJC17 Cyril Dicks
Diamorphine chart noting that Mr Dicks was given **diamorphine** on:-
20th March 1999 at 18.00 hours 20mgs.
21st March 1999 at 17.30 hours 20mgs.
22nd March 1999 at 18.10 hours 20mgs.

CASES BJC 84,85,86

Care plan commenced on 8th February 1999 for sore left ankle – red marks and red heel. For daily evaluation. Dressed with bioclusive on each abrasion now developed into PA. It notes dressing applied/renewed on 8th, 9th, 11th, 12th and 15th February 1999.

Another care plan commenced on 15th February 1999 for pressure sore left and right heel. To have evaluation every two days. Dressed with asorbine protect surrounding area with WSP allevyn 9x9 cling. The evaluation notes state that dressing were applied/renewed on 11th, 14th, 15th, 18th, 19th, 21st, 22nd February 1999 and 3rd, 8th, 12th, 13th, 15th, 17th and 19th March 1999.

BJC22/JR1 Harry Hadley

Additional notes for 5th October 1999 – Sultan ward – diagram of pressure sores to buttocks, thigh, heel, swollen groin, and swollen penis and above knee to waist oedema.

BJC23 Charles Hall

Nothing new to report.

BJC26 Alan Hobday

27th July 1998 referral to physio and clinical notes from 5th August 1998 to 4th September 1998 stating arm supported by 2 pillows.

BJC31 Catherine Lee

Nothing new to report.

BJC34 Geoffrey Packman

Nutrition care plan and pressure sores. Nutritional needs for wound healing and to control weight gain. Complying well with dietician's recommendations.

BJC36 Gwendoline Parr

Nothing new to report.

CASES BJC 84,85,86

BJC37 Code A

Nothing new to report.

BJC40 Violet Reeve

Nothing new to report.

BJC42 James Ripley

Nothing new to report.

BJC44 Elizabeth Rogers

Nothing new to report.

BJC47 Daphne Taylor

Nothing new to report.

BJC48 Sylvia Tiller

Nothing new to report.

BJC52 Alice Wilkie

Additional to daily summary from inserts.

4th August 1998

Clinical notes – from Haslar. MTS 0/10, Barthel 1/10. Catheterised/pressure area vulnerable. Prognosis poor too dependent to return to Addenbrookes. Transfer to Daedalus ward then decide on placement. Keep bed at Addenbrookes.

6th August 1998

Transfer for 4-6 weeks.

10th August 1998

Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrookes. Review in 1 month if no specialist medical or nursing problems discharge to nursing home. Stop Fluoxetime.

21st August 1998

Marked deterioration over last few days. S/C analgesia commenced yesterday. Family aware and happy.

18.30 hours death confirmed by C/Nurse. Family present. For cremation.

BJC61 Code A

Nothing new to report

BJC63 Frank Horn

Nothing new to report

CASES BJC 84,85,86

BJC65 Code A

Nothing new to report

BJC67 Ruby Lake

Oramorph chart – given on 18/8/98 at 14.15 hours 5mgs
19/8/98 at 00.15 hours 10mgs
19/8/98 at 11.50 hours 10mgs

Diamorphine chart – given on 19/8/98 at 16.00 hours 20mgs
20/8/98 at 09.15 hours 60mgs
20/8/98 at 07.35 hours 20mgs
20/8/98 at 16.30 hours 40mgs
need to check as chart difficult to understand.

Also given with diamorphine was hyoscine and midazolam.

A **waterlow score** of 25 was recorded on admission to GWMH on 18/8/98. Care plans also commenced on admission for small ulcerated areas on lower legs 1 small area on right leg and 2 small areas on left leg, 2 sacral pressure sores 1 small area on left buttock and area in cleft of buttocks, constipation, catheterised, hygiene and to settle at night. A barthel score of 9 was also recorded on admission as well as a nutritional risk assessment of 17. A handling profile was also completed noting that Mrs Lake had leg ulcers and sacral pressure sore and catheter. It was noted that **she was in pain and needed the help of 1 nurse and a zimmer frame.** A mouth assessment was also completed. An assessment sheet also noted that Mrs Lake was to mobilise slowly was deaf and needed a hearing aid, wore glasses and her speech was good. It also noted that she was on normal diet but her appetite was poor and she required encouragement.

Daily Summary
18th August 1998
Summary of significant events – admitted from E3 Haslar with fractured left neck of femur from fall at home. Slow post op recovery. Leg ulcers on both legs and break on sacrum. For slow mobilisation.
19th August 1998
Summary – **11.50 hours complaining of chest pain. Oramorph 10mgs given doctor notified. Very anxious diamorphine 20mgs commenced in syringe driver.**
20th August 1998

CASES BJC 84,85,86

Summary – 12.15 hours continues to deteriorate. **Driver recharged 10.10 diamorphine 20mgs midozalam 20mgs and hyoscine 400mgs**. Family informed.

Night – continues to deteriorate very bubbly suction attempted without success and distressed when moved. **Syringe driver recharged diamorphine 20mgs midozalam 60mgs and hyoscine 800mgs 07.35 hours.**

21st August 1998

Summary – deteriorating slowly. Family present all afternoon. Died at 18.25 hours.

BJC68 Mabel Leek

Spell summary – admitted to Gosport War Memorial Hospital with bronchopneumonia. SC analgesia syringe driver 10/12/98.

BJC71 Code A

Additional comments to be made to care plans from Disk Hants008.

Dietary/fluid intake care plan commenced on 11th January 1996.

5th January 1996

Clinical notes - transferred to Dryad Ward present problem immobility, depression, small superficial area on left buttock. Ankle dry lesion left ankle. Both heels suspect. Transfers with hoist. (page 12)

9th January 1996

Clinical notes –Painful right hand increasing agitation. **?needs opiates**. (page 12)

10th January 1996

Summary – condition remains poor. Seen by family and Dr Barton to **commence on oramorph 4 hourly**. To stay in long stay bed wife aware of poor condition. (page 23)

13th January 1996

Summary – catheter by passing in distress. Washout given. (page 23)

17th January 1996

CASES BJC 84,85,86

Summary – seen by Dr Barton medication increased. Tense and agitated. Chest very bubbly. **Skin marking easily despite hourly turning and use of pegasus mattress.** 20.30 hours further deterioration. (page 25)
23rd January 1996
Summary – remains unchanged **15.45 hours syringe driver recharged diamorphine 120mgs**. (page 27)

BJC72 Helena Service

Additional comments to be made to daily summary from disk Hants008.

Care plans commenced on 3rd June 1997 for help to settle at night and on 4th June 1997 for hygiene and constipation.

Daily Summary
3rd June 1997
Night – **spenco mattress in situ nursed on alternate sides. Zinc and caster to sore sacrum.** *(out of date)*
02.00 hours failed to settle restless and aggressive. (page 20)

BJC74 Harry Dumbleton
Nothing new to report

CASES BJC 84,85,86

BJC84/JR8 Lilian Taylor

Date of Birth Code A Age: **84**
Date of Admission to GWMH: **21st January 2000**
Date and time of Death: **05.30 hours on 14th February 2000**
Cause of Death:
Post Mortem: **No**
Length of Stay: **24 days**

Mrs Taylor's past medical history was noted to be:-

- Bilateral cataracts extraction
- Thyroidectomy
- Ischaemic heart disease
- Atrial fibrillation
- Hypertension
- Mild stroke with left hemiparesis
- Right axillary thrombosis

Mrs Taylor was a widow and had 5 children. She lived alone in a ground floor council flat and managed very well. She was very independent and did not smoke or drink. Mrs Taylor was diagnosed with cancer of the stomach and underwent a subtotal gastrectomy on 12th January 2000 at the Royal Haslar Hospital. She spent five days in the high dependency unit and admitted to Gosport War Memorial Hospital on 21st January 2000 for palliative care.
The transfer letter (page 245) may have been written by a nurse.
On admission to Gosport care plans commenced for sleep, catheter, hygiene, sacral area red/broken area, elimination, wound site, reduce diet/vomiting. (pages 265 to 279) A waterlow was completed with a score of 14 recorded rising to 22 on 11th February 2000. (page 285) A barthel ADL index was also completed with a score of 15 noted and then reducing to 3 on 11th February 2000. (page 287) A nutritional screening tool was completed noting a score of 14. (page 283/284) A handling profile was also completed noting that Mrs Taylor had abdominal discomfort, wears glasses for reading and watching television, usually independent and complaint. That the wound site was clean and dry but the drain site leaking. It also noted that Mrs Taylor was nursed on an air mattress, that she walks with the aid of a stick, needed the help of nurses to help her into bed and a hoist for a bath. The later evaluation noted that Mrs Taylor needed help turning in bed by 2 nurses and that she had been unable to get out of bed and had been catheterised. (pages 289/290/291)
Stopped Warfarin in December 1999 to reduce risk of embolus.

CASES BJC 84,85,86

Daily summary

21st January 2000

Summary of significant events – admitted from D3 Haslar. She was to be admitted to the GP Unit. Dr Barton was the GP on Sultan.Had subtotal gastrectomy for CA stomach on 12th January 2000. Spent 5 days in HDU stopped warfarin in December 1999. **On arrival mobile with stick,** hypertension. She was independently mobile with a poor appetite. 21st January 2000. Independent with hygiene, wound clean and dry, drain site slightly leaking mepore dressing in situ. Legs dry and oedematous. Appetite poor on puree liquid diet. Food and fluid chart commenced. (page 193)

24th January 2000

Clinical notes – difficulties with food and fluid intake. For OT assessment for social services. (page 73)

Summary – 13.45 seen by Dr Barton to have extra cheese in evening to improve protein. (page 193)

25th January 2000

Clinical notes – abdo pain overnight. BS present no vomiting. Abdo soft. PM – **vomited with old coffee if fresh blood appears will need transfer.** (page 73)

Summary – 08.40 hours seen by Dr Barton **commenced on ciproxin for kidney infection**. Mrs Taylor feeling generally unwell. 13.30 vomited coffee ground vomit. 14.45 hours BP 170/90 pulse 104 temp 38 paracetamol given. 15.00 hours seen by Dr Knapman to treat nausea with IM or oral metaclopramide PRN if vomits fresh blood for transfer to RHH. Dr Barton to review tomorrow. (page 193)

26th January 2000

Summary – no further episodes of vomiting. 11.45 hours small amount of vomit and blood. Nocte – small amount of vomit containing blood. Diarrhoea overnight. (page 194)

27th January 2000

Clinical notes – had sub total partial gastrostomy on 11th January 2000 since having become **nauseous and has vomited small amount of frank blood. Is in pain and frightened.*** (page 73/74)

Summary – seen by Dr Barton referred to Dr Bee Wee. **Discontinue aspirin** and antibiotic tomorrow. (page 194)

28th January 2000

Clinical notes – **palliative medicine at Countess Mountbatten house** (Dr Bee Wee) recommend haloperidol 1.5mg nocte for nausea. **Comfortable aware that her operation was for possible malignancy. She states does not know result of surgery nor does she wish to. Continue current management with encouragement of mobilising and rehab***. (page 74)

* **N.B.*Contrast between 2 opinions about this lady within 24 hours.***

CASES BJC 84,85,86

Summary – seen by Dr Barton who spoke with son. 20.00 hours seen by Dr Bee Wee, **said bright and alert**, boarded for haloperidol 1.5mg nocte increased to BD if not effective or consider S/C infusion of haloperidol or cyclizine. Patient is aware of diagnosis/prognosis but does not wish to confront or discuss this. (page 194)

30th January 2000

Summary – **complaining of pain in right calf no redness**. Healthcare asked to visit. 18.00 hours healthcare contacted again will visit asap. Pyrexia 38.4 NOK informed who was very upset on phone. 18.40 hours in consultation with Haslar and Accident and Emergency ambulance called. Transfer to Haslar NOK notified. 22.00 hours returned from Haslar ? **DVT/?chest infection**. Complaining of pain left lung area. For U/S tomorrow. (page 195)

31st January 2000

Summary – complaining of pain right calf. Left leg more oedematous than right up to sit in chair. Very poor apyrexial. 13.30 hours seen by Dr Barton for palliative care. (page 195)

1st February 2000

Clinical notes – USS booked for 2nd February. Still nauseated controlled by haloperidol ? needs increase tomorrow. (page 74)

Summary – U/S arranged for tomorrow. **Seen by Dr Barton if nausea persists haloperidol maybe increased to 5mgs over 24 hours via syringe driver**. (page 196) *(Gosport notes)*

2nd February 2000

Clinical notes – haloperidol increased 5mg S/C in 24 hours if remains cheerful over weekend return to oral. ? needs referral to social services. (page 75/76)

Summary – seen by Dr Barton no DVT seen on U/S at RHH. Syringe driver increased to 5mgs over 24 hours. If nausea settles reduce to 2.5mgs and reduce to oral medication once condition stabilised restart social services referrals. (page 196)

Seen in A&E at H**4th February 2000**

Clinical notes – still vomiting profusely and remains pale and unwell. Wound she be candidate for continuing care in hope we might get her home. (page 75/76)

Summary – seen by Dr Barton for referral to elderly services ? possible transfer to Dryad ward for ? care. (page 196)

7th February 2000

Clinical notes – seen by Dr Lord – suggest increase haloperidol to 4-5mg S/C in syringe driver over 24 hours. If in pain S/C diamorphine 2.5-5mg PRN 4 hourly. Aware she is poorly. Best on Sultan Ward for next week, as she will deteriorate rapidly. (page 75/76)

CASES BJC 84,85,86

Summary – seen by Dr Lord increase haloperidol S/C via syringe driver 4.5 over 24 hours. (very frail) If in pain for **SC diamorphine 2.5-5mgs S/C 4 hourly PRN**. Oral fluids as tolerated will leave on Sultan Ward for next week. (page 196)

10th February 2000

Summary – 12.15 hours S/C site resited 5mg diamorphine and 5mg haloperidol commenced over 24 hours as complaining of pain. (page 197) Stopped Aspirin and Digioxin.

11th February 2000

Received 5 mgms diamorphine.

12th February 2000

Clinical notes – **further deterioration having small amount of diamorphine S/C. Seems comfortable**. (page 75/76)(*early morning round*)

Summary – **right leg looking cyanosed specifically toes**.(*possible embolism again*) Leg warm but toes cold. Mrs Taylor complaining of aching leg. Dr Barton informed.

11.40 increased to 20 mgms Diamorphine. (*Ischaemia is bad pain.*)

Nocte – syringe driver site has pinpoint of redness slept well. (page 197)

14th February 2000

Clinical notes – 05.30 hours condition deteriorated died peacefully. Verified by S/N Dolan in the presence of N/A Wilde. Relatives informed. (page 75/76)

Summary – 05.30 died peacefully son informed will visit. (page 197)

Comment

A curative gastrectomy was performed at Haslar. However when Mrs Taylor reached Gosport, this was not understood and the treatment given was Palliative not curative.

There are contrasting opinions about her state of health and mind between the 2 units between 27th and 28th January 2000, almost a different person.

Mrs Taylor developed embolisms, the risk of her surviving an embolectomy was poor. (*why not started on Warfarin?*)

It has to be a matter of concern and poor practice that there is little evidence that there was communication with the surgeons or surgical nurses at Haslar. Gosport assumed palliative and terminal care whereas Haslkar had assumed that Mrs Taylor would have rehabilitaion and their notes suggested active care.

Her good response to the Gastrectomy suggests a fit woman.

CASES BJC 84,85,86

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

CASES BJC 84,85,86

BJC85/JR9 Arthur Cousins

Date of Birth: **31st March 1918** Age: **86**
Date of Admission to GWMH: **10th July 2000**
Date and time of Death: **00.45 hours on 25th August 2000**
Cause of Death: **1. (a) Chronic obstructive pulmonary disease**
2. Squamous slow growth Carcinoma diagnosed in Dec 1999. (carcinoma of lung)
Post Mortem:
Length of Stay: **47 days**

Mr Cousins past medical history was noted to be:-

- Malaria/hepatitis – war
- COPD
- Diverticular disease – 1992
- Soft tissue injury left wrist - 1993
- Achilles tendonitis – 1995
- Atrial fibrillation – 1999
- Colonscopy – 1999
- BCC left forehead – 1999
- Carcinoma lung - 1999

Mr Cousins was bought up in Gosport. He was one of a large family and only had a sister alive. Before the war he was employed as a joiner working on building sites. During the war he was in the Royal Hampshire Regiment and travelled throughout Europe. During his time in the war he contracted malaria and hepatitis and sustained a neck injury. He returned from the war and continued working as a joiner. Mr Cousins was married for over 50 years he had two sons and a daughter. His wife developed Alzheimer's and he became her main carer. They lived in a three-bedroom house with a stair lift.
Mr Cousins was admitted to the Royal Haslar Hospital on 19th June 2000 with increasing shortness of breath. He had undergone a pleural biopsy, which revealed he had lung cancer in November/December 1999. On 19th June 2000 while at Haslar he sustained a fall and fractured his sternum. Mr Cousins was transferred to Gosport War Memorial hospital on 10th July 2000.

On admission care plans commenced for hygiene, constipation, sleep, and catheter care. (page 314 to 331). A handling profile (page 334/335) was completed noting that Mr Cousins was unsteady, had chest pain as result of fall, needed the help of 1 nurse and a zimmer frame. A nutritional screening (page 332/333) score of 13 was recorded noting Mr Cousins was at risk. A mouthcare assessment (page 336) was completed. A waterlow score (page 338) and barthel ADL score (page 340) was recorded weekly from 12th July 2000 until 21st August 2000.

CASES BJC 84,85,86

Daily summary

10th July 2000

Clinical notes – transfer from Haslar. Fell whilst inpatient onto face and chest. Fractured sternum. At present SOB not mobilising. Cough, chest wheeze and chest pains. (page 268/239/270/271/272)

Clinical notes – painful left shoulder and right leg weakness. (page 272) Referred to physio. (page 20/21)

Summary of significant events – transfer from A5 RHH at 11.30am. Excerboration of COPD, AIF, SOB. Suffered a fall during stay on A5 and fracture to sternum. On regular analgesia and regular nebuliser due to SOB. Oxygen therapy 24°/3 litres to be given PRN. Satisfactory admission. Seen by Dr Wilson ECG performed MRSA swab sent to lab. **Patient unaware of cancer.** Dr Wilson examined Mr Cousins right leg weakness present. **? CVA ?? due to cerebral metastases.** (page 302)

Nocte – 3 episodes overnight requiring oxygen. (page 302)

12th July 2000

Clinical notes – complaining of left sided chest pain. Plan PRN oramorph and monitor. (page 273)

Summary of significant events – complaining of left sided weakness radiating to left arm. Looks anxious, dysphonic, expectorated small amount of sputum. Seen by Dr Wilson to monitor. (page 302)

Summary – for oramorph PRN Pulse 130 irregular. X-ray right leg to be done. Right leg very swollen erytheme present, very small blister present to back of heel. Right foot very swollen to be kept elevated. Referred to physio. (page 302/303)

14th July 2000

Clinical notes – x-ray report left shoulder and right hip – bony injury. (page 273)

17th July 2000

Clinical notes – chesty – abdomen difficult examination discussion with Mr Cousins re wife's needs very emotional does not want to put wife into a home. (page 274)

Summary of significant events – **seen by Dr Wilson in great deal of pain and very distressed.** Oxygen given. **Oramorph 5mgms given at 12.15 hours** with good effect may be repeated 4 hourly as necessary. (page 303)

18th July 2000

Clinical notes – cough/yellow sputum. Using PRN oxygen. Plan to continue with steroids, analgesia and becloforte. GP appointment booked but deferred until discharge. (page 275)

20th July 2000

Clinical notes – reviewed. Continues to complain right-sided abdo pain. Bowels opened. On examination comfortable at rest transfers independently to bed. Ankle oedema ++. ? constipated. (page 276)

24th July 2000

Clinical notes – well pain settled. Had increasing shortness of breath. (page 277)

CASES BJC 84,85,86

Summary of significant events – experienced some dysphonic at 12.15 hours nebuliser given. Some relief. Became more dysphonic and cyanosed. Dr Wilson informed. No complaints of chest pain. Nebuliser given. Condition improved. (page 303)

25th July 2000

Clinical notes – coughing up sputum. Antibiotics. (page 278)

Summary of significant events – seen by Dr Khawaja predrusilone increased. Sputum specimen to be obtained. (page 304)

7th August 2000

Clinical notes – bowel opened x 6 yesterday. On examination pulse 98 irreg. Refer to phsyio. (page 279)

8th August 2000

Clinical notes – feeling well on PRN oxygen nocturnal. (page 279)

Summary of significant events – seen by Dr Khawaja to be referred to physio. (page 304)

11th August 2000

Clinical notes – SOB pain left side chest. Diagnosed with anxiety. Has been offered oramorph but declined. (page 280)

Summary of significant events – became very short of breath. Appeared to have ? panic attack. Nebuliser given with effect. Remain panicky. Visited and examined by Dr Beasley. Diazepam 5mg PRN. Same given at 23.00 hours. Sat up in bed with 24% oxygen. Eventually settled. Anxious when awake requires a lot of reassurance. (page 304)

13th August 2000

Summary of significant events – continues to have episodes of SOB. Diazepam PRN over weekend. Oxygen used as required. (page 304)

18th August 2000

Clinical notes – SOB/anxious/bed night. Wife place in Addenbrookes rest home. Gets very tearful no cure for his chest. Plan to increase steroids, humidified oxygen, **reg oramorph 5mg** and PRN diazapam/midozolam. (page 281)

Discussion with Mr Cousins re treatment may have to go to acute ward at Haslar or Queen Alexandra to be ventilated. Advised not the right thing to do he agrees to stay at GWMH and has agreed to try morphine. (page 282)

Summary of significant events – 11.15 hours became very agitated and anxious. Son told him his wife gone into a rest home. Complained of feeling unwell. **Oramorph 5mgs given with good effect**. Nocte – now boarded for oramorph on **a regular basis**. **10mg given at 22.00 with effect**. Awake at 2.30 hours anxious and distressed. Oxygen given became less anxious at 05.30 hours. Complaining of chest and abdo pain. Prescribed neb plus **oramorph 5mg** given with effect now settled. (page 305)

19th August 2000

Summary of significant events – continues on **regular oramorph** family have visited and aware of poor prognosis. (page 305)

20th August 2000

CASES BJC 84,85,86

Summary of significant events – further deterioration extremely anxious causing SOB. **Arthur has agreed to try syringe driver for 24 hours**. Remains concerned that he will become addictive to morphine – reassurance given that he will not. (page 305) **Syringe driver commenced at 12.40 hours with diamorphine 10mgms and midazolam now needs almost continuous oxygen**. (page 306)

21st August 2000

Clinical notes – agitated evening started **midozolam and diamorphine S/C syringe** driver. If **Mr Cousins passes away nursing staff may certify**. (page 282/283)

Summary of significant events – poor condition remains. More settled occasional episodes of SOB and anxiety. Driver recharged at 11.10 hours with 10mgs diamorphine and midazolam 20mgs. (page 306)

22nd August 2000

Summary of significant events – seen by Dr Khawaja on round. Abdomen very distended. **Syringe driver recharged at 15.50 hours**. 17.30 hours very twitchy and agitated. **Complaining of pain driver recharged with diamorphine 20mgs and midazolam 30mg hyoscine 40mcgs.** 18.10 hours became very distressed and agitated. **Diamorphine 10mg IM given**. Oxygen almost continuous. 20.00 hours more settled, less agitated and now peaceful. Family visited. 03.00 hours settled night. **Syringe driver continues as prescription**. Abdomen remains distended. (page 306/307)

23rd August 2000

Summary of significant events – all care given. Syringe driver satisfactory peaceful. 16.15 hours syringe driver recharged **diamorphine 30mgs midozalam 40mg and hyoscine 400mcg**. The increase in drug therapy was due to Arthur becoming quite distressed particularly whilst being attended to. (page 307)

Night – comfortable night initially but became quite distressed and very much pain on movement/turning. **Syringe driver charged to 40mg diamorphine as beginning to be bubbly.** Oxygen given continuously overnight. Mouthcare given – mouth and lips very dry. (page 308)

25th August 2000

Summary of significant events – 00.10 comfortable although left leg and lower abdomen becoming quite mottled. 00.40 condition deteriorated suddenly. 00.45 died peacefully. Family informed. (page 308)

Clinical notes – condition continues to deteriorate died peacefully at 00.45 hours. Death certified by SS/N A Tubbritt witnessed by HCSW M Duffy and C Arnold. Family informed. (page 284)

Comment

Good palliative care.

CASES BJC 84,85,86

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

CASES BJC 84,85,86

BJC86 Christina Town

Date of Birth: Code A Age: **91**
Date of Admission to GWMH: **9th May 1996**
Date and time of Death: **01.30 hours on 28th November 1996**
Cause of Death:
Post Mortem: **no**
Length of Stay: **203 days**

Mrs Town's past medical history was noted to be:-

- Fractured hip after fall in 1993

Mrs Town had two daughters and lived with one of them. A home carer called daily to help Mrs Town with personal needs. She was a small frail lady who wore glasses for reading. She had a long-term catheter in place which required daily wash outs for which the district nurses attended to. Mrs Town was admitted to Sultan Ward of the Royal Haslar Hospital for respite care on 9th May 1996. She was transferred to Gosport War Memorial Hospital for long term stay on 31st May 1996.

Care plans commenced for hygiene, confused and frail, elimination, reddened area to sacrum and settle at night. (page 57 to 94) A handling profile on 7th September 1996 noted that Mrs Town's had poor communication, sometimes non-complaint, does not appear to be in pain, **nursed on pegasus airwave mattress, she had 2 hourly turns** and wears pads for incontinence. (page 81/82)
A **Barthel** ADL index (score 1) was completed weekly. (page 109/110)
A Waterlow was completed with a score of 29 noted. (page 107) A nutritional assessment was also completed on 26th May 1996 noting a score of 13. (page 106) An assessment of activities of daily living was completed noted that Mrs Town **needed cot sides** (*why?*), had short term memory loss, irregular eating habits, catheter in place that needed x2 weekly washouts and that she was immobile and needed a wheelchair. (page 134)

Daily summary

9th May 1996
Summary of significant events – admitted to Sultan Ward for respite care. (page 96)
23rd May 1996
Summary – fell x 2 bump on left side of head. Small skin flap on leg numerous bruises. Sounds chesty. (page 96)
24th May 1996
Summary – seen by Dr Hajiartoris for referral to Dr Lord ? long stay bed. (page 96)
31st May 1996

CASES BJC 84,85,86

Clinical notes – transfer to Dryad ward. Immobile to make comfortable. **Happy for nursing staff to confirm death. Keep on regular medication.(WHY?)** (page 45)
Summary – transfer from Sultan ward to Daedalus already seen by Dr Bark.
Night – seems settled became restless and attempted to get out of bed. (page 96)

1st June 1996
Summary – **very aggressive** on being put to bed boarded for triclolos.(p116) (page 96)

3rd June 1996
Summary – seen by Dr Lord no changed in treatment. (page 97)

13th June 1996
Summary – recatheterised. (page 97)

14th June 1996
Summary – seen by Dr Barton antibiotics commenced as urine very offensive. (page 97)

17th June 1996
Clinical notes – catheterised pressure area intact. Continue NHS long stay. (page 46)

1st July 1996
Summary – seen by Dr Lord nil ordered. (page 97)

15th July 1996
Summary – referred to dentist. (page 97)

29th August 1996
Summary – fell from bed. (page 97)

30th August 1996
Clinical notes – fell out of bed. Bruising to back of head and right knee. Skin flap right arm. Neurological obs OK until today. (page 46)
Summary – seen and examined by Dr Barton bed rest today. Daughter informed of accident. (page 97)

5th September 1996
Summary – appears to have cold and chest infection. **Seen by Dr Barton who is to see daughter. She is happy to leave treatment up to us**. (page 97)

6th September 1996
Summary – both eyes inflamed bathed and eyes drops instilled. Complaining of headaches paracetamol given. 20.20 hours found on floor check for injures. Small laceration to right upper foot, cleaned with n/saline and bioclusive applied. Accident form completed. (page 97)

7th September 1996
Clinical notes – **found on floor again**. New graze right foot. (page 46)
Summary – seen by Dr Peters. (page 97)

9th September 1996
Clinical notes – **found on floor twice by nursing staff. ? climbs over cot sides ? crawls around cot side (was a problem at home). (page 46)**(*should have taken cot sides down)*

CASES BJC 84,85,86

Summary – seen by Dr Lord no change. (page 98)

14th September 1996

Summary – condition discussed with daughter was surprised her mother may not survive chest infection. Future treatment discussed and **assured her mother would remain comfortable**. (page 98)

18th September 1996

Summary – visited by daughter. Mrs Town showed us **her right forearm**. She cannot tell us how she did it obviously done it in last ½ an hour as still bleeding. No idea how and when she did it. Steristrips applied and accident form completed. (page 98)*(indicates very poor level of supervision)*

20th September 1996

Summary – sleepy today. (page 98)

23rd September 1996

Summary – seen by Dr Lord to remain in long stay bed. (page 98)

29th September 1996

Summary – marked deterioration. (page 98)

7th October 1996

Clinical notes – seen by doctor explained Mrs Town's is mentally and physically frail. Agreed not for IV or NG tube for antibiotics or fluids. Uncertain about treatment for future re chest infections. **Agreed to keep Mrs Town comfortable.** (page 47)

Summary – daughter seen by Dr Lord Mrs Town not for transfer to be made more comfortable if condition deteriorates further. (page 98)

11th October 1996

Summary – diet and fluid intake poor. (page 98)

23rd October 1996

Summary – **found on floor beside bed** assisted back to bed no apparent injuries. (page 98)

8th November 1999

Summary – appears to have had a TIA immediately put back to bed and obs noted. Dr Brookes duty doctor informed. Granddaughter informed as daughter on holiday. Remains pale to be observed. (page 99)

18th November 1996

Clinical notes – deteriorating in bed most of the day. Continue NHS continuing care. (page 47)

Summary – seen by Dr Lord PRN nebuliser prescribed. (page 99)

25th November 1996

Summary – deterioration continues. (page 99)

28th November 1996

Clinical notes – **condition deteriorated during night breathing shallow limbs cyanosed.** 01.30 hours death confirmed by SS/N Tubbritt witnessed by N/A M Gallagher and N/A K Wallington. Daughter informed. (page 47)

Summary – 01.20 hours contacted daughter eventually condition deteriorated rapidly. 01.30 hours died. (page 99).

CASES BJC 84,85,86

(Page 7) Diamorphine 40 mgms is a high dose. Bad prescription, undated, not administered.

Comment

The nursing care was a poor standard , there was little evidence of management of falls and cot sides were contra indicated.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

Declaration and statement of truth.

I understand that my duty is to help the Court with those matters which are within my expertise and in relation to which my advice has been sought, and I have complied with that duty.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

Signed. Code A **Date** 26th November 2004.

Irene Waters. R.G.N., R.S.C.P.H.N., LL.M., Master of Nursing, M.Sc. Public Health.