

Other Document Form

Number

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Title ORIGINAL REPORTS REMAINING 2^S MATTHEW COHN.

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Further actions no(s)

Code A

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Expert Review

Edith Aubrey

No. BJC/04

Date of Birth:

Code A

Date of Death: 15 June 1996

Mrs Aubrey lived at home with her husband until April 1994 when she was admitted to a nursing home. Her past medical history included probable cerebrovascular disease, depression with paranoid features, and ischaemic heart disease.

Whilst the experts have described this case as end stage dementia more probably of vascular origin, it is unclear from the medical notes what led to Mrs Aubrey's final demise. She was given transdermal Fentanyl explicitly to calm her and this dose was progressively escalated.

In June 1996 a syringe driver was prescribed as required and was commenced on 7 June 1996. The conversion of therapeutic treatment to Diamorphine via a syringe driver was reasonable in the experts' views.

From a review of the case by the Key Clinical Team it was noted that the patient was unable to communicate and was clearly distressed and agitated, perhaps due to pain. In their view the doctors could have been criticised for not trying to treat the possible pain.

Expert Review

Henry Aubrey

No. BJC/05

Date of Birth: Code A

Date of Death: 2 June 1999

Mr Aubrey was admitted to the Royal Haslar Hospital in May 1999. He was transferred to Gosport War Memorial Hospital on 1 June 1999. The history of the presenting complaint was noted on admission to be carcinoma of the lung, plural effusion and query cerebral secondaries. The notes also records that Mr Aubrey was depressed waiting to die.

Mr Aubrey was commenced on a Fentanyl patch at 3.30 p.m. that afternoon and 10mgs of Oramorph was given.

Mr Aubrey's treatment was continued the next morning with high dose Morphine and Midazolam.

The experts noted in their analysis that although Mr Aubrey had a terminal diagnosis and was recognised to have given up, the need for such a large dose of Diamorphine and Midazolam was not clear. The experts noted that size of the dose was open to criticism and although not the 'best treatment' it was unclear that this was negligent.

Expert Review

Code A

No. BJC/13

Date of Birth: Code A

Date of Death: 16 August 1999

Code A was transferred from the Queen Alexandra Hospital where she had been admitted on 21 July 1999 to Gosport War Memorial Hospital on 5 August 1999 for rehabilitation and assessment.

Code A had severe heart failure and difficulty in swallowing.

Although a diagnosis had been made of depression this is disputed by **Code A** **Code A** husband in the officer's report.

The expert team felt that although her treatment may have been suboptimal this was a dying patient and diamorphine has a palliative effect in these circumstances.

It is clear from the notes that **Code A** had a poor prognosis but the choice of medication although sub optimal was acceptable in the experts view in the setting it was provided.

Expert Review

Geoffery Packman

No. BJC/34

Date of Birth: **Code A**

Date of Death: 3 September 1999

Mr Packman was admitted to Gosport War Memorial Hospital in July 1999 following the development on an irritating rash on his side and groin.

It appears from the medical notes that he had an episode of black stools prior to being discharged from Portsmouth Hospitals NHS Trust.

Following admission to Gosport War Memorial Hospital on 23 August 1999 Mr Packman was noted as remaining very poorly with no appetite. It was noted in Mr Packman's nursing records that he was passing fresh blood per rectum on 25 August 1999.

On 26 August 1999 he complained of feeling unwell with indigestion pain in his throat together with nausea and vomiting.

At this point he was commenced on opiate medication. No active measures were taken to resuscitate Mr Packman and, following rapidly increasing doses of Diamorphine, he died on 3 September 1999.

There is a variation in the view taken of this case by the experts reviewing the Notes. Concern is expressed by Dr Lawson that although the death was natural, the gastrointestinal bleed was potentially treatable.

An expert report from a gastrointestinal surgeon/physician is to be sought.

Expert Review

Elizabeth Rogers

No. BJC/44

Date of Birth:

Code A

Date of Death: 4 February 1997

Mrs Rogers was transferred from the Royal Haslar Hospital to Gosport War Memorial Hospital on 30 January 1997.

She had been treated at the Royal Haslar Hospital with a chest infection and a urinary tract infection. She had severe Parkinson's disease. On transfer it was noted she had a catheter in place, was bed bound, slightly dysphagic and her sacrum was red but intact.

On 2 February 1997 she was prescribed oral Morphine due to an increase in pain.

On 3 February 1997 in view of the pain not being controlled by oral Morphine, a syringe driver was commenced with 40mgs of Diamorphine, 20mgs of Midazolam and 400mcgs Hyoscine.

The experts note that the dose of Diamorphine approximated to a doubling of opioid medication but agreed that most practitioners would have used opiates to control this patients pain. Some criticism was made of the dose of diamorphine given but this was felt to not to have shortened Mrs Rogers life.

Expert Review

Sylvia Tiller

No. BJC/48

Date of Birth:

Date of Birth: 13 December 1995

Mrs Tiller was admitted to Queen Alexandra Hospital on 3 November 1995 after suffering with congestive cardiac failure and a background of ischaemic heart disease. The experts note that she was “clearly a dying woman”. She was transferred to Gosport War Memorial Hospital on 4 December 1995.

Mrs Tiller was given small amounts of Oramorph and only in the last twenty-four hours was set up a syringe driver with Diamorphine, Hyoscine and Midazolam. Although Dr Naysmith questioned the rationale for making “more adequate analgesia available” in the admission plan, the experts noted the appropriateness of using high levels of analgesic in patients who are about to die to provide solace. To withhold such treatment in their view would be unacceptable.