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Number 1217

Title ORIGINAL REPORTS BAKER 2's MATTHEW COHAN.

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Code A

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Expert Review

Dorothy Stanford

No. BJC/60

Date of Birth: Code A

Date of Death: 27 November 1993

Mrs Stanford was a widow living at Egremont Rest Home when she suffered a severe stroke in November 1993. She was admitted to Queen Alexandra Hospital suffering with a right hemiplegia and was catheterised and fed via a naso gastric tube.

Prior to her transfer to Gosport War Memorial Hospital on 23 November 1993 Mrs Stanford was noted as having been pyrexial with scattered crepitations and was thought by the expert team to have a probable chest infection.

On arrival at Gosport War Memorial Hospital Mrs Stanford was described as "***very poorly***" and the Nursing Admission Form noted that "***Mrs Stanford was highly dependent and her levels of consciousness varied***". The expert team noted that opioid pain relief was started but without any obvious need. The comment "***needs analgesia***" was made in the notes but without any indication of concurrent pain.

Since Mrs Stanford was unable to take anything by mouth a syringe driver was set up containing Diamorphine 40mgs with Hyoscine and Midazolam.

Mrs Stanford died two days later. The experts concluded that Mrs Stanford was likely to die because of the severity of the stroke and probable chest infection but they have criticised the use of opiates without clear indication.

Expert Review

Code A

No. BJC/61

Date of Birth: Code A

Date of Death: 16 February 1999

Code A prior to a stroke in 1997, had non-insulin dependent diabetes and hypertension which was treated with Atenolol.

Following his severe left sided hemiparesis, **Code A** was admitted to the Queen Alexandra Hospital. Having been operated on to insert a PEG tube in March and April 1997 **Code A** was transferred to the Gosport War Memorial Hospital on 9 April 1997.

In Autumn 1998 **Code A** leveloped Bullous Pemphigoid, which worsened despite topical steroids and became super infected with MRSA. Alongside the distress caused by these legions, **Code A** had pre-existing pain in his hips and shoulders and possibly left thalamic pain.

Code A was on long term MST and Amitriptyline. The MST was increased gradually. A Fentanyl patch was tried briefly but this was picked off. Midazolam was added to the medication to quell the distress of the itch and blisters and to calm **Code A**

The conversion to syringe driver was described by the experts as excessively over generous but they noted that **Code A** at that point, was agitated and distressed and the motive seemed solely to keep him comfortable. The experts all agreed that he was unavoidably dying from his stroke.

Expert Review

Code A

No. BJC/62

Date of Birth: Code A

Date of Death: 22 March 1999

Code A prior to her fall on 16 January 1999, lived on her own in a second floor flat. She suffered a fractured neck of femur following the fall and underwent a hemiarthroplasty on 19 January 1999 at Haslar Hospital.

She was transferred to Gosport War Memorial Hospital on 10 February 1999, since she was failing to make progress.

Although Code A initially made some progress she was noted to be in severe pain and began to deteriorate. Her limbs became contracted and it was painful to move her. She was given 5mls of Oramorph with benefit but then refused further oral medication. Code A had a history of confusion.

She was started on a high dose of Diamorphine via a syringe driver accompanied by Midazolam. The dose was not increased until the day before she died when the nurses noted Code A was stiff and in pain when being handled.

The experts considered that the starting dose of Diamorphine was too high but death was inevitable and natural and not due to the medication.

Expert Review

Frank Horn

No. BJC/63

Date of Birth: Code A

Date of Death: 12 November 1999

Mr Horn was an elderly man with an extensive medical history including carcinoma of the larynx, Bell's palsy and multiple small strokes. Although suffering a severe stroke in 1995 he was rehabilitated at St Mary's Hospital and eventually went to live with his daughter. He was frail but fully mobile at that time.

Mr Horn was admitted in October 1999 to Queen Alexandra Hospital with shortness of breath and chest pain. A diagnosis was made of heart failure with a chest infection and the possibility was raised that he was aspirating his food.

Mr Horn was transferred to Gosport War Memorial and it was hoped after rehabilitation he would be transferred to a residential home.

Mr Horn was made DNAR on admission without any detailed assessment or any evidence of discussion with either patient or family. He deteriorated markedly a few days after transfer and was started on Diamorphine 20mgs together with Midazolam and Hyoscine.

Mr Horn was very sleepy within twelve hours and by twenty-four hours later was twitchy, distressed and objecting to nursing care.

Dr Naysmith raises the possibility of Mr Horn being opioid toxic.

The experts agreed that the starting dose and increase was more than they would have expected but do not think that the medication contributed to Mr Horn's death.

[Dr Naysmith 3B]

Expert Review

Do B.
21/12/12?
21/12/11?

Code A

No. BJC/64

Date of Birth: Code A

Date of Death: 8 April 1999

Code A was living at home with her daughter at the time of her admission to Queen Alexandra Hospital with dehydration, diarrhoea and vomiting.

Code A was very unwell and dependent and on transfer to Gosport War Memorial Hospital on 31 March 1999 it was noted that she had a poor mental state and it was questioned whether rehabilitation would be successful.

She was started on co-codamol on admission although no indication in the medical or nursing assessment notes was made of why this was done.

Code A markedly deteriorated on 4/5 April 1999 and was started on a syringe driver. Although the dose of Diamorphine was criticised by the experts as being high, it was noted that the deterioration had been recorded only three hours after the syringe driver was started and therefore that it was probable that Code A was dying in any event and would have done so even without the medication prescribed and dispensed via the syringe driver.

Expert Review

Code A

No. BJC/65

Date of Birth: Code A

Date of Death: 10 May 1998

Code A was living in Russell Church Court Rest Home at the time of her admission by Dr Lord to Gosport War Memorial Hospital. She had worsening long-standing renal failure and was documented as having a problem with postural hypotension.

On admission it was noted that Code A was observed to be in pain and the following day she was started on Oramorph 5mgs four hourly pain relief.

The following day it was noted that she was sleeping and had bubbly breathing and a syringe driver was set up with 40mgs of Diamorphine together with 400mcgs Hyoscine and 20mgs Midazolam.

The experts have questioned the need for Code A to be give Midazolam in view of the fact she had never been agitated and questioned the use of Morphine in a patient with chronic renal failure.

The experts have noted she was very unwell but the indication of the use of opiates was not certain.

[Dr Lawson "***The doses used could have contributed to her death***" – 2B]

[Dr Naysmith: "***I do not think she would have died when she did had she not been given these opioids***"– 3B]

Expert Review

Phyllis Horne

No. BJC/66

Date of Birth: Code A

Date of Death: 6 May 1998

DoB
5/2/1916
Not
1988

Mrs Horne was a widow who suffered from deteriorating health including severe Alzheimer's disease and in 1996 moved into Acorn Lodge Residential Home.

Mrs Horne was unable to look after herself and after a number of years she was unable to move any part of her body and became completely bedridden.

Mrs Horne was admitted to Queen Alexandra Hospital on 16 March 1988 suffering from dizzy spells. Two weeks previously she had suffered a minor stroke with facial palsy. She was subsequently transferred to Gosport War Memorial Hospital on 26 March 1988 for continuing care. The management of Mrs Horne's agitation was a difficult issue. She was noted as being frightened, agitated and appearing in pain. On 3 May 1998 she was started on a Fentanyl 25mcgs patch.

Mrs Horne's condition continued to deteriorate and forty-eight hours later she could not swallow. A syringe driver was set up containing Diamorphine 40mgs and Midazolam 40mgs. Mrs Horne died the following day.

The experts note that Mrs Horne was frail, agitated and unwell but expressed concern as to the high starting dose of opioids and the fact that there was no attempt to use non opioid analgesics. It is recognised that dementia and cerebrovascular disease are both terminal illnesses and it was felt that Mrs Horne would have had a relatively short prognosis in any event notwithstanding the opioid medication.

[Dr Naysmith – 3B]

Expert Review

Mabel Leek

No. BJC/68

Date of Birth: Code A

Date of Death: 18 December 1998

Mrs Leek had a long history of pain due to osteoarthritis and suffered from osteoporosis with multiple fractures over several years. She had limited mobility. She suffered with chronic pain and from 1996 had been treated with Morphine, 10mgs twice a day. Mrs Leek had problems with incontinence and was also noted as having angina and chronic obstructive airways disease. She lived on her own with extended home care visiting twice daily and had meals on wheels and a home help.

Following her left tibia and fibula fracture, which was treated at Royal Haslar Hospital, Mrs Leek, was transferred to Gosport War Memorial Hospital on 6 August 1998 for further rehabilitation.

On admission she was prescribed 60mgs twice a day of Morphine because of the severe pain in her joints and the pressure ulcers.

The dose of Morphine was gradually increased and a syringe driver was commenced on 14 December 1998 following a deterioration which was recorded in the clinical notes.

The conversion to syringe driver increased the Diamorphine by thirty per cent but Mrs Leek was described as not swallowing and unresponsive.

The experts concluded unanimously that although the rate of increase of analgesia was sub optimal there was no negligence in the terminal care of Mrs Leek.

Expert Review

Euphemia Skeens

No. BJC/69

Date of Birth: Code A

Date of Death: 29 October 1995

Dob
8/6/1908
R 87

Mrs Skeens lived at home on her own with the help of a carer prior to her admission to Queen Alexandra Hospital on 10 October 1995 after suffering a stroke which left her with a left hemiparesis.

On 20 October 1995 Mrs Skeens was transferred to Gosport War Memorial Hospital for long stay rehabilitation.

Following admission, she became increasingly chesty and unable to clear secretions and had pain from her left arm where she fell when she had the stroke.

Mrs Skeens became pyrexial and consideration was given as to whether or not to prescribe antibiotics. A decision was taken to pursue symptomatic management only and Oramorph 5mgs PRN was commenced. This was increased to 10mgs the next day.

On 28 October 1995 Mrs Skeens was noted as being distressed and restless and a syringe driver was commenced at 40mgs of Diamorphine. This controlled the agitation and restlessness and she was recorded as being peaceful and relaxed. The experts conclude, at this stage, Mrs Skeens was inevitably dying and she did so the following day. Dr Naysmith noting that she doubted the opioid made any significant difference to Mrs Skeens' outcome.

Expert Review

Rhoda Marshall

No. BJC/70

Date of Birth: Code A

Date of Death: 7 January 1996

Ms Marshall lived in Hedley House Residential Home before being admitted to Queen Alexandra Hospital on 14 December 1995 following a fracture of her pubic rami when she fell getting out of a chair.

Ms Marshall was admitted to Gosport War Memorial Hospital on 29 December 1995 for long-term rehabilitation.

Her medical history included dementia, Parkinson's disease, hypothyroidism and heart failure.

There were difficulties noted by the experts in interpreting whether Ms Marshall was frightened of moving or was in fact in pain. She was not weight bearing at that time although had been before the fracture.

The clinical notes record that her pain control was inadequate and she was started on 10mgs Oramorph four hourly on 30 December 1995. This was changed to a syringe driver to give continuous pain relief on 2 January 1996. The starting dose of 40mgs Diamorphine was doubled to 80mgs on 4 January and raised again that day to 120mgs.

Ms Marshall was noted to be deteriorating slowly on 6 January and died the following day at 2.30 p.m.

The experts considered that the pain suffered by Ms Marshall was unskilfully managed, and there was a possibility of opioid toxicity, but were unanimous that no negligence occurred in the management of Ms Marshall's terminal phase.

Expert Review

Code A

No. BJC/73

Date of Birth: Code A

Date of Death: 8 October 1997

Code A lived with her elder sister on the ground floor of her house having suffered from Multiple Sclerosis which had been diagnosed in 1954 when she was thirty years of age. Code A was unable to walk and was well known to Gosport War Memorial Hospital. She used to attend there for respite care and then was an inpatient with continuing care for a number of years.

Code A suffered with long term pain and was on opioids, initially Fentanyl, in April 1996 and then increasing doses of Oramorph. This caused problems with severe constipation. Code A had difficulties tolerating Oramorph and there was uncertainly as to her ability to swallow. Vomiting became a major problem so she was started on a syringe driver in July 1996. She was transferred in September to a Fentanyl patch following sore skin sites and that stayed until the beginning of October.

On 6 October 1997 Code A was noted as having a great deal of pain over the weekend. She was clearly much more unwell and the experts raised whether there was a cardiac event that had taken place.

The syringe driver was recharged with 250mgs Diamorphine on 7 October 1997 and Code A died the following day.

Although the experts criticised the sudden increase in opioid dose, none of them felt the treatment of Code A was negligent; Dr Naysmith noted that "***This lady was clearly dying. I do not think that anything in her analgesia caused or even significantly hastened, an inevitable death***".

Expert Review

Harry Dumbleton

No. BJC/74

Date of Birth: Code A

Date of Death: 12 June 1993

Mr Dumbleton was admitted to Queen Alexandra Hospital on 26 April 1993 suffering with cerebrovascular disease, parkinsonism and fits.

Mr Dumbleton did not improve significantly during his stay and was transferred to Gosport War Memorial Hospital on 26 May 1993 for long stay continuing care.

It was recorded in the Gosport Notes that he had multiple falls and was very confused and immobile. At one point Mr Dumbleton was verbally and physically aggressive prior to being sedated.

An entry in the Notes on 11 June 1993 records that Mr Dumbleton "***Deteriorated over the last couple of days***". Mr Dumbleton was started on a syringe driver containing Diamorphine 40mgs, Hyoscine 40mcgs and Midazolam 20mgs.

Mr Dumbleton died less than twelve hours later.

The experts have all noted the difficulty of making a firm conclusion in the absence of a medication card in the Notes. Nevertheless Dr Naysmith noted that "***There had been a rapid deterioration in general condition for about five weeks prior to the acute admission and the deterioration was such that death was neither unexpected or untimely***".

Expert Review

DOB.
13/12/05
OR
13/2/05 - R16H.

Wilfred Harrington

No. BJC/75

Date of Birth: Code A

Date of Death: 21 July 1993

Mr Harrington was admitted to Gosport War Memorial Hospital on 8 June 1993 for a two-week period of respite care. Mr Harrington was suffering from severe heart failure and chronic renal failure. He did not walk without aid.

In the last week of life he developed contractions of the arm and severe hip pain which was initially thought to be a fracture. He was given Oramorph for the first time on 20 July 1993 at a dose of 20mgs four times a day. A syringe driver was set up the following day but within an hour Mr Harrington had died.

The experts were agreed that Mr Harrington died of end stage heart failure despite active management and although the dose of Diamorphine could be criticised for being too high, it was clear that Mr Harrington was already dying and that this therapy did not significantly influence the outcome.

Expert Review

Horace Smith

No. BJC/79 and JR07

Date of Birth: Code A

Date of Death: 6 April 1999 (at the Royal Haslar Hospital)

Mr Smith had been admitted to Royal Haslar Hospital on 9 March 1999 with acute alcoholic pancreatitis in association with alcoholic liver disease and chronic obstructive pulmonary disease.

Mr Smith was transferred to the Gosport War Memorial Hospital on 30 March 1999 for continuing care but was transferred back to the Royal Haslar Hospital on 31 March 1999 since he had become acutely unwell with severe abdominal pain. It was clear that he had an acute abdomen which was painful and distended and was transferred back to Ward B3 at the Royal Haslar Hospital.

Mr Smith's drug treat at Gosport War Memorial Hospital included a single dose of Pethidine for the acute abdominal pain which the experts concluded was entirely appropriate medication in the circumstances and would not have influenced his death six days later.