# Code A

DOCUMENT RECORD PRINT

# Officer's Report

Number: R8K

TO: REF:
STN/DEPT:

FROM: Code A REF:
STN/DEPT: MCIT W TEL/EXT:

SUBJECT: DATE: 24/11/2002

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Sir,

On the 23/11/2002 I spoke with Code A re action 222 and the death of his wife Code A nee OSBOURNE Code A

Code A was born in Richmond, London; she married and had two children. She worked part time for the NHS in a domestic capacity. In later life she was diagnosed as having an enlarged heart and once a year was seen by a consultant. In early 1999 she began suffering from headaches and depression. This was a condition that would worsen. In July 1999 Code A was taken to the QA her blood pressure was so low that a reading could not be taken. It was thought that this might be causing her headaches.

The consultant told Code A that he didn't know how his wife could stand let alone get to the hospital. On the 05/08/1999 Code A was sent to the GWMH for 2-3 weeks bed rest. She was seen by a consultant on the 12/08/1999 and given 3 months to live. Code A was unable to eat and it was felt that there was little that could be done.

On the 12/08/1999 staff at the hospital called Code A They asked his permission to sedate his wife, which he agreed. At this stage Code A was unable to speak. Code A died on the 16/08/1999. The death certificate showed;

1) Cardiac failure
2) Ischaemic Heart disease
3) Myocardial infarction.

Dr BEASLEY signed the certificate. Code A was cremated.

Code A

DOCUMENT RECORD PRINT

# Officer's Report

Number: R7BK

TO: REF:
STN/DEPT:

FROM: Code A REF:
STN/DEPT: MCD E TEL/EXT:

SUBJECT: DATE: 02/01/2004

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I visited Code A at his home address on Tuesday 9th December 2003 (09/12/2003) in accordance with the policy log.

I introduced myself and gave Code A a set of medical records relating to his wife, Code A Code A

I outlined his concerns as noted in officers report 8K.

Code A additional comments are as follows:

His wife wasn't depressed, she had low blood pressure. She was diagnosed as being depressed by a specialist from St Christopher's Hospital, Fareham . She was admitted to the Queen Alexander Hospital for 2 wks where she showed no signs of recovery and wasn't eating. Code A would visit twice daily in order to feed her.

She was then moved to the GWMH .

Code A would like to know why his wife wasn't seen by the consultant, Mr WATKINS , from the outset of his wife's illness.

Code A requested an appointment with the consultant whilst his wife was at the GWMH and was told in "3 months time".

When his wife did see the consultant she was taken by car by her son-in-law, she was due to be taken by the hospital bus, at this time Code A couldn't even stand.

Upon her return from QA to the GWMH Code A describes his wife as appearing like a zombie, though she could talk and would occasionally become raised and argumentative.

At 1900 hrs that day Code A received a telephone call from the hospital stating that his wife was stressed and they were looking to give her some sedation. Code A states that authorisation is given by the Dr so why did they need to ask his permission.

DOCUMENT RECORD PRINT

A few days later Code A could not recognise anyone nor could she speak. She was sat in a chair in a 'zombie like state'.

Code A has since discovered that during that last week, the head of Mulberry Ward (psycho ??? Ward) had been called down to assess his wife and her antidepressant tablets had been stopped.

Code A would like to be notified in person and he states he doesn't mind when that is.

# Code A

Code A

Date of Birth Code A Age: **69**
Date of admission to GWMH: **5th August 1999**
Date and time of Death: Code A
Cause of Death: **1) CCF**
**2) Ischaemic Heart Disease**
**3) MI**
Post Mortem: **Cremation**
Length of Stay: **13 days**

Code A past medical history:-
Heart failure
Depression
Hypotension
Severe CCF
MI - 1996
Right femoral hernia repair - 1997
Varicose veins – 1972
Small benign vocal cord polyp

Code A was married and lived with her husband in a bungalow, they had a daughter and a son. They managed on their own at home with no outside help and were self caring. Code A was quite active before her admission and would go dancing 2 to 3 times a week. It was noted that she was allergic to pencillin.
Code A was admitted to the Queen Alexander Hospital on 21st July 1999 after suffering from Congestive Cardiac Failure and with depression and anxiety. She was transferred to the Gosport War Memorial Hospital on 5th August 1999 for rehabilitation and assessment.

On admission a comprehensive nursing assessment was completed as well as a mouth assessment.
Care plans for sleep, swallowing problem, constipation and hygiene were also made.
A Barthel ADL index was completed for August noting various scores between 17-4.

A Waterlow score was also completed for August noting scores between 17-25.
A nutritional assessment for August with a score of 23 was recorded.

**5th August 1999**

Admitted to Gosport War Memorial Hospital with CCF/depression for rehabilitation and assessment. Notes state that Code A was to be made comfortable and that the prognosis looks poor – happy for nursing staff to confirm death.
Notes also state that Code A had trouble with swallowing and was seen by a dietician. Help was to be given with daily care.

**9th August 1999**

Not feeling well – problems swallowing to commence food chart.

**10th August 1999**

Referral made for psychiatric assessment.

**12th August 1999**

End stage heart failure (probably iscahemic). Current prognosis is 3 months. Code A feels could not cope at home but would have home if she had to go to residential care. Requested pressure relief cushion for chair.

**14th August 1999**

Agitated – contacted Code A agreed sedation via syringe driver.

**15th August 1999**

**Syringe driver 40mgs.**

**16th August 1999**

Notes state started diamorphine 20 mgs today. Not for resus. Staff to confirm death. Explained poor prognosis to husband and son.
Died 16.20 hours death verified by SSN Hallman and S/N Shaw.

# OPERATION ROCHESTER
# CLINCAL TEAM'S SCREENING FORM

**Patient Identification** DC Code A Code A

**Exhibit number** BJC-13

| Care / Death/Harm | Optimal 1 | Sub-Optimal 2 | Negligent 3 | Intend to Cause Harm 4 |
|---|---|---|---|---|
| Natural A | | Bad LVF, depression, but no explanation for midazolam | | |
| Unclear B | | | | |
| Unexplained By Illness C | | | | |

## General Comments

69-year-old woman, well until 1996, when she presented with LVF ?due to apico-posterior MI
Admitted (?)
1999-03-08
1999-04-27: Domicillary visit
1999-07-21: for control of cardiac failure, hypotension, dysphagia [Not for 555]
Transferred to Dryad 1999-08-05
Prognosis '3/12' 1999-08-12 [Watkins]

199/593 'Prognosis looks poor. I am happy for ny staff to confirm death.'

R. Diamorphine 20-200 mg in 24h 1999-08-05
R. Oramorph 5-10 mg 4hrly 1999-08-05
R. Midazolam 20-80 mg in 24h ?when prescribed Given from –08-14

NOTE:
no simple analgesic
no indication for midazolam [nursing notes say 'to keep Code A comfortable' 466/593]

**Final Score:**

**Screeners Name: R E Ferner**
**Date Of Screening:**

**Signature**

BJC/13
Code A
69

Severe heart failure, difficulty swallowing and depression.
12/8/99 seen by cardiologist who said the prognosis was around 3 months with no treatment options. She became very agitated over the next 2 days and was started on an infusion of midazolam to calm her down. This seems reasonable to me. I am not quite sure why the diamorphine was added at 20mg over 24 hours although if breathlessness was a feature, diamorphine can be useful. She died after 7 hours ie about 6-7 mg which is a small dose.

She had severe cardiac disease and died of this. I thought her care was reasonable.

PL grading A1

29-DEC-2003 5:02

| Exhibit No | Patient Identification | Assessment Note | Assessment score |
|---|---|---|---|
| BJC/13 | Code A | Clearly had a poor prognosis when admitted to GWM. Very frail. But the drugs written up on the day of admission, when she was essentially asymptomatic apart from exhaustion and a tendency to agitation, imply that death was expected.<br><br>Her cardiac review indicated that, because of her low output state, she would be very vulnerable to any drug which, as a side effect, lowered her blood pressure still further and that many normal psychiatric medications were therefore ruled out. It seems to me therefore that the dose of midazolam given when she became agitated on 14.8.99 was inappropriately high and given by an inappropriate route. Admitting that she had major swallowing problems and was therefore unwilling to have oral medication, the sublingual route would have been available, and small doses could have been titrated to response. I note the coincidence in time between starting the midazolam and the deterioration in her condition which occurred between 13.8.99 and 16.8.99.<br><br>On the day of her death I can see no indication that she reported pain. I am therefore at a loss as to why diamorphine 20mg, a high dose in a frail, completely opioid naïve lady, was started on that date. I suspect that the combined medication may have accelerated her inevitable death. | B3 |

# Expert Review

## Code A

## No. BJC/13

**Date of Birth:** Code A

**Date of Death:** Code A

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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.