

Other Document Form

Number

D 1241

Title AMEN) 69 EXPERT REVIEW RE Code A

(Include source and any document number if relevant)

Receivers instructions urgent action Yes No X REF WITH NOMINAZ MICLET
& PAULINE CASTLE.

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

Code A

O/M	SIO

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Code A

No. BJC/64

Date of Birth: **Code A**

Date of Death: **Code A**

Code A was living at home with her daughter at the time of her admission to Haslar 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/64

X **Date of Birth:** **Code A**
Date of Death:

X **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. X

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.

Note CORRECTION to THE ABOVE.

① **Code A** was 1st admitted to HASLER Hosp.
NOT Q/A Hosp THEN TO G.W.M. Hosp.

② SHE (**Code A**) HAD PARKINSON DISEASE
Which would account for the poor mental state

③ DATE OF BIRTH **Code A**

Please correct & return

Code A