HAMPSHIRE CONSTABULARY

CHARLES HALL

CHARLES HALL

Charles Hall

Date of Birth: Code A Age: **89**
Date of admission to GWMH: **5th July 1993**
Date and time of Death: **11.25 hours on 6th August 1993**
Cause of Death:
Post Mortem:
Length of Stay: **32 days**

Mr Hall's past medical history:-
Peripheral vascular disease
Non insulin dependent diabetic
Iron deficiency anemia

Mr Hall was married and lived with his wife in their own home. They had a daughter and received good help form their neighbours. Mrs Hall was finding it increasingly difficult to cope.
Mr Hall was admitted to the Royal Haslar Hospital where he underwent a sigmoid colectomy and colostomy following diverticullitis and a gangerous gall bladder. He was transferred from Haslar Hospital to Gosport War Memorial Hospital on 5th July 1993 for nursing care and assessment.

Care plan were commenced on 5th July 1993 for a blackened area to left heel, 7th July 1993 right elbow red and flaky, sacrum red and dry, 10th July 1993 sacrum slightly red, 14th July 1993 hygiene, poor mobility, vomiting, urinary incontinence, settle at night and colostomy.
An assessment of daily living was completed noting that Mr Hall had some shortness of breath on exertion, needed a diabetic diet, colostomy satisfactory, mobilises short distances with Zimmer frame.
A Waterlow score of 21 was recorded on 5th July 1993 and one of 22 was recorded on 29th July 1993.

5th July 1993

Admitted to Sultan ward from Haslar for nursing care and assessment.
Sigmoid colectomy and colostomy five weeks ago following diverticullitis and gangerenous gall bladder. Readmitted to Haslar one week ago wife could not cope, appetite down, colostomy working ok.
Nursing report – admitted from Haslar refer to Social Worker.

10th July 1993

Clinical notes state vomited x 3 brown fluid.
Nursing report – vomited x3 complaining of pain in abdomen. Fainted at lunchtime when stood up.
15.10 hours fall getting off commode. Accident form completed.

13th July 1993

Clinical notes state waiting physio and OT assessments. Abdomen soft.

14th July 1993

Clinical notes state Mr Hall was in renal failure.

15th July 1993

Clinical notes discussion with wife re poor prognosis.
Nursing report – seen by Dr Walters who has spoken with wife and patient re poor prognosis. Boarded for diamorphine 2.5mg-5mgs IM 4 hourly.

19th July 1993

Clinical notes state slightly better – pain at night from left foot. Morphine 5-10mg 4 hourly as required.
Nursing report – seen by Dr Walters boarded for oramorph 5-10mgs 4 hourly for neck pain.

22nd July 1993

Clinical notes state low R and diet. Continues to vomit. Sleeping better.

23rd July 1993

Nursing report – seen by physio wound treatment to heel discussed.

28th July 1993

Clinical notes state has necrotic heel – gradually improving.
Nursing report – referred to Dr Lord for long term care.

29th July 1993

Nursing report – seen by Dr Lord to be transferred to Daedulus ward.
Transferred to Daedulus Ward.
Clinical notes state seen by Dr Lord, Daedulus ward – renal failure much better. Diuretics stopped. Heel ulcer – black, sacrum red and vulnerable, confused. Suggest oral fluids and oramorph.

2nd August 1993

Clinical notes state black heel – 2" diameter, offensive, surrounding heel very red. Barthel 5. Encouraged fluids and oramorph if required.
Nursing report, seen by Dr Lord dressing to heel changed.

5th August 1993

Clinical notes state further deterioration needs analgesia and chat with wife.
Nursing report – condition deteriorating. Commenced on oramorph patient comfortable and appears pain free. Turned 2 hourly day and night.

6th August 1993

Nursing report – visited by wife at 10.30 hours fully aware of poor prognosis. Died peacefully 11.25hours certified by Sister Jones. Daughter contacted and Dr Barton informed.

Expert Review

Charles Hall

No. BJC/23

Date of Birth:

Date of Death:

Code A

Mr Hall was admitted to Gosport War Memorial Hospital on 5 July 1993 after he had undergone a sigmoid colectomy and colostomy following diverticulitis and a gangrenous gall bladder.

On admission, in addition to the rehabilitation issues following his abdominal surgery, he was suffering pain in his left foot which was associated with vascular disease.

He was started in August on oral Morphine which was converted to Diamorphine via a syringe driver on 5 August 1993.

The experts note that although he undoubtedly had severe underlying disease the acceleration from one dose of Oramorph to 40mgs of Diamorphine was sub optimal treatment.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
Code A

Exhibit number
BJC-23

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		Perhaps inevitable – unclear; R. 40 mg diamorph in 24h, then dies		
Unclear B				
Unexplained By Illness C				

General Comments

89-year-old married man, successful fem-pop bypass in 1987, chronic renal failure, recurrent anaemia of 4... grams, 1991,1992
1993 – sigmoid colectomy for benign disease in May or June
1993 – readmitted unable to cope; indwelling catheter, weak +++, Barthel 5, heel sore
1993-07-05 > GWMH
R.
1993-07-05 paracetamol up to qds
diamorphine and later oramorph and treatment for vomiting.
1993-07-14 Acute on chronic renal failure, K+ 6.9 on 'Frumil' and cimetadine...
1993-07-19 Morphine elixer [sic] 5-10 mg ?PRN or diamorphine 2.5-5 mg IM.

1993-07-29 > Daedalus
1993-08-05 'Further deterioration in general condition...'
R. diamorphine 40mg sc inf in 24h.
1993-08-06-11-25 dies

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

BJC/23
CHARLES HALL
89

Had recently been through major abdominal surgery. Past history of peripheral vascular disease and surgery for it. He was deteriorating before he arrived on Daedalus. The main problem seemed to be the vascular disease and the deteriorating heel ulcer causing pain. In July he had 2 dose of morphine elixir. On 5/8/93 he had 10mg of oramorph at 09.15 and was then put on 40mg of diamorphine via syringe driver at 17.00. He died the following morning.
He undoubtedly had very severe underlying disease and would have died but I consider the move from one dose of oramorph to 40mg to be excessive.

PL grading B3

BJC/23	Hall, Charles	Very frail and terminally ill when transferred to Daedalus. Poor prognosis had already been discussed prior to transfer. Given a single dose of oramorph 10mg. This relieved symptoms and made him comfortable. If he were not in renal failure, the diamorphine equivalent would have been 20mg/24hrs. Since he was, he probably only needed 10mg/24hrs. In fact was given diamorphine 40mg/24hrs as starting dose, and died within 24 hours. Nothing to suggest intent, only that there was a lack of understanding of how to go from oral to SC and how to allow for the effect of his renal failure	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7A

TO:
STN/DEPT:

REF:

FROM: DC Code A ROBINSON
STN/DEPT: MCIT, E

REF:
TEL/EXT:

SUBJECT: Charles Sydney HALL Code A

DATE: 28/10/2002

Sir,

I visited L Code A at her home address, Code A , in response to her letter dated 16/10/2002. This concerned her late father (details above) and the time he spent at the GWMH.

Ms. Code A will say that her father was a fit and active man. He had been a gunner in the Royal Artillary before leaving to become a diver's assistant and subsequently a publican.

He had undergone surgery for poor circulation in his foot around 1978, whereby he had a new vein inserted into his leg. He suffered no further problems with his leg but was diagnosed as a 'late onset diabetic'

Mr. HALL was admitted to Royal Hospital Haslar some time around May/June1993. This was due to him feeling unwell and being sick. He was diagnosed as suffering from a ruptured gall bladder, he underwent surgery for the removal of his gall bladder and the fitting of a colostomy bag.

Mr HALL made a full recovery and was discharged from Haslar some three weeks later to the care of his family.

He then returned home (Code A) be cared or by his wife,Violet Ethel HALL,b. 02/12/1904.

At this point in time Mr.HALL was up and dressed every day, he never remain in bed and was recouperating well,however, his elderly wife had suffered as a result of all the stress and worry of his illness and his operation and it was suggested by the district nurse that Mr. HALL be admitted to the GWMH,in order for his wife to have some respite.

Mr.HALL was initially put into a ward on the first floor, Mrs. H Code A cannot recall the ward name.

She states that her father was up and dressed every day, he never remained in bed. He was unhappy with the fact that he had to return to hospital when there was nothing wrong with him. He was eating normally and generally moaning and being grumpy with the staff. He spent his time listening to music and studying the racing form in his daily paper. He was in full use of all his facualties.

At this time he had a small bed sore on the heel of his foot but this did not cause him any real discomfort and to her knowlage he didn't require any special treatment for it.

Mrs. L Code A states that had her father been in pain then he would have moaned about it and everyone would have been aware of it.

Approximatly a week later, her father was moved to Dryad Ward on the ground floor so that he could access the garden area.

Mrs. Code A belived that her father was being moved so that he could receive some rehabilitation type care. She states that when he was admitted to the ward, he was dressed and fully mobile.

DOCUMENT RECORD PRINT

Mrs. Code A has given the following information in relation to the last week of her fathers life.
Sunday 1st August 1993 (01/08/1993). Mrs H Code A visited her father, he was sat in the day room listening to music on the radio, he was fully clothed in his suit. He told her that he didn't like it in the new ward and that he'd been dreaming about rabbits.
Mrs Code A T spoke to a nurse about her father because she thought that he had not been taking his diabetic medication. The nurse informed her that Mr. HALL had 'kidney problems' and this was the reason for him appearing strange.
On Mrs.H Code A T's next visit she was called in to the nurses office and asked if they could put her father on Morphine, when she asked why she was told that it would make him more comfortable. She states that she was told that Dr BARTON had said that she wanted him on Morphine.
Mrs. H Code A refused to give her consent and suggested that they ask her mother, who was his legal next of kin. At the time of this visit her father was up, dressed and appeared well.
Mrs.H Code A T states that her father never complained to her or her mother of any pain.
Thursday 5th August 1993 (05/08/1993)
Mrs Code A visited her father with her husband. Mr. HALL was in bed and was able to have a normal conversation with them. She did not notice any sort of apparatus around her father which could have been used for administering drugs.
Friday 6th August 1993 (06/08/1993)
Mr. HALL was visited around 0900/1000 hrs by his wife and a neighbour. He was described as sleeping peacefully.
Around midday, the hospital contacted Mrs. Code A T to inform her that her father had died.
Monday 9th August 1993 (09/08/1993)
M Code A T took her mother to the GWMH in order to collect her fathers belongings and his death certificate.
They were concerned and distressed to see that the cause of death had been given as Bronchopneumonia and Senile Dementia. The certificate was certified by Dr.BARTON.
Code A states that her father never displayed any symptoms of dementia nor was it ever discussed with her family whilst he was in hospital.
She was also concerned that there was nothing that related to her fathers 'kidney problem'.
She states that her family didn't want to query the certificate because her mother was extremely upset and as she said 'it wouldn't bring him back'
Mr. HALL was cremated in accordance with his long held wishes, there was no post mortem.
Mr.HALL's GP was Dr. LYNCH, Stakes Rd Surgery, Gosport.