MC7

Other Document Form

Number: 1559.

Title E-MAIL 14/8/08 re MACKENZIE LETTER

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated No(s) of actions raised	Receiver **Code A**
Statement readers instructions	Statement Reader
Indexed as indicated No(s) of actions raised	Indexer
Examined - further action to be taken	O/M | SIO
Further action no(s)	Indexer
When satisfied all action raised, Office Manager to endorse other Document Master Form.	

Code A

From: Code A
Sent: 14 August 2008 16:15
To: Williams, David
Cc: McTavish, Philip
Subject: Rochester

Dave

Relevant extract from Dr Black's statement
Dr Black

SUMMARY OF CONCLUSIONS

Gladys RICHARDS presents an example of a common, complex problem in geriatric medicine. A

Code A

In my view a major problem in assessing this case is poor documentation in Gosport Hospital in both the medical and nursing notes, making a retrospective assessment of her progress difficult. Good Medical Practice (GMC 2001 states that "Good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"....."in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical case must include - taking suitable and prompt action when necessary".... "Referring the patient to another practitioner when indicated...."in providing care you must - recognise and work within the limits of your professional competence"..."prescribe drugs and treatments, including repeat prescriptions only where you have adequate knowledge of the patients health and medical needs". The lack of detail in the medical notes, the absence of evidence of asking for advice on 17th August and the lack of recording why decisions were made or if the patient was properly examined present poor clinical practice to the standards set by the General Medical Council. In particular, I am concerned the anticipatory prescription of Opioid analgesia on her admission to Gosport War Memorial Hospital. If no justification for this can be identified or proven, then I believe that this was negligent practice and may have contributed to her fall on the ward. **I also believe that th** Code A

Code A

Re Lacks statement

This was taken on 11/08/04 so it was never forwarded to CPS it was not forwarded to Dr Black when he made his statement but her concerns are

Haematoma as the reason to prescribe diamorphine.

In my original statement I refer to **Phillip BEED** N45 telling me that my mother had developed a massive haematoma and that this was the cause of her pain and the reason for the use of **Diamorphine** C64. This conversation took place on Tuesday 18th August 1998 (18/08/1998).
This is in Mrs Lacks first statement and was forwarded to CPS

On 21st August 1998 (21/08/1998) my mother died. I was present at her death and shortly afterwards I and

my daughter Code C N74 laid my mother out.

We washed her face and hands and brushed her hair. We then changed her into a clean nightie. In order to change the nightie we had to turn her on to both sides so I had a clear view of her body. There was no sign of a haematoma nor did she have any pressure sores. (This was not mentioned in her first statement) (Karen Read was never statemented nor it appears seen)

There is no mention of haematoma in Dr Blacks statement although in the medical notes he examines he states the following

When she is transferred to Gosport War Memorial Hospital she is seen by Dr BARTON who fails to record a clinical examination apart from a general statement she is a frail and dementedaslarH lady. However, she does state she is not obviously in pain. Despite this, she has written up her drug charts for both low dose of Code A I can find no clinical justification at all for this in the notes. If she was worried about pain and feared that it would be hard for the nursing staff to get hold of the doctor, then it would be reasonable to write up a prn of a mild pain killer such as Paracetamol and then possibly a small dose of an Opioid if ordinary analgesia did not work. Dr BARTON also writes up on the regular prescription side a significant dose of Code A , although this has prn put next to it. I believe this to be highly sub-optimal prescribing.

There is no clear reason from the prescribing of the Code A which again Dr Black is critical of.

<u>Bronchopneumonia as cause of death</u>.

Dr Black addresses this

There is no doubt that after people have been dying over a number of days, if a post mortem is performed, then secretions and changes of Bronchopneumonia are often found in the lungs as the very final agonal event. This allows clinicians to put the phrase "Bronchopneumonia" on the death certificate. Unfortunately, under current guidance to Coroners if 'fractured neck of femur' is written on the death certificate, then the Coroner has little option but to perform a post mortem as the death is deemed to be non accidental. Where patients have not died immediately after a fractured neck of femur, some Coroner's Officer's encourage clinicians to leave 'fractured neck of femur' off the death certificate to save the relatives the potential trauma of a post mortem. I believe this is poor national practice, but it is not a specific criticism in this case.

I hope this makes sense if you want me to forward the complete statements I can do although they are both some 20 pages long

Regards
R