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Number T293.

Title EMAIL Code A WITH EXPERT REVIEWS FOR QA.

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Code A

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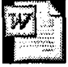
Code A

From: Code A
Sent: 09 March 2005 09:23
To: Code A
Subject: FW: Operation Rochester



3229009_1.doc (30 KB)

Dick,

Please QA the attached as usual.

Thanks,

Owen.

-----Original Message-----
From: Lohn, Matthew [mailt Code C
Sent: 08 March 2005 13:55
To: Code A
Cc:
Subject: FW: Operation Rochester

Owen

Further to our discussions today please find attached my conclusions on the four 3A's. I am happy for them to remain classified as 3A's although as mentioned the cases have been particularly difficult to review since the team concluded there was negligence on the part of the treating physicians.

I will forward under separate cover today the amount and payee instructions for our bill.

I look forward to hearing from you in due course with regards to an update on the progress of the investigation

Kind regards

Matthew

MATTHEW LOHN
Partner
Public and Regulatory Law
Code A
m Code A
w

<<3229009_1.doc>>

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Norma Windsor

No. BJC/56

Date of Birth: Code C

Date of Death: 7 May 2000

Mrs Windsor was admitted to Gosport War Memorial Hospital on 27 April 2000 complaining of weakness, exhaustion and depression following a recent bout of diarrhoea and vomiting.

Prior to her admission, Mrs Windsor had been waiting a heart bypass following a sub endocardial myocardial infarction in 1998.

On 5 May 2000 Mrs Windsor suddenly deteriorated with low blood pressure and a thready pulse.

Mrs Windsor was transferred to St Mary's General Hospital for acute medical care but died two days later.

The experts, in reviewing this case, have questioned whether the GP caring for her in Sultan Ward had appreciated how ill she had become. Differential diagnoses were considered including severe sepsis, or an adrenal crisis. In the context of the investigation being undertaken by Operation Rochester, it should be noted that there is no evidence of any significant analgesia being prescribed to Mrs Windsor while she was an inpatient at Gosport War Memorial Hospital.

Thomas Jarman

No. BJC/29

Date of Birth: Code C

Date of Death: 27 October 1999

Died
10/11/1999.

Prior to his move to the Code C in June 1999 Mr Jarman was a Code C

Mr Jarman had been diagnosed with hairy cell

leukaemia in May 1999.

Mr Jarman was admitted to Queen Alexandra Hospital and then transferred to Gosport War Memorial on 27 October 1999 for rehabilitation following an episode of bronchopneumonia.

Mr Jarman was recorded, on admission, to be choking on his feeding and was seen by the speech and language therapist.

On 7 November 1999 Mr Jarman was noted to be distressed and agitated and was given oral Morphine with no effect. That night Mr Jarman remained distressed and screaming louder; a syringe driver was commenced with Midazolam and low dose Diamorphine.

Further deterioration was noted on 8 and 9 November 1999 and the doses of Diamorphine were increased. Mr Jarman became unresponsive and was felt to be pain free.

Although there was some concern expressed by the experts in reviewing this case at the escalating levels of Diamorphine, it was felt that the underlying medical problems would account for his death and there was no evidence of any intent other than to make Mr Jarman comfortable in his terminal phase.

Edwin Carter

No. BJC/08

Date of Birth: Code C

Date of Death: 24 December 1993

Mr Carter was a Code C and was admitted to the Gosport War Memorial Hospital on 8 November 1993 for pain control and long term care. Code A previous history of a cerebrovascular accident and was believed to have Code C

On admission, it was noted that Mr Carter was reluctant to eat, needed help with personal hygiene and used a Zimmer frame for mobility. The notes, on admission, state that Mr Carter was not suffering but on 20 November 1993 Mr Carter began deteriorating and was commenced 20mgs of Morphine Sulphate.

Although Mr Carter requested his medication be stopped on 22 November 1993 he was complaining of pain again on 11 December 1993 when Oramorph 10mgs was given.

Mr Carter was seen by Dr Lord on 20 December 1993 were it was noted that a syringe driver could be commenced when necessary. This proved to be the case on 22 December 1993. Mr Carter died two days later.

Some of the experts note that the dose of opiates was quadrupled at the time of transfer to a syringe driver.

Although the experts questioned why such dosage should have been given, they acknowledge that Mr Carter was already so close to death that it would not have made any significant difference to his length of life.

There was a variation in initial views amongst the experts but they concluded, on reviewing the notes that, although the treatment may have negligent, it did not appear there was any attempt to cause harm to Mr Carter.

Clifford Houghton

No. BJC/28

Date of Birth: Code C

Date of Death: 6 February 1994

Prior to his last admission to Gosport War Memorial Hospital Mr Houghton lived with Code C

Mr Houghton had suffered a right hemiparesis in 1991 which impaired his mobility and power of speech.

In October 1993, since Mrs Houghton was finding it increasingly difficult to cope, Mr Houghton was admitted for two weeks care at the Gosport War Memorial Hospital at six weekly intervals.

Because of suspected transient ischaemic attacks, Mr Houghton was admitted on 31 January 1994 prior to the completion of the six week period at home.

On 3 February 1994 Mr Houghton's condition was described as deteriorating, he was breathless and distressed. He was written up for a syringe driver which was commenced on 6 February 1994. The initial dose of Diamorphine was 40mgs over twenty-four hours which was increased to 60mgs following a review by Dr Peters.

Mr Houghton died that evening.

The experts, in reviewing this case, note that the dose of Diamorphine which was started was high but Mr Houghton was clearly in the terminal phase of his life already.

The experts felt that the high starting dose was negligent but needed to be viewed in the context of a man who was dying in any event.