Other Document Form

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Examined - further action to be taken

Further actions no(s)

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

Code A

O/M	SIO

Indexer

Code A

From: Williams, David M
Sent: 04 May 2005 14:34
To: Code A
Cc: Grocott, David; Niven, Nigel; Code A
Subject: Code C CPS file.

Code A

Please delete my E mail of yesterday.. I have now reviewed the Code C reports from Dr BLACK and added the key points to the attached overview which I will forward to the CPS in letter format highlighting the key issues..

Operation
CHESTER PITTOCK.c

Operation ROCHESTER.

Code C Code C

KEYPOINTS May 2005.

Code C Code C Born Code C Code C

Code A

Code A

Code A

Code A

Medical records examined by Key Clinical team who assessed the care delivered prior to death as negligent and cause of death unclear.

Code A

Code A

Code A

Code A A

2 Code A

2

2

Case assessed by multidisciplinary key clinical team. 2004.

Code A

Dr Jane BARTON. From caution interview with police 3.3.2005.

Workplace demands were substantial. A choice to be made between detailed note making or spending more time with patients.

Due to demands of work adopted a policy of pro-active prescribing.

Dr BARTON noted Dr LORDS poor prognosis of Code C on 5 Code A nd believed that Dr LORD felt that Code C was unlikely to get better and that he was not likely to live for a significant period.

Following admission to GWMH on 5 Code A Code C placed under the care of Dr Jane TANDY. Assessed by Dr BARTON.

Would have seen Code C ery week day Monday to Friday.

Dr BARTON made the note of 9th January 1996, prescribed arthrotec for pain in the hand.

Mr Code C seen by Dr BARTON and Dr TANDY on 10th January.. Dr TANDY noted dementia etc, and wrote that he was for TLC. This indicated to Dr BARTON that Dr TANDY agreed with Dr LORD'S assessment and felt Mr Code C was not appropriate for attempts at rehabilitation but for appropriate nursing care and treatment only. Discussed with Code A

Dr BARTON prescribed Oramorph no doubt as a consequence of liaison with Dr TANDY. This was for relief from pain anxiety and distress. Also proactively wrote prescription for diamorphine upon the basis that Oramorph may be insufficient, and that further medication should be available should he need it.

On Monday 15th January 1996 Dr BARTON would have reviewed all of the patients in the usual way including M Code C . Believes she may have been Code A condition had deteriorated over the weekend experienced marked agitation and restlessness and significant pain and distress. Believe assessment was that Code C Code C terminal decline.

Tried to judge medication as necessary to provide appropriate relief whilst not excessive.

Dosages effectively increased appropriate to increased pain/ distress of patient.

Code A

Code A Code C settled. With quiet breathing not distressed.. drug treatment continued therefore not inappropriate.

Code A

the most likely cause of death.

Code A

- Given patient numbers 44, and admission numbers Dr BARTON should have been able to satisfactory manage in a half post as clinical assistant with regular consultant supervision.
- It is completely unacceptable for the trust to have left Dr BARTON with continuing medical responsibilities without consultant supervision and regular ward rounds, to fail to do so would be a serious failure of responsibility by the trust in its governance of patients.

Expert Dr David BLACK (Geriatrics) reports that Code C was extremely frail and dependent, and at the end of a chronic disease process of depression and drug related side effects spanning 20 or more years.

- Problem in assessing care due to lack of documentation.
- Lack of notes represents poor clinical practice, no written justification for high doses of Diamorphine and Midazolam.
- Drug management afforded to patient is sub-optimal.
- Starting dose of 80mgs of diamorphine is approximately 3 times the dose that conventionally applied.
- Combination of higher than standard doses of drugs, Diamorphine, and Midazolam combined with Nozinan likely to have caused excessive sedation and may have shortened life by a short period of time, hours to days.
- Whilst care is sub-optimal cannot prove to be negligent or criminally culpable.
- Predictions of how long terminally ill patients live are impossible, even palliative care experts show enormous variation.
- Medication likely to have shortened life but not beyond all reasonable doubt.

Other key witnesses.

Code A

Dr Althea LORD employed as Consultant Geriatrician at GWMH, Queen Alexandra Hospital and St Mary's Hospital Portsmouth between March 1992 and June 2004. Consultant for all patients over 65yrs requiring specialist care for their physical health. Assessed Code C prognosis as poor (ie patients chances of survival were slim and unlikely to survive for long) on 4th January 1996, transfer to GWMH

Dryad ward in order to address patients physical and psychiatric needs. Not intended to be a comprehensive care plan.

Dr Jane TANDY employed by East Hants Primary Care trust as Consultant Geriatrician in elderly medicine since 1994, covered Dryad ward until late 1996. On 10th January 1996 DR TANDY had overall medical responsibility of the ward. Dryad was a long term care ward containing frail and elderly patients difficult to manage due to medical or nursing requirements. There was no resident doctor on the ward which was covered by local GP Dr BARTON. Dr TANDY's responsibilities included a ward round once fortnightly. No requirement for a GP to notify Dr TANDY of every change to drugs prescribed to patients, unless her advice was sought by the GP, this occurred infrequently.

Code A Dr TANDY conducted a ward round with Dr BARTON and Sister HAMBLIN and prescribed 5mg Oramorph to alleviate pain and distress. Thereafter Dr TANDY recites the drugs prescribed by Dr BARTON, and comments that she would have used lower dosage of Diamorphine and Midazalam (than prescribed by Dr BARTON) her practice was to use the lowest dose to achieve the desired outcome diminishing adverse effects. There was no resident doctor to review the medication.

Dr Michael BRIGG a Gosport general practitioner. On 20th January 1996 responding to nursing concerns as to the patients clinical response to Haloperidol, Dr BRIGG stopped the dose and increased dose of Nozinan. He did not see the patient at the time but visited later.

Nurse Gillian HAMBLIN. Consultants attended once fortnightly on Mondays unless on leave when it would be monthly. Her practice was to challenge Dr BARTON if she did not feel levels of drugs prescribed were appropriate. Syringe drivers used once a patient becomes incapable of swallowing. The term TLC means that a patient was very likely to die. Nurse HAMBLIN commenced the syringe driver diamorphine on 15.1.1996., and an increased dosage on 18.01.1996. There no policy or protocol regarding the use of syringe drivers prior to 2000.

Nurse Lynne BARRATT administered Diamorphine to Code C on the Code A

Code A

Nurse Freda SHAW administered Diamorphine to Code C Code A

Code A n accordance with policy witnessed the accurate recording of Diamorphine prescribed, and recorded on drug charts.

Nurse Sharon RING re - charged the syringe driver with Diamorphine on Code A and witnesses and recorded the withdrawal of Diamorphine for the patient on 4 other occasions.

Nurse Fiona WALKER witnesses withdrawal of drugs for Code A

Nurse Mary MARTIN variously administered Code A and verified the death of Mr Code A