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

Receiver

Code A

O/M	SIO

Indexer

Grocott, David

From: Code A
Sent: 10 February 2004 09:51
To: Grocott, David
Subject: FW: gosport reports

Gosport-1-58.doc
(74 KB)

-----Original Message-----
From: Peter.Lawson@ Code A
Sent: 26 November 2003 07:41
To: Code A
Subject: gosport reports

Dear Code A
Attached should be the reports for all the cases up to the last meeting. Just done the first case of the new batch and will work my way through them in time for a meeting in the new year.

Peter

<<Gosport-1-58.doc>>

Peter Lawson
Consultant Physician and Geriatrician
N[illegible]al
Code A
Code A

BJC/01A
VICTOR ABBATT
Code A
Admitted with bronchopneumonia
Was cyanosed at time of admission
Given temazepam 10mg at 2215
Died at 0005

Bad medicine to prescribe and give temazepam to someone with breathing difficulties
But already very unwell
PL grading A2

BJC/02
DENIS AMEY
Code A
There are no drug cards or relevant nursing notes
Severe PD
Developed gangrenous – decided on conservative treatment

Started on morphine elixir on 11/12/90
On 120mg diamorphine sc per 24 hours by 19/12/90

This is a huge dose but might have been appropriate
There is not enough detail in the notes to be sure of what the opiate requirements were
- probably some medication cards and casenotes missing

He was clearly very unwell and in pain
However the dose of opiate might have contributed to his death
PL grading B but difficult to give a number

BJC/03
LILY ATTREE
Code A

Known to have nasopharyngeal ca invading base of skull

Started oromorph prn	15/8/96	25mg total
	16/8/96	20mg total
	17/8/96	20mg then started 20mg 4 hourly
converted to sc infusion on	20/8/96	50mg/24 hours

slight dose increase from oromorph to driver but probably needed because of pain

increased to 75mg/24 hours on 21/8/96 then kept stable until death on 24/8/96
Terminal disease, dealt with well

PL grading A1

BJC/04
EDITH AUBREY
Code A

Fractured neck of left femur
DHS repair 2/10/94

Previous medical problems eg cerebrovascular disease, dementia and stroke
29/4/96 Fentanyl started, distress when being moved, control of pain
14/5/96 increased to 50mcg
20/5/96 increased to 75mcg
Diazepam continued to help with distress
Reasonable conversion to diamorphine syringe driver
Midazolam also used for agitation

The final cause of death is not entirely clear
Management of pain and distress was reasonable

PL grading B1 or B2

BJC/05
HENRY AUBREY
Code A

Unproven but probable diagnosis of lung carcinoma

No records for episode prior to transfer to Dryden except Dr Reid's letter and nursing transfer letter. Neither mention significant pain. Dr Bee Wee mentions opiates for control of cough.

Was on oromorph 10mg BD on 25/5/99
Transferred to Dryden on 1/6/99
Immediately put on fentanyl 25mcg patch and also given oromorph 10mg
Following day at 09.25 given syringe driver with 60mg diamorphine and 40mg midazolam. He died at 18.30

He had a terminal diagnosis and was recognised to have given up.
However the need for such a large dose of diamorphine is unclear (distress is mentioned but not pain).

PL grading B3 because the doses cannot be justified by the available notes.

BJC/06
ELLEN BAKER
Code A

sudden deterioration soon after admission. Consistent with acute myocardial infarction and pulmonary oedema. Treated appropriately with oxygen, frusemide (diuretic) and small dose of diamorphine. There are no concerns about this one.

PL grading A1

BJC/06A
CHARLES BATTY
Code A

History of Code A
Lengthy stay in hospital, condition appeared stable with agitation and difficult behaviour. This was initially treated with lorazepam and thioridazine.
Pain mentioned in nursing notes on 28/12/93 not mentioned in available medical notes. Cause of pain not clear. Went from little analgesia to oromorph 60mg in 24 hours. Within 8 hours converted to syringe driver with an increase in dose. Dose kept stable for next 3 days up to his death.

Cause of pain unclear. Large opiate dose without other forms of pain relief and rapid change to driver. Cause of death is unclear.

PL grading B2

BJC/06B
DENNIS BRICKWOOD
Code A

Hip fracture, Code A osteoporosis with vertebral fractures, myeloma.
Aiming for home but had an unsuccessful home visit.
Developed musculoskeletal chest pain and chest infection. Chest xray suggested anterior rib fracture. Codydramol ineffective. Converted to oromorph then dose increase to MST then large dose increase to syringe driver. Died 24 hours after starting driver. No other analgesics tried ?would have responded to NSAID or heat packs.

Cause of death unclear and use of analgesia was not ideal

PL grading B2

BJC/07
STANLEY CARBY
Code A

Admitted with a severe stroke, rapidly deteriorated and died.
When he deteriorated he was prescribed a large dose of diamorphine via driver. However he died within 45 minutes of it being started ie too soon for it to have a significant effect.

Cause of death was the extension of stroke. The large dose of diamorphine makes care sub-optimal but it no effect on his death.

PL grading A2

BJC/08
EDWIN CARTER
Code A

2 previous strokes
Code A of stomach
Was in pain at time of admission. Initially controlled with MST at 20mg twice daily. Increased to 30mg BD on 13/12/93. Deteriorating and report of pain appearing to be uncontrolled when being turned on 22/12/93. Diamorphine and midazolam syringe driver set up. MST 30mg BD changed to diamorphine 80mg via syringe driver ie approx 4-fold increase in dose. Died on 24/12/93.

Likely to have been dying of his Code A and he started to deteriorate before the syringe driver was set up. But the dose change appears excessive.

PL grading A3

BJC/08A
EDITH CHILVERS
Code A

Dense stroke with severe pain ?thalamic in origin. Only 23 pages of notes and it is difficult to know how the opiates were titrated against the pain. She ended up on a very high dose but it might have been appropriate and I cannot give a grade from the available notes except to say that the description of the stroke suggests it was enough to account for her death.

BJC/09
SIDNEY CHIVERS
Code A

Had a stroke. Initially doing fairly well but it became clear he was not going to make it home. There was a suspicion of ~~Lewy Body Dementia~~ Code A for which traditional antipsychotics should be avoided; his dose of risperidone was increased (risperidone is a new antipsychotic which should have been OK). He deteriorated soon after the dose increase with pain in his hands and also abdominal pain. Treated with opioids and then large dose of midazolam.

I am not sure what his pain was caused by although stiffness and pain could have been due to risperidone and abdominal pain due to constipation. After starting with oramorph the opioid dose was escalated through fentanyl 25mcg to diamorphine driver 60mg and 80mg midazolam in 3 days.

Cause of death unclear and opioids escalated without trying other ways of stopping the pains.

PL grading B2

BJC/10
HUBERT CLARKE
Q4
Code A

A man with cerebrovascular disease and falls
In his short hospital admission he suffered cardiac chest pain and a pneumonia. He was well looked after with good use of medication via a syringe driver.

PL grading A1

Code A

Code A

Code A

BJC/13

Code A

69

Code A

BJC/14
RONALD CRESDEE
Code A

Code A of bronchus with oesophageal obstruction and stent.
Started with prn oramorph then regular oramorph, dose increased and then diamorphine syringe driver. Good dose conversion. Cause of death clear.

PL grading A1

BJC/15
ARTHUR CUNNINGHAM
Code A

Code A
Admitted from a Nursing Home with "Code A behaviour.
In June 1998 could use a mobile phone and went into Gosport in a taxi.
Admitted from Day Hospital with large necrotic sacral sore.

The sacral sore must have been painful but the reasons quoted for starting the diamorphine/midazolam infusion were related to his behaviour. Even on 23/9/98 when his became more bubbly the change to the infusion was to increase the midazolam ie sedation rather than hyoscine to reduce secretions. Pain mentioned by Dr Barton on 24/9/98 as controlled just. No mention of pain on 25th and 26th September but the dose of diamorphine was increased on both days.

Cause of death probably bronchopneumonia although the medication might have contributed to it. Care sub-optimal

PL grading B2. Different to the majority view but I can see why others would grade worse.

BJC/16
ELSIE DEVINE
Code A

Multi Code A moderate chronic renal failure, paraproteinaemia.
Occasionally aggressive and restless. Prescribed thioridazine for this.
When she became more agitated she was started on fentanyl and then converted to large doses of diamorphine and midazolam via a syringe driver. Pain was not raised as an issue.

Cause of death is not clear and the use of opioids questionable especially when considering the doses.

PL grading C2

BJC/17
CYRIL DICKS
Code A

Code A very dependent.
Deteriorating gradually then rapidly over the weekend of 20-21/3/99. One nursing record states sc analgesia and midazolam started on 20/3/99. There is no record of this on the available medication cards or in the medical notes. Elsewhere in GWMH notes the nurses write diamorphine doses given via syringe driver in the notes in red. This is not done here. I do not know if he was given diamorphine.

Cause of death is not clear anyway but if diamorphine was not given it was natural. Care reasonable but he fell on the ward and they were prepared to use diamorphine where it was not clearly indicated.

PL grading A2

BJC/18
KATHLENE ELLIS
Code A

Code A stroke developed a chest infection. They tried to feed via a nasogastric tube but could not. Gave thickened fluids, she deteriorated. Care was of a good standard.

PL grading A2

BJC/19
MARY GERMAN
Code A

Code A ith spinal secondary deposit.
In pain. Controlled by MST. There was a brief period on oramorph before an appropriate conversion to diamorphine via syringe driver. Good use of analgesia.

PL grading A1

BJC/20
LEONARD GRAHAM
Code A

Code A a with hallucinations and infection, probably chest. This was treated but he continued to deteriorate. He had a sudden terminal event and was given an appropriate small dose of diamorphine. He died rapidly.

PL grading A1

BJC/21
SHEILA GREGORY
Code A

Fractured neck of femur, other medical problems

The original aim was rehabilitation but there was an early entry about keeping her comfortable. There was a suggestion of a stroke early in her stay in GWMH and she deteriorated. The decision was then made to refer for Nursing Home care ie she was unlikely to improve any further. She then deteriorated with distress and breathlessness. The staff wondered about a chest infection but did not start antibiotics. Oramorph helped the distress and breathlessness so she was started on a reasonably low dose of diamorphine through a syringe driver. They gave frusemide as a diuretic in case the breathlessness was due to fluid on the lungs. In the end the cause of death was not entirely clear. I wonder if they should have tried antibiotics or explained why they were not used. However I think she would have died whatever was done from 15/11/99.

PL grading B2

BJC/22
HARRY HADLEY

Code A

Code A f bladder. They originally tried to help with the agitation without increasing the opiate but had to re-introduce MST. The starting dose of diamorphine looks too high but they increased it the next day, tried to reduce it and found that they had to increase it again. The underlying illness was terminal but the control of agitation and distress was handled poorly.

PL grading B2

BJC/23
CHARLES HALL
Code A

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/24
NORA HALL
Code A

Adenocarcinoma of the pylorus. Pain and vomiting were the issues. Pain control was done very well (with low doses of opiates via syringe driver) and vomiting was addressed but proved difficult to stop.

PL grading A1

BJC/25
EILEEN HILLIER
Code A

Carcinoma of breast in 1962 treated by mastectomy and radiotherapy. Admitted for treatment of depression. Sinuses on chest wall started discharging and then bleeding. She was physically deteriorating and the consensus opinion was for palliative care. Low doses of opiates were used and the only element I did not like was the administration of diamorphine by intramuscular injection rather than subcutaneously.

PL grading A1

BJC/26
ALAN HOBDAY
Code A

He had a severe stroke followed by an extension of the stroke. There were feeding difficulties but he made some progress. On 7/9/98 he developed focal seizures and increased pain in his arm. Diamorphine via syringe driver started and the dose needed increasing because of ongoing discomfort. I would have started at 10mg rather than 20mg over 24 hours (hence grade 2) but otherwise the analgesia was appropriate and well controlled. Cause of death was the stroke.

PL grading A2

BJC/27
ALBERT HOOPER
Code A

Code A with multiple medical problems. Became chesty and was given sc hyoscine to dry his secretions. He continued with pain and required a small sc dose of diamorphine. When it became clearer that he had a chest infection antibiotics were not given but this was probably appropriate. It was decided to treat him palliatively (ie inevitably going to die) and this was done well.

PL grading A1

BJC/28
CLIFFORD HOUGHTON

Previous disabling stroke. Deteriorated during this admission possible due to a further stroke. He became agitated and distressed. Started on 40mg diamorphine via syringe driver without a dose for immediate relief. 3 hours later a bolus dose was given and the driver dose was increased to 60mg. He died 8 hours later. Cause of death probably related to the stroke but the starting dose of diamorphine appears very high and rapidly increased. This could have contributed to his death.

PL grading B3

BJC/29
THOMAS JARMAN
Code A

Hairy cell leukaemia. Possible stroke and infection on admission. In his last few days he was distressed and agitated with some pain/discomfort on being turned. The difficulty is knowing how much of the distress and agitation was due to pain. Trying midazolam and low dose diamorphine via syringe driver seems reasonable to me but the dose escalation at the end seems excessive. The underlying medical problems were enough to account for his death.

PL grading A3

BJC/30
ELSIE LAVENDER
Code A

Head injury or brain stem stroke. She had continued pain around shoulders and arms for which the cause was never found. It was possibly musculoskeletal pain from the fall downstairs. Other forms of analgesia such as anti-inflammatory drugs or hot/cold packs might have worked. The most worrying aspect is the big dose escalation when converting from MST to diamorphine via syringe driver (approx 5 fold dose increase). The cause of death is not clear and the dose escalation might have contributed.

PL grading B3

BJC/31
CATHERINE LEE
Code A

Severe Code A and hip fracture. Required oramorph on admission to GWMH. Described as being uncomfortable but better on oramorph. The dose of opiates was converted well from oral to subcutaneous. She had medical problems with a poor outlook but the main descriptions in the notes are of restlessness and agitation rather than pain. The final cause of death is not clear although the medical problems were probably enough. Indication for the opiates is not entirely clear.

PL grading B2

BJC/32
STANLEY MARTIN
Code A

Suffered a dense stroke, deteriorated rapidly because of either a chest infection or myocardial infarction. Small dose of opiate used appropriately.

PL grading A1

BJC/33
DULCIE MIDDLETON
Code A

Suffered a dense stroke requiring feeding through a gastrostomy feeding tube. Developed pneumonia and abdominal pain requiring analgesia. Doses of analgesia were appropriate and she died of natural causes.

PL grading A1

BJC/34
GEOFFREY PACKMAN
Code A

I have more concerns with this case than the other members of the team. This man was treated for a myocardial infarction but died of a gastrointestinal bleed. I have been told that this was considered as the diagnosis in Queen Alexandra Hospital and the decision was made not to treat it. I have not found this and I believe they did not take this seriously in GWMH and treated him with opiates. I consider the cause of death to be natural (although potentially treatable) and the medical care terrible.

PL grading A3
If I can be shown a clear decision to treat the GI bleed conservatively the grading will be A2

BJC/35
EVA PAGE
Code A

Carcinoma of lung. Described as distressed and anxious. The care and use of analgesia seems reasonable although they flirted with fentanyl for a short while and used intramuscular injections. Cause of death natural. Care being graded as sub-optimal is perhaps a little picky but relates to the changes in opioid and method of administration rather than the doses used.

PL grading A2

BJC/36
GWENDOLINE PARR
Code A

Repaired fractured neck of femur and umbilical hernia repair. Past history of dementia. Tried thioridazine for agitation but then used low dose opiates. Medication for heart failure was initially dropped and then increased although the reasons for this were not clear.

PL grading A2

Code A

BJC/38
MARGARET QUEREE
Code A

Had significant medical problems prior to operation for Code A Urine and Code A infections after the operation. She appears to have become physically frailer and more confused. She was reported to be in pain when the MST was started at a low dose. After 3 days of MST she was more agitated and distressed. She was then started on a high dose of diamorphine via a syringe driver with 5-fold increase in the relative dose over 2 days. Although she died of the combination of medical problems, the use of opiates and sedation (midazolam) was poor with rapid dose escalation. However the escalation appears to be in response to patient distress and the starting dose was reasonable.

PL grading A2

BJC/39
JOAN RAMSEY
Code A

Died in Bognor Hospital ?wrong case notes.

BJC/40
VIOLET REEVE
Code A1

Stroke with marked left sided weakness and later she developed swallowing difficulties. The main problem was intermittent distressing crying out for no obvious reason. There were 2 second opinions. The first suggested trying regular low doses of oramorph and an antipsychotic agent. The next opinion agreed and said to avoid sedation. It looks as though they found midazolam the best way of controlling this behaviour and therefore continued sedation. When diamorphine was introduced into the syringe driver it was at a lowish dose and kept at that level until the last 24-36 hours. The dose was trebled in the last 36 hours but she was more agitated and it was apparent that she was dying.
The death was because of her medical problems but they did struggle to control her distress and crying out even after taking second opinions.

PL grading A2

BJC/41
GLADYS RICHARDS
Code A

This lady had a fractured neck of femur replaced with a hemiarthroplasty. This dislocated and she needed a further operation. There was pre-existing Alzheimer's. On return to GWMH she had pain treated with oramorph as required. She then developed severe pain and required a regular background of analgesia via syringe driver. The starting dose of 40mg seems excessive but her opiate requirement had increased considerably in the 15 hours before the driver was started and the dose is probably acceptable. I do not consider the opiates to be implicated in her death. The standard of care probably sub-optimal eg fall out of chair leading to dislocation.

PL grading A2

BJC/42
JAMES RIPLEY
Code A

The question here is whether what happened on 9/4/00 was due to excessive use of opiates. He had not received MST for more than 24 hours before that event and he recovered rapidly. Furthermore the A&E record states that the pupils were equal and reactive. They are not recorded as being pin-point.

PL grading A2

Code A

Code A

BJC/44
ELIZABETH ROGERS
Code A

This lady had severe Code A Disease and there was a question about a stroke at the time of admission. Admitted to Haslar with a possible stroke. Too unwell for a Nursing Home so transferred to GWMH. Seen to be in pain especially when moved. Started on oramorph as required but this did not completely control the pain so put on diamorphine via a syringe driver. The dose approximates to a doubling of opiate. She became comfortable and deteriorated further. I cannot find a reason for the final diamorphine dose increase on her final day. Medical problems were enough to account for her death but the opiate dose was escalated quickly.

PL grading A2

BJC/45
ENID SPURGIN
Code A

She fell and fractured her right hip. Repaired with a dynamic hip screw. She could get from bed to chair with the help of 2 nurses before transfer and had paracetamol as required for pain relief. Pain became an issue as soon as she arrived on Dryad. Analgesia started with oramorph regularly then regular codydramol and then MST at low dose. The dose was increased after continued pain was noted. She had deteriorated on the day a syringe driver was started but she is recorded as denying pain. Diamorphine was started at 80mg per 24 hours via syringe driver. This is a very high dose working out to a 5-6 fold increase in dose. It is not clear who chose this dose but the way the drug was prescribed the nurses could have used a dose anywhere between 20 to 200mg/day. It had to be reduced because she was too drowsy and it probably contributed to her death.
The other problem is the wound infection which could have been the cause of at least some of her pain. On our Orthopaedic rehabilitation ward we are happy to treat wound infections without liaising with Orthopaedics (the ward is run by Geriatricians). I would have used a different combination of antibiotics but I do not know the antibiotic policy or bacterial sensitivities in Gosport. If the wound infection had not shown signs of improving in 3 days I would have sought Orthopaedic or Microbiology advice.

PL grading B3

BJC/46
JEAN STEVENS
Code A

Stroke with marked weakness of left side complicated by a myocardial infarction and aspiration pneumonia. On day of transfer had suffered chest pain all day but had not told anyone (page 24). A strange decision was made to stop her prophylactic anti-anginal treatment and use GTN as required and oramorph. She was reported to be uncomfortable on the day of conversion to diamorphine via syringe driver. She then deteriorated rapidly. The pain was likely to be cardiac and I think they should have tried specific angina treatment before resorting to regular opiates. Angina after a myocardial infarction has a poor prognosis especially in someone who has other severe problems. However I think the use of opiates was overdone.

PL grading A2

BJC/47
DAPHNE TAYLOR
Code A

Severe weakness and requirement for gastrostomy feeding following a stroke. The pain was said to be due to contractures down the hemiplegic side. Other analgesics were not tried before fentanyl and then diamorphine pump. The pain of contractures might have responded to other forms of medication and not so well to opioids. She had severe medical problems and would have died soon. Sedation from the opioids could have made her more susceptible to not being able to clear her own secretions or developing a chest infection.

PL grading A2

BJC/48
SYLVIA TILLER
Code A

Congestive cardiac failure on a background of ischaemic heart disease. Became hypotensive with treatment. Became very low in mood, on several occasions expressing the wish to die. She was dependent on others for most activities of daily living. In Dryad she developed leg pain and then cardiac sounding chest pain. She received opiates including diamorphine via syringe driver, starting dose 40mg after just 2 doses of oramorph (higher than I would have started at; in the previous hospital she received 10mg daily at one point which was more appropriate). She had severe medical problems but I think the opiate starting dose was excessive and could have hastened her death.

PL grading B2

Code A

Code A

BJC/50
FRANK WALSH
Code A

Very little to go on in the notes but he had a stroke and developed a chest infection. This was treated with oral antibiotics but he deteriorated and died. Nothing suspicious about his treatment and the cause of death appears clear.

PL grading A1

BJC/51
WALTER WELLSTEAD
Code A

Vascular d Code A, increasing behavioural problems in NH. Fractured neck of femur earlier in the year. During the final admission he had painful contractures of his legs which required paracetamol. The pain increased on 6/5/98. He was started on a syringe driver of diamorphine at 15mg per day. This is a reasonably low dose which was increased when more pain was documented 4 days later. A low dose of midazolam was added when he became restless.
The syringe driver was set up when it was clear that he had reached the end stages of his physical and Code A illnesses. The doses used were not excessive.

PL grading A1

BJC/52
ALICE WILKIE
Code A

Dementia and probable UTI. Transferred to Daedalus because she was thought to be too dependent to return to her Code A I cannot find details for the period 6-21/8/98. However she was suddenly prescribed diamorphine at 30mg per 24 hours via syringe driver without any previously recorded analgesia. There might be a missing drug card because her laxative was not prescribed from 15/8/98 onwards. There is insufficient detail in the available notes and I suspect there are notes missing.

No grading

BJC/53
IVY WILLIAMSON
Code A1

Malignant melanoma with pulmonary metastases. She deteriorated with an exacerbation of COPD but then deteriorated markedly with breathlessness and agitation. She was treated for the breathlessness but also kept free of pain and agitation with appropriate use of diamorphine and midazolam via syringe driver.

PL grading A1

BJC/54
JACK WILLIAMSON
Code A

This man had severe peripheral vascular disease and ulcers. He required opiates to control his pain up to the operation of amputating both his legs. After the operation they went through the "analgesia ladder" gradually increasing the strength and dose of the analgesics. He appears to have suffered a cardiac event at the end and was given appropriate treatment at appropriate doses.

PL grading A1

BJC/55
ROBERT WILSON
Code A

This man is recorded as having a Code A and poor nutritional status. He was admitted with a left humerus fracture. During his last days on Dickens ward he was on regular paracetamol and codeine as required, needing one dose of codeine most days. On transfer to Dryad he received 2 doses of oramorph and was then put on a moderate dose of oramorph every 4 hours with paracetamol as required. Liver and kidney problems make the body more sensitive to the effects of oramorph – he had both of these problems. He deteriorated and was converted to a syringe driver at a dose which was a close conversion from the oramorph dose. Over the next 2 days the dose was increased without obvious indication.

PL grading B3

BJC/56
NORMA WINDSOR
Code A

This is different to the other cases, with the concern being the time taken to refer the lady to St Marys rather than the medication used. She had a history of diarrhoea and vomiting, chronic lymphatic leukaemia and ischaemic heart disease (awaiting CABG). After not improving or slowly declining, she suddenly deteriorated on the morning of 5/5/00. She was hypotensive with a thready pulse. If the decision was for active treatment she should have been sent to A&E immediately rather than waiting for a bed to come up. From how she was that morning and with her underlying cardiac status, I think she would have died anyway.

PL grading A3

BJC/57
DOUGLAS MIDFORD MILLERSHIP

Code A

History of COPD, ischaemic heart disease, heart failure and a stroke. There was a sudden deterioration early morning after 12 days on the ward. The exact cause was not clear but he rapidly deteriorated and died. Medication prescription does not contain any worries. The care seems to have been of a reasonable standard.

PL grading A1

BJC/58
JAMES CORKE
Code A

Code A Disease. He was still alive at the time of the last entry in these notes and there was nothing suspicious or worthy of comment up to that point

Either no grade or A1