

**Other Document Form**

Number

D908

Title RESULT OF ANALYSIS OF ADDITIONAL NOTES 21 CASES BY DR FERNER

(Include source and any document number if relevant)

Receivers instructions urgent action Yes /  No

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

Code A

Indexer

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

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

ROBERT WILSON

**Exhibit number**

BJC-55

Code A

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			<b>Code A</b>	
Unexplained By Illness C				

**General Comments**

A 75-year-old X-navy Scot with 6 children (+ one adopted) by first wife and stepdaughter by second, who was shown to have EtOH gastritis in 1994, admitted in 1997 with EtOH **Code A**

Admitted 1998-09-22 with displaced #(L) humerus after a fall. Treated conservatively.  
Given 5mg or 2.5mg doses of morphine on Dickens, total 15mg (+ 10mg dose in A&E); then codeine or paracetamol  
Discharged 1998-10-14 from Dickens to Dryad, taking paracetamol & trazodone...

Transferred to Dryad with Barthel 7, where pain treated with Oramorph 10mg every 4h > rapid decline (chesty) > sc diamorphine 20mg/24h > 40mg/24h > 60mg/24h

Died 1998-10-18-23-40

Death was presumably from overdose of opiates in a man with poor opiate metabolism and reduced tolerance (?encephalopathy). Unless the decision had been taken to treat pain regardless of consequences, this was negligent.

1997-03-04      gamma GT = 45 (upper limit normal)

1997 ?      Discharge script, Queen Alexandra Hospital = spironolactone, thiamine, frusemide, multivit

1998-09-24      Pain +++ from (L) humerus

1998-10-14      Discharge note to Dryad ward '#(L) Humerus, alcoholic hepatitis'

SO - NO EXTENUATING EVIDENCE, EXCEPT NOTE ON -09-24

SO - NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:**

ROBIN FERNER.

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**  
**Code A**

H. CLARK.

**Exhibit number**  
**BJC-10**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Probable infarct ?pneumonia Reasonable doses ?too low for comfort			
Unclear B				
Unexplained By Illness C				

**General Comments**

94-year-old X-navy widower, small CVA, TIA, falls, calcific aortic valve disease, old TB.  
 Admitted 2000-04-24, but recovered.  
 GTN spray.  
 Well OPD 2000-05-11, then re-admitted 2000-06-05 after fall.  
 2000-06-08: chest pain (?MI, ? pneumonia)  
 R. erythromycin + haloperidol  
 Then diamorph sc 5mg  
 Then Oramorph 10 mg  
 Then diamorph 5 mg/24h added  
 + 2000-06-17-14-40.  
 Additional information: referral letter from 2000-04-26 – 'small stroke'  
 GTN spray – rare; smoker  
 Leg Ulcer = Staph  
 So: NO CHANGE – 1A

**Final Score:**

**Screeners Name: R E Ferner**

**Date Of Screening:**

**Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

Code A

R. CRISJEE

**Exhibit number****BJC-14**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Admitted for terminal care; appropriate dose- escalation			
Unclear B				
Unexplained By Illness C				

**General Comments**

79-year-old X-butcher  
C/a bronchus, oesophageal stricture from this, PEG tube  
1996-06-18: Oramorph 10 mg x 5 a day  
1996-06-27: Oramorph 20 mg x 5 a day  
1996-07-04 (?) syringe driver – diamorphine 50 mg/24 h  
1996-07-06 diamorphine up to 100 mg/24 h  
1996-07-07 diamorphine up to 150 mg/24 h  
1996-07-07 +  
Drug chart for hyoscine  
1996-06-13: complete oesophageal obstruction, TOF, PEG  
Countess Mountbatten referral form  
Drugs chart: oramorph 10mg q 4 hours diamorphine 50 mg/day [1996-07-04]  
Nursing care plan: paranoia, thioridazine, fall  
Barthell 8, Waterlow 23  
Notes from Sultan ward: 50 > 100 > 150 mg diamorphine for bubbling & distress  
SO – NO CHANGE FROM 1A

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

Code A

A. Cunningham

**Exhibit number****BJC-15**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Seriously ill 'poor prognosis', sacral sore, Parkinsons, wt loss; but rapid increase in diamorph/midazolam sometimes with no clear reason	CONSENSUS WAS 3B	
Unexplained By Illness C				

**General Comments**

79 year-old X-RAF; #ankles, spine 1945; Parkinsons from 1980s, Renal calculi, NIDDM  
 Wheelchair; confusion + agitation + paranoia  
 1994-12-01 Dolphin Day Hospital  
 1997-09-29 'Second admission.. to attempt to improve mobility'  
 1998-07-13 Thrombocytopenia, leukopenia  
 1998-07-? inpatient  
 1998-08-28 discharged to Thalassa nursing home  
 1998-09-24 bed sores, mortally ill  
 1998-09-27 dies  
 R. 1998-09-21 Oramorph  
 R. 1998-09-14 Coproxamol  
 R. 1998-09-21 Diamorph 20-200 + midazolam 20-80mg  
 R. 1998-09-25 Diamorph 40-200 (80 given) + midazolam 20-200mg (100 given)

Nursing notes 1998-07-23: Very cross..., -24: Parkinson's worse, fall, & quite demanding  
 BMs - 6.3 - 15.7  
 ECG - ST segment elevation in V3

SO - NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

*M. Gorkman*

**Exhibit number**

**Code A**

**BJC-19**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Good pain relief, quiet death at last			
Unclear B				
Unexplained By Illness C				

**General Comments**

78-year-old widow, c/a lung on bronchoscopy + mets to supraclavicular node and ?rib  
 Discharged on MST, readmitted unable to cope  
 R. Diclofenac, Oramorph (carefully calibrated) (15 mg every 4 hours) then appropriate dose of  
 diamorphine (30 mg/day)

BUT bad prescription for oramorph from 24/11: crossings out, inaccurate date...  
 Blank results sheets, so  
 NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner**

**Date Of Screening:**

**Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

Code A

L. GRAHAM

**Exhibit number****BJC-20**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Small dose diamorphine during agonal collapse			
Unclear B				
Unexplained By Illness C				

76-year-old Glaswegian ex-sailor who developed Parkinsons, with memory loss and hallucination (pixies, buses with six wheels...)

Diagnosed ? Lewy Body Dementia

Also squamous cell c/a lung successfully treated by L UL resection in 1988

Also renal stones and prostatic enlargement with tendency to UTIs

Gradual deterioratation: 'a sad case' [56/912] Then ? UTI, abiotics, decline, 'mobility worsened over the last week' [850/912], admission [447/912], incontinent of urine and faeces, unable to swallow, given sc fluids [128/912].

Transfer to Daedalus 2000-09-04 Then -09-14 Unresponsive, incont faeces, grey, tachypnoeic, distressed, unrecordable BP, given 2.5 mg diamorphine, died. [461/912, 151/912]

PM: natural death

BUT prescription for 'PRN' diamorphine suboptimal.

1997-06-03 Dr Kerr's letter – sulpiride

2000-08-17: normal FBC; 1999-03-03 kidney stones;

1987: RIH repair discharge form + many blank or uninformative sheets + communications sheet

SO – NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

SHEILA GABORY.

**Exhibit number**

Code A

**BJC-21**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Nature of last illness undetermined		
Unexplained By Illness C				

**General Comments**

91-year-old widow, ex-smoker, previous LVF, previous ?depression, ? early dementia 1995, managed shopping , although in home, until  
 1999-08-15 admission with #NOF  
 1999-09-03 transfer to Dryad ward... Barthel 3-4 [later 6, 7, 4]  
 Very slow progress  
 1999-11-16 'Further deterioration' ?chest infection > no antibacterials  
 1999-11-18 Treated with as required 'Oramorph' and then regular 'Oramorph'  
 1999-11-20 Started subcut diamorphine  
 1999-11-22-17-20 'died peacefully'

1995-02-06 Letter from Althea Lord 'does not like day centres.'

Note from Feb/March ?1995

part of a drugs chart from Sept 1999

ECG strip, showing atrial ectopy and lateral T-wave changes

SO – no new information

SO – NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:**



**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

Patient Identification

Code A

N. HALL

Exhibit number

BJC-24

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Sought advice from BeeWee Dying from c/a stomach vomiting main problem small doses of opioid			
Unclear B				
Unexplained By Illness C				

**General Comments**

83-year-old married woman, daughter died of c/a oesophagus aet 41  
 penicillin allergy  
 hysterectomy & oophorectomy  
 varicose veins & thrombophlebitis  
 NIDDM

1992 Lumpectomy for c/a breast  
 1997-02-12 abdo pain, ? cholecystitis Settles with a'iotics [wt april 1997 85.3 kg]  
 1999-04 c/a stomach with palliative gastrectomy  
 admitted to sultan ward  
 main problem = vomiting  
 given co-proxamol  
 subsequently MST 10 mg bd  
 subsequently readmitted  
 diamorphine by sc injection then syringe driver – 10 mg over 24h, increased to 20 mg over 24 h  
 chart for 19-20<sup>th</sup> June scrappy (p. 161/322)

Examination sheet: 'not distressed' 'abdominal pain & vomiting for 1/52'  
 '12<sup>th</sup> Feb' referral letter ;looks distended.  
 SO - NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification***E. Hillier***Exhibit number**

Code A

**BJC-25**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	<u>CONSENSUS</u> <u>WAS 1A</u>			
Unclear B	Clearly very unwell Not certain if she could have been treated for benign disease. Slow increase in palliation			
Unexplained By Illness C				

**General Comments**

75-year-old spinster X-schoolmistress, D. C/a breast 1962 – subsequent radiation damage to chest  
episodes of depression with psychosis  
1995-01 admitted, psychotic depression – ECT  
? lump in axilla ? c/a also back pain  
D. to nursing home 1995-03-11  
1995-05-23 Readmitted to GWMH (?Mulberry ward)  
more depression  
subsequently – infection of chest wall sinus, blood loss, decision for palliative care

Co-prox 1995-07-14  
MST 10 mg bd 1995-07-21  
morphine sulphate 1995-07-21 10 mg qds  
ditto tds 1995-07-25  
then IM diamorphine 5 mg qds 1995-07-31  
+ prn diamorphine 5mg

1995-01-21 Long stay prescription sheet

Lab report showing ^ T4

Admission sheet: infected sinus, ECT; ECT abandoned because unacceptable degree of confusion

Nursing notes on dressing sinus

SO – NO CHANGE

**Screeners Name: R E Ferner****Date Of Screening:****Final Score:**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

Code A

A. Hooper

**Exhibit number****BJC-27**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	90-year old dying slow increase in R.			
Unclear B				
Unexplained By Illness C				

**General Comments**

90-year-old retired sales manager  
previous cholecystectomy and nephrectomy  
COPD on LTOT  
Macroglobulin gamma uncertain significance  
Bloody diarrhoea  
Anaemia and vitamin deficiencies  
AF + IHD  
Gross leg oedema  
alb 24 tot prot 85  
sacral sore  
Re-admitted 2000-08-18 with diarrhoea, then transferred to GWMH 2000-09-12  
Pain (L) leg, ? depression, started citalopram + diazepam + amitriptyline

- drowsy
- bronchopneumonia
- death

syringe driver hyoscine 0n 2000-10-06  
added diamorphine 10 mg on 2000-10-07  
added midazolam 10 mg  
then ^ diamorph 20 mg and midazolam ^ 20 mg  
DIAZEPAM ± AMITRIPTYLINE ± CITALOPRAM could have contributed  
OT assessment, Haslar: Elderly care team  
2000-06-09 Gastroenteritis, Anaemia, Multiple myeloma  
Endoscopy OK  
SO – NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

Code A

T. JARMA

**Exhibit number****BJC-29**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Reasonable treatment in frail man with stroke, sepsis & leukaemia		<u>CONSENSUS WAS 3A</u>	
Unclear B				
Unexplained By Illness C				

**General Comments**

97-year-old widower, X-decorator, smoker for > 60 years  
 1999-05-17 A. with diarrhoea & falls. 'Already very weak from age.' Neuts 1.7, spleen 20cm D.  
 hairy cell leukaemia + C diff  
 1999-06-11 D. to Red House Rest Home  
 1999-10-08 Re-admitted – unwell for 5d. Rt hemi, dehydration, septicaemia  
 Becomes very confused and cries out constantly  
 1999-11-02 'not very well'...please make comfortable  
 Oramorph 5-10 mg/every 4 h Then diamorphine 20 mg/day, then ? increased, then +  
 1999-11-10-14-50 +  
drug chart from 1999-10-09: 'Augmentin', cefaclor  
ECG: SR 60; axis 0; non-specific ST-T flattening  
SO – NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

Code A

E. LAVENDER

**Exhibit number****BJC-30**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			Blind diabetic lady with stroke, in pain, but dose increased by a factor of 5!	
Unexplained By Illness C				

**General Comments**

83-year-old widow, IDDM since 1943, blind.  
1989-05-08 A. Daedalus – fall – rapid recovery  
1985-05-08 D. home

DF118 > MST 10mg bd > MST 20 mg bd >  
1996-03-04 Oramorph SR tablets 30 mg bd [≡ diamorph 20 mg/ 24h]  
1996-03-05 Diamorph 100 mg/24 h  
1996-03-06 +

DM outpatient notes from 1984-5?  
Some illegible chem. path. forms

Not relevant

SO – NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification***S. MARTIN***Exhibit number****BJC-32**

Code A

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	<u>CONSENSUS WAS 1A</u>			
Unclear B		A somewhat high single IM dose (5 mg) in a dying elderly man		
Unexplained By Illness C				

**General Comments**

84-year-old man - peripheral vascular disease, epilepsy, c/a bladder (D. 1997-06)  
 1997-01-07 A. Chest infection, CCF  
 1997-02-22 Dense Right hemi, wheelchair, Barthel 2  
 1997-03-07 Transferred Daedalus  
 1997-07-01 discharge home > shared care 6/52 home, 2/52 in  
 E.g. 1997-07-22 to -08-04; 1997-09-16 to -10-13;  
 1998-01-06 Last planned admission . Night-time nausea and vomiting ?MI  
 1998-01-07 Rx diamorphine 5mg IM  
 1998-01-08-08-00 'Given 5mg diamorphine IM to assist breathing [365/457]  
 1998-01-08-08-20 Died

drug chart  
discharge prescription

Nothing relevant  
SO - NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

Code A

D. M. J. DECTON.

**Exhibit number****BJC-33**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Very unwell, abdo pain, ?LVF comfortable and small amounts gradually increased			
Unclear B				
Unexplained By Illness C				

**General Comments**

85-year-old woman, with angina  
 2001-05-10 found on floor A. Left hemi  
 2001-07-04 Episode LVF  
 2001-08-21 'diamorphine 5 mg Given subcut with good effect...' and several subsequent doses given  
 2001-08-29 abdo pain inspite of sc morphine diamorphine 20 mg/24h by driver  
 2001-08-31 diamorphine 30 mg/ 24 h  
 2001-09-02-13-25 Dies

1977 letter: Dupuytren's & opn for it  
2001-05-25 Clinical continuation sheet: 2001-05-31: Barthel 1/20

SO – NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

Patient Identification

G. R. *Change*Exhibit number

Code A

**BJC-41**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		In great pain after #hip; oramorph first; but rather high dose of sedatives and diamorph		
Unclear B				
Unexplained By Illness C				

**General Comments**

91-year-old widow with dementia, in Glen Heathers Home, and 17 falls in 1998  
#NOF >THR  
>A. Daedalus 1998-08-11 in pain... oramorph 10mg doses 4h  
Fall & dislocation, requiring sedation IV and replacement  
In pain afterwards  
given haloperidol/midazolam/diamorphine 1998-08-19  
from 19<sup>th</sup>, 40mg diamorphine

1995-02-06: Dr Lord letter  
ECG showing AF and deep ST-T changes ?ischaemia, ? digoxin  
See also BJC-41 AF1C  
Haslar prescribed diclofenac  
SO – NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**



**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

E. SPURGIN

**Exhibit number****BJC-45**

Code A

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		No use of NSAIDs – but had been on omeprazole at one time	If dose of opiate increased from 20 mg MST bd to 80mg diamorph/day	
Unclear B			<u>CONSENSUS WAS 3B</u>	
Unexplained By Illness C				

**General Comments**

A 92-year-old woman (nephew Capt on IoW), a little deaf but otherwise well  
 Probable inferior MI 1989; ?Lyme disease – a'bodies negative  
 R#NOF 1999-03-19  
 DHS Haslar next day, discharged to Dryad apparently with pain on movement  
 Analgesia:  
 1999-03-26 : oramorph 5-10 mg up to 4h  
 1999-03-26: also regular oramorph, 10mg qds until 1999-03-28  
 1999-03-31 to –04-05: MST 10 mg bd; then 20 mg bd until –04-11  
 1999-04-12: diamorphine sc 20-200 mg in 24h  
 Seems to have been started at 80mg/24h (=160 mg morphine/24h)

Not Lyme disease:1989: ? collapses. V well save for arthritis/ /Probably inferior MI1981: stress # femurSO – NOTHING RELEVANT & NO CHANGE**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

Code A

J. Stevens

**Exhibit number****BJC-46**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		?Apparently changed from co- dydramol to > 10 mg qds morphine ?why	<u>CONSENSUS</u> <u>WAS 3B</u>	
Unexplained By Illness C				

**General Comments**

73-year-old woman, dense hemi, MI, aspiration pneumonia,  
 Admitted Haslar 1999-04-26: chest pain, then (L) hemi  
 Transferred Daedelus 1999-05-20  
 NGT, dense (L) hemi, urinary catheter, incontinent faeces, 'quite alert.'

At that time, apparently on co-dydramol only  
 HASLAR NOTES MISSING

Given Oramorph 5mg x 4 in 24h for pain, + 10 mg qds (only 3 doses given); then Diamorph 20 mg in  
 24 h (1999-05-21) with two prescriptions for same on next day (?because dose of hyoscine changed,  
 as per nursing notes, and back of Rx chart)

Dies 1999-05-22-22-30

1987 toenail fungus

1981 O/A

1969 gynae > hysterectomy

SO – NOTHING RELEVANT TO LATER EVENTS

SO – NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

Patient Identification

W. WELLSFORD

Exhibit number

Code A

BJC-51

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	CONSENSUS WAS 1A			
Unclear B	Probably reasonable in view of discomfort, failure to respond to treatment, and relatively low doses (but ? too much haloperidol)			
Unexplained By Illness C				

82-year-old widower, ex-Burma, ex-boatyard varnisher, from nursing home, previous Ao aneurysm repair, dementia requiring admissions previously, inguinal hernia  
 Admitted 1998-03-12 with R#NOF > DHS, but subsequent wound infection  
 Discharged back to NH -03-20  
 1998-04-07: admitted to GWMH (?) with increased aggression and poor mobility since #  
 Developed contractures of knees, noted to be in pain  
 Paracetamol >  
 1998-05-06 diamorphine 15 mg/24h + haloperidol; 20 mg  
 1998-05-10 30 mg/24h + haloperidol;  
 1998-05-11 30 mg/24h + midazolam  
 1998-05-13 +

1995, 1997 Nursing notes, etc from Mulberry ward

'6/52 history of agitated behaviour at rest home, with periods of out of character behaviour – recently threw himself downstairs...'

1997- oct to dec: 'Walter put himself on floor in corridor...'

SO – NO CHANGE IN THIS

Final Score:


Screeners Name: R E Ferner

Date Of Screening:

Signature

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

107 William

**Exhibit number**

Code A

**BJC-53**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	<u>CONSENSUS</u> <u>WAS 1A</u>	Unclear why midazolam alone was given at first; otherwise well managed		
Unclear B				
Unexplained By Illness C				

**General Comments**

78-year-old woman, diagnosed with malignant melanoma of antrum 1994, resected  
 2000-07-26 Admitted from dom visit after a fall; had cellulitis; found to have large pulmonary mets  
 Treated with paracetamol, then 'Kapake'  
 Transferred Sultan (?) 2000-08-03  
 At that time, treated with PRN co-codamol (hip and abdo pain)  
 Bronchoscopy 2000-08-09 confirms they are melanomatous  
 Transferred Daedalus 2000-08-21  
 regular co-codamol, swapped to tramadol 2000-08-25  
 Occasional oramorph 2.5 to 5 mg, or ibuprofen  
 Treated with midazolam by infusion 2000-08-31 20mg/24h, then same + diamorph 10 mg next day  
 Dies 2000-09-01

2000-02-18 - 'No evidence of recurrence...'2000-08-22 Mets - no active Rx justified...

SO - NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

Patient Identification

Jack Wilkinson

Exhibit number

Code A

**BJC-54**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	Severe disease with major surgical intervention, and long-term need for opiates			
Unclear B				
Unexplained By Illness C				

**General Comments**

Frail 81-year-old man, wife dying of metastatic melanoma, with 20-year history of vvv eczema, ulcers, previous skin grafts, previous admissions, and previous MI, Barretts, recurrent anaemia, Zimmer frame, difficulties moving

2000-07-05 Ambulance: bleeding from ulcers; osteomyelitis, severe pain, bilateral amputation

2000-08-29 Transferred to Daedalus, having co-cod, tramadol, and oramorph, and phantom pains

2000-09-18 condition deteriorated, MRSA in stumps, collapsed, in pain, laboured breathing: diamorphine 10mg/24h

2000-09-18 dies

1999-02-24 Split skin graft: bibasal fine crackles..., SM, RBBB...

1996-10-28 colonoscopy, OGD

1997 OGD = Barrett's

2000-08-17 Oromorph. 10-20 mg every 3 h PRN - 7 doses

SO - NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

**Patient Identification**

Nelson Windsor

**Exhibit number**

Code A

**BJC-56**

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A			Failure to examine, diagnose or treat effectively – but no excess prescribing	
Unclear B				
Unexplained By Illness C				

**General Comments**

69-year-old woman with known follicular lymphoma (or ?CLL) since Feb 1998 or earlier, angina waiting for CABG, subendocardial MI 1998, skin rash treated with corticosteroids, and a history of diarrhoea and vomiting for a few weeks, Admitted GWMH 'to build up' 1999-04-27 when Rx included atenolol and quinalapril; continued in spite of d&v, and patient became hypotensive > Transferred St Mary's 2000-05-05  
O/A in extremis, tachycardia, no BP recordable, R pleural effusion  
Renal failure noted  
In spite of fluids, inotropes, ITU  
Died 2000-05-07-02-55

Probable result of (a) sepsis - +ve urine culture – and (b) continued ACE-I treatment and possibly (c) Addison's after stopping steroids.

1998-11-26 ?recovering from MI – CK 896, AST 89 ?allergic to aspirin, atenolol

2000-04-26 1. CLL/lymphoma, FOB+ ?why, OGD normal. Biopsy.

2000-05-05 Coliforms

1978-08-21 Gastric problem... ? Hernial gastropathy

1978-09-13 'Evidence of old ulceration c. radiating folds...'

V&P 1979

SO – NO RELEVANT INFO

SO – NO CHANGE

**Final Score:**

**Screeners Name: R E Ferner****Date Of Screening:****Signature**

**OPERATION ROCHESTER**  
**CLINICAL TEAM'S SCREENING FORM**

Patient Identification

Code A

Exhibit number

**BJC-71**

Code A

Care Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			Seems to be enormous jump in opiates from oramomorph 5 mg qds (or q4h) to 80 mg diamorphine/d; ?? dies from resp depression	
Unexplained By Illness C				

**General Comments**

82-year-old married man, known depression (ECT ++), completely dependent, buttock sore, urinary catheter...

1996-01-05 Transferred to Dryad  
 1996-01-09 'needs opiates'  
 1996-01-10 Oramorph 5 mg qds x 1 dose [≡ 15 mg diamorphine or less]  
 1996-01-15 Diamorph 80-120 mg: given 80 mg x 3 doses  
 1996-01-17 Diamorphine increased to 120 mg/day (x 7 doses)  
 1996-01-21 'Respiratory rate 6/minute. Not distressed'  
 1996-01-24-01-45 Dies

1995-12-27 CXR OK, abdo ?pseudoobstruction  
 1996-01-08 chronic resistant depression, long courses ECT, Barthel 0, recent chest infection  
 ? date Rx Nozinan + From -01-17 to -01-23, diamorphine 120 mg/ 24h (7 doses) + a further dose  
 Appears to have been given 120 mg on -01-17 at 08.30 and at 15.35 hours

SO - APPARENTLY HAD TWO DOSES OF 120mg DIAMORPHINE WITHIN 12 HOURS ON 17<sup>TH</sup> JAN - BUT THIS NEGLIGENCE WAS NOT DIRECT CAUSE OF DEATH. ALREADY 3B  
 SO - NO CHANGE

Final Score:

Screeners Name: **R E Ferner**Date Of Screening: 17<sup>th</sup> Nov 2003

Signature