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Code A

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Operation Rochester
Conference at Marriott, Northampton
7th September 2003
MINUTES

Present:

Professor R Forrest
Doctor R Ferner
Doctor A Naysmith
Irene Waters
Doctor Peter Lawson
Matthew Lohn

Det Ch Supt Watts
DI Niven
Code A

Professor Forrest presented the findings of the Clinical Team, that have now been produced onto an excel spreadsheet.

The meeting discussed the definitions of the care bands A, B, C and 1, 2, 3 after which Det. Ch. Supt. WATTS asked for clarification of band C. Professor FORREST explained that in basic terms the treatment a patient falling into that care band had received had killed the patient. DI NIVEN asked why this was not specified on the chart. Doctor NAYSMITH responded that the definition should read there was no explanation for the treatment meted out to patients falling into band C. No explanation for treatment was agreed as the rating explanation.

The Clinical Team identified seven cases that had raised concerns, all given a B3 rating – B. Cause of death unclear, 3. Negligent care – and are listed as follows:

1. CUNNINGHAM (BJC15) – Code A diamorphine for no apparent reason. Midazolam given caused concern to the family, who had not been informed by Staff at the Hospital. Dr NAYSMITH added that this man would have died and would have been suffering some pain, but not the type that would respond to the drugs administered. She also added her concern over how rapidly the doses were increased.
2. Elsie DIVINE (BJC16) – Code A behaviour and was demented and aggressive, but had shown no signs of pain and was due for transfer to a Rest Home. Fentanyl patch was administered, an alternative to an infusion of Diamorphine, for pain relief. It appeared to the Clinical Team that this had been prescribed to calm the patient rather than treat any pain which they described as a very dangerous practice. The Team added that this patient then died shortly afterwards.
3. Sheila GREGORY (BJC21) – Code A infection, the oral morphine prescribed would have been appropriate for a cancer patient, but was totally inappropriate for patients in the condition GREGORY was in. there was then mention of Pharmacokenetic's, the study of how the body handles drugs. Dr NAYSMITH went on to add that she was frail and may not have recovered from her chest infection but, "they never

gave her that chance". Irene WATERS further added that on the notes it had been left for the Nurses to confirm death, which suggests expectation. Dr Lawson noted that the day she was admitted she had been written up for Diamorphine.

4. Elsie LAVENDER (BJC30) – Code A the effective dose from Morphine to Diamorphine. The team suggested the argument could be that the dose was increased as necessary, but conclusions were that it was a vast leap and "at least negligent" and "a bad mistake". Dr Ferner referred to BNF, British National Formulary published by the British Medical Association and the Royal Pharmaceutical Society to support the argument that these were excessive dosages.
5. Enid SPURGIN (BJC45) – Code A rapidly escalated Opiates. It was left to the Nurses discretion to initiate between 20 and 200g doses of Diamorphine a day, felt to be a particularly large dosage scope. Dr Ferner added that this patient was among others that were given prescriptions for high doses.
6. Jean STEVENS (BJC46) – Code A Hasler Hospital were missing, but the only mention on the transfer letter between hospitals was that she was suffering some skin irritation. The patient died within 48 hours after receiving high doses of medication.
7. Robert WILSON (BJC55) Code A as with those previously mentioned, was given high doses of Morphine, causing him to put on 30lbs of fluid. There is no documentation of any measures taken to deal with this. The Clinical Team concluded that Morphine was inappropriate as his liver was incapable of metabolising stating it would be very dangerous prescribed to a patient with liver dysfunction.

Det. Ch. Supt. WATTS asked the Investigation team if they had any questions/queries regarding these findings.

Code A asked in the case of Enid SPURGIN Code A consider to be a normal prescribed dose. A discussion followed starting with Dr Lawson suggesting that under normal circumstances this would be judged on a daily basis and there should be no requirement to write a dosage range. Dr NAYSMITH queried what the procedure would be if there was no Doctor available to which Dr Lawson responded that in his experience an appropriate dose would be decided allowing a range of double that quantity. Dr NAYSMITH concurred. Irene WATERS added that this prescription practice was excessive and she would expect a safer range from a GP. Dr NAYSMITH concluded that these were patients with aches and pains and the drugs administered were inappropriate, while Dr FERNER suggested that small doses via injection rather than a variable rate infusion to deal with extra pain would be appropriate. At the end of the day these measured doses and infusions would be calculated to assess future appropriate quantities.

The Clinical team were thanked for their continued support and the meeting was reminded of the Family Conference being held at Netley on the 11th September, stating that no detailed information would be given at this meeting as the investigation is still at an early stage, but it would be stated that progress had been made.

All of the Clinical Teams original notes were requested by Det. Ch. Supt. WATTS, 1. for disclosure purposes and 2. as part of the analytical process. This will be facilitated over the next couple of weeks.

Det. Ch. Supt. WATTS then revealed a further 20 cases that have been highlighted, 16 by Professor BAKER and the other 4 from concerned families coming forward in light of the current investigation.

A: Dr NAYSMITH reminded the meeting that 2 of the current batch had the wrong case notes attached.

Professor FORREST asked if any statistical work would be carried out. Det. Ch. Supt. WATTS stated that there would be no requirement at the moment and he didn't want to draw any parallels to the SHIPMAN enquiry.

Professor FORREST finally stated that the Clinical Team had been and would continue to be happy to work together, adding that two of the benefits of these latest meetings were having a Nurse present and in this latest session, having a Police Officer included in the meeting as an independent observer. Whilst in no way contributing to the conclusionary text the officer was able to confirm that it was sufficiently clearly written for the lay individual to understand.

DI NIVEN concluded the meeting by thanking the teams.