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INVESTIGATION OF a written complaint 2nd October 1998 from Mr C.R.S Farthing

Code A

REGARDING his stepfather Mr Brian Cunningham **Code A**
[deceased 25th September 1998]

INVESTIGATING OFFICER: Mrs S Frogley

INVESTIGATION COMMISSIONED ON 9th October 1998

BY

Mrs Barbara Robinson
Elderly Services Manager G.W.M.H.

INVESTIGATION COMPLETED: 5/11/98

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1 THE COMPLAINT

Mr C Farthing wrote to complain of the events leading up to his stepfathers' admission into Gosport War Memorial Hospital, his subsequent treatment while on Dryad Ward Mr Farthing also feels the content of the medical certificate did not seem to reflect his medical condition.

2. APPROACH TO THE INVESTIGATION

2:1 INTERVIEWS TOOK PLACE:

• Mr C.R.S Farthing	Complainant	23/10/98
• SR Gill Hamblin	Dryad Ward Manager	19/10/98
• Dr Barton	Clinical Assistant	20/10/98
• Dr A Lord	Consultant - Elderly Acute Services	28/10/98

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2:2 DOCUMENTS REVIEWED

• Letter of Complaint	2/10/98	App 1
• Sequence of events diary		2
• Letter re error in original letter of complaint	9/10/98	3
• Medical Death Certificate		4
• Dept of Medicine for Elderly People Record of care		5
• Dryad Ward nursing records		6
• Dryad Ward Medical records		7
• Dr Lord Report		8
• Sr G Hamblin Report		9
• Letter to Dr Grocock	17/9/98	10
• Letter to Dr Grocock	23/9/98	11

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3. BACKGROUND TO THE COMPLAINT

Mr C dot Code A was an ex RAF pilot who was invalided out after an air crash in 1945. He cared for and nursed his wife at home who died of cancer 10 years ago. Mr C had been attending Phoenix Day Hospital since June 1998 under the care of Dr Scott Brown. while living at Alverstoke House. He was admitted to Mulberry Ward A for assessment on 21/7/98 because the staff at Alverstoke House were finding it difficult to manage his care and he refused to stay at the home.

Diagnosis **Parkinson's Disease and Dementia**

Depression

Mylodysplasia

Diet controlled diabetic

On admission to Mulberry Ward 21/7/98 he was very distressed by his lack of mobility and independence as his Parkinson's disease worsened .He expressed feelings of worthlessness and hopelessness regarding his future . During his stay he was regularly reviewed by Dr Lord .

His Waterlow Pressure Sore Prevention score was completed on the following dates 21/7/98 2/8/98 8/8/98 22/8/98 and was 19 on the 27/8/98 it was 20.

Following the ward round on the 27/8/98 Dr Lord felt he should be discharged to Thalassa Nursing Home[where a place had been found by his social worker because MR C did not want to return to Alverstoke Nursing Home]. He was discharged on the 28/8/98. On discharge Dr Lord arranged for Day Hospital follow up because she was concerned about his physical state- loss of weight, mylodysplasia, retention of urine, in addition his long standing Parkinson's Disease and lumbar spinal injury.[app8] The O/T was requested to visit to assess in terms of mobility and any adaptions he may need.

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4. NOTES OF MEETING WITH Mr Farthing on the 23/10/1998

4.1 Mr F explained that his stepfather had been admitted as an emergency to Dryad Ward with "serious bed sores". Two weeks prior to this he had complained of a "sore behind" while in the nursing home. Both he and his wife thought no more about it. It was a complete surprise to find out he had bed sores.

4.2 On the day of admission he visited and found Mr C in a reasonable mood, able to communicate and he didn't appear to be in pain.

4.3 On 21/9/98 before leaving, he saw a staff nurse. She explained his condition was very serious and remarked that if she allowed a condition half as serious as this to develop before admission to hospital, she would expect to be dismissed. Prior to leaving he asked for an appointment to see a doctor. He was told that it would be better to have the results of investigations before seeing a doctor.

4.4 On the 23/9/98 he was phoned in London. He was told his stepfather had been very difficult with the staff and his condition had deteriorated. Both he and his wife returned immediately.

4.5 On arrival he said he was very shocked to find Mr C in a semi-vegative state and on a "syringe driver". This felt like a repeat performance of when his mother died 10 years ago. She was also on a syringe driver. He asked if the syringe driver could be temporarily switched off to allow him to ask him if he had any last wishes - although Mr C had seven step children he was the only one who had kept in touch. He was informed that the syringe driver would need the authority of a doctor to be switched off.

4.6 On 24/9/98 Mr F and his wife visited and realised that by now his stepfather would "just fade away and die on the machine" and he would be unable to communicate with him again.

4.7 On 24/9/98 he was seen by Dr Barton who he found to be very "reasonable" and he accepted the situation. Mr F said that Dr Barton said that this "acute pain" was from the pressure sores and that it **was the toxins generated by them** that would bring about his death" also by this time it was apparent that a bronchial condition had developed.

4.8 On the 26/9/98 late evening they were informed of Mr F's death.
Between 11.30 - 12 midnight he and his wife arrived at Bury Road entrance to find instructions to go to the side entrance. They pushed the bell for the hall porter but there was no reply. They waited sometime and finally returned to the Day Hospital entrance. Mr F said they waited 20 minutes and the night porter was very unhelpful.

4.9 Mr C phoned GWMH on 28 September after receiving a phone call from Dr Lord's secretary to make another appointment. The 2nd October was the earliest appointment. No apology was given. He Saw Mr Mike Sharpe, Patient Affairs Officer who he found to be very efficient and helpful.

4.10 30 September Mr F collected the death certificate and took it down to register at Gosport Town Hall. It was a Locum Registrar who Mr F says was very meticulous. He was asked if he agreed with the death certificate. He said he did not and chose to go back to Dr Brook

4.11 On attempting to contact the surgery he said he had a curious response and was told no-one could see him. He felt he was being side-tracked. He has been unable to see or speak to Dr Brook.

4.12 The undertaker contacted him and asked him to contact the Coroners Office. He felt, on talking with the Coroner, that "he was not impartial and was probably part of the medical Mafia". He said he was very obnoxious, reported that the post-mortem had been done and the cause of death was "Bronchial Pneumonia" and that his stepfather was not tested for toxins.

By this time Mr F said he was very angry and decided to cancel his appointment with Dr Lord because "it would be simply wasting everyone's time."

4.13 Mr F feels let down by a very insensitive system. No-one came to see them in this very difficult time. He said he was willing to met Dr Lord anywhere and anytime.

4.14 Mr F said he would have accepted if sacral ulcer had been recorded as the disease or condition directly leading to death, with Bronchopneumonia as the second significant condition contributing to death.

4.15 Mr F said he had spoken to Sean Golding, Social Worker who, according to Mr F , said the nursing home were not treating his sacral ulcer as it was being treated at the Day Hospital.

He has officially complained to the Nursing Home Inspector

4.16 Mr F offered for me to see Mrs Shirley Sellwood (his late stepfather's carer)

4.17 Mr F said finally he feels that he was badly neglected by all services.

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5. NOTES OF MEETING WITH SR GILL HAMBLIN - DRYAD WARD 19/10/98

5.1 Sr H was on duty on the 21st September 1998 and helped admit Mr C from Dolphin Day Hospital. The reasons for admission were-

- General deterioration in his health
- Severe pressure sore on his sacrum
- Parkinson's Disease

On admission he was in pain and discomfort. Sr Hamblin was unable to contact Shirley Sellwood N.O.K to inform her of his admission (this was at Mr C's request). Sr H saw Mr F briefly on the 21st September and explained his step father was very poorly when he arrived on the ward late afternoon.

5.2 Sr H remembers the patient was an articulate man who was also suffering with Dementia. He had a history of being difficult to manage and help. Mr C gave his n.o.k as Shirley Sellwood who had been his carer and friend for many years, he didn't appear to want any contact with Mr Farthing.

5.3 Mr C remained agitated and frightened and at approximately 20.30 hrs on the 21/101/98 a " multi-disciplinary "decision medically led was made to commence pain relief via a syringe driver. Midazalone 20 mgms was given at 23.00hrs also to relieve his anxiety. Sr H feels very strongly this was the right decision and stated in her experience the dosage of morphine was relatively low initially. It was slowly increased over the next few days to manage the pain.

5.4 Sr H was aware that Mr F did phone on 22/9/98 and was told by S/N Hallam that a syringe driver had been commenced and there had been an incident where his stepfather had "thrown a dressing over the floor".

5.5 Sr H was not on duty on 22/9/98. She saw Mr Farthing again on Wed 23/9/98 at approx 1pm with Staff Nurse Freda Shaw. Mr F was angry that the syringe driver had been commenced and asked for it to be discontinued. Sr H explained that she would have to consult with Dr Lord before doing what he requested. The reason Mr F stated was that he wished to ask his stepfather if he had any "last requests". Sr H asked him what other method could they use to provide adequate pain control? Mr F did not reply. Dr Lord was contacted and said that the syringe driver should be continued.

5.6 Sr H observed that when Mr F visited, he never sat by his stepfather's bed, preferring to sit in one of the day rooms. She thought this was unusual. Shirley Sellwood, the named person as N.O.K. never visited at the same time as Mr F.

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5.7 Sr H arranged for Mr F to be seen by Pastor Mary on 23/9/98 which he did for approximately 1½ hours. Sr H felt that Mr F was now fully aware that his stepfather was dying. Prior to this he didn't appear to have any insight into the needs of Mr C.

5.8 On Thursday 24/9/98 Mr F was seen by Dr Barton who explained yet again why the syringe driver was being used, and it's advantages. She also explained he may develop a chest infection again and that he might not respond to antibiotics, but the staff would make sure he was kept comfortable and pain free.

5.9 On the morning of 25/9/98 Mr F visited and stayed in the day room. Sr H went off duty at lunch time on Friday and Mr C died at 23.15 hrs on the 26/9/98

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6 NOTES OF MEETING WITH DR BARTON 20/10/98

6.1 Dr Barton remembered admitting Mr C on Monday 21 September 1998. Sr Hamblin and herself went to Dolphin Day Hospital and physically transferred the patient

6.2 Dr Barton said Mr C was in considerable pain, angry and aggressive. The smell from his pressure sore was very offensive.

6.3 Dr Barton stated that in her opinion Mr C required a syringe driver to deliver the morphine to enable his severe pain to be relieved.

6.4 Dr B saw Mr Farthing on 24 September for approximately 45 Minutes and explained that his stepfather was very ill. She said that he was developing a chest infection and this would probably be the cause of death. She also said he was toxic from the pressure sore.

6.5 Dr B was on leave from 25/9/98 to 2/10/98 and in her absence Dr Brook, asked one of her partners Dr Brook to cover and be responsible for her daily visits.

6.6 Dr B felt there were no legal problems with the death certificate because Dr Brook was acting as her deputy and had seen the patient.

6.7 Dr B said she could not fault the nursing care Mr C had received.

6.8 Dr B said she felt from the letter of complaint that Mr F fears medical staff are hiding things. She was on annual leave and perhaps if she had signed the death certificate and explained, it might have made it easier for Mr F to accept the outcome

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7 NOTES OF MEETING WITH DR A LORD CONSULTANT PHYSICIAN IN GERIATRICS 28/10/98

7.1 Dr Lord explained Mr C was discharged from Mulberry Ward and arrangements were made for his follow up at Dolphin Day Hospital. On his admission to Dolphin Day Hospital on 14/9/98 he had "grazing of the sacrum and a linear black scar in the natal cleft (app 8)

7.2 Advice was given to the Nursing Home about ensuring adequate pressure relief in bed and a chairs as well as advising that he should lie on his side.{app5]

S/N L Shaw (DDH) repeated this advice on 17/9/98 (Dr Lord was a witness). Dr Lord also spoke to Mr C on 17/9/98 and emphasised the importance of lying on his side. Dr Lord felt this was important because Mr C did not always comply with medical and nursing requests. She said that she would see him again on 21/9/98. Mr C said "he wanted to die" and did not feel he'd still be alive on the 21st.

The OT also contacted the nursing home re pressure relief.

7.3 When Dr Lord reviewed Mr C on 21/9/98 the sacral sore was much larger, necrotic and extremely offensive. She admitted him the same day to Dryad Ward.

7.4 Dr Lord feels because Mr C attended the Day Hospital that when he returned to his carers, ie the nursing home, they were responsible for his continuing care. She does not feel the Day Hospital is anyway responsible (app 8)

7.5 Dr Lords next scheduled round on Dryad was for 28/9/98 and Mr F was given an appointment for 5pm to see her. Dr Lord had not, up till this point, been aware of Mr F's existence or involvement.

Dr Lord said that Mrs Shirley Sellwood was recorded in his records as his N.O.K. Although Dr Lord has known Mr C since Sept '97 at no time had she been contacted by any of his family.

7.6 Dr Lord states with the pressure of work and the fact that each morning session in Gosport exceeds 5 hours, she is unable to see relatives except after the ward round of that ward.

7.7 On 23/9/98 Sr Hamblin phoned her to say that Mr Farthing wanted his stepfather's syringe driver with morphine turned off so he could speak to him. She discussed all Mr C's problems, his severe pain and anxiety and necrotic offensive pressure sore which could not be treated without analgesia. Dr Lord felt it was "not opportune to discontinue Mr C's analgesia, as the main aim of treatment was to keep him pain free and comfortable. Dr Lord asked Sr Hamblin to relay this to Mr F.

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7.8 Dr Lord said that at no time did she decline to see Mr F or cancel any appointments. He was given the appointment by nursing staff to see her after the ward round (which is her normal procedure) Mr F cancelled this appointment saying he would be in London for a couple of days. Mr F was advised to contact Dr Lord's secretary at QAH which he did and was given an appointment for 3pm 2/10/98. This was also cancelled by Mr F around noon on 2/10/98

7.9 Dr Lord said the post-mortem was requested by Dr Brook after she had discussed it with herself. Dr Brook contacted her on 1 October while in Outpatients at Gosport. Dr Brooks had been contacted by her surgery to say that Mr F was not happy to accept the certificate that was issued and wished it to be changed to "septicaemia due to sacra ulcer" Dr Lord advised that this could not be done as it was a professional document and she advised Dr Brook to contact the Coroner which she did on the same day.

7.10 After the post-mortem the cause of death was issued by the Coroner the first disease was recorded as **Bronchopneumonia** this confirmed the original decision that Dr Brook had agreed with Dr Lord . The Medical Certificate no 231662 [app4] records this.

7.11 Dr Lord is aware that Mr F is also making an official complaint to the Nursing/Residential Care Home Inspector.

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8. FINDINGS

8.1 Mr C's general health deteriorated over the last three months.

8.2 Mr C appeared to be unable to settle in the nursing home after he was unable to live fairly independently in his warden controlled flat.

8.3 From the evidence I found Mr C did not always comply with nursing and medical reports.

8.4 It is recorded that the nok was his old friend/carer Mrs Shirley Sellwood. There appeared to be a long standing relationship/communication issue within the family.

8.5 Following discharge from Mulberry Ward to Thalassa Nursing Home, advice was given to the nursing home about adequate pressure relief. Mr C would not always comply to this advice (ie lying on his side)

8.6 Dr Lord arranged, following discharge, for Mr C to attend Dolphin Day Hospital for follow up. On his first admission to the Day Hospital on 14/9/98 he was found to have grazing of the sacrum and a linear black scar in the natal cleft. (app 5)

8.7 Mr F and his wife do not appear to have been informed of Mr C's condition re his pressure sore while he was in Thalassa Nursing Home. They are pursuing an official complaint against the Nursing Home.

8.8 The sacral sore deteriorated rapidly during the period 14/9/98 to admission to Dryad Ward on 21/9/98 (app 5 & 6). The sacral area was dressed during his day visit

8.9 Mr C was admitted directly from the Day Hospital to Dryad Ward on 21/9/98. His pressure sore was very offensive and he was in a lot of pain.

8.10 The syringe driver containing morphine was commenced to keep him pain free and comfortable. It was a multi-disciplinary decision to assist in the management of Mr C's pain

8.11 On Mr F's request it was discussed whether they could comply with stopping the driver. The Consultant Dr Lord did not agree to this request. The nursing staff were also in agreement. Mr F was informed of the decision and the reasons why.

8.12 Mr C did not understand how poorly his stepfather was on admission. He was seen the following day by Dr Barton for 45 mins. Mr C appears to have misunderstood Dr Barton's explanation as to what would be ultimately the possible cause of death. He thought Dr Barton said it would be "the toxins". Dr Barton said she thought it would be a chest infection .

8.13 Mr C saw Pastor Mary for 90 minutes on the same day, this was arranged by Sr Hamblin.

8.14 Nursing staff reported that Mr C chose not to communicate with his stepson even when he was able to. The relief of Mr C's pain was considered of paramount importance by nursing and medical staff.

8.15 Dr Barton went on annual leave and handed over to Dr Brook. Dr Brook did sign the death certificate but discussed it with Dr Lord who knew Mr C extremely well prior to issue.

8.16 Dr Brook's surgery did contact her to say Mr F was querying the death certificate. Dr Lord advised her to contact the coroner. Neither Dr Lord or Dr Brook attempted to contact Mr F.

8.17 The coroner, after discussion with Dr Barton, decided to do a post mortem. The coroner's office agreed that **Bronchopneumonia** was the condition directly leading to Mr C's death. They informed Mr F directly, who remains unhappy with this decision.

8.18 The distress and circumstances of his stepfather's illness reminded him of the death of his Mother. His Mother also required a syringe driver and was unable to communicate with him.

8.19 Mr F cancelled two appointments to see Dr Lord. The first 28/9/98 was cancelled because he was in London and the second for 2/10/98 because Mr F felt "it would be a waste of time."

8.20 Mr F was unable to arrange an appointment convenient to him between these dates. It is unfortunate he failed to keep the second appointment to discuss his concerns directly to Dr Lord.

8.21 Mr F feels very let down by an "insensitive system".

8.22 The medical and nursing staff found it difficult to support/understand Mr F because of his initial attitude and seemingly uncaring attitude to Mr C's pain relief.

9 RECOMMENDATIONS

To be agreed by the service with an action plan
I would like to thank all the staff for helping with the investigation of this complaint.

Investigating Officer: Sue Frogley

Signature: Code A **Date:** 6/11/98.