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HAMPSHIRE CONSTABULARY

EDITH AUBREY

DOCUMENT RECORD PRINT

Officer's Report

Number: R11G

TO:
STN/DEPT:

REF:

FROM: Code A YATES
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 23/01/2003

Sir,

Re Action 186

I visited Margaret Yvonne BARNEY of Code A
(Code A on 16th January 2003 (16/01/2003).

Mrs BARNEY wished to report her suspicions about the death of her mother Edith Mary AUBREY nee LEE-LOVEJOY at the Gosport War Memorial Hospital on 15th June 1996 (15/06/1996) and that of her father Henry Charles AUBREY on the 2nd June 1999 (02/06/1999). The circumstances are as follows. Mrs AUBREY who was born on 28/09/1911 was divorced from her husband and was referred to a psychiatrist in 1991 suffering from paranoid thoughts and depression. She was treated as a day patient at Addenbrook where she received some form of injections, believed weekly, for this disorder. Some when just before 1994 she was being cared for at Treloare Rest Home, Anglesea Road, Alverstoke and during this period she suffered a fall. Mrs AUBREY was taken to the QA Hospital where she was treated and then admitted to Daedalus Ward at the Gosport War Memorial Hospital where she spent the rest of her life. Mrs BARNEY stated that the care at the hospital was good at first but towards the end of her life she was placed on Diamorphine via syringe driver and was heavily sedated. Mrs AUBREY died on 15/06/1996 and the certificate was signed by Dr Jane BARTON giving the cause of death as bronchopneumonia and senile dementia, she was buried at Henley Road Crematorium.

Mrs BARNEY queried the death of her mother at the time and entered into correspondence with the hospital. Mrs BARNEY stated that in her opinion, her mother was administered Diamorphine via syringe driver to advance her demise and questioned why fluids or nourishment by drip had not been given. She received a reply from Dr LORD who explained that Mrs AUBREY's mental and physical condition had deteriorated by early July 1996 and she was becoming increasingly anxious and distressed. It was felt that Diamorphine administered via a syringe driver would alleviate the distress, anxiety and discomfort she was suffering. A drip would have provided some fluids but no nourishment, her deterioration was gradual and the overall outlook was poor. Dr LORD did not consider it appropriate under these circumstances to either give fluids by drip or feed by naso-gastric tube.

Henry Charles AUBREY (B.06/08/1911) was admitted to the Royal Navy Hospital Haslar in May 1999 with a throat ailment and was diagnosed as having throat cancer. Two weeks later (01/06/1999) he was

transferred to the GWMH where he died the next day (02/06/1999). Mrs BARNEY did not have much more information on her father other than his death was certified by Dr BARTON and the cause of death was given as Carcinoma of Bronchus and left ventricular failure.

Both her parents were patients of Dr EVANS and Partners, Gosport Health Centre, Bury Road, Gosport .

Mrs BARNEY states that her sister Mavis BARKER of 95 David Smith court, Calcot, Reading (01189 413414) is also interested in the outcome of this investigation.

I informed Mrs BARNEY that Operation Rochester is an ongoing police investigation which will take some time before it reaches a conclusion. I have given her a contact number for Operation Rochester and informed her that the FLO, Code A , would make contact in the near future.

EDITH AUBREY

Edith Aubrey

Date of Birth: Code A Age: **85**
Date of admission to GWMH: **12th June 1995**
Date of Death: **06.05 hours on 15th June 1996**
Cause of Death:
Post Mortem:
Length of Stay: **Nearly 1 year**

Mrs Aubrey's past medical history:-

Probable CVA
Depression with paranoid features
Ischaemic heart disease
Deafness
Arthritis of finger
Diabetes – non insulin dependent (diet controlled)
Dementia/schizophrenia

Mrs Aubrey lived at home with her husband until April 1994 when she was admitted to a Nursing Home. She had a son and 3 daughters.
She was admitted to hospital on numerous occasions.

2nd October 1994

Mrs Aubrey was admitted to hospital with a fracture to her right neck of femur. She had a 2cm x2cm graze on her right shin and a pressure sore at the top of her right lower leg.

12th June 1995

Admitted.

July 1995

Family query medication Haloperidol and asked why they were not informed.
Mrs Aubrey is noted to be agitated.

25th July 1995.

Small broken area on skin.

9th September 1995

Small break on sacral area.

November 1995

Small break on sacral area.

January 1996.

Mrs Aubrey had problems with swallowing. She was assessed using the Waterlow Pressure Sore tool and had a score of 31 which is very high

March 1996

One of her daughters became unhappy with the nursing care that Mrs Aubrey was receiving.

The notes described her as becoming quite abusive. Other members of the family apologised and said that they were happy with the care she was receiving.

April 1996.

Mrs Aubrey became agitated when nails cut. Diazepam given. Fentanyl patches to control Edith's pain, which she has.

May 1996

Agitated, Fentanyl changed. Fentanyl changed to 75 mgms.

30th May 1996

Marked deterioration. Not swallowing.

June 1996

Syringe driver prescribed if required. Pressure areas in tact.

7th June 1996

Breathing deteriorated. Syringe driver commenced at 15 00 hours.

8th June 1996

Family started to stay overnight.

15th June 1996

Mrs Aubrey deteriorated overnight, she died at 06.05 hours. Death verified by S/N Treadore witness by S/N Tubb? Family present..

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**

Q99883 (EA) EDITH AUBREY BJC-04

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B	fentanyl > diamorph seems entirely reasonable, dose ?low			
Unexplained By Illness C				

General Comments

84 years, Barthel 0-2, MTS 0, Waterlow 30
History of mental and physical ill-health, including angina ?MI. Unfit for GA for biopsy in 1975.
#tib & fib, then #NOF.
Transferred 1994-11-01, and died 1996-06-15-06-05
Family did not wish her to have haloperidol – row (604/1170)
Initially prescribed morphine/diamorphine 1994-11-09,1995-01-26,1995-03-14, 1995-07-13, but not administered
Brief prescription for small dose haloperidol 1995-07-12
Pain on trimming nails
Helped by fentanyl patches [50 > 75] , from 1996-05-20 to 1996-06-07, then
diamorph 60 mg; R. 40-100 mg/24h
BNF says fentanyl 75 = morphine 270 {≡ 120 mg diamorphine daily}

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/04
EDITH AUBREY
84

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

Exhibit No	Patient Identification	Assessment Note	Assesement score
BJC/04	Aubrey, Edith	End stage dementia, probably vascular, with a previous history of schizophrenia, for which all medication had been stopped because family members were very keen that she not be sedated in any way. Extremely difficult to nurse – agitated and fighting when nurses attempted to give care – described as " a danger to herself and her attendants" (though not clear that she would actually have been strong enough to hurt a nurse other than, possibly, biting). Given transdermal fentanyl explicitly "to calm her" and dose progressively escalated. Also given very small doses, probably inappropriately small, of diazepam Dr Barton the prescriber but notes explicit that "Dr Lord aware". Letter of complaint from one daughter (described as always having been difficult by her siblings). Response from CEO explicitly states that "Dr Lord felt she was in the last days of her life" and "Dr Lord does not practise euthanasia". But I was not clear from the notes that this lady's dementia was end stage, nor that her death was actually from dementia. She had Barthels of 0 and MMTs of 0, but that seemed to be relatively long standing.	C3

Expert Review

Edith Aubrey

No. BJC/04

Date of Birth: Code A

Date of Death: 15 June 1996

Mrs Aubrey lived at home with her husband until April 1994 when she was admitted to a nursing home. Her past medical history included probable cerebrovascular disease, depression with paranoid features, and ischaemic heart disease.

Whilst the experts have described this case as end stage dementia more probably of vascular origin, it is unclear from the medical notes what led to Mrs Aubrey's final demise. She was given transdermal Fentanyl explicitly to calm her and this dose was progressively escalated.

In June 1996 a syringe driver was prescribed as required and was commenced on 7 June 1996. The conversion of therapeutic treatment to Diamorphine via a syringe driver was reasonable in the experts' views.

From a review of the case by the Key Clinical Team it was noted that the patient was unable to communicate and was clearly distressed and agitated, perhaps due to pain. In their view the doctors could have been criticised for not trying to treat the possible pain.