ELIZABETH
ROGERS

DOCUMENT RECORD PRINT

Officer's Report

Number: R8L

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 24/11/2002

Sir

On the 23/11/2002 I spoke with Mrs Diane DAVIES re action 209 relating to her mother Elizabeth RODGERS, nee JONES , Code A

Mrs RODGERS was born in Wigan; she married twice and had a total of five children. She worked in clerical posts and was a full time mother. In later life she suffered from Parkinsons but was in generally Code A Eighteen months before she died she moved down to a rest home in Fareham, Thatched Cottage at Hill Head. In January 1997 Mrs DAVIES thought her mother was ill, however the doctor would not admit her to hospital.

Upon Mrs DAVIES insistence her mother was seen by a Dr LODI who told Mrs DAVIES that her mother had had a stroke. She was admitted to Haslar Hospital on the 12/01/1997. Mrs RODGERS needed care with regard to getting dressed and getting up. Staff at Haslar asked Mrs DAVIES that if anything happened did she want her mother resuscitated. Mrs DAVIES replied "Yes". The nurse is alleged to have replied "We normally wouldn't bother".

Whilst at Haslar Hospital Mrs RODGERS did not have a CAT scan. It was the opinion of medical staff that she had not had a stroke but instead had a chest infection. Although Mrs DAVIES was not very pleased with the care her mother received at Haslar. She asked when she may see an improvement in her mother's condition and was told that as soon as Mrs RODGERS Parkinsons tablets arrived she would see a marked improvement.

On the 30/01/1997 Mrs RODGERS was deemed well enough to be transferred to the GWMH for bed rest and rehabilitation. Mrs DAVIES does not believe her mother was in pain. It was viewed that Mrs RODGERS would be better off in a nursing home than a rest home and she would remain at the GWMH for about 3 weeks whilst a place was found for her.

Mrs DAVIES saw her mother on 01/02/1997 and was told by staff that her mother was undergoing tests for MRSA. Mrs RODGERS was in a side room and told her daughter she had not been fed. When Mrs DAVIES next saw her mother it was on the 03/02/1997 the doctor, who she believes was Dr BARTON , told her that her mother was very sick, she had had another stroke and would die. Mrs DAVIES stated that it had not been shown that her mother had had a stroke in the first place. Dr BARTON told Mrs

DAVIES that her mother was on morphine and she would not recover. Mrs DAVIES was concerned about the morphine and Dr BARTON told her that this would not kill her mother.

Mrs RODGERS died late on the 04/02/1997. The cause of death was shown as Cerebrovascular accident and Parkinsons. Dr BARTON signed the certificate. There was no PM and Mrs RODGERS is buried at Hill Head Cemetery. As a result of all her worries Mrs DAVIES complained to the NHS but has never received a satisfactory reply.

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AV

TO: REF:
STN/DEPT:

FROM: Code A REF:
STN/DEPT: MCD E TEL/EXT:

SUBJECT: DATE: 20/11/2003

I visited Diane DAVIES at her home address at 1830 hrs Thursday 20th November 2003 (20/11/2003).

The visit was in accordance with the policy log. I gave Mrs DAVIES a set of medical notes relating to her mother, Elizabeth ROGERS b.16/06/1929 - 04/02/1997 and went through the concerns raised by her as per officers report 8L.

Mrs DAVIES went on with the following details:

Her mother had been unconscious at Haslar Hospital , she had a chest infection and a urinary infection. Whilst at Haslar she hadn't been fed. Food was left for her and if she didn't eat it, it was taken away, she wasn't helped by staff.

Mrs DAVIES helped her eat soft foods and brought and gave her drinks. She says that her mother had problems swallowing and was unable to feed herself prior to going into hospital. She couldn't swallow her tablets which had to be broken up over her food. Mrs DAVIES noted that medication was left at the side of her mothers bed for her to take herself.

Whilst at Haslar Mrs DAVIES signed her authority for her mother to have a colostomy bag, she also discovered that her mother hadn't been given any tablets for her Parkinsons disease for the first 2 ½ weeks in hospital.

When Mrs ROGERS went into GWMH Mrs DAVIES expectations were that she was getting better.

On Monday 3rd February 1997 (03/02/1997) Mrs DAVIES noted that her mother began receiving morphine . She received a telephone call informing her that her mother had taken a turn for the worse and she should come in and see the doctor. She attended with her niece, Susan TAYLOR , and was told by a doctor that her mother had taken a turn for the worse, she'd had another massive stroke which was worse than before and that she was going to die.

The Dr informed Mrs DAVIES that her mother was on morphine and that her brain was completely gone.

Mrs DAVIES asked if her mother would be taken off morphine to see if she would get better and was

told that they didn't need to stop it to see if that was the case but that wasn't going to happen, the morphine would kill her.

Mrs ROGERS never regained consciousness. Her pain relief was increased as it was felt she was still in pain.

On Tuesday 4th February 1997 (04/02/1997) Mrs ROGERS is described as restless. She moaned and groaned when the nurses turned her.

Mrs DAVIES wanted to go and check on her children and was advised by the nurses that it would probably be alright to leave for a couple of hours.

Upon leaving the nurse appeared to push the syringe drivers to give a little boost saying "This will settle her down".

Within 10 minutes of arriving home Mrs DAVIES was called back to the hospital but her mother had already died.

Mrs DAVIES would like a letter to warn that the notifications were ready for dispatch and then to receive her notification by way of letter.

Mrs DAVIES is a very emotional lady who is receiving counselling in relation to this matter.

I feel it would be prudent to advise her personally and to make sure that the relevant support structure is in place at the time.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7DX

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: OPERATION ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 24/06/2004

I visited Diane DAVIES at her home address at 1000 hrs, Wednesday 23rd June 2004 (23/06/2004) in relation to the letter dated 04/05/2004 from Alexander HARRIS.

I informed Mrs DAVIES of the contents of OR's 7AV (ROBINSON) and 8L Code A

Mrs DAVIES having read the copy of the medical records supplied by the police wishes to add the following;

Entry on Tuesday 4th February 97 (04/02/1997) "still in pain". She asks "How did they know she was in pain?" Mrs DAVIES and her brother Kenny had been with their mother throughout the entire period and she hadn't moved position or given any indication that she was in pain. Mrs DAVIES says that later that evening her mother had moaned when nursing staff had changed her side of lying. Mrs DAVIES says the moans were more of discomfort because her mother was a frail lady who didn't like to be moved as it was uncomfortable for her. It is not her opinion that her mother was in pain.

Mrs DAVIES having read the Haslar notes wishes to say that when her mother was admitted to Haslar and she was asked about resuscitation (as per O/R) when she said "Yes" the member of nursing staff told her that they would provide her mother with "aggressive treatment".

Mrs DAVIES has read in the Haslar notes that a Dr has written 'discontinue aggressive treatment' after only a couple of days.

Mrs DAVIES was not aware of this decision at the time.

Mrs DAVIES has also become aware that her mother's level of sodium at Haslar gives a cause for concern.

She states that her mother was put on morphine whilst at Haslar and her brother Billy queried it. He felt she did not require it. Mrs DAVIES is not sure if this treatment was discontinued.

Mrs DAVIES states that her mother was not given her tablets for her Parkinson's disease and having read up on the subject believes that this could have given the appearance of having suffered a stroke.

Mrs DAVIES wants to know why her mother never had a C.A.T scan whilst at Haslar. Mrs DAVIES states that after her mother had died and she remained at the hospital in a distressed state, she was spoken to by a nurse who had expressed surprise that her mother had died saying that she had seen her on the Saturday afternoon and they had shared a joke about Wigan playing 'her' team in the rugby.

Mrs DAVIES says that she visited her mother briefly on Saturday 1st February and had had to wait whilst two nurses had taken MRSA swabs. Mrs DAVIES says that she didn't see this procedure but previously when such swabs had been taken she had been allowed to be present. She wonders if diamorphine was being administered at this point although the medical records state the MRSA swabs were taken at this point. When Mrs DAVIES left her mother at the end of this short visit her mother begged her not to go.

Mrs DAVIES believes that her mother knew that 'they' were killing her.

Mrs DAVIES says that she has a recollection of her mother holding up a piece of paper whilst in Haslar upon which she had written "They're killing me" or "They're trying to kill me". Mrs DAVIES is not sure if this event took place in reality or in one of her nightmares. She has looked for the note but has not found it to date. Mrs DAVIES asks:

1) will she be able to see the medical expert reports
2) if her mother's case is not progressed is there a right of appeal
3) where is Professor BAKER's report. They were told that they could have a meeting with him.
4) when will the families be told about their relatives

I asked Mrs DAVIES for her doctors name in relation to the last paragraph of the solicitors letter regarding the 'independent medical expert'. Mrs DAVIES became very upset and refused to name her GP. She stated that he had looked over her mother's medical records as a favour to her and that when she had spoken with Ann ALEXANDER she had done so in confidence. She said that she didn't want to get him involved.

I explained our obligations under the Criminal Procedure and Investigations Act 1996. Mrs DAVIES was clearly distressed by this request. I feel that she felt she had put her GP in a difficult position. She drew my attention to the fact that she had told me that her GP was looking at the records. I informed her that her solicitors letter had indicated that a medical expert had reviewed the records and that any report or notes made in relation to this had to be retained.

Mrs DAVIES said that he hadn't made any notes and that this wasn't 'fair'.

She then became very defensive and declared that she would have her mother's records independently reviewed as she couldn't understand why our medical experts had any question marks over what happened to her mother as it was clearly obvious.

Mrs DAVIES continued in this manner for the next 1½ hrs and I eventually left at 1315 hrs.

Mrs DAVIES will speak to her GP to ask him to put into writing any concerns he may have. She will approach him and then will inform me of his identity.

She can't understand why the 'SHIPMAN enquiry' was started and finished within two years. If they can

do it, why can't we.

She believes that family group members who make a fuss and go on the television and to the papers get treated better by the police and get more attention. She believes that their cases will go forward to keep them quiet.

Mrs DAVIES is diagnosed as suffering from Post Traumatic Stress disorder and this case is clearly taking its toll on her well being.

She states she will contact Ann ALEXANDER to clarify the situation with regards to her GP and the confidentiality aspect.

Mrs DAVIES wishes it to be noted in big red letters "My mother was not in pain and didn't warrant large doses of pain killers and a large dose of sedative".

ELIZABETH ROGERS

Elizabeth Rogers

Date of Birth: Code A Age: **67**
Date of admission to GWMH: **30th January 1997**
Date and time of Death: **22.50 hours on 4th February 1997**
Cause of Death:
Post Mortem: **Burial**
Length of Stay: **6 days**

Mrs Rogers past medical history:-
Parkinson's disease

Mrs Rogers had been married twice, her first husband died in 1979. She had 2 daughters and 3 sons, 2 sons and a daughter lived in Wigan and another daughter lived in Gosport. Mrs Rogers moved down to Gosport from Wigan as she was getting no help from her family.
She was admitted into Thatched Cottage Residential Home as she became immobile and had swallowing problems.
From the Home Mrs Rogers was admitted to the Royal Haslar Hospital with a chest infection and urinary tract infection. It was noted that she had a catheter in place, was bed bound, slightly dysphagic, had lost weight and her sacrum was red but intact. Mrs Rogers was transferred to the Gosport War Memorial Hospital for continuing care on 30th January 1997.

On admission care plan commenced for constipation, catheter, personal hygiene, MRSA and sleeping.
On 30th January 1997 a Barthel ADL index was completed scoring 2. A Waterlow score of 26 was also completed A mouth assessment was also completed on 31st January 1997.
A handling profile was completed noting that Mrs Rogers needed the help of 2 nurses and hoist for transfers.

30th January 1997

Transferred to Dryad Ward. Transfer form notes grazed sacrum markings on hip and buttock skin intact.
Summary – admitted from A5 at Haslar after being admitted on 12th January 1997 ***following CVA*** [1] and has end stage Parkinsons. Screened for MRSA.

[1] Did not have CVA.

2nd February 1997

Summary – due to increase in pain and distress oramorph 10mgs given at 09.45.

PM – oramorph 10mgs at 14.00 and 18.00 hours. Extremely stiff when being attended to.

3rd February 1997

Summary – **pain not controlled by oramorph.** Seen by Dr Barton syringe driver commenced at 8.20 hours diamorphine 40mgs midazolam 20mgs and hyoscine 400 mgs. Daughter contacted and grand-daughter also notified of poor condition. Family seen by Dr Barton. Driver still insitu and running to time.

4th February 1997

Summary – further deterioration. Family seen by Dr Barton. Pastor Mary has also visited. Syringe driver renewed at 08.20 hours diamorphine 60mgs midazolam 40mgs and hyoscine 400mcgs remains peacefully.

Died peacefully at 22.30 surrounded by family

Clinical notes – Condition quickly deteriorated appeared comfortable and peaceful. Relatives at bedside death at 22.50 verified by RGN Dorrington. For burial.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**

ELIZABETH ROGERS **Code A** **G093918** **BJC-44**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	End-stage PD, severe distress, recent ?stroke ?infection > more disabled			
Unclear B				
Unexplained By Illness C				

General Comments

67-year-old mother of five, from Wigan, in rest home, 'end-stage' Parkinsons, treated for 15years, chronic urinary retention, admissions with constipation, treated with DOPA and pergolide and orphenidrine
Admitted to Haslar 1997-01 with ? stroke and chest infection – unrousable then
Admitted GWMH 1997-01-30, in pain not relieved by oral morphine sulphate up to 10mg 4 hourly.
Diamorphine '40-200 mg' started 1997-02-04 (i.e. 25% dose increase)
Therefore probably reasonable
I have been un able to find relevant medical notes.

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/44
ELIZABETH ROGERS
67

This lady had severe Parkinson' 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

Exhibit No	Patient Identification	Assessment Note	Assessment Score
JR/02	Rogers, Elizabeth Fiegan	Admitted with a marked neurological deterioration of uncertain cause, which progressively improved. But extremely dependent and not felt by Dr Lord to be a candidate for a PEG. Tended to pull out NG tubes, venflons etc. So oral intake very poor and tended to get dehydrated. Definitely improving at time of transfer. Had gone from GCS 6 to fully alert and able to hold a conversation. Only analgesia at time of transfer was cocodamol 2 tabs at night. (Had diamorphine 2.5mg sc prescribed PRN but had never been administered.)	1A

Expert Review

Elizabeth Rogers

No. BJC/44

Date of Birth: Code A

Date of Death: 4 February 1997

Mrs Rogers was transferred from the Royal Haslar Hospital to Gosport War Memorial Hospital on 30 January 1997.

She had been treated at the Royal Haslar Hospital with a chest infection and a urinary tract infection. She had severe Parkinson's disease. On transfer it was noted she had a catheter in place, was bed bound, slightly dysphagic and her sacrum was red but intact.

On 2 February 1997 she was prescribed oral Morphine due to an increase in pain.

On 3 February 1997 in view of the pain not being controlled by oral Morphine, a syringe driver was commenced with 40mgs of Diamorphine, 20mgs of Midazolam and 400mcgs Hyoscine.

The experts note that the dose of Diamorphine approximated to a doubling of opioid medication but agreed that most practitioners would have used opiates to control this patients pain. Some criticism was made of the dose of diamorphine given but this was felt to not to have shortened Mrs Rogers life.