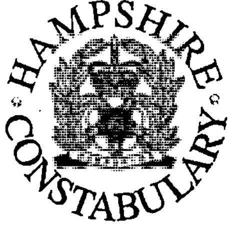

ALICE WILKIE

DOCUMENT RECORD PRINT

Officer's Report

Number: R7DA

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE Code A ROBINSON REF:
STN/DEPT: OPERATION ROCHESTER TEL/EXT:

SUBJECT: DATE: 29/04/2004

I visited Marilyn JACKSON at her home address on 11/02/2004. Present at the meeting were her daughters Emily YATES and Lisa PAYNE. The family had the opportunity to compare the copy of Alice WILKIE's medical records as supplied by the police against their copy of Alice WILKIE's records as supplied by the local health authority.

The family will say that Alice was born in the London area on Code A she was one of six children.

She married Albert WILKIE and had one child, Marilyn and adopted a son, Andrew. She worked initially as a tailoress and subsequently in grocers and newsagent type shops. She moved to Arundel upon her retirement with her husband and upon his death she moved to the Gosport area and lived with her daughter.

With regards to her medical history, the family can say that at some point whilst in her late 50's, early 60's Alice was checked for TB and as a result had part of a lung removed.

When she moved to Gosport in 1992 she was displaying signs of dementia.

She had an ulcer and was passing blood that was successfully treated.

Alice's doctor was Dr Yeo from the Gosport Health Centre.

Her dementia grew progressively worse and in 1997 she went to live in Addenbrook Residential Care Home for Dementia.

On 31/07/1998 Alice was admitted to the Queen Alexandra Hospital suffering from dehydration. She had a UTI infection which had not responded to antibiotics and had been admitted to resolve the problem.

She responded well to treatment and on 6th August 1998 (06/08/1998) was transferred to Daedalus Ward at the Gosport War Memorial Hospital for rehabilitation and a 4/6 week assessment of her condition.

When visited by her daughter on the day of her admission, she was sat having her tea and feeding herself.

By the weekend, the family describe her as an 'empty shell' she would just sit like a 'zombie'.

She had been admitted mobile but by the weekend had to be moved with the aid of a hoist.

Within days she had become bed bound. Mrs JACKSON spoke with a nurse she believes was named JOYCE (surname) who told her that her mother was deteriorating.

On 17th August 1998 (17/08/1998) Mrs JACKSON received a telephone call from the hospital from Phillip BEAD asking her to "come in for a chat".

He told her that her mother wasn't very well and Mrs JACKSON was concerned as she didn't want her mother to suffer any pain.

Mrs JACKSON was of the opinion that something 'wasn't right' but she didn't get the impression from the meeting that her mother's death was imminent.

Mrs JACKSON would visit at different times of the day and she noticed that the trays of food for patients were left out of reach of the patients and that the food was unsuitable. Her mother was given, thick dry sandwiches which she couldn't chew.

On 20th August 1998 (20/08/1998) Mrs JACKSON visited her mother during the morning. She describes her mother as being very sleepy and appeared to be in discomfort. She asked her mother if she was in pain and her mother told her that she was. Mrs JACKSON approached a member of staff, she believes it was a SN JOYCE and asked her to check her mother.

She waited for an hour and no nurse came so she approached Phillip BEAD who told her that "We'll give you mum something for the pain, it will make her sleepy but she will hear you and she'll know what's going on".

Mrs JACKSON left the hospital at 1400 hours and rang Lisa, her daughter. She asked her to go and check on Alice.

Lisa PAYNE went to the hospital and asked about her grandmother, she was told "Your mother seems to think that she's in pain".

Lisa states that at this point Alice was sleeping peacefully.

At 2000 hrs Mrs JACKSON returned to the hospital, she found her mother to be unconscious, she didn't move or respond to anything.

Mrs JACKSON and her family stayed with Alice throughout the night, it was at this point that they met Mrs G McKENZIE and Mrs L RICHARDS who were visiting their mother.

Alice WILKIE never woke up and her breathing was quiet and shallow.

The night staff offered Mrs JACKSON a bed for the night, she describes them as being very nice.

During the early part of the morning the curtains, which were drawn around Alice's bed, were pulled back and a woman, who is believed to be Dr BARTON , looked in and said "Won't be long now".

Mrs JACKSON recalls that her mother's catheter bag was full of blood.

Around tea time, Phillip BEAD told Mrs JACKSON to go and get some rest as she may have another night of sitting with her mother. Mrs JACKSON would only go after being assured that she would be notified if there was any change in her mother's condition.

The family then left and went to get something to eat, they arrived back on the ward at 1830 hrs, they saw Phillip BEAD, who moved quickly into Alice's room and as they arrived at her door he said "She's heard your voice, she's just gone". The family describe Alice as looking 'yellow and waxy' they do not believe that she had only just died.

Their concerns are as follows;

The speed from which Alice was well/walking to being in a comatose state.

They were not aware that a syringe driver was in use.

No one spoke to the family about pain relief for Alice.

They received no warning or communication as to the severity of 'Alice's' condition.

The family have read the police copy of Alice WILKIE's medical files and wish to point out the following.

1. Pg 64, with reference to the dosage of diamorphine and medazolam, they query the times this was given.

2. Pg 88 Dr LORD has written DNR (Do not resuscitate) the family were not consulted over this decision.

3. Missing page from police records for 04/08/1998 - 21/08/1998, should be between pages 88-89 (page copied and exhibited EY/AW/1 - sent to clinical team).

4. Page 125, entry dated 17/08/1998, family dispute this, Mrs JACKSON states this did not happen, she was not consulted.

5. Entry as 21/08/1998, 1830, family dispute the time of death.

6. Pg 115 entry 06/08/1998 refers to 4/6 weeks assessment, no indication of impending death.

7. Pg 140 13/08/1998 entry written in error relating to medication given to Gladys RICHARDS .

8. 19/08/1988 entry for death of Gladys RICHARDS. The family is concerned that Alice WILKIE received medication intended for Gladys RICHARDS.

DOCUMENT RECORD PRINT

9. QA records show Alice eating and drinking, GWMH records have no records to this effect. There are no fluid input/output charts.

10. Pg 113 Carer contact numbers are wrong.

11. Death Certificate gives cause of death as dementia and pneumonia. The family were informed Alice had pneumonia nor is there any indication in the medical notes.

12. Why was Alice not seen by a Dr from 10/08/1998 - 21/08/1998.

13. Pg 25 dated 17/8 who decided that active treatment was not appropriate and why? Is this a nurses job?

14. 20/08/1998 who checked for the pain as indicated by Mrs JACKSON?

15. Why was the analgesic ladder never used?

16. Who prescribed diamorphine?

17. Why was there such a lack of communication?

ALICE WILKIE

Alice Wilkie

Date of Birth: Code A Age: **82**
Date of admission to GWMH: **6th August 1998**
Date and time of Death: **18.30 hours on 21st August 1998**
Cause of Death:
Post Mortem:
Length of Stay: **16 days**

Mrs Wilkie's past medical history:-
Dementia

Mrs Wilkie lived at Addenbrooke Residential Home a psychogeriatric care home where she needed 24 hour care. Mrs Wilkie had a daughter and grand-daughter.
Mrs Wilkie was admitted to the Queen Alexander Hospital on 31st July 1998 with unresolved urinary tract infection, decreased mobility and pyrexia.
She was transferred to Gosport War Memorial Hospital on 6th August 1998 for 4-6 week observation.

On admission care plans commenced for nutrition due to dementia, restricted mobility, pressure area care, constipation, catheter care, hygiene and settle at night.
A handling profile was completed noting that Mrs Wilkie was withdrawn and does not communicate, gets agitated at times, is in pain occasionally, nursed on air mattress, has a pressure relieving cushion in her chair, has been catheterized and needs the assistance of 2 nurses and a hoist for transfers.
A Barthel ADL index score of 1 on 6th August 1998 and 2 on 9th August 1998 were completed. As well as a Waterlow score of 15 on 6th August 1998.
A nutritional assessment score of 22 was also recorded on 6th August 1998.

6th August 1998

Admitted to Daedulus ward, too dependent to return to nursing home for 4-6 weeks observations then decided on placement. Catheter in situ.
Contact records – seen by Dr Peters.

17th August 1998

Contact record – deteriorated over weekend. Daughter seen aware of worsening condition agrees active treatment not appropriate, to use syringe driver if in pain.

21st August 1998

Contact record – condition deteriorating comfortable and pain free. 18.30 death confirmed, family present.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification | **Exhibit number**
ALICE WILKIE Code A | BJC52

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Frail and demented, but not clear why she died. High dose of diamorphine from start (unless I have missed record)	Could belong here	
Unexplained By Illness C				

General Comments

82-year-old widow from psychogeriatric home, history of Alzheimer's, several previous respite admissions
admitted with UTI 1998-07-31
transferred GWMH
Condition deteriorated around 1998-08-17
No apparent difficulty in sleeping on 16th & 18th
> diamorphine 30mg/24h on 20th
Died 1998-08-21-18-30

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/52
ALICE WILKIE
82

Dementia and probable UTI. Transferred to Daedalus because she was thought to be too dependent to return to her Rest Home. I cannot find details for the period 6-21/8/98. However she was suddenly prescribed diamorphine at 30mg per 24 hours via syringe driver without any previously recorded analgesia. There might be a missing drug card because her laxative was not prescribed from 15/8/98 onwards. There is insufficient detail in the available notes and I suspect there are notes missing.

No grading

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/52	Wilkie, Alice N3	Cannot see in the case record any of the medical notes for the final admission to Daedalus, or the second drug chart which must have existed. In the absence of the notes it is very difficult to make any sensible assessment. She had late stage dementia and had become very dependent following a UTI which required IV antibiotic therapy. She was needing 2 nurses and a hoist for transfers. It is therefore possible that she would have died of her dementia in GWMH whatever management had been carried out. The only relevant drug chart I can find shows that she was treated with a syringe driver containing diamorphine 30mg and midazolam 30mg on 20/8 and 21/8 (the day of death). The nursing notes suggest the syringe driver may have been initiated on 17/8, when permission was given by the son, but there is no other evidence of this. And I have no evidence on which to judge whether the deterioration in her general condition prior to 17/8, alluded to in the nursing note of that date, was due to medical problems or secondary to opioid or other treatment. I judge the treatment to be sub-optimal simply on the basis of the inadequacy of the nursing notes. It may in fact have been medically entirely appropriate, although I would be very surprised if such a frail elderly lady with no malignant disease or fracture required a dose of diamorphine of 30mg/24 hours.	B2

Expert Review

Alice Wilkie

No. BJC/52

Date of Birth: Code A

Date of Death: Code A

Prior to admission to Gosport War Memorial Hospital on 6 August 1998 Mrs Wilkie received twenty-four hour psycho geriatric care at Addenbrooke Residential Home.

Mrs Wilkie was admitted to the Queen Alexandra Hospital on 31 July 1998 with an unresolved UTI, decreased mobility and pyrexia. She was transferred to Gosport War Memorial Hospital on 6 April 1998 for a four to six week observation.

The experts have noted that in the absence of any Medical Notes in respect of Mrs Wilkie's final admission it is difficult to make a firm assessment.

Dr Naysmith postulated that Mrs Wilkie would have died of her dementia in Gosport War Memorial Hospital whatever management had been carried out. A question was raised as to why a frail, elderly lady, with no malignant disease or fracture, required a dose of Diamorphine 30mgs over twenty-four hours but, in the absence of the above Medical Notes, the experts have felt it difficult to conclude, with any degree of certainty, as to their view of the level of the standard of care provided to this patient. No expert rated this case lower than 2B.

HCO002148-0012