HAMPSHIRE CONSTABULARY

MABEL LEEK

DOCUMENT RECORD PRINT

Officer's Report

Number: R16G

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCD

REF:
TEL/EXT:

SUBJECT: OP ROCHESTER

DATE: 07/07/2004

Regarding the death of Mabel Alice LEEK , known as "Poppy" Code A I report as follows;

I have seen her daughter J Code A o Code A She was aware of the police investigation, she had spoken about it with her sister (Thelma BOWDEN-SMITH , Code A but they did not see any connection between it and the death of their mother. I gave her the approved outline of the investigation.

She says that her mother was born in the Republic Of Ireland on 21/02/1906, her husband worked for the Admiralty and consequently they travelled extensively through his work commitments. She survived her husband by approximately 10 years. She lived alone, latterly she was partially looked after by carers, basically they would assist her to get up in the mornings and help her to bed in the evenings. She suffered from Rheumatoid Arthritis, had occasional chest problems and high blood pressure at times, her daughter says that these were the normal sort of ailments in a lady of that age. Although able to get around indoors she did not really leave the house much due to her lack of mobility.

Poppy is described as having fragile bones and in 1998 she suffered a broken leg, she was admitted to either Haslar or Queen Alexandra Hospital , and this would be approximately 6 months before she died, she was never to leave hospital.

Following her initial treatment, which included plastering her leg, Poppy was transferred to the Gosport War Memorial Hospital . June USHER had no reason to suspect that her mother would not be returning home at some stage. Poppy would be visited every day by one of her two daughters, who would visit on alternative days.

Initially Poppy was no different to when she was at home, mentally she was as normal, she was quite OK in her mind. However June USHER soon noticed that her mother was always sleepy or asleep, she went onto say that "all of the old dears seemed to be asleep". June will say that she was never told what medication her mother was being given, she never asked and she said that there was never anybody to ask, they never seemed to see a doctor in the hospital. She recalls that on one occasion her mother "didn't know where she was". June complained about this and was led to believe that it was caused by some medication given in relation to a urinary infection. She understood that this was stopped after that day, this incident occurred several weeks before Poppy died.

A few weeks prior to her death the two sisters were asked to asked to find accommodation for their mother, so arrangements were in hand to locate a suitable nursing home. In fact they were given a date in which to achieve this by. However Poppy fell into a coma approximately 4 days prior to her death, June believes that she had contracted pneumonia.

Poppy died on 18th December 1998, (18/12/1998) a death certificate was issued, cause of death given as Bronchopneumonia and certified by J.A.BARTON .

June has no objections to the investigation and would welcome the support etc offered to other family group members.

MABEL LEEK

Mabel Leek
Date of Birth: Code A Age: **92**
Date of Admission to GWMH: **6th August 1998**
Date and time of Death: **17.15 hours on 18th December 1998**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **135 days**

Mrs Leek's past medical history:-

- Fracture left hip 1995
- Hysterectomy
- Bilateral cataract extraction 1985
- Angina 1989
- Appendectomy
- Tonsillectomy
- Osteoarthritis knees 1983
- Osteoporosis

Mrs Leek had two daughters who lived in Gosport. She lived on her own with extended home care visiting twice daily. She also had meals on wheels and a home help. Mrs Leek was allergic to aspirin. Mrs Leek fractured her left tibia and fibia, which was plated at Royal Haslar Hospital. Mrs Leek was transferred to Gosport War Memorial Hospital on 6th August 1998 for further rehabilitation.

On admission care plan commenced for sleeping, catheter, small necrotic ulcer right heel, hygiene, POP on left leg, wound on left leg, MRSA (barrier nursed), pain in knees and red sacrum. A Waterlow score and Barthel score were recorded fortnightly and a handling profile was completed noting Mrs Leek had pain in both knees, was nursed on Pegasus mattress, skin intact and needed the assistance of 2 nurses, a hoist and glide sheet.

Daily summary
6th August 1998
Transfer letter – from Haslar to Dryad Ward. Transfers with a zimmer and 2 nurses. Needs assistance with hygiene. Needs lots of encouragement and physio. Leg needs to be elevated with four pillows on top of a chair to reduce swelling.
Clinical notes – admitted to Dryad ward with **fracture to left tibia and fibia.**
Summary – admitted from Haslar following fracture left tibia reduction fixed with plate and screws. POP in situ. Large lacerations under plaster. Photos in notes. Incontinence, difficulties with mobility.

7th August 1998
Summary – **oramorph given 10mgs.**
8th August 1998
Summary – **breakthrough pain boarded for MST 40mgms bd.**
10th August 1998
Clinical notes – seen by SLT review 2 weeks.
24th August 1998
Clinical notes – seen by SLT.
1st September 1998
Clinical notes – swallowing problems. Restless at night.
Summary – seen by Dr Barton.
14th September 1998
Clinical notes – not mobile. Barthel 6. Ulcer left ankle much same. **Pain left heel. Catheterised. Oramorph for pain then on MST 50mgs increasing to 60mgs** (on long term MST).
Summary – seen by Dr Lord.
4th October 1998
Summary – very difficult to manage.
13th October 1998
Summary – arrangements made to transfer to Royal Haslar Hospital for review of POP causing distress, more swollen over last few das. Bed elevated.
Clinical notes – complaining of swelling foot.
Clinical notes – referral to Royal Haslar Hospital cast seems tight, foot swollen.

Clinical notes – accident and emergency department. ORIF left ankle 8 weeks ago and scotch cast now increasing pain under scotch cast. Cast removed today much improvement. On examination **clear dry ulcer 3cm x 3cm.** Surgical scar healed x-ray fracture site united acceptable postal ?? backing out of screws. Plan – walking boot and gentle mobilising.
19th October 1998
Clinical notes – **pressure sore on heel.** Plastic surgeon to review.
Summary – has been to Haslar for review. **Small necrotic area on left heel.** Spilt milk on arms and fore arm. Slight redness. Accident form completed.
26th October 1998
Clinical notes – went to Royal Haslar Hospital. Cast removed for **MST 70mgs.** Right knee painful, **heel black area.** Barthel 5. Residential care discussed.
Summary – seen by Dr Lord once ulcer healed for rehab with physio.

28th October 1998
Summary – seen by Dr Barton re pain control **MST increased from 70 to 80** mgms.
9th November 1998
Clinical notes – Barthel 4. Left heel ulcer sloughly surrounding skin inflamed. Pain reasonable, controlled.
Summary – seen by Dr Lord to commence Flucloxacillin 500mgs for 7 days because of swelling near the ulcer on left ankle.
20th November 1998
Summary – heel swab taken.
23rd November 1998
Clinical notes – **on increase dose of MST**. Left heel clean smaller but little slough. Healthy tissue around. To nursing home in New Year if stable. Mrs Leek agrees.
Summary – Nursing home subject bought up with patient and daughters. Dr Lord pleased with progress of heel ulcer.
1st December 1998
Summary – heel swab retaken.
3rd December 1998
Summary – not ready for discharge. Refer to Haslar Social Services.
7th December 1998
Clinical notes – heel ulcer sloughly with some necrotic tissue. Pain better less drowsy.
Summary – seen by Dr Lord no change in treatment. To be reviewed in New Year.
13th December 1998
Summary – **unresponsive at times**. No supper taken but did have a drink.
14th December 1998
Clinical notes – deteriorated over weekend. **Pain relief a problem start S/C analgesia and make more comfortable**. Happy for **nursing staff to confirm death.**
Summary – **remained unresponsive when moved in pain**. Seen by Dr Barton. **Syringe driver commenced** with **diamorphine 80mgs.**
15th December 1998
Clinical notes – **further deterioration on S/C analgesia and comfortable.**
Summary – syringe driver recharged with **diamorphine 80mgs still appears in pain and distressed at being moved. Syringe driver recharged with diamorphine 100mgs.**
16th December 1998
Summary – **syringe driver recharged with diamorphine 100mgs**. Still distressed.
17th December 1998
Summary – syringe driver recharged with **diamorphine 130mgs.**
18th December 1998
Clinical notes – died 17.15 hours verified by S/N Shaw and S/N Wigfall.
Summary – **syringe driver recharged with diamorphine 160mgs**. Condition deteriorated. Died at 17.15 hours for cremation.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**

MABEL LEEK 1906-02-21 q574912 BJC-68

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Analgesia limited – mainly opiates; doses high esp towards end; cause of death unclear		
Unexplained By Illness C				

General Comments

A 92-year-old woman with bad OA for 40 years, requiring MST as early as 1996 (10 mg bd) and with incontinence and falls, also said to have angina and COAD

1998-07-25 Repair #tib and fib (L)
1998-08-06 Transferred from Haslar to GWMH
1998-09-11 Drugs chart shows MST 60mg bd, but no paracetamol, oral NSAID…
1998-12-08 ESR 100 (still)
1998-12-14 Noted to be unresponsive. Given diamorphine 80, 80, 100, 100, 130, 160, 160 mg on successive days with midazolam. Nursing notes do say 'distressed when moved.' Was on MST 60 mg bd ≡ 45 mg diamorphine/24 h + 5 mg Oramorph once
1998-12-18-17-15 Dies

*Rx chart from August, notes from Haslar, MISSING

Final Score:

Screeners Name: R E Ferner
Date Of Screening: 17th Nov 2003

Signature

BJC/68
MABEL LEEK
92

This lady had a history of a lot of pain due to arthritis and had previously required low dose MST for this in 1997. She also had pain from her heel ulcer. They tried different types of analgesic for the pain but gradually the dose of MST increased with a small dose reduction at one stage. The conversion to syringe driver increased the opiate dose significantly and then it continued to increase without any clear mention of pain or distress in the medical or nursing notes.

PL grading 2B
Group grade 2B

Exhibit No	Patient Identification	Assessment Note	Assessment Score
BJC/68	Leek, Mabel	Widespread OA and osteoporosis with multiple fractures over several years, very limited mobility and chronic pain. On MST 10mg BD + oramorph 2.5mg PRN since 1996. Spontaneous #L tib/fib, plated Haslar and sent to GWMH for rehab. Developed pressure ulcer inside POP. Considered for plastic management but not offered. Returned from Haslar to GWMH for rehab/placement. At that stage notes indicate (but cannot find drug charts to correspond) that she had been on MST 30mg BD on admission and was prescribed 60mg BD on 11/9 because of severe pain in joints and ulcer. Slow progression of doses upwards from there. 70mg BD on 23/10, 80mg BD on 28/10 but for at least a month and possibly until 14/12. At that point she had "deteriorated over the weekend" and a S/D was put up. Diamorphine dose raised by >30% at that point, but she was described as not swallowing and unresponsive before S/D started. ?Have I missed a drug chart in between? Thereafter S/D doses raised quite reasonably with frequent descriptions of pain and distress. Midazolam went up more steeply but she was on long term Temazepam 10mg so would be to some extent tolerant.	1A

Expert Review

Mabel Leek

No. BJC/68

Date of Birth: Code A

Date of Death Code A

Mrs Leek had a long history of pain due to osteoarthritis and suffered from osteoporosis with multiple fractures over several years. She had limited mobility. She suffered with chronic pain and from 1996 had been treated with Morphine, 10mgs twice a day. Mrs Leek had problems with incontinence and was also noted as having angina and chronic obstructive airways disease. She lived on her own with extended home care visiting twice daily and had meals on wheels and a home help.

Following her left tibia and fibula fracture, which was treated at Royal Haslar Hospital, Mrs Leek, was transferred to Gosport War Memorial Hospital on 6 August 1998 for further rehabilitation.

On admission she was prescribed 60mgs twice a day of Morphine because of the severe pain in her joints and the pressure ulcers.

The dose of Morphine was gradually increased and a syringe driver was commenced on 14 December 1998 following a deterioration which was recorded in the clinical notes.

The conversion to syringe driver increased the Diamorphine by thirty per cent but Mrs Leek was described as not swallowing and unresponsive.

The experts concluded unanimously that although the rate of increase of analgesia was sub optimal there was no negligence in the terminal care of Mrs Leek.