ELSIE DEVINE

BJC/16 Elsie Devine

Date of Birth: Code A

Date of admission to GWMH: **21st October 1999**

Date and time of death: **20.30 hrs on 21st November 1999**

Cause of death:

Post Mortem:

Length of Stay: **31 days**

Mrs Devine's past medical history:

Code A

Code A

Code A

21st October 1999

Daily summary states admitted from Queen Alexander Hospital after

Code A

Code A Seen by Dr Barton.

Transfer to Dryad ward for continuing care. Code A

Code A. Plan:- to assess rehabilitation to continue, looking for Residential Home in due course.

25th October 1999

Seen by Dr Reid – continue.

1st November 1999

Daily summary states seen by Dr Reid commenced Code A

Code A

Home visit to see if function better in own home.

3rd November 1999

Contact record – son and daughter in law concerned safety of Mrs Devine returning home. Referral made to social services.

12th November 1999

Seen by social worker 24 hour chart to be completed

15th November 1999

Code A

Daily summary states seen by Dr Reid referral made to Dr Luznat.

18th November 1999

Put on waiting list for Mulberry Ward.

19th November 1999

Code A

Please make more comfortable happy for nursing staff to confirm death.

Daily summary notes marked deterioration over last 24 hours extremely

Code A

Code A **Seen by Dr Barton situation explained.**

Code A

Contact record - social services to close case. Mulberry ward also informed.

20th November 1999

Daily summary states condition remains poor, family aware of condition.

Seen by pastor Mary.

Code A

21st November 1999

Daily summary states condition continues to deteriorate slowly. Family visited. Code A

Asked to see at 20.30 hours died peacefully.

Death verified by S/N Dunleavy in presence of E/N Wigfall.

Comments

No pain why Code A Code A taken off, when on? Aggressive sedation- no pain recorded.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness		2C		

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
Elsie DEVINE Code A

Exhibit number
BJC-16

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		'Deteriorated', creatinine increased, then fentanyl, then S/D		
Unexplained By Illness C				

General Comments

albumin 20, U
)

Code A

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/16
ELSIE DEVINE
88

Code A

Cause of death is not clear and the use of opioids questionable especially when considering the doses.

PL grading C2

BJC/16	Devine, Elsie		C4

Code A

Summary of Clinical Team comments on category 3 cases.

BJC/16
ELSIE DEVINE (88)

Code A

Code A

PL grading C2

Code A R

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Code A		
Unexplained By Illness C				

Code A

Irene WATERS

Elsie Devine
Date of Birth: Code A
Date of admission to GWMH: **21st October 1999**
Date and time of death: **20.30 hrs on 21st November 1999**
Cause of death:
Post Mortem:
Length of Stay: **31 days**

Mrs Devine's past medical history:

Code A

Code A

Code A

being transferred to the Gosport War Memorial Hospital for rehabilitation and continuing care on 21st October 1999.

On admission care plans were commenced dated 22nd October 1999 for

Code A

21st October 1999

Daily summary states admitted from Queen Alexander Hospital after

Code A

Code A Plan:- to assess rehabilitation to continue, looking for Residential Home in due course.

25th October 1999

Seen by Dr Reid – continue.

1st November 1999

Daily summary states seen by Dr Reid commenced Code A weighed twice weekly, for home visit.

Home visit to see if function better in own home.

3rd November 1999

Contact record – son and daughter in law concerned safety of Mrs Devine returning home. Referral made to social services.

12th November 1999

Seen by social worker 24 hour chart to be completed

15th November 1999

Code A

Daily summary states seen by Dr Reid referral made to Dr Luznat.

18th November 1999

Put on waiting list for Mulberry Ward.

19th November 1999

Code A

Code A Son seen and aware of condition.

Please make more comfortable happy for nursing staff to confirm death.

Code A

Contact record - social services to close case. Mulberry ward also informed.

20th November 1999

Daily summary states condition remains poor, family aware of condition.

Seen by pastor Mary.

Code A

21st November 1999

D

Code A

v

Asked to see at 20.30 hours died peacefully.

Death verified by S/N Dunleavy in presence of E/N Wigfall.

Comments

No pain why Code A Code A when on? Aggressive sedation- no pain recorded.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness		2C		