RUBY LAKE

BJC67 Ruby Lake
Date of Birth: Code A
Date of Admission to GWMH: **18th August 1998**
Date and time of Death: **18.25 hours on 21st August 1998**
Cause of Death:
Post Mortem:
Length of Stay: **4 days**

Code A

Code A

Code A On 5th August 1998 Mrs Lake was admitted to the Royal Haslar Hospital via accident and emergency after falling at home. She fractured her left neck of femur and underwent a left cemented hemiarthroplasty later that day. Mrs Lake recovery was slow as she suffered from bouts of angina and breathlessness. She was transferred to Gosport War Memorial Hospital on 18th August 1998 for continuing care. The transfer letter noted that Mrs Lake could slowly mobilise with the aid of a Zimmer frame and had a broken area of skin on her left buttock and on the cleft of her buttocks. It also noted that she had a small appetite and needed lots of encouragement.

Daily summary
18th August 1998
Clinical notes – transferred to Dryad ward for continuing care. Fracture neck of femur (left) on 5/8/98. Catheterised, transfers with 2 nurses. Barthel 6. Plan – Get to know, gentle rehabilitation. Happy for nursing staff to confirm death. (page 72)
21st August 1998
Clinical notes – died peacefully 18.25 hours. Verified by S/N Ring and S/N Theadorus. (page 72)

Comment
There were no drug charts included in the Bundle. It was not clear what nursing care was given. If the lack of records is an indication that no assessment for care needs was made, no care plan drawn up and no risk assessments made, then this was a standard of care which was far below an acceptable standard expected of competent nurses at the time. The lack of an appropriate care plan and evaluation sheet means that with no information about the care assessed or given that the poor outcome of this nursing episode would indicate a poor standard of care.

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				
Unexplained by Illness				

BJC67 Ruby Lake

Oramorph chart – given on 18/8/98 at 14.15 hours 5mgs
19/8/98 at 00.15 hours 10mgs
19/8/98 at 11.50 hours 10mgs

Diamorphine chart – given on 19/8/98 at 16.00 hours 20mgs
20/8/98 at 09.15 hours 60mgs
20/8/98 at 07.35 hours 20mgs
20/8/98 at 16.30 hours 40mgs

need to check as chart difficult to understand.

Also given with diamorphine was hyoscine and midazolam.

A **waterlow score** of 25 was recorded on admission to GWMH on 18/8/98. Care plans also commenced on admission for small ulcerated areas on lower legs 1 small area on right leg and 2 small areas on left leg, 2 sacral pressure sores 1 small area on left buttock and area in cleft of buttocks, constipation, catheterised, hygiene and to settle at night. A barthel score of 9 was also recorded on admission as well as a nutritional risk assessment of 17. A handling profile was also completed noting that Mrs Lake had leg ulcers and sacral pressure sore and catheter. It was noted that **she was in pain and needed the help of 1 nurse and a zimmer frame.** A mouth assessment was also completed. An assessment sheet also noted that Mrs Lake was to mobilise slowly was deaf and needed a hearing aid, wore glasses and her speech was good. It also noted that she was on normal diet but her appetite was poor and she required encouragement.

Daily Summary
18th August 1998
Summary of significant events – admitted from E3 Haslar with fractured left neck of femur from fall at home. Slow post op recovery. Leg ulcers on both legs and break on sacrum. For slow mobilisation.
19th August 1998
Summary – **11.50 hours complaining of chest pain. Oramorph 10mgs given doctor notified. Very anxious diamorphine 20mgs commenced in syringe driver.**
20th August 1998

Summary – 12.15 hours continues to deteriorate. **Driver recharged 10.10 diamorphine 20mgs midozalam 20mgs and hyoscine 400mgs**. Family informed.
Night – continues to deteriorate very bubbly suction attempted without success and distressed when moved. **Syringe driver recharged diamorphine 20mgs midozalam 60mgs and hyoscine 800mgs 07.35 hours.**

21st August 1998

Summary – deteriorating slowly. Family present all afternoon. Died at 18.25 hours.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
Ruby LAKE 1913-10-23 G065575

Exhibit number
BJC-67

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

General Comments

An 84-year-old woman, known sero+ve arthritis (? SLE), living at home with daughters' support, lipodermatosclerosis,

1993-09-24 A. QAH LVF, AF, Renal failure, Ao Sclerosis
1998-07-02 Sultan ward: painful leg ulcers, given tramadol
1998-08-05 A. Haslar # (L)NOF > opn > angina & heart failure
1998-08-18 Transferred to Dryad
1998-08-21-18-25 Dies

- MISSING Haslar notes
- MISSING Haslar drugs chart AND discharge drugs
- MISSING DRUGS CHART AND NURSING NOTES FROM GWMH

THEREFORE NOT ASSESSABLE

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
RubLak 1913-10-23 G065575

Exhibit number
BJC-67

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		ADD: 2B – chest pain and possible heart failure BUT large doses of sedatives and opiates		
Unexplained By Illness C				

General Comments

An 84-year-old woman, known sero+ve arthritis (? SLE), living at home with daughters' support, lipodermatosclerosis,

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1998-08-18 Transferred to Dryad
1998-08-21-18-25 Dies

- MISSING Haslar notes
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- MISSING DRUGS CHART AND NURSING NOTES FROM GWMH

THEREFORE NOT ASSESSABLE
ADD: The missing nursing notes and Rx chart show (a) chest pain, (b) 'bubbliness' and rapid deterioration; and (c) prescription of substantial doses of opiates and sedatives, rapidly escalated. She MAY have had an infarct and severe chest pain ± heart failure, but this is not clear.
SO
Becomes 2B

Final Score:

Screeners Name: R E Ferner
Date Of Screening: 18th August 2004

Signature

BJC/67
RUBY LAKE
84

Fall with hip fracture. Transferred to Dryad on 18/8/98. Clerked in. Next entry in medical notes is her death. I cannot find her nursing notes or medication card. I cannot give a grade for this.

Group agreed – impossible to grade

BJC/67	Lake, Ruby	Transferred to continuing care after #NOF on 18.8.04 when seemed frail but OK. Next entry that she had died 3 days later. No nursing notes or drug charts from that admission in the folder so no information at all about the intervening events. No comment possible.	

RESTRICTED

DOCUMENT RECORD PRINT

Officer's Report

Number: R7EP

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: OPERATION ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 11/10/2004

The Key Clinical Team met and discussed the following cases on Saturday 9th October 2004 (09/10/2004). All team members were present, Lillian TAYLOR BJC/84 & JR/8 was marked as 2A. The individual marks are as follows: Ann NAYSMITH 2A, Peter LAWSON 2A, Irene WATERS 2A and Robin FERNER 2b.

Arthur COUSINS BJC/85 & JR/9 1A.

All teams members scored the same.

Christina TOWN BJC/86.

Noted that Mrs TOWN never received any opiates but was prescribed 40-200mg Diamorphine. Because of this she is scored as a 2A. Individual scoring is as follows A.NS=1A, PL-2A, R.F-2A, IW-2A.

Ruby LAKE BJC/67 was marked as a 3B.
Individual scores = A.NS=3C, PL=3B, IW=2A, RF=2B.

Cyril DICKS BJC/17 to remain as 2B.

Alice WILKIE BJC/52 : No further data to assist.