ALICE WILKIE

D 779

OPERATION ROCHESTER

Report summarising screening assessment of first 61 cases analysed

This report is compiled from the annotations made during the initial screening of each case. No subsequent editing or amendment is included in this report. However, it should be noted that only the first 20 cases were screened truly blind. In assessing the first 20, I applied the same standards as I would to my own practice, ie that of an experienced medical practitioner in the specialty of palliative medicine. It is my personal belief that excellent clinical practice, ie the best possible decision making given the clinical information available and the patient's preferences, should be the same in all settings, whether specialist or generalist.

However, during the conference after the screening of the first 20 cases it was made clear to me that I was setting an unrealistically high standard for practice in a rehabilitation/continuing care setting. My assessments of all subsequent cases were influenced, therefore, by the views of the other members of the clinical team. There will not be complete consistency in my assessments between the first 20 cases and the subsequent ones.

The screening matrix used for scoring in all cases was as follows:

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

In each case the screening assessment was made contemporaneously with the study of that case record. It was not made retrospectively at a later date from my handwritten notes, although they informed my judgement by summarising the important points I abstracted when going through each record.

The following table brings together the assessment notes made on each patient and my own screening assessment score, prior to discussion with other members of the clinical team.

BJC/52	Wilkie, Alice	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. Code A 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

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**

Code A

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

D965

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification Code A

Exhibit number BJC52

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

General Comments

Code A

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

P L

BJC/52
ALICE WILKIE
82

Code A

There is insufficient detail in the available notes and I suspect there are notes missing.

No grading

D1334
U/17

ALICE WILKIE
BJC52
I have been through all of her notes again and even with the newly found GWMH medical notes I cannot find an explanation for her deterioration on 17/8/98 and the need for a syringe driver. That is not meant to imply that there was no indication but there are insufficient clinical notes to make a judgement (in particular, still no nursing notes from GWMH)
No score

D 1044

Alice Wilkie

Date of Birth: Code A
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:-
Code A

Mrs Wilkie lived at Code A
Code A
Code A
Mrs Wilkie was admitted to the Queen Alexander Hospital on 31st July 1998

Code A

6th Au

17th A

21st A

Comment
There were no medical notes. The nurses appeared to assess Mrs Wilkie's care needs and the care plans seemed appropriate. It is not possible to form any opinion about the care without more information.
Administration of medicines.
Need to see medical notes

D1099

6.55 BJC/52 **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

Code A

Mrs Wilkie was admitted to the Queen Alexander Hospital on 31st July 1998

6th Aug

17th Au

21st Au

Code A

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				

D1754

D1254

BJC52 Alice Wilkie

Additional to daily summary from inserts.

Code A

Expert Review

Alice Wilkie

No. BJC/52

Date of Birth: Code A

Date of Death: 21 August 1998

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

Code A

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.

Code A