EVA PAGE

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Eva Page

Date of Birth: Code A Age: **88**
Date of admission to GWMH: **27th February 1998**
Date and time of Death: **21.30 hours on 3rd March 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **5 days**

Mrs Page's past medical history:-
Confusion
1995 - Atrial fibrillation
CCF
1995 – LVF
1997 – TIA
1995 – Digoxin Toxicity

Mrs Page was widowed and lived at Chesterholm Lodge Residential Home. She had a son.
Mrs Page was admitted to Queen Alexander Hospital as an emergency suffering with anorexia, decreasing mobility, sleeping a lot and becoming dehydrated. She was transferred to Gosport War Memorial Hospital on 27th February 1998 for palliative care.

On admission a Barthel ADL index score was recorded of 2. Care plans commenced on the day of admission for settle at night, constipation, catheter care and personal hygiene.
An handling profile which noted Mrs Page can make her wishes known, she had pain on movement, dry paper thin skin, to be nursed on Pegasus biwave mattress, she had a catheter insitu for retention of urine and needs help of 2 nurses and a hoist was completed on 28th February 1999. A Waterlow score of 27 recorded also on 28th February 1999.

27th February 1999

Admitted from Queen Alexander Hospital for palliative care. It was noted that Mrs Page was withdrawn and anxious. That she would call out frequently and needed reassurance. Also noted was that Mrs Page was on a normal diet and fluids was incontinent of faeces had a catheter for retention of urine and needed help with all hygiene needs.
The transfer form noted that Mrs Page has bio? to red sacrum, an old facial wound from 15th February 1998 after fall (scabs on nose) and swelling inner left eye.

Summary – admitted from Charles Ward for palliative care.
Clinical notes – opiates commenced. **Happy for nursing staff to confirm death.**

28th February 1999

Summary – very distressed, calling for help and saying she is afraid.
Oramorph 2.5mgs given with no relief. Thioridazine given with no effect
Clinical notes – jerks a lot agitated. Not in pain.

2nd March 1999

Summary – commenced fentanyl 25mgs this am. Very distressed. Seen by Dr Barton to have diamorphine 5mgs IM given at 8.10. Seen by Dr Lord diamorphine 5mgs IM given for syringe driver with diamorphine.
Clinical notes – no improvement. Quieter PM S/C diamorphine. Fentanyl patch started today.
Agitated and calling out even when staff present.
Ct fentanyl patches. Son seen concerned about deterioration today. Explained agitation and drowsiness was probably due in part to diamorphine accepts mother is dying and agrees continue present plan.

3rd March 1999

Summary – rapid deterioration this AM. Neck and left side rigid. Syringe driver commenced at 10.50 with diamorophine 20mgs and midazolan 20mgs. Son stayed all day aware of poor prognosis.
Condition deteriorated died 21.30 for cremation.
Clinical notes – Died peacefully verified by SN Dorrington. Son informed for cremation.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
EP 1909-12-28 Q579096

Exhibit number
BJC-35

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		C/a lung Diamorphine used for confusion rather than pain Rapid increase in dose		
Unclear B				
Unexplained By Illness C				

General Comments

88-year-old widow from Rest Home AF
1995-03-29 A. ?LVF and AF 1995-03-31 discharged
1995-07-03 A. digoxin toxic, 1995-07-06 discharged
1997-04-30 Collapse Right hemi and dysphasia Recovers
1997-05-07 Discharged
1998-02-06 E/A with what turns out to be c/a lung
1999-02-19 Transferred Charles ward
1998-02-27 Transferred GWMH for palliative care
1998-02-28 One dose Oramorph
1998-03-02 fentanyl patch 25 microg
1998-03-02 diamorph 5mg sc x 2 then
1998-03-03 diamorphine 20 mg/ day
Dies that day

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

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EVA PAGE
88

Carcinoma of lung. Described as distressed and anxious. The care and use of analgesia seems reasonable although they flirted with fentanyl for a short while and used intramuscular injections. Cause of death natural. Care being graded as sub-optimal is perhaps a little picky but relates to the changes in opioid and method of administration rather than the doses used.

PL grading A2

BJC/35	Page, Eva	Dying of lung cancer. Transferred to GWMH for palliative care. Confused and agitated, frightened and calling out ?cerebral metastases ?exacerbation of pre-existing cerebro-vascular disease as a result of illness ??pre-terminal agitation. Trial of tranquillisers did not produce improvement so used stat doses of diamorphine and a fentanyl patch mainly for sedation – pain does not seem to have been a feature of the illness. Deteriorated rapidly after fentanyl applied and died the next day, about 12 hours after a syringe driver was set up. Not ideal palliative care. Fentanyl 25mcg would have been much too high a dose to be tolerable for a frail old lady with minimal discomfort. However, it was then translated across into diamorphine without any further increase, indeed with if anything a slight decrease (exact equivalence would probably have been 30mg).	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7DB

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 05/05/2004

At 1630 hrs on Wednesday 26th November 03 (26/11/2003) I visited Mr Bernard PAGE at his home address in relation to his mother, Eva Isobel PAGE. The visit was in accordance with the policy log. I outlined Mr PAGES concerns as per document 317.

Mr PAGE agreed its content and went on to give further concerns as per his statement made to Supt. CLACKER, these being; the cause of death given on his mothers death certificate was not indicated in the medical notes.

His mothers normal daily medication was suddenly stopped without reason and opiates commenced until his mother died. Mr PAGE notes that in his mothers medical records between 25/02/1998 - 27/02/1998 is an entry 'all other drugs stopped by Dr LORD', he asks "who wrote this" and why were his mothers heart tablets stopped.

Why were opiates used when the notes do not say his mother was in pain.

The dispensing of certain drugs should only have been used specifically by a consultant specialist and been under their supervision.

Mr PAGE has concerns over the record keeping in relation to the prescribing and administering of drugs and why his mother was given so many types of medication.

Mr PAGE will forward notes made by his daughter Samantha.

He wishes to be notified by letter with a meeting to follow if required.

Expert Review

Eva Page

No. BJC/35

Date of Birth: Code A

Date of Death: 3 March 1998

Mrs Page was transferred to Gosport War Memorial Hospital on 27 February 1998 for palliative care having been treated at Queen Alexander Hospital as an emergency suffering with anorexia, decreasing mobility and dehydration.

On admission to Gosport War Memorial it was apparent that Mrs Page was dying of carcinoma of the lung. She was confused and agitated to begin with and a trial of tranquillisers did not produce any improvement. She was treated with Diamorphine and a Fentanyl patch mainly for sedation although the expert questioned whether this was appropriate in view of the lack of pain complained of. The experts agree that the cause of death was natural.