HAMPSHIRE CONSTABULARY

MARGARET QUEREE

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Margaret Queree

Date of Birth: Code A Age: **84**
Date of admission to GWMH: **29th July 1994**
Date and time of Death: **12.00 hours on 10th October 1994**
Cause of Death:
Post Mortem:
Length of Stay: **74 days**

Mrs Queree's past medical history:-

Osteoarthritis.
Back pain.
Quinsy.
Heart failure.
Jaundice.
Right hip replacement.
Bilateral leg cellulites.

Mrs Queree was born in Gosport and was a widow. She was the eldest of nine children and had five children of her own. Mrs Queree lived in a warden controlled flat until June 1994 when she was admitted to St Vincent House Residential Home. Her daughter, who lived in Gosport, visited regularly. Mrs Queree was admitted to the Queen Alexander Hospital in May 1994 for constipation and overflow. She underwent surgery for PV discharge and pelvic abscesses. She had a permanent colostomy put in place. She was transferred to Gosport War Memorial Hospital on 29th July 1994 for rehabilitation. It was noted that Mrs Queree's sacral area was very red with a small break on sacrum that she was slow to mobilise and had a catheter in situ.

On admission care plans commenced for poor diet and fluid intake, small sacral sore, incontinent, personal hygiene, mobility, colostomy and to settle at night.
A Waterlow score of 14 was recorded on 30th August 1994 and 20 on 2nd October 1994.

29th July 1994

Clinical notes transfer to Daedulus Ward for 1 week rehabilitation. Transfers with 2 nurses and a hoist. Reluctant to mobilise and very depressed.

15th August 1994

Clinical notes – mobilising 10 steps. Eating better. Barthel 7. To be discharged to a Nursing Home.

6th September 1994

Nursing report – offensive discharge from vagina. Dr Beasley informed

7th September 1994

Nursing report – no discharge overnight. Seen by Dr Brand leave well alone at present but should discharge return ? for refer back to surgeon.

12th September 1994

Clinical notes – confused episodic, not mobile, oedema.

Nursing report – to be long stay now.

22nd September 1994

Nursing report – swabs taken to check for MRSA.

26th September 1994

Nursing report - carrier of MRSA.

3rd October 1994

Nursing report – commenced MST.

4th October 1994

Nursing report – MST increased to 20mgs. Daughter seen about deteriorating condition. Warned to expect worst

5th October 1994

Clinical notes. – deteriorated generally, not eating and drinking well. Small dose of opiates (MST) commenced for general distress.

6th October 1994

Nursing report – very agitated and confused. Restless and distressed. Daughter contacted. Syringe driver commenced at 14.10.

7th October 1994

Clinical notes – much more peaceful since S/C analgesia commenced.

10th October 1994

Clinical notes – further deterioration – died peacefully 12.00 midday. Certified by Sister Joines.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
Q522583 MQu

Code A

Exhibit number
BJC-38

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		rapid dose escalation (M20 to M40 to D40 to D80) patient in obvious distress, and frail after opn with persistent vag discharge		
Unclear B				
Unexplained By Illness C				

General Comments

84-year-old widow, son + 40s MI, immobile from spine pain> warden > rest home
Spell in Daedalus Jan 1994,
readmitted from day hospital 1994-05-19,
vaginal fistula (diverticular abscess)
Hartmann's
Back to Daedalus 1994-07-24
Co-proxamol
Improves initially, but
1994-10-05 'has deteriorated generally over last four days…'
MST 10 mg bd for 3 doses, then 20mg bd for 4 doses, then diamorphine 40mg/24h, for one dose, then 80mg/24h for 3 doses
+ 1994-10-10

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/38
MARGARET QUEREE
84

Had significant medical problems prior to operation for rectovaginal fistula. Urine and vaginal infections after the operation. She appears to have become physically frailer and more confused. She was reported to be in pain when the MST was started at a low dose. After 3 days of MST she was more agitated and distressed. She was then started on a high dose of diamorphine via a syringe driver with 5-fold increase in the relative dose over 2 days. Although she died of the combination of medical problems, the use of opiates and sedation (midazolam) was poor with rapid dose escalation. However the escalation appears to be in response to patient distress and the starting dose was reasonable.

PL grading A2

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/38	Queree, Margaret	A frail elderly lady with considerable pain from OA knees, mainly, depression and a degree of confusion. Had recurrent infections, partly because she was catheterised. Initially used coproxamol PRN for pain, apparently with reasonable success. Once her frailty increased and a decision was made by Dr Lord to stop her diuretics, she seems to have been quickly started on MST, rapidly increased, then transferred to high dose diamorphine by S/D. On MST 20mg BD at time of transfer, diamorphine dose started at 40mg = MST 60mg BD, then doubled the following day and maintained till death. Nurses found her noisy and demanding, and very confused, on MST 20mg BD, so she was clearly not obtunded by that dose but on diamorphine she is described as "sleeping peacefully".	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7CO

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: OP ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 12/04/2004

I visited Code A at her home address on 20th November 2003 (20/11/2003)in relation to her mother Margaret Jane QUEREE b. Code A - 10/10/1994. I provided her with a set of her late mother's medical records and outlined the concerns noted in officers report as per the policy log.

Code A wished to add the following information.

Dr BARTON didn't discover the cause of Mrs QUEREE's stomach problems, it was the staff at St Vincents Care Home that brought the problem to Code A attention and it was Dr BEASLEY who referred Mrs QUEREE to the QA Hospital for tests. Dr BARTON dismissed Mrs QUEREE's complaints as "fussing".

The operation Mrs QUEREE had at the QA resulted in her having a colostomy bag.

In 1982 Mrs QUEREE had her hip replaced at the King Edward IV Hospital , during which she had a 'bad reaction' and her heart stopped. She also suffered from Osteoarthritis and diverticulitis. Her arthritis was particularly painful.

Mrs H Code A tes that in relation to her mother eating, the food tray was placed out of her mothers reach so she used to go in daily to ensure that her mother ate properly.

Mrs H Code A recalls that a nurse she felt was particularly unpleasant was Sheila ROGERS , she refers to her as "Jack Boot Annie".

Mrs H Code A complained at the time to a Dr (not Dr LORD) that her mother wasn't eating on a regular basis and that she was left out in a chair from 7 in the morning until bed time.

Mrs QUEREE was also given a catheter so she didn't have to be taken to the toilet. This caused her a great deal of distress.

At one point there was an infection on the ward and everyone had to 'gown up'. Mrs QUEREE felt that 'everyone' blamed her because she had a colostomy bag which had brought the 'germ in'. This upset Mrs QUEREE immensely.

Mrs Code A was told of this by a ward maid (cleaner) she cannot recall her name. Mrs HOARE complained to a staff nurse about these comments being made to her mother. This staff nurse (unknown) was very angry at the time and assured Mrs HOARE that she would speak to the staff about it. Mrs HOARE believes that she spoke with the ward supervisor.

Code A states she visited daily, morning and evenings so she was aware of her mother's daily condition.

Her mother had told her that when she was put to bed, if she rang for attention then no one would answer.

Code A states that on the day she visited her mother and was told that she had been put onto diamorphine due to being in a lot of pain, she had not complained of any pain the previous evening.

She queried the dose and was told by nursing staff that her mother was on a very low dose to settle her down.

M Code A asked if Dr BARTON had given permission and was told that she had done so over the telephone.

M Code A describes her mother as being very sleepy as a result of having a bad nights rest the previous night, she had been given a cage to put over her knees to keep the bedclothes off her legs and hence reduce her pain.

When M Code A returned that evening to visit her mother was drifting in and out of sleep.

On 7th October 94 (07/10/1994) Mrs QUEREE is described as being in a 'deep sleep'. When asked nursing staff told Code A that the morphine dose had been increased. When this was queried as Mrs QUEREE hadn't complained of any pain during her family's visits, Mrs HOARE was told "When the morphine wears off she tells us she's in pain".

At this point Code A believes her mother was on a syringe driver.

On 8th October 94 (08/10/1994) the family was told that Mrs QUEREE was getting worse.

Code A states she couldn't believe the speed of her mothers decline. She wasn't told how much the size of the dose of morphine had been increased but knew that it had been. When she asked a nurse why she had increased the dose, she was told "Because I was told to".

Code A describes her mother as being incoherent and mumbling.

M Code A and her family is concerned that her mother died so quickly.

She states that the authorities kept her mother in hospital whilst they worked out where her mother was going to live after she was discharged as she was going to require 24 hour nursing care.

Code A would like to be notified by letter.

DOCUMENT RECORD PRINT

Officer's Report

Number: R8M

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 24/11/2002

Sir,

On the 23/11/2002 I spoke with Mrs HOARE re Action 199 and her mother Margaret Jane QUEREE nee OSBOURNE DOB Code A DOD 10/10/1994.

Mrs QUEREE was a local lady who married an Army officer and spent time all round the world; she had six children and was a full time housewife. She was widowed in 1986.

In June/July 1994 Mrs QUEREE underwent an operation on her bowel at the QA Hospital. The problem with the bowel had been reported to Dr BARTON Mrs QUEREE's GP, who did nothing until Mrs HOARE insisted that this problem was investigated. After the operation Mrs QUEREE was sent to the GWMH for recuperation and seemed well. She had been prescribed some painkillers for arthritis.

Whilst at the GWMH Mrs HOARE would see her mother everyday, she would help her to eat and spend time with her. Mrs [redacted] Code A s told by one of the nurses Sheila ROGERS that she was not allowed to go to the hospital until 2pm. This was because Dr BARTON felt she interfering. Dr BARTON also didn't want Mrs HOARE to accompany her mother when the consultant saw her. However Mrs HOARE continued to visit her mother and see the consultant with her.

Although Mrs QUEREE didn't want to be at the GWMH she is described as being happy and alert on the 05/10/1994. She was looking forwards to the birth of two great grandchildren. Later the same day she seemed very down and by the 06/10/1994 was remaining in bed and was very sleepy. Mrs HOARE spoke with Dr BARTON who told her that her mother didn't have long to live, that she was in a lot of pain and the morphine was helping with this. Mrs HOARE felt that this was a drastic step. On the 07/10/1994 her mother went into a coma. There was no change until the 10/10/1994 when Mrs QUEREE died.

The cause of death was shown as broncholitis and the certificate was signed by Dr BARTON. There was no PM and Mrs QUEREE was cremated. It is clear that there was a long standing disagreement between Mrs [redacted] Code A nd Dr BARTON over the care of Mrs QUEREE.

Code A

Expert Review

Margaret Queree

No. BJC/38

Date of Birth: Code A

Date of Death: 10 October 1994

Mrs Queree was admitted to the Queen Alexander Hospital in May 1994 where she underwent surgery for pelvic abscesses. She had a permanent colostomy put in place. She was transferred to Gosport War Memorial Hospital on 29 July 1994 for rehabilitation. As noted by the experts, Mrs Queree had significant medical problems prior to her operation and both urine and vaginal infections after the operation. She became frail and confused and was commenced on Morphine Sulphate. After three days she was then started on a high dose of Diamorphine via a syringe driver with a fivefold increase in the relative dose over two days.

The experts confirm that in their view she died of natural causes. The use of opiates and sedation was rapidly increased although this properly appears to be reasonable in response to the distress demonstrated by the patient.