HAMPSHIRE CONSTABULARY

# SYLVIA TILLER

DOCUMENT RECORD PRINT

# Officer's Report

Number: R10C

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCIT (W)

REF:
TEL/EXT:

SUBJECT: OPERATION ROCHESTER

DATE: 05/11/2002

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Sir,

At 1325 hours on Monday 4th November 2002 (04/11/2002) I visited Code A F Code A where I spoke with Mrs Alison MURRAY (Nee TICKNER) B.,29.05.68 (T Code A Code A

Also present was her mother Mrs Josephine Elizabeth TICKNER (Nee TILLER) B. Code A (14/10/1942) of Code A

Their concerns involved their grandmother/mother respectively, Mrs Silvia Mary Constance TILLER (nee CREESE) B Code A (81 yrs) on her death on 13th December 1995 (13/12/1995).

Mrs TICKNER stated that her mother Mrs TILLER was admitted to Haslar Hospital early in 1995 as the result of a problem with water retention in her body.

She was then transferred from Haslar to Sultan Ward at Gosport War Memorial Hospital for a short stay before being transferred to Charles Ward at the Queen Alexandra Hospital.

It was as the result of her mothers stay at the QA Hospital that she started to worry about the treatment her mother was receiving, in that on one visit Mrs TICKNER was told by a male nurse that her mother had had a fall and they thought this had been brought about by the fact that she had been given more water tablets than she should have had, which is alleged to have caused her heart to swell, possibly high blood pressure, hence her fall.

On another visit a staff nurse asked why her mother, Mrs TILLER, was on Diamorphine, when she said she did not know, Mrs TILLER was taken off of it and her condition improved remarkably, she was now sat up in bed and talking.

Because of the family's concern over this treatment at the QA they requested that Mrs TILLER be transferred back to the Gosport War Memorial Hospital and indeed on or about 10th December 1995 (10/12/1995) Mrs TILLER was transferred to Dryad Ward at the hospital to the care of Dr BARTON.

At this time the family were told by Dr BARTON that if Mrs TILLER continued to make such an improvement that there was something else that could be given.

On the 12th December 1995 (12/12/1995) both daughter and granddaughter visited Mrs TILLER, who at this time was well and talking about being home for Christmas, when, during this visit complained of a slight pain in her chest.

The staff were informed and the family asked to leave whilst treatment was given to Mrs TILLER.

At 0530 hours on 13th December 1995 (13/12/1995) Mrs MURRAY received a telephone call from her mother (Mrs TICKNER) to say that the hospital had called and that her mother (Mrs TILLER) was not well and that she ought to go to the hospital.

As the granddaughter (Mrs MURRAY) only lives around the corner from the hospital, she went straight round to the ward, where she found her grandmother Mrs TILLER, now attached to a syringe driver which was resting on her shoulder, being treated by sister Gill HAMBLIN.

Her grandmother was alive and able to talk at this time but later passed away that day 13th December 1995 (13/12/1995).

The family's concern is that cause of death has been given as A) Congestive Cardiac Failure. B) Myocardial Infarction (Heart Attack), but they were aware that when Mrs TILLER was at Haslar she was placed on an ECG machine and told by the doctor that there was no problem with her heart.

Submitted for information.

# SYLVIA TILLER

**Sylvia Tiller**

Date of Birth: Code A Age: **81**
Date of admission to GWMH: **4th December 1995**
Date and time of Death: **07.20 hours on 13th December 1995**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **10 days**

Mrs Tiller's past medical history:-

CCF
Cholecystectomy
Hysterectomy
Arthritis
Mild CVA
Non insulin dependent diabetic
Mastitis
Hypertension

Mrs Tiller lived alone in her own flat. She has 2 daughters and 2 sons. One of her daughters would help for 4-5 hours a day and a grand-daughter would do her laundry. Mrs Tiller was admitted to the Queen Alexander Hospital on 3rd November 1995 after suffering a MI/CCF she was later transferred to Charles Ward suffering from end stage cardiac failure and was transferred to Gosport War Memorial Hospital on 4th December 1995.

On admission to Gosport War Memorial Hospital care plans commenced for non insulin dependent diabetic, sleep, wound on sacrum, at risk of developing pressure sores, elimination, catheterised and personal hygiene.
A Barthel ADL index score of 0 was recorded on 5th December 1995 as well as a Waterlow score of 28.
A lifting/handling risk calculator was also completed scoring 25.

**4th December 1995**

Transfer form – admitted to Dryad ward suffering end stage cardiac failure, has poor appetite, diamorphine and halperidol both 10mgs via syringe driver, sacrum very red, has had some weight loss and has been catheterized.
Clinical notes – very poorly breaks on sacrum. Family aware of poor prognosis.
Summary – admitted from Charles Ward Queen Alexander Hospital.

**5th December 1995**

Summary – all care given, seen by Dr Barton.

**6th December 1995**

Clinical notes – told nursing staff wishes to die. If distressed TLC.

Summary – deteriorating slowly, lower half of body still very oedematous, legs leaking small amounts serous fluid.

**8th December 1995**

Summary – a little brighter.

**9th December 1995**

Summary – looks poorly, however quite bright. Family visited.

**10th December 1995**

Summary – agitated and complaining of pain in legs, oramorph 5mg given at 16.50hours.

**11th December 1995**

Summary – complaining of central chest pain. Oramorph 5mg given.

**12th December 1995**

Clinical notes – Further deterioration comfortable on oramorph.

Summary – daughter seen syringe driver discussed. Oramorph 5mgs given. 19.30 complaining of chest pain distressed, syringe driver commenced diamorphine 20mgs over 24 hours. Family visited.

**13th December 1995**

Summary – condition deteriorated over night died at 07.20 hours grand-daughter present certified by Dr Barton at 07.45.

Clinical notes – died 07.20 hours for cremation.

# OPERATION ROCHESTER
# CLINCAL TEAM'S SCREENING FORM

**Patient Identification**
**SYLVIA TILLER** Code A

**Exhibit number**
**BJC-48**

| Care / Death/Harm | Optimal 1 | Sub-Optimal 2 | Negligent 3 | Intend to Cause Harm 4 |
|---|---|---|---|---|
| Natural A | | Unwell and in pain with terminal CCF, already had diamorphine 10mg/24h, and oversedated. Then from Oramorph <20mg/day to diamorph 40mg/24h | | |
| Unclear B | | | | |
| Unexplained By Illness C | | | | |

## General Comments

81-year-old woman with NIDDM, IHD, previous hemi?,
Admitted 1995-10-06 to –12 for trial of enalapril
Readmitted 1995-10-27 dizzy & unwell – enalapril stopped
Readmitted 1995-11-03 AF, CCF
1995-11-04 Transfer to John Pound, ?scabies; possible further infarct: ^SoB, chest pain, ^CK, ^AST
1995-11-17 Transfer > Charles ward Syringe driver with 10 mg diamorph started, but stopped later because of oversedation
1995-12-04 Transfer > Dryad
Oramorph 5mg x 3 doses –12-10 to –12; then diamorph 40mg/24h [≡ 80 mg morphine in 24h ?why such large jump]
Died 1995-12-13-07-30

**Final Score:**

**Screeners Name: R E Ferner**
**Date Of Screening:**

**Signature**

BJC/48
SYLVIA TILLER
81

Congestive cardiac failure on a background of ischaemic heart disease. Became hypotensive with treatment. Became very low in mood, on several occasions expressing the wish to die. She was dependent on others for most activities of daily living. In Dryad she developed leg pain and then cardiac sounding chest pain. She received opiates including diamorphine via syringe driver, starting dose 40mg after just 2 doses of oramorph (higher than I would have started at; in the previous hospital she received 10mg daily at one point which was more appropriate). She had severe medical problems but I think the opiate starting dose was excessive and could have hastened her death.

PL grading B2

29-DEC-2003

| Exhibit No | Patient Identification | Assessment Note | Assesement score |
|---|---|---|---|
| BJC/48 | Tiller, Sylvia | Clearly a dying woman. Given small amounts of oramorph, which is good for heart failure. Only in the last 24 hours set up on a syringe driver with diamorphine, hyoscine and midazolam. Think the dose of diamorphine inappropriately high, but I am sure it made little difference to the outcome.<br><br>Concerned about the admission plan to GWMH: Had complained of no pain or breathlessness at all, but plan was "make more adequate analgesia available" and diamorphine written up that day ?what was the motivation. Patient had clearly and repeatedly expressed a wish to die. | A2 |

# Expert Review

## Sylvia Tiller

## No. BJC/48

## Date of Birth: Code A

## Date of Birth: Code A

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Mrs Tiller was admitted to Queen Alexandra Hospital on 3 November 1995 after suffering with congestive cardiac failure and a background of ischaemic heart disease. The experts note that she was "clearly a dying woman". She was transferred to Gosport War Memorial Hospital on 4 December 1995.

Mrs Tiller was given small amounts of Oramorph and only in the last twenty-four hours was set up a syringe driver with Diamorphine, Hyoscine and Midazolam. Although Dr Naysmith questioned the rationale for making "more adequate analgesia available" in the admission plan, the experts noted the appropriateness of using high levels of analgesic in patients who are about to die to provide solace. To withhold such treatment in their view would be unacceptable.