DOROTHY STANFORD

DOCUMENT RECORD PRINT

Officer's Report

Number: R11AZ

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: OP ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 20/08/2004

Sir

On Thursday, 19th August 2004 (19/08/2004) I visited Mildred Mary HART , who lives with her husband Ron at Code A Mrs HART is the daughter of Dorothy Lilian STANFORD who died at the Gosport War Memorial Hospital on 27th November 1993 (27/11/1993). Dorothy STANFORD's medical records were among those taken from Professor BAKER and she has initially been classed as a category 2. Mrs HART has been able to say the following.

Dorothy Lilian HART nee CUMMINGS was an only child and was born on Code A Code A in Gosport. In 1937 she gave birth to her only daughter Mildred out of wed-lock so left her child to be brought up by her mother while she carried on with her life. For this reason Mrs HART was not able to comment on a considerable part of her mother's life. Mrs HART went to live with her mother around 1953 having left school. Her mother had since married Percy STANFORD in 1950 and they were living at Code A

Dorothy's GP was Dr. WHITE at the Cleveland Road Surgery who is apparently still practicing. Dorothy was an insulin dependent diabetic and had been for some considerable time. In later years she lost her sight which was believed to be Diabetes related. Other than this she led an active and healthy life and even when she lost her sight she was still mobile and agile, walking great distances with the aid of a white stick.

Mrs HART married in 1959 and moved away from the area. Dorothy's husband Percy died on 26th January 1988 (26/01/1988) leaving Dorothy living at home alone. Dorothy found it difficult to look after herself because of her blindness but was a proud woman and refused to move away from Portsmouth to live with her daughter in Redditch. Around January 1992 Dorothy moved into Egrement Rest Home, 26, Chetwynd Road, Fratton, Portsmouth . This was a private rest home and was financed by the sale of 6, Cleveland Road. Dorothy apparently enjoyed her stay at this rest home and was still agile and walking with the aid of her stick

Mrs HART believes it was early to mid November 1993 when she received a telephone call from the rest home stating that her mother had had a stroke and had been taken to the Queen Alexandra Hospital in Cosham. Mrs. HART and her husband drove straight to the hospital that morning. Her mother was in

bed and very poorly. She was confused and had lost the use of her legs. Mrs HART and her husband returned to Redditch after this visit intending to return in a couple of days but before they had a chance to visit again they had a phone call from the hospital stating that her mother had been transferred to the Gosport War Memorial Hospital.

Within a couple of days of that last telephone call they received another from the Gosport War Memorial Hospital informing them that Dorothy was very poorly, had been placed on Morphine and was not expected to live more than a couple of days. Mr HART left work immediately and drove his wife to Gosport to visit her mother.

They arrived at the Gosport War Memorial Hospital in the early afternoon and found Dorothy in a private room which they described as spotlessly clean and nice. Dorothy was heavily sedated and did not appear to know that they were there. Mrs HART noticed that her mother had been connected to a pump which she could hear working, she assumed that this was dispensing the morphine but this was never explained to her. Mrs HART also presumed that her mother must have been in considerable pain because her mother was on morphine but again did not receive any explanation. After an hour they left to find overnight accommodation and then returned that evening to find no change in Dorothy's condition.

On Friday, 26th November 1993 (26/11/1993) they returned to the hospital, there was still no change in her mother's condition so they went to a solicitors to inform them of her mother's condition and ask them to act on their behalf should Dorothy pass away to take care of the will and estate.

Mrs. HART returned to visit her mother that afternoon and remained there until 2200 hrs. Her youngest son Kevin visited that afternoon but drove back to Chester that evening. Kevin now lives at Villa Cottage, Bishops Offley, Eccleshall, Stafford. ST216ET .

On the morning of Saturday 27th November Mrs. HART's husband Ron telephoned the hospital but was informed that Dorothy had passed away at 0610 hrs that morning. The cause of death shown on the death certificate was

1(a) Bronchopneumonia
(b) Cerebrovascular accident
11 Diabetes mellitus .

The death was certified by J A BARTON BM. Dorothy was cremated at Portchester Crematorium on 3rd December that year.

Mrs HART stated that she had not had any concerns about the treatment of her mother, was very impressed with the cleanliness of the room that her mother had been placed in and assumed that she was getting the best possible care. On reflection she is able to say that no person from the hospital ever explained what had happened to her mother and what treatment was being given and why. The only time that she saw a nurse tend to her mother was to give an insulin injection which when queried the nurse stated that insulin injections would be given as normal right up to death.

Dorothy had been visited by Joy and Sandy HAYWARD of Code A at the Gosport War Memorial Hospital when she was first admitted and before Mrs. HART had managed to travel down from Redditch. The HAYWARD's were friends of Dorothy and stated that she was quite

chatty when they visited yet was heavily sedated by the afternoon when Mrs HART arrived.

Another next of kin listed was Jean BEDFORD but she is now suffering with severe dementia and is in a nursing home in Emsworth.

Mrs HART has asked if she could be informed before any contact is made with the persons mentioned in this report especially her son. She has also requested that she be kept informed as to the progress of her mother's case and would appreciate being added to our mailing list. Mrs HART has been given contact numbers for the Operation Rochester team and advised about contact with the press. They are a lovely couple who although surprised that we are reviewing her mother's case will support the police in whatever action they take.

DOROTHY STANFORD

Dorothy Stanford

Date of Birth: Code A Age: **77**
Date of Admission to GWMH: **23rd November 1993**
Date and time of Death: **05.45hours on 27th November 1993**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **4 days**

Mrs Stanford's past medical history:-

- Registered Blind
- Insulin dependent diabetic

Mrs Stanford was a widow, she had a daughter and lived in Egremont Rest Home. Mrs Stanford was admitted to Queen Alexandra Hospital via her GP suffering from a left CVA with right hemiplegia. She needed assistance with all activities of daily living. Mrs Stanford was transferred to Gosport War Memorial Hospital on 23rd November 1993. She had been catheterised and was fed via a naso gastric tube.
On admission a nursing admission form was completed noting that Mrs Stanford was highly dependent and her levels of consciousness varied. Care plans were completed on admission for NG tube, catheter, hygiene, insulin dependant diabetic and immobility.

Daily summary
23rd November 1993
Transfer form – NG tube in situ. Skin intact but dry at times. Referred to physio requires turning in bed and regular mouthcare. Catheterised on 20/11/93. Temperature requires fan therapy.
Nursing report – transferred from Queen Alexandra Hospital. Seen by Dr Barton. NG tube in situ.
24th November 1993
Clinical notes – some improvement in general condition.
25th November 1993
Nursing report – refusing fluids. Seen by Dr Barton to **commence syringe driver at 11.50 hours.**

26th November 1993
Nursing report – visited by Mrs Hart. To contact solicitors and undertakers if dies before 17.00 hours today.
Clinical notes – further deterioration on S/C analgesia.
27th November 1993
Died at 05.45 hours. Pronounced dead by Sister Goldsmith. For cremation.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
DOROTHY STANFORD Q290098 **Code A** **+1993-11-27 BJC-60**

Exhibit number

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Frail, with serious stroke, BUT given opiate without obvious need, in moderate-to-high initial dose; and no clear reason for death		
Unexplained By Illness C				

General Comments

78-year-old blind, insulin-dependent diabetic lady [diagnosed ?1948, 1957]
1993-11-03 Unresponsive. A. Dense right hemi + dysphagia with NG tube + neglect of affected side and needed full nursing care. Barthel 3, 3, 0
Prescribed paracetamol PR or PO, but none given. No evidence of pain in nursing notes.
1993-10-22(23) Transferred to GWMH; given insulin if BM > 10
1993-10-23 NG tube blocked; commenced on diamorphine 40 mg/24h sc infusion + midazolam 20 mg + hyoscine [400 MILLIGRAMS?]
1993-10-27-05-45 Dies

Final Score:

Screeners Name: R E Ferner
Date Of Screening: 2003-11-13

Signature

BJC/60
DOROTHY STANFORD
78

A very unwell lady with a severe stroke and swallowing difficulties. She was likely to die because of the severity of the stroke and a probable chest infection. There was no mention of pain in the medical or nursing notes. However she was started on a syringe driver with a dose of diamorphine of 40mg per day without having previously been on any analgesia. I can see no indication for the opiate.

PL grading 3B
Group grading 2B

Exhibit No	Patient Identification	Assessment Note	Assessment Score
BJC/60	Stanford, Dorothy	Dense hemiplegia with NG tube feeding. Had been pyrexial with scattered creps for several days before transfer. Described as "very poorly" on arrival at GWMH. With agreement of daughter decided to stop tube feeding, and not to give antibiotics (although she had had antibiotics in QAH). Also commented "needs analgesia" but with no indication of pain, or reason to give painkillers. Had not previously been on analgesia. Unable to take anything by mouth. S/D containing diamorphine 40mg with hyoscine and midazolam set up on 25/11; patient died on 27/11/93. I am sure this lady's prognosis was very poor, particularly if NG feeding had been continued. She was likely to have died of aspiration pneumonia pretty soon. But I can see no reason at all for her to have been given diamorphine by SC infusion, and certainly not in a starting dose of 40mg.	2A

Expert Review

Dorothy Stanford

No. BJC/60

Date of Birth: Code A

Date of Death: Code A

Mrs Stanford was a widow living at Egremont Rest Home when she suffered a severe stroke in November 1993. She was admitted to Queen Alexandra Hospital suffering with a right hemiplegia and was catheterised and fed via a naso gastric tube.

Prior to her transfer to Gosport War Memorial Hospital on 23 November 1993 Mrs Stanford was noted as having been pyrexial with scattered crepitations and was thought by the expert team to have a probable chest infection.

On arrival at Gosport War Memorial Hospital Mrs Stanford was described as "***very poorly***" and the Nursing Admission Form noted that "***Mrs Stanford was highly dependent and her levels of consciousness varied***". The expert team noted that opioid pain relief was started but without any obvious need. The comment "***needs analgesia***" was made in the notes but without any indication of concurrent pain.

Since Mrs Stanford was unable to take anything by mouth a syringe driver was set up containing Diamorphine 40mgs with Hyoscine and Midazolam.

Mrs Stanford died two days later. The experts concluded that Mrs Stanford was likely to die because of the severity of the stroke and probable chest infection but they have criticised the use of opiates without clear indication.