HAMPSHIRE CONSTABULARY

DAPHNE TAYLOR

DAPHNE TAYLOR

6.50 BJC/47 Daphne Taylor

Date of Birth: Code A Age: **70**
Date of admission to GWMH: **3rd October 1996**
Date and time of Death: **01.25 hours on 20th October 1996**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **18 days**

Mrs Taylor's past medical history:-
Hypertension
Vertigo of central origin
Bilateral visual impairment due to ischaemic retionpathy

Mrs Taylor lived with her husband they had a daughter and a son. Mrs Taylor was a retired sub post office manager. Mrs Taylor was admitted to the Royal Haslar Hospital on 29th September 1996 after suffering a stroke. She was transferred to the Gosport War Memorial Hospital on 3rd October 1996 for rehabilitation.

On admission care plans commenced for sleep, pain right arm left leg, PEG feed, bowels, catheter, personal hygiene, immobile, at risk of developing pressure sores, has scratches on left leg and mouth care.
An assessment form was completed noting that Mrs Taylor wore a hearing aid in her left ear, wears glasses and is blind in left eye, unable to walk, is PEG fed and has been catheterised.
A Barthel ADL index was completed with a score of 0 recorded.
A Waterlow score of 20 was recorded.

3rd October 1996

Transfer form – admitted for rehabilitation after CVA, catheterized, drowsy, PEG fed, understands, but has no speech.
Summary - admitted from A5 Haslar to Daedulus ward with left CVA right hemiplegia. NBM swallowing reflex absent. Seen by Dr Barton medications boarded, chesty and rattly.

7th October 1996

Summary – Seen by Dr Barton appears to be in pain, boarded for Fentanyl patches 25mgs every three days. MRSA swab.
Seen by Dr Lord to be referred to dietician and Speech and Language therapy, seen husband not to be transfused.
Clinical notes – poor prognosis aim to maintain BP.

9th October 1996

Summary – in a great deal of pain boarded for 50mgs Fentanyl patches.
Clinical notes – condition deteriorated. **Nursing staff may confirm death.**
Would not use antibiotics but make comfortable.

10th October 1996

Summary – Fentanyl patch renewed as patch applied on 9th fell off.
Authorised by Dr Barton.

11th October 1996

Summary – more settled. MRSA negative.

17th October 1996

Summary – Left arm elbow still very painful on movement. Dr Barton seen
X-ray from Haslar has requested repeat X-ray.

18th October 1996

Summary – AM very unsettled night appeared distressed and in pain. Syringe driver set up with 40mgs diamorphine and midazolam 20mgs over 24 hours.
Fentanyl patch removed appears more comfortable.
PM appears more peaceful and relaxed, no pain, rousable on turning.
Family seen by Dr Barton and informed of poor prognosis. Feed to continue.
Clinical notes – condition deteriorated last night S/C analgesia commenced.

19th October 1996

Summary – condition deteriorating, chesty very bubbly. Diamorphine 40mgs via syringe driver. Husband contacted still wishes feeding to continue.

20th October 1996

Summary – 01.25 hours died peacefully for cremation. Verifed by SSN Tubbritt and S/N Nelson.

Expert Review

Daphne Taylor

No. BJC/47

Date of Birth: Code A

Date of Death: 20 October 1996

Mrs Taylor was admitted to the Royal Haslar Hospital on 29 September 1996 after suffering a cerebrovascular accident. She was transferred to the Gosport War Memorial Hospital on 3 October 1996 for rehabilitation.

On 7 October 1996 Mrs Taylor was felt to be in pain and was prescribed Fentanyl patches.

Mrs Taylor was noted to be in a great deal of pain and the strength of the Fentanyl patches were increased.

On 18 October, following a very unsettled night when Mrs Taylor appeared to be distressed and in pain, a syringe driver was set up with 40mgs of Diamorphine and 20mgs of Midazolam over twenty-four hours.

Although Mrs Taylor had a severe stroke which left her unable to swallow or speak, she was being tube fed. However, she was prescribed rapidly escalating doses of opioids without there appearing to be a comprehensive assessment made for her pain.

The experts note that she had an irrecoverable cerebrovascular and would have died soon in any event.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification
Code A

Exhibit number
BJC-47

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Immediate use of large dose opiate Fentanyl 25 ≡ 90 mg morphine/day		
Unexplained By Illness C				

General Comments

70-year-old retired sub post office manager, previous history of hypertension, deafness, vertigo & ischaemic retinopathy
(R) hemi + dysphasia + hemianopia 1996-09-29 from haemorrhagic infarct
PEG tube
Barthel 0
Transfer note [82/109] shows no analgesia
Noted 1999-10-07 to have pain in (R) arm & leg > fentanyl patch 25 microgram > 50 > then diamorphine 40 mg/24h, then 'peaceful' then 'bubbly' then
Dies 1996-1-20-01-25

SO: while underlying condition poor, several problems: went directly to opiate; dose was potentially high (≡ morphine 90 mg/d) did not allow for fentanyl in skin when changing to diamorph;

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/47
DAPHNE TAYLOR
70

Severe weakness and requirement for gastrostomy feeding following a stroke. The pain was said to be due to contractures down the hemiplegic side. Other analgesics were not tried before fentanyl and then diamorphine pump. The pain of contractures might have responded to other forms of medication and not so well to opioids. She had severe medical problems and would have died soon. Sedation from the opioids could have made her more susceptible to not being able to clear her own secretions or developing a chest infection.

PL grading A2

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/47	Taylor, Daphne	Irrecoverable CVA. Rattly chest on admission. PEG fed – likely to succumb to aspiration pneumonia at some point, and probably sooner rather than later. Had spastic contracture of arm on hemiparetic side, which gave her pain. No sign of any simple analgesia – discussion of getting a splint but no evidence it ever happened. No muscle relaxants, baclofen etc. Instead, straight on to fentanyl 25mcg, increased after 1 patch to 50mcg and then, after 3 patches, became distressed one night and syringe driver put up at 2am. Ironically, opioid dose decreased in syringe driver – suspect that was inadvertent, because they didn't know how to convert from fentanyl to diamorphine. Quickly died thereafter. Noted to be very drowsy from the time the fentanyl was started. But PEG feeding maintained. Cannot see justification for high dose opioids when her pain was likely to be musculo-skeletal and essentially not morphine sensitive.	B2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7N

TO:
STN/DEPT:

REF:

FROM: DC Code A ROBINSON
STN/DEPT: MCIT E

REF:
TEL/EXT:

SUBJECT: OPERATION ROCHESTER

DATE: 29/01/2003

Daphne Rita TAYLOR Code A – 20/10/1996

I visited Code A , the husband of the above, at his home address Code A Code A on 29th January 2003 (29/01/2003).

Mr TAYLOR will say that his wife was born in Corby, they were married in 1946 and had three children. John TAYLOR Code A Paul TAYLOR Code A Code A, Sandra TAYLOR Code A She worked in the textile industry in her teens and upon starting her family remained at home.

The family moved to run the Fleet Post Office in 1974 and Mrs TAYLOR helped in the running of it.

She retired with her husband to their Stubbington address in 1986.

Mrs TAYLOR is described as being fit and healthy. She smoked throughout her life, approximately ten cigarettes a day.

In 1965 she had a hysterectomy and in 1994 attended Haslar Hospital, Gosport for an operation to try and establish a reason for reoccurring headaches. Nothing was found as a result of the examination but the headaches appeared to decrease.

Mr TAYLOR also believes that his wife had a scan to try and establish the cause of her headaches.

In September 1996 Mr TAYLOR discovered his wife lying on the floor next to her bed. She was conscious but incoherent.

Mrs TAYLOR was taken to Haslar Hospital where she remained for two weeks under the care of Surg. Comm. EDMINSTONE . She was diagnosed as having suffered a stroke which had left her without speech and unable to swallow. Her left hand was frozen in a claw shape.

Whilst at Haslar Mrs TAYLOR began to improve considerably but had to be fed via a tube inserted in her nose. She was prone to pulling out the tube and so a tube was inserted directly into her stomach.

Mr TAYLOR states that although his wife could only mumble she was able to understand everything said to her and could make herself understood.

After two weeks Mrs TAYLOR was assessed by Dr LOGAN who informed Mr TAYLOR that he believed Mrs TAYLOR would make a good recovery.

This was also the view of Dr EDMINSTONE. The decision was made to move Mrs TAYLOR to the Gosport War Memorial Hospital , Gosport. Mr TAYLOR didn't travel with his wife to GWMH but visited her shortly afterwards.

He discovered that his wife had been placed in Daedalus Ward and went to speak to staff to find out where her bed was. He was spoken to by a female member of staff, he believes she was the ward sister and that her name was Sheila. She said to him "Do you want me to keep feeding her?".

Mr TAYLOR assured her that he did and went to see his wife who was propped up in bed and appeared happy and comfortable. She clearly recognised her husband.

Mr TAYLOR visited his wife daily and was concerned that his wife was not receiving the remedial treatment that she had whilst at Haslar, namely physiotherapy twice a day.

On Thursday 17th October 1996 (17/10/1996) Mrs TAYLOR is described as being alert and comfortable, she beckoned her husband back to her for a hug at the time of his departure.

On Friday 18th October 1996 (18/10/1996) when Mr TAYLOR visited he found his wife lying on her right side with what he describes as a 'pump' lying on her chest. Mrs TAYLOR was 'asleep' and didn't awake again.

On Saturday 19th October 1996 (19/10/1996) Mr TAYLOR asked if he should notify his family members for them to visit and was told that he should.

On Sunday 20th October 1996 (20/10/1996) the family visited during the morning. He believed that his wife was lying in exactly the same position. It didn't appear that she had been moved since the Thursday.

At 12.15 hrs the same day Mr TAYLOR received a telephone call from the hospital informing him that his wife had died.

Daphne TAYLOR's death certificate was signed by J A BARTON BM and gives 1(a) Bronchopneumonia, ii Cerebrovascular accident as her cause of death.

She was cremated.

Mr TAYLOR believes that the female Dr from the Lee Health Centre was his wife's Dr.

His concerns are that his wife was killed by painkillers administered via the 'pump '.

He believed that his wife would make a good recovery and would eventually be well enough to leave the

hospital.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BF

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 09/12/2003

I visited Code A at his home address at 1100 hrs, Monday 8th December 2003 (08/12/2003) in relation to his wife Daphne Rita TAYLOR Code A and in accordance with the policy log.

I outlined his concerns as per report 7N and supplied him with a copy of his wife's medical records.

He further added, why was his wife given the pump, she had not complained of any pain.

She was not eating enough at GWMH but had a peg fitted so why didn't they increase her nourishment.

When he saw her after her death, all the blood had drained to the right side of her face where she had been lying since the 18/10/1996.

Mr TAYLOR is happy to receive a letter or a telephone call.