GOSPORT

REVIEW OF EVIDENCE – WILKIE

NMC FILES

Ford report NMC file 1

Conclusions:

- No diagnosis made to explain reported deterioration around 15.8.98;
- No clear evidence of pain
- No explanation in nursing or medical notes as to why commenced on diamorphine and hyoscine – other oral analgesics could have been tried first
- Undated prescription for variable doses of diamorphine, hyoscine and midazolam was poor practice and potentially hazardous
- Inadequate medical and nursing and records
- Drugs administered may have hastened death, but she may have died at that time anyway

Letter of complaint from M Jackson (pp E Yeats) 1.6.02 NMC file 2

Mother transferred from QAH to GWMH for rehabilitation. After transfer to GWMH, mother appeared increasingly sleepy, weak, and unwell – could not stand unaided. Called into P Code A office a few days after transfer and told that she was dying and nothing could be done to help her. Told PB did not want mother to suffer.

PB recorded in medical notes that I had agreed to syringe driver and active treatment not appropriate – this is false.

Note in records to say mother dying comes from Philip Bede – no corresponding note from medical staff.

20.8.98 – mother appeared to be in pain. Told nursing staff, who were dismissive. Asked twice for help and waiting 1 hour for **Code A**

PB did not examine or carry out pain assessment – said would arrange pain relief that would make her sleepy.

Left hospital 13.55 – nothing had been done to alleviate discomfort.

Nursing notes falsely record syringe driver started 13.50.

Daughter attended - Code A said "your mother seems to think that your grandmother is in pain"

Returned to hospital 8pm – mother on diamorphine and unconscious.

Why was mother placed on syringe driver with diamorphine when only that afternoon, nursing staff were unaware she was in pain?

Why was diamorphine given in 30mg doses, not 5 – 10 mgs.

Why was no other pain relief tried before diamorphine?

Why was no pain assessment carried out?

Late pm 21.8.9, persuaded to go home by nursing staff who said they'd call if any change. Returned short while later – Code A said she had just died. Obvious she had died earlier.

Records falsely state daughter and granddaughter present at death.

Medical records contain mix-ups:

- *Note states mother given oramorph, then crossed out (mix up with notes of Gladys Richards)*
- *Time of death on file given as 18.30 and 21.20 (time Gladys Richards died) (Nurse Sylvia Roberts wrote the notes)*
- *Notes lacking in detail re: fluid intake/urinary output*
- *21.8.98, blood in catheter bag (witnesses by daughter and granddaughter) not noted*

Acknowledgement letter 12.8.02 NMC file 2

Letter from Code A to Mrs Jackson ref: PRE/19/Code A/11978 – case to go to PPC 27.8.02

Contact fax 13.9.02 NMC file 3

Fax from Mrs Jackson to say all correspondence should be addressed to Emily Yeats

Update letters 27.9.02 NMC file 4

Letter from Code A to Mrs Jackson ref: PRE/DEC/20/Code A/12053 and Emily Yeats ref: PRE/DEC/20/Code A/12053 to inform of PPC's decision to adjourn pending outcome of CPS investigations

Records NMC file 4

Nursing notes 6.8.98 – 21.8.98

17.8.98 am – condition has generally deteriorated over the weekend. 7.45pm Daughter seen – aware that mum's condition is worsening, agrees active treatment not appropriate, & to use of syringe driver if Mrs Wilkie is in pain – signed Code A

21.8.98 12.55 Condition deteriorating during morning. Daughter and granddaughter's visited + stayed. Patient comfortable and pain free – signed C Joice

21.8.98 18.30 Death confirmed at 18.30 family present – signature illegible

Medical notes 4.8.98 – 21.8.98

10.8.98 assessment note by Dr Lord

21.8.98 Marked deterioration over last few days. SC analgesia commenced yesterday family aware and happy – signed by Dr Barton

21.8.98 18.30 – pulse and breathing ?? no heart sounds pupils fixed death confirmed family present for cremation – signed by Code A *C Nurse*

Prescription record 31.7.98 – Undated (21.8.98)

Fluoextine, co-danthramer, zopiclone, lactulose, promazine, augmentin charts for 31.7.98 – 19.8.98

Undated prescription s/c diamorphine 20 – 200mg, hyoscine 200 – 800mg, midazolam 20 – 80mg Dr Barton

Administrations: 20.8.98 13.50 30mg diamorphine, 20mg midazolam (initialled), 21.8.98 30mg diamorphine, 20mg midazolam (initialled)

POLICE FILES

Officer's report 29.4.04 police file review file 2

Visit to Marilyn Jackson (d), Emily Yeats (gd) and Lisa Payne (gd).

Family have compared their notes, as provided to them by LHA, with notes held by police. Noted police records had a page missing between p88 and 89 (clinical records end 2.8.98) (*cf notes on NMC file, we have clinical notes 4.8.98 – 21.8.98)*.

Admitted to GWMH for 4/6 week assessment of condition and rehabilitation - mobile and able to feed self – by weekend, like "an empty shell", had to be moved by hoist, bed bound.

17.8.98 – tel call from hospital asking her to come in – spoke to PB – Mrs Jackson concerned as did not want mother to suffer any pain.

20.8.98 – mother sleepy and appeared to be in discomfort – mother said she was in pain – approached SN Joice and asked her to check on mother.

Waited an hour and no nurse came

Went and fetched PB – he said "we'll give your mum something for the pain but it will make her sleepy"

Left hospital 2pm – rang daughter and asked her to go to hospital and check

Lisa Payne went to hospital – asked about grandmother and was told "your mother seems to think she's in pain" – grandmother sleeping peacefully

20.00, Mrs Jackson went to hospital – mother unconscious – stayed overnight – night staff very nice, arranged bed

21.8.98 am – mother's catheter bag full of blood

Tea time – Code A old Mrs J to get some rest – assured her he'd notify of change in condition – family left and returned 18.30 – Code A said "she's heard your voice she's just gone"

Mrs Wilkie looked yellow and waxy – not as if she had just died

Concerns:

- *Speed with which went from being well/walking to comatose*
- *No one spoke to family re: pain relief*
- *Not aware syringe driver in use*
- *No warning or communication about severity of condition*
- *Query time diamorphine given*
- *P88 Dr Lord wrote DNR – family not consulted*
- *Dispute PB's entry 17.8.98*
- *P140 13.8.98 – error in record, refers to medication error (Gladys Richards)*
- *19.8.98 entry re: death (Gladys Richards)*
- *No fluid input/output charts*
- *Cause of death pneumonia – never informed about this*
- *Not seen by doctor 10.8.98 – 21.8.98*
- *17.8.98 – who decided active treatment not appropriate?*
- *20.8.98 – who checked for pain?*

Expert conclusions

Ferner: Unclear cause of death/treatment sub-optimal or negligent – high dose of diamorphine from start

Lawson: No grading – believes missing drug chart/notes – insufficient detail in notes available

Naysmith: Unclear cause of death/sub-optimal treatment – missing medical records for final admission and a second drug chart - late stage dementia, became v dependant following UTI requiring IV antibiotics – may have died of dementia in GWMH whatever management – only relevant drug chart seen for 20/21.8.98 – nursing notes suggest syringe driver may have been initiated 17.8.98, when permission given, but no other evidence of this – no evidence to judge whether deterioration alluded to 17.8.98 due to medical problems or secondary to opioid treatment – sub-optimal based on inadequacy of medical notes – high starting dose of diamorphine

Summary for report

Evidence in the case of Wilkie

On 1 June 2002, Mrs Wilkie's daughter Mrs Jackson wrote to the NMC to complain about the care given to her mother prior to her mother's death in August 1998. She made a number of general points, but I have summarised below those could perhaps be attributed to individual named nurses.

She noted that her mother was transferred from Queen Alexandra Hospital to GWMH for rehabilitation – on admission, she could walk and feed herself with assistance. After transfer, her mother appeared increasingly sleepy, weak and unwell, and could not stand unaided. After a few days, she received a call telling her to go to the hospital and spoke to Code A *in the office. He told her that her mother was dying*

and nothing could be done for her. Mrs Jackson told Code A *that she did not want her mother to suffer.*

On 20.8.98, Mrs Jackson considered that her mother was in pain, and told nursing staff, who were dismissive. She had to ask for help twice, and wait one hour, until Code A *attended and said that he would arrange pain relief which would make Mrs Wilkie sleepy. When Mrs Jackson left the hospital at 13.55, nothing had been done to alleviate her mother's discomfort. When Mrs Jackson returned to visit at 20.00, her mother was unconscious.*

On 21.8.98, Mrs Wilkie's catheter bag contained blood. Late in the afternoon of 21.8.98, the nursing staff persuaded Mrs Jackson to go and take some rest. She only agreed when they assured her that they would call her if anything happened. When she returned to the ward at 18.30, Philip Bede said that Mrs Wilkie has just died, and had heard their voices before she went. From her mother's appearance, Mrs Jackson believes that her mother had not only just died.

Having reviewed her mother's records, Mrs Wilkie has the following complaints:

- *On 17.8.98,* Code A *made an entry in the nursing notes "Condition has generally deteriorated over the weekend Daughter seen – aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain". Mrs Jackson denies that her conversation with* Code A *was as recorded. She states that she did not agree that active treatment was not appropriate, and that there was no discussion about a syringe driver. She maintains that she was never told about the syringe driver.*

- *Nobody carried out a pain assessment a) when Mrs Jackson complained about her mother's pain on 17.8.98 or b) before starting the s/c diamorpine on 20.8.98.*

- *The drug administration record states that the syringe driver was started at 13.50. Mrs Jackson maintains that she did not leave the hospital until 13.55, and the syringe driver had not been started when she left.*

- *The nursing records falsely state that Mrs Wilkie's family were with her when she died.*

- *There are errors in the nursing records. On a nursing care plan there are two incorrect entries:*

    - *13.8.98, entry scored through, reads "oramorph 10mgs given at 21.00 as distressed. Settled and slept. Written in error as outside Gladys Richards room!"*

    - *21.8.98 "condition remained poorly pronounced dead @ 21.20 hrs by S/N Sylvia Roberts ?? ?? relatives (2 daughters) present". Elsewhere in the nursing notes, it is recorded that Mrs Wilkie died at 18.30, which is around the time when Mrs Jackson returned to the ward.*

  These entries are initially/signed, but I cannot identify the authors.

- *There is no mention in the notes about the blood in the catheter bag on 21.8.98.*

- *Why was her mother given diamorphine, and why was she started on such a high dose? The prescription chart, written by Dr Barton, was undated. She prescribed as a regular daily review (not PRN) diamorphine 20-200mg/24hr, hyoscine 200-800mg/24hr and midazolam 20-80mg/24hr, all to be administered subcutaneously.*

This case has been reviewed by a number of experts instructed by the police. The first of these was Professor Ford, who reported in December 2001. His conclusions were:

- *The initial assessment and plan as noted by Dr Lord on 10.8.98 was reasonable.*

- *No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15.8.98, and there was no recorded medical assessment.*

- *There is no clear evidence of pain or explanation of why Mrs Wilkie was started on the syringe driver.*

- *Oral analgesics could and should have been tried before starting the syringe driver.*

- *The undated prescription was poor practice and potentially very hazardous, as Mrs Wilkie was a frail elderly underweight patient with dementia.*

- *The medical and nursing records are inadequate.*

- *The use of the syringe driver may have hastened death, but Mrs Wilkie was a frail dependant lady with dementia who was at high risk of developing pneumonia even if she had not been administered sedative and opiate drugs.*

As part of the second police investigation, this case was reviewed by the panel of experts. Their conclusions were:

- *Irene Waters (nurse)*

  No opinion expressed about the quality of nursing care.

- *Robin Ferner (pharmacologist)*

  Noted that there was a high dose of diamorphine from the outset. Concluded that treatment was sub-optimal or negligent, but unclear as to cause of death.

- *Peter Lawson (geriatrician)*

  Unable to assess cause of death and standard of care as medical notes and a section of the drug chart were not available from the police.

- *Anne Naysmith (palliative care expert)*

Noted that medical notes and a second drug chart appeared to be missing from the material provided by the police, but concluded that the cause of death was unclear and treatment sub-optimal. This conclusion was based on the inadequacy of the medical notes. The patient was in late-stage dementia and had become very dependent following a UTI requiring IV antibiotics. She may have died of dementia in GWMH whatever management had taken place.

Wilkie – conclusion

In my view, there is at least one potential allegation of misconduct that could be put to Code A *and it relates to his disputed note on 17.8.98. Mrs Jackson accepts that there was a conversation about her mother's pain, but denies that she agreed active treatment was inappropriate or that a syringe driver should be used. Accordingly, she alleges that* **Code A** *falsified the note of their conversation.*

There are clear evidential issues with this allegation:

- *It would appear that the only people present during the conversation were Mrs Jackson and* Code A
- *Mrs Jackson accepts that she was concerned that her mother should not suffer pain;*
- *The passage of time will make it difficult to prove to the required standard exactly what was said during a conversation almost 10 years ago.*

Of the other possible allegations, my views are as follows:

- *The failure to carry out a pain assessment on 17.8.98 is difficult to attribute to a named nurse, but could potentially form the basis of an allegation against* **Code A** *as he was the person who eventually dealt with Mrs Jackson's concerns;*
- *I do not consider that Mrs Jackson's allegation about the start time of the syringe driver on 20.8.98 is capable of proof or that, if proved, would be likely to lead to the removal of the nurse responsible. The most that could be proved would be a 5-10 minutes discrepancy between the time Mrs Jackson says she left the ward and the time the syringe driver is recorded as starting;*
- *Whilst it may be possible to prove that the notes incorrectly record the time of death, and that the family was present at death, and the PPC may consider that this is unlikely to lead to removal;*
- *It would be possible to prove that the notes contain an incorrect entry dated 13.8.98 that was then scored through and corrected, but the PPC may consider that this is unlikely to lead to removal;*
- *We could prove that there was no entry in the notes on 21.8.98 that the patient's catheter bag contained blood. However, we would then have to prove that a the catheter bag did contain blood, that an individual named nurse did or should have noticed this, and that the individual named nurse failed to record this in the notes. In my view, this is not possible;*

- *Finally, there is the wider concern about the alleged poor prescribing, the administration of high starting doses, and the failure of the nurse(s) to challenge. Potential evidential issues relating to these concerns are as follows:*

    - *The identity of the nurse who started the syringe driver is not clear, but his/her initials appear on the prescription records and so it is possible that he/she could be identified.*

    - *We could seek an independent expert to review the material we have and give an opinion on the prescription and whether a nurse should have challenged it/administered medication on the strength of it as per the prescription record. However, I note that two of the experts instructed by the police comment on the apparent absence of a drug chart and the inadequacy of the records. This may make it very difficult for us to prove a positive case.*

    - *We are not in a position to make an allegation of inadequate record keeping against any named nurse(s), as we have no information about who was responsible for the records, who was on duty, etc.*

    - *One possible course would be to liaise with the GMC and establish whether they are looking into this patient and proposing to take action in respect of the prescription. If they are, we may wish to wait until GMC action is concluded, and then follow their findings. However, there has already been a substantial passage of time since the incident. Alternatively, we may ask the GMC if we can adopt or share any evidence they obtain during the course of any investigation.*