Elsie Devine

Code A

DoD 21/11/1999

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Consultant Geriatrician

Tel: (Direct Line)
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RIR/BJH/Code A

Date Dictated: 27.9.00
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Mrs L Humphreys
Complaints Manager
Portsmouth Healthcare Trust
Trust Central Office
St James' Hospital
Locksway Road
Portsmouth

Dear Lesley

RE: Elsie DEVINE, Code A (Deceased) – HN: Code A
HA: Code A

Thank you for asking me to supply a medical report on Mrs Devine. I enclose this. If you would like any further clarification please contact me.

Yours sincerely

Dr R Ian Reid, FRCP
Consultant Geriatrician

MEDICAL REPORT
RE: Mrs Elsie DEVINE (Deceased) Q680266
Code A
Code A

I understand that Mrs Devine had been admitted to Mulberry Ward at Gosport War Memorial Hospital (?date) and had been transferred to Queen Alexandra Hospital on the 9th October 1999

with a diagnosis of urinary tract infection. If I remember correctly (I do not have her Queen Alexandra Hospital records) Mrs Devine had also been diagnosed as having had nephrotic syndrome and chronic renal failure. Mrs Devine was transferred to Dryad Ward at Gosport War Memorial Hospital on the 21st October 1999. When transferred to Dryad Ward Dr Barton, our Clinical Assistant, recorded that she had a past medical history of dementia, myeloma and hypothyroidism, that she had a Barthel score of 8 and a MMSE score of 9 out of 30 and that she was able to transfer with the assistance of one person and was continent. The nursing records indicate that Mrs Devine was confused. Reference is made in the nursing records to a past history of aggression associated with the confusion.

I saw Mrs Devine on the 25th October where I recorded that she was mobile unaided and able to dress herself. The nursing staff told me that she was able to wash herself with supervision and that she was continent.

When I saw her Mrs Devine was mildly confused. Blood pressure was 110/70. She had a normochromic anaemia which I attributed to her chronic renal failure (urea 22.7 mmol/L and creatinine 203 umol/L on the 7th September (there were previous U and E recordings as follows:

DATE	UREA	CREATININE
1st April 1999	15.1 mmol/L	151 umol/L
12th May 1999	16.7 mmol/L	160 umol/L
8th June 1999	15.5 mmol/L	155 umol/L
16th July 1999	23.5 mmol/L	192 umol/L

Thyroid function tests done on the 22nd October 1999 revealed Mrs Devine to be Euthyroid. Her haemoglobin on the 22nd October was 9.5 gr/dL with normal indices. At that time Mrs Devine was on treatment with Thyroxine 100 mcg daily, Frusemide 40 mg daily.

I reviewed Mrs Devine on the 1st November and Amiloride 5 mg daily was added to her therapy the following day. (Mrs Devine had marked peripheral oedema and was also hypoalbuminaemic (albumin 18 gr/L)).

I reviewed Mrs Devine again on the 15th November when I recorded that she was very aggressive at times and very restless and that she had needed Thioridazine. An MSSU sent on the 11th November showed more than 10 white blood cells per UL but there was no growth on culture.

On examination on that day (15th November 1999) Mrs Devine's heart rate was a 100 per minute regular and her temperature was 36.4°C. Her JVP was not elevated and HJR was negative. There was very marked pitting oedema of her legs extending onto her thighs. There were no added heart sounds and her chest was clear. The nursing staff informed me that Mrs Devine's bowels had been working irregularly but that the rectum had been empty on digital examination on the 13th November and that she had a good bowel action since then.

In view of her aggressive and restless behaviour I asked Dr Lusznat (Consultant in Old Age Psychiatry) to see Mrs Devine.

Dr Taylor, Locum Staff Grade Psychiatrist reviewed Mrs Devine on the 18th November. She noted that Mrs Devine did not seem to be depressed and that her physical condition was stable. She stated that she would make arrangements for Mrs Devine to go on the waiting list for Mulberry ward (an Old Age Psychiatry Ward). Earlier that day Dr Barton had seen Mrs Devine and had prescribed Fentanyl Patches, as she was concerned that Mrs Devine was physically distressed as well as

mentally distressed.

Overnight there was a further deterioration in Mrs Devine's condition. She was reviewed by Dr Barton on the morning of the 19th November. Dr Barton has recorded that Mrs Devine was confused and aggressive. Nursing records report that Mrs Devine was extremely aggressive, refusing help etc. She was prescribed Chlorpromazine 50 mg at 8.30 am. Her condition did not settle and Dr Barton commenced a subcutaneous infusion of Diamorphine 40 mg per 24 hours and Midazolam 40 mg per 24 hours in order to relieve Mrs Devine's distress.

On that date (19th November) the results of Urea and Electrolytes (done on the 16th November) became available. These demonstrated a marked decline in Mrs Devine's renal function – Urea 19.8 mmol/L and Creatinine 360 umol/L. Mrs Devine received no further Amiloride or Frusemide (or Thyroxine). She became much more peaceful on the above sedation. Her condition continued to deteriorate slowly and she died at 2030 on the 21st November 1999.

Mrs Devine's initial nursing assessment showed that she had a reduced appetite but that she was able to eat and drink independently. The weekly Barthel score showed that Mrs Devine remained able to feed herself and drink independently until her final deterioration.