David S. van Beek, nee Gene E. Roloff
c/o Michael E. Roloff
PO Box 12142, Portland, Oregon 97212

July 16, 2017

HOSPICE SOUTHWEST
SOUTHWEST WASHINGTON MEDICAL CENTER aka SOUTHWEST MEDICAL CENTER
400 NE Mother Joseph Pl
Vancouver, WA 98664
360-514-2000 Fax: 360-501-7517
By fax and by email.

Subject: Probable homicide of Elvina Roloff

Dr. David Smith expected her to live one to two months (without treatment) and requested that she come to see him in two to three weeks. She died three days after leaving the hospital.

Dr. Y. Chen informed me that this type of cancer progresses slowly.

Several times in her medical records she reported NO PROBLEM WITH BREATHING and NO PAIN. There were NO reports saying she had difficulty with breathing or pain.

She was not DNR status, as claimed by her adopted daughter. Neither did the adopted daughter have POA over her health decisions, as she claimed.

NURSING VISIT REPORTs on the 5th and 6th of February, 2001 indicated normal vital signs.

No nursing professionals were present in the home when she died at the home of her adopted daughter at 15607 NE 270th Circle, Battle Ground WA 98604 34 miles from HOSPICE SOUTHWEST.

The coroner was not contacted by telephone. Neither were the R.N.s Hatfield and Higgins. The sheriff was not contacted. Nobody examined the body of Elvina Roloff before she was released to the funeral home. No blood samples were drawn for possible analysis. Medications were destroyed without recording amounts or examining the purity.

Question: How did Amy Tuom decide that the death of Elvina Roloff was not a homicide? (By destroying the medications, it is implied that Amy Tuom had declared that the death of Elvina Roloff was not homicide.)

Sincerely,
David S. van Beek David S van Beek

CC: Clark County Sheriff's Office, Fax (360) 397-2367
P.O. Box 410, Vancouver, WA 98666

Michael E. Roloff, PO Box 12142, Portland, Oregon 97212

Attachments:

1. January 16, 2001 Dr. K. Yturri examination report. (No confusion mentioned.)
2. January 23, 2001 REPORT OF OPERATION by Dr. B. Harwood. (No confusion mentioned).
3. February 3, 2001 ADMISSION RECORD SOUTHWEST WASHINGTON MEDICAL CENTER.
4. February 5, 2001 NURSING VISIT REPORT by R.N. R Hatfield. (Normal vital signs).
5. February 6, 2001 NURSING VISIT REPORT by R.N. J. Higgins. (Normal vital signs).
6. February 7, 2001 NURSING VISIT REPORT by R.N. J. Higgins. (Visit declined).
7. February 8, 2001 POSTDEATH CHECKLIST by R.N. Amy Tuom. (Death Feb 7 23:45).

This document is available online as a single PDF file at http:// dbs2000ad.com/elvina/2017-07-17-possible-homicide.htm or http:// bit.ly/elvina-homicide.

More information is available online at http:// dbs2000ad.com/elvina/elvina-index.php

See "No quantities of medications destroyed

HOSPICE SOUTHWEST
POSTDEATH CHECKLIST

Patient's Name: Roloff Elvina

MR # 25-51-54

Date of Death: 2/7/01

Reported Time of Death: 2345 2/7/01
Reported by SIL Dan
Time of RN Visit 0030 2/8/01

Item	Items Completed			Name of Individuals Notified	Comments
	Yes	No	If No, Explain		
MD Notified	X		Dr David Smith		
Family Notified	X		Present		
Coroner Notified	X		fax 2/8/01		397-6120 (fax) 397-8405 (phone)
Clergy Notified					
Mortician Notified	X		Haynes Fun. Home		
IDT Members Notified	X				
Vendors Notified	X		Caremedical		
Family Given Support	X				
Postdeath Care Completed	X				
Postdeath Documentation Completed	X				

List Medications Destroyed

Lorazepam tabs / intensol
Roxanol

RN Signature: Amy Tuom Date: 2/8/01

Witness Signature: Marie Cheatham Date: 2/8/01
(Do not sign unless medications were destroyed in your presence.)

PHYSICAL E[illegible] FAMILY PHYSI[illegible]OUP

Date: 1/16/01 Name: Alvina Roloff

DRUGS ALLERGIES:	Family History:	Habits:
	Mo:	EtOH:
Social:	Fa:	Smoking:
	Sibs:	Caffeine:
Exercise:	MGPs:	Drugs:
	PGPs:	
Meds:	Aunts/Uncles	Immunizations:
	Surgical History:	Sexual History:

01/16/01 ROLOFF, ALVINA DOB: 11/07/25

S: Alvina is a 75-year-old woman with a 50+ pack year smoking history who continues to smoke a pack of cigarettes per day. She is here with worsening difficulty breathing, fatigue, decrease in appetite with slight weight gain. She also has a significant history of hypertension. She is on Zestril 10 mg per day. She denies any chest pain, light-headedness, palpitations, or claudication-type pain. She is presently retired and living with family. She is generally inactive, but the family is concerned about her present health. She is multigravida, postmenopausal x many years. She is not on HRT, although it has been attempted without any vaginal bleeding.

PAST MEDICAL HISTORY: Significant for:

1. Hypertension.
2. Emphysema.
3. Postmenopausal, not on HRT.

PAST SURGICAL HISTORY: Negative.

FAMILY HISTORY: Significant for hypertension. No known cancers.

HABITS: Smoking history. No alcohol. A couple cups of coffee daily. Doesn't get much exercise.

HEALTH MAINTENANCE: Generally not up-to-date. She just recently has gotten insurance.

REVIEW OF SYSTEMS: Unremarkable except for that mentioned above.

O: See flow sheet. Important to note is the fact that she has severe obstruction on spirometry, although pulse ox is around 95% to 96%. Cystocele with atrophic vaginitis on pelvic examination.

A: Emphysema is the cause of this woman's symptoms; however, I would like to get a chest x-ray on her when she returns in a month. We were unable to do it today because there was no x-ray tech.

P: We will start her on Serevent two puffs twice daily followed by Flovent 110 mcg two puffs twice daily. She is to continue her Zestril and I am going to start her on some Celebrex 200 q. day for her multiple joint pains, primarily hips, and also Ditropan XL 5 mg q. day for her incontinence secondary to her cystocele which may or may not help. Follow-up in a month. If these problems are present at that time we will do a chest x-ray and see how she is doing.

Reviewed. [signature]

K. Yturri, PAC d:01-16-01 r:01-19-01 t:01-21-01 FJA16042.cfc

1-23-01: ↓BS on (R) mid → lower lung.
CXR → (R) pleural effusion.
↓ to 83% pulse O_2 on RA → exercise, then up to 93% at rest.

SOUTHWEST WASHINGTON MEDICAL CENTER
REPORT OF OPERATION

ROLOFF, ALVINA M **DOB:11/07/1925**
MR:025-51-54 **ACCT:0102304409**

DATE OF OPERATION: 01/23/2001
PREOPERATIVE DIAGNOSIS: Right pleural effusion.

POSTOPERATIVE DIAGNOSIS:

SURGEON: Brian Harwood, M.D.

ASSISTANT:

ANESTHESIOLOGIST:

PROCEDURE PERFORMED: Thoracentesis.

INDICATIONS: Right pleural effusion.
ANESTHESIA: Topical lidocaine.

DESCRIPTION OF PROCEDURE: With the patient in her room, being monitored with EKG monitoring, blood pressure monitoring and O2 saturation monitoring, the ultrasound device was used to localize fluid in the 8th intercostal space along the posterior axillary line. After anesthetizing the pleural space with a 21-gauge needle with 1% lidocaine, a 16-gauge catheter was introduced into the pleural space and approximately 1000 cc of serosanguinous fluid was removed.

The patient's blood pressure and oxygenation were both monitored during this and she experienced no difficulties. The postoperative x-ray is pending.

Pleural fluid was sent for the following studies: cell count, specific gravity, protein, glucose, LDH, amylase, C&S, AFB, fungus, cytology and pH. A large bottle of fluid was sent for cytology and cell block will also be done on this.

BRIAN P. HARWOOD, M.D.

D: 01/23/2001
T: 01/24/2001 6:27 P/ham
cc: BRIAN P. HARWOOD, M.D.
EDWARD J. SALE, M.D.

PRINT

ROLOFF, ALVINA M
025-51-54 11/07/1925
0102304409 IP IP
ADM: 01/23/2001 4SOS43401
EDWARD J. SALE, M.D.
EXPECTED ADM:

SOUTHWEST WASHINGTON MEDICAL CENTER
☐ MEDICAL CENTER CAMPUS
☐ MEMORIAL CAMPUS

REPORT OF OPERATION

[redacted]

SOUTHWEST WASHINGTON MEDICAL CENTER
P.O. BOX 1600
400 N.E. MOTHER JOSEPH PLACE
VANCOUVER, WASHINGTON 98668

ADMISSION RECORD

ACCOUNT NO.	ADMISSION DATE	TIME	FC	DATE OF BIRTH	SEX	MS	SERVICE	STATION	ROOM NO.	INITIALS	ADC	PT. TYPE	UNIT NUMBER
0103404745	02/03/01	1330	M	11/07/25	75Y F	W	HSP	OPN	-	PAC		OPN	025-51-54

PATIENT NAME AND ADDRESS
ROLOFF,ELVINA M
15607 NE 270TH CIRCLE
BATTLEGROUND WA 98604

SOC. SEC. NO. 538-46-2436
HOME TEL.NO. (360)687-0211

PATIENT EMPLOYER
PRIVATE RESIDENCE

TEL.NO. EXT.

PATIENT OCCUPATION
RETIRED

GUARANTOR NAME AND ADDRESS
ROLOFF,ELVINA M
15607 NE 270TH CIRCLE
BATTLEGROUND WA 98604

SOC. SEC. NO. 538-46-2436
HOME TEL.NO. (360)687-0211
RELATIONSHIP SELF

GUARANTOR EMPLOYER
PRIVATE RESIDENCE

TEL.NO. EXT.

GUARANTOR OCCUPATION
RETIRED

RELATIVE
CHEATHAM,MARIE
PO BOX 555
HEISSON WA 98622

RELATIONSHIP DAUGHTER
HOME TEL.NO. (360)687-0212

RELATIVE EMPLOYER

INSURANCE 1
MEDICARE-HOSPICE 541011 CAR.
GRP #: POLICY #:537368043D
ROLOFF,ELVINA M
AUTHORIZATION NO.

INSURANCE 2 CAP
GRP #: POLICY #:
AUTHORIZATION NO.

INSURANCE 3 CAR.
GRP #: POLICY #:
AUTHORIZATION NO.

INSURANCE 4 CAP
GRP #: POLICY #:
AUTHORIZATION NO.

INSURANCE 5 CAR.
GRP #: POLICY #:
AUTHORIZATION NO.

INSURANCE 6 CAP
GRP #: POLICY #:
AUTHORIZATION NO.

DIAGNOSIS / COMPLAINT
ADENOCARCINOMA UNKNOWN PRIMARY Lung

ACCIDENT TYPE
PLACE OF ACCIDENT
NATURE OF ACCIDENT
DATE / TIME

ADMITTING / ORDERING PRACTITIONER	CODE	PREVIOUS NAME	ALLERGIES / VALUABLES	LANGUAGE	CHURCH	DENOMINATION
SMITH,DAVID A	816	ROLOFF,ELVINA M	n	NO		NPR

PRIMARY CARE PHYSICIAN	CODE	COMMENTS	PREV. VISIT DATE
VTURRY,KATE	986		01/23/01

ATTENDING PHYSICIAN	CODE	KAISER HEALTH RECORD #	ADM TYPE / SOURCE	ARRIVAL MODE
SMITH,DAVID A	816		3 1	

FINAL DIAGNOSIS

CODE	
162.9	

PROCEDURES

CPT	

CONSULTANTS:

TRANSFER:

EXPIRED: ☑ YES ☐ NO

AUTOPSY: ☐ YES ☐ NO

DISCH. DATE 2-7-01 TIME : AM PM HOSP. DAYS

SIGNATURE OF ATTENDING PHYSICIAN
X

MEDICAL RECORDS

HOSPICE SOUTHWEST
SOUTHWEST WASHINGTON MEDICAL CENTER

NURSING VISIT REPORT
WEEK OF 02/05/01

Patient Name Elvina Roloff **MR#** 025 51 54
Mental Status drowsy, restless, confused **BP** 128/66 **Pulse** 80 **Resp** 18 **Temp** 98.6°

1. **Pain Assessment:** Present pain level? 0-1-2-3-4-5-6-7-8-9-10 (unable to state)
Describe: (verbal) (nonverbal) (NA) restless, moans if moved
Patient satisfied with pain management? (Y) N If no, what pain level would be satisfactory? _____ **24 hr. pain F/U?** Y N
Current regime: Roxanol 0.25 ml q 4-6° PRN Changes _____
[ ] Inf. therapy: pump/gravity Vol_____ Mg/ml_____ Mg/hr_____ Bolus_____ Drsg. Site change? Y N _____
Plan/Changes _____

2. **Resp. Status:** Lungs clear? (Y) N If no, describe _____ Dyspnea @ rest [N] O_2 ___ L. con't prn

3. **Circulatory:** Heart Sounds [+] WNL or, describe irreg Skin color WNL Edema -0-
Decubitus/Wound (size, stage, location, Tx) redness + scratches on coccyx. Covered c allevyn.

4. **Nutrition:** Intake fair N/V, Dysphagia, Anorexia, **Weight** (NA) def

5. **GI:** LBM 2/2/01 Describe loose, liquid Pattern QD QOD Abd: (soft) distended firm tender (ascites) (other) _____
Bowel tones + Bowel care reg: mom @ HS tonight + Tb.
GU: Urine (WNL) or _____ Catheter: Y (N) Change (type, size) _____

6. **ADL's:** Mobility status TF to w/c c (A) Equipment using hosp bed, APM, w/c Karnofsky % 30

7. **Psychosocial Status:** Patient restless, poor verbal response Caregiver dtr coping well.

8. **Teaching:** Nursing _____ Death and Dying _____
Progress Note: Have been using lorazepam 1mg Q 6° for restlessness c poor s/sx relief. Now using Roxanol 0.25 ml c pt able to sleep few hrs @ a time.

Date 02/05/01 Time 1400 RN Plan 2-3x wk RN Signature R Hatfield

1. **Pain Assessment:** Present pain level? 0-1-2-3-4-5-6-7-8-9-10 (unable to state) [circled]

Describe (verbal) (nonverbal) (NA) restless daughter states pt has muscle discomfort in legs

Patient satisfied with pain management? Y [circled] N If no, what pain level would be satisfactory? ______ **24 hr. pain F/U?** Y N [circled]

BP L/R 130/70 Pulse 88 Resp 16 Temp def Change in assessment? Y N

Progress Note: NV since 2/5 - Foley - 16Fr c 5cc balloon placed c difficulty - O: 300 clear urine. Enc lorazepam 0.5mg q3°-4° = 1mg at noc, alleviate doc. Appears restlessness. Family supportive & caring. MD office updated orders received family update

Date 2/6/01 Time [illegible] RN Plan 2-3x wk RN Signature J Higgins

1. **Pain Assessment:** Present pain level? 0-1-2-3-4-5-6-7-8-9-10 (unable to state)_____

Describe (verbal) (nonverbal) (NA)_____

Patient satisfied with pain management? **Y N** If no, what pain level would be satisfactory? _____ **24 hr. pain F/U?** Y N

BP L/R_____ Pulse_____ Resp_____ Temp_____ Change in assessment? Y N_____

Progress Note: TC to family, visit ~~during~~ declined. Pt sleeping well. Enc roxanol 0.5 q 4, Lorazepam 0.5mg q 4. Family very supportive has hired RN in place.

Date 2/7/01 Time 1030 RN Plan 3-5x ~~wk~~ RN Signature J Higgins RN