HAMPSHIRE CONSTABULARY

G.31

Station : **Gosport`** Division : **GG**

Department : **CID** Date : **05 October 1998**

Subject : **Gladys Mable RICHARD** Code A **died 21st August 1998**
Complaint of unlawful killing by neglect

D.I. Morgan

Ma'am

The above lady died at Gosport War Memorial hospital, after a series of falls and neglect by staff at the hospital. The daughters of Mrs Richard have brought notes regarding her treatment, and have asked the Police to consider a prosecution.
The daughters are Mrs Gillian Mackenzie, Code A and Mrs Lesley Lack Code A Retired SRN after 42 years. (Daughter also Nurse at Haslar)

History
Mrs Richard has been in a nursing home at Lee on Solent for 4 years. The Glen Heather, Nursing home, Milvil Road, LoS.
While at the home she fell and broke her hip, and she was made to walk on the injured leg 2 times before receiving treatment. A complaint has been made to Mrs Hogarth of the nursing home inspectorate regarding this. (see appendix A)
The fall occurred On the 29th July 1998 at 1330 hrs and she arrived a Royal Hospital Haslar at 2030hrs.
The head of the femur was broken and the bone over lap was '3 inches'.
She was operated on the next day and discharged to Gosport War Memorial Hospital on the 11th August 1998.
On the 13th August she fell from a chair onto her hip, she was given a strong tranquilliser and no examination of hip done. The staff considered that her screaming was dementia and that she had fallen on to her bottom. At 2130 hrs the staff admitted that Mrs Lack may have been right about leg.
On 14th August She was x-rayed and returned to Haslar for operation. No general anaesthetic given an epidural administered and the leg was manipulated in the casualty theatre. She was admitted to the orthopaedic ward. She was given fluids and recovered enough to get out of bed after 48hrs.
On 17th August after examination by surgeon, for which she stood, was transferred back to the War Memorial. The transfer was delayed until midday. Mrs Lack saw her in her bed and she was screaming with pain. The transfer to the bed had again displaced the hip and the splint. A nurse attended and with the help of Mrs Lack straitened the leg. Mrs Lack asked for the leg to be X rayed but this could not be done with out a doctors signature.

At 1800hrs she was examined by Dr. Barton who stated she had a heamatoma at the site of the wound. The doctor stated she intended to give Oramorph 4 hourly through night for pain relief.

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On the morning of the 18th the daughters were told that she had had a peaceful night and that the cause of the pain was a massive haemtoma at the site of the operation. They were told that the planned management for pain relief was to use a syringe driver with diomorphene. This would ensure she did not suffer when being washed, moved or changed.
She did not have a drip, which would have given nourishment, and liquid.
The Doctor suggested that there would be a lung infection from this treatment.
From Wednesday 19th August until Friday 21st August the sisters remained with their mother when she died. During this time she received nil by mouth, and was not seen by a Doctor.
Mrs Richard has been cremated.
When the death certificate was handed to the Registrar it stated that Mrs Richard's had died of Pneumonia 2 days. The sister now query this as a doctor did not attend their mother during the last days.

Notes were made by Mrs Lack prior to the death of her mother copies as Appendix B

Complaints
Detailed complaint has been made to the Portsmouth Healthcare NHS Trust Central Office at St James Hospital, Portsmouth.

The complaint has been answered by Max Millett point by point and this is place in the report as Appendix C

Conclusion
There has been a great deal of neglect, and miss treatment of this lady by the hospital, and this is accepted by the Hospital Trust. It is the belief of the 2 daughters that Dr Barton is guilty of unlawful killing, by neglect. That is by omitting to have a drip, for nourishment and liquid, she starved Mrs Richard's, and caused her kidney to fail. Both of these would bring about premature death.
When interviewed they stated that the course of action as outlined above was not discussed, but on page 5 of Mrs Lacks notes she writes " the out come of the use of a syringe driver was explained to us fully. We agreed."
In any criminal case this would cause an obstacle, for a prosecution.

My thought is that if the sisters wish to pursue this further they should refer it to the General Medical Council.
In the mean time I have referred the case to Mr Thomas Coroners officer, for the view of the coroner, who may wish for this report. However as the body is no longer available he believes the coroner will not get involved.
I have also asked for research to be started at the library TT.

For your information

R.M.Maddison
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