HAMPSHIRE CONSTABULARY

G.31

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

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

Subject : **Gladys Mable RICHARD born 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.

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

Code A

Appendix A

Notes of complaint made by Mrs Lack to Nursing Home inspectorate

Ref. Gladys Mabel Richards.

Following my Mothers admission to Haslar with a fractured neck of Femur - I was asked by the Social Services Dept why I had stated that if and when my Mother recovered she would not be returning to the Nursing Home she came from. The level of care is no longer acceptable to me. The following is a catalogue of unacceptable events over the past seven months culminating in the latest accident from which I made the decision.

December 97. Just after Christmas. Heavy fall. with severe facial bruising. No phone call. Found on normal daily visit. Staff surprised I had not been told. Mother continually moaning and holding her head. Pain in shoulder. Medication changed following Consultants visit. Appoint with GP. to discuss this. Mothers speech affected. Hearing aids (both ears) lost yet again. Frequent requests over 7 months for renewal - no result.

March. Fall hurting ribs. Mother clutching side. No Xray as quote "They dont do anything for ribs nowadays". Request from N. Home to increase her medication, as mother calling a "wailing".

April. On visiting at lunch time found sitting in lounge with wet hair. On enquiry found hair had been washed in bath. ? Why when she had the hairdresser each week. Two days later developed cough generally unwell. Brought to the attention of staff. daily. 5 days later very poorly. Copious mucous-e coughing holding her side Requests for GP to see from family Mother very poorly. 5 days before seen by GP.

April 11th. Fall Pain in hip - to Haslar for Xrays. No bony injury

Very shocked. Night Time Discharged back to home Family visiting for lunch & supper daily and sometimes for breakfast. Good days & bad days Glasses lost staff requested to look for them please. No result. Mother deaf in both ears is now existing with no form of communication other than staff shouting at her and now without her glasses (post cataract op) so she cannot see properly. She is almost blind in the other eye from another cataract.

April 22nd. Collapse in dining room. Telephoned from Home to come. Mother unconscious. Home don't know what happened. "Collapsed" at dining table and put to bed.

Family nursed Mother day and night for the next approx 10 days as staff stated they could not watch her. Mother regained consciousness but was very poorly. She remained continent. Attempting to get out of bed or chair if she needed the toilet. Staff again stated they could not watch her. She was very ill and remained in her room. I stayed during the day - my sister slept in the room during the night. When Mother wanted the loo during the night - although the bell was rung - my sister stated staff did not respond and my sister toileted my Mother. There were no falls during the period we stayed.

May. Told by staff that my Mother had been 'lost' for over an hour at night and finally found down the back stairs. Told by staff Mother wanders - always around 2am. - All she needs is taking to the toilet and settling back to bed.

Decision made to have Ground floor room.

Wesley visiting daily throughout lives remind for lunch & supper most days – but always for supper.

16th July. Fall at 7.45 am. Getting up to go to loo on her own. Cut to bridge of nose and forehead grazing large facial swelling. To Hasbro. I went with her. X-rays and head scan done. Back to N. Home 1.30pm.
Visited and fed daily.

17th July Electronic pad put by bedside to alert staff if Mother got out. Frequently found to be unplugged.
Told by other relatives that Mother was left in lounge till 10.45pm.
I stayed to stay later after I had fed her her supper.

21st July. Phoned 10am to say I could not visit today 3pm My sister visited about 10.45 – 11am. Asked where Mother was. Told she has put herself back to bed. Found to be on the bed Head against the wall sideways on. Foetal position across the bed.
Still no visit from GP following fall.

23rd July. Asked for help following supper to put Mother to bed. She had been very poorly daily since 16th and I no longer could manage her without help. Shirley RGN said she would send a carer to help me when she could. At 8.15pm Diane came to help me. Mother put on the toilet and washed and undressed and nightie put on. Taken to bed – sat on bed and legs lifted to bed to take tights off. Nurse C/asst. and I removed her tights which were clean to discover dried hard faeces covering sole of foot and up between each toe to the front surface of her foot. A warm soapy flannel removed the faeces and the RGN in charge was informed in front of staff in the office for handover.

'24th. Spoke to care assistant Jackie who had got my Mother up the previous day. She stated she must have stepped in it during the day. This is not feasable as there was no dirt on slippers or tights. I suggest She was not checked in the morning

July. Mother taken to the toilet by me. Found to be red on her buttocks with very small 'skin off area' I Opened door from toilet and asked care assr for a clean pad and whatever cream is used here for sore buttocks. I was given a large container of E.45. I explained I did not want a moisturiser for a moist area. She said I'm only a care assr, I dont know! I saw Sue RGN through the door. Request repeated. Mother still standing by the toilet distressed at waiting Sue brought E.45. Explained again. Sue said You'll have to wait if you want something else Im busy. I waited. I washed moth and put clean pad on and walked her back to the lounge. Sue came 20 mins later. saying "stores" are not due till tomorrow but I have put some drapolene into a small pot for Mothers use. I asked the care assr I saw to please apply some to the sore area when they next took her to the Toilet.
Next day I told Margaret RGN about the small area broken.
3 days later I asked Margaret How was Mum's bottom. She replied I dont know I haven't seen it yet.
July. My daily visits continued.
My mother still without hearing aids or glasses and I am told that the Hearing Aid Dept have no priority for those over 90. Mum is 91 - but she was 90 when they were lost.

Wed 29th July.

Could not get to the N. Home for lunch time feeding as I was at the Radcliffe in The Avenue feeding another Grandma as my daughter was away. Rang home to tell them I'd be in later.

I arrived at 3.50pm. Mother was laying in her arm chair – anxious expression I asked a care assistant to help me sit Mother up. We did so with difficulty and my Mother screamed out. I saw John Perkins RGN Matron/Manager in the hall doorway. I asked if there was anything wrong with Mother – Is she OK. She's fine he said. I explained I would not be here to feed her at 5pm as I had to get to Southampton Airport Fog had delayed flights from Guernsey so my timing was out. I left at 4.15. I arrived back home at 6.10pm. Message on my answerphone at 3.28pm from Margaret RGN. Your Mother had a little fall earlier. She is alright but a bit noisy and upset. I know your come at teatime but could you come earlier and sit with her.

6.15pm I rang the Home. I spoke to John Perkins RGN. I asked about the message. I said I've seen you since the message and spoken to you.

Yes he said. but I did not know about your Mum's fall till it was mentioned at the 6pm handover when Margaret went off duty. Well how is she I asked. – well she is OK now he said.

Right I said my daughter has a meeting in Fareham 7pm 8pm. I'll call when I get back from the house. I got back at 8.30pm. 3 messages on my answerphone.

① 8.08pm John. Your mother is quite agitated & noisy perhaps you would like to come & sit with her.

2) 8.29. Mother is calling as if she may have pain We have given her to bed I may call the Doctor.

3) I'm sure here – night staff. I'm sorry but I'm sure you're Mother has a fractured Femur. When I came on John said Go and see Gladys – she has been shouting for ages and when I saw her it was obvious. I'm called an ambulance.

I rang back and said I'd meet the ambulance at Haslar.
On admission the Xrays were consistant with having been walked since fall. There was shortening of limb with external rotation of foot
Despite the injuries and the trauma – things are even worse because of her inability to hear.
The frustrations of X'ray – Drips – keeping still etc have been exhausting for all concerned and not least Mum who could not hear and cried and wailed in fear.

As a family we have wanted to move Mum for some considerable time and have discussed this but felt the move would be unfair as she knew her surroundings and where things and rooms where She was familiar on a day to day basis.

I asked for a full explanation from Glen Heathers for the 29th.
We had a interview with Pauline RGN. Consultant Advisor to Glen Heathers
Several statements from staff were read out to us.

They confirmed

The fall was at 2.50pm.
It was in the dining room.
What was she doing in the dining room at this time following 12noon lunch? No answer.
Frequently those sitting quietly at the table are left in this room. If Mum was left - she would have attempted to get up to go to the loo.
The statements show she was walked to the lounge.
" " " " " " to the bedroom from the lounge.
I do not know what time this was.
A Dr was not called.

Fall at 2.50pm.

To Hasler at 9pm.

Walked twice in the meantime.

(There are numerous incidents I could relate.
RGN raised voices. Care shouting at residents
Call system going for ages.
Moths named clothes as other residents
Drawers full of other peoples clothes
In 10 days following Moths collapse in April John did not visit he room once.
Constant requests for hearing aids made me feel a nuisance
I could go on).

The above events are a true statement

August 1998.

Code A

Appendix B

Notes made by Mrs Lack Prior to Death of Mother Mrs Richard.

(1)

Ref Gladys Richards **Code A**

No Analgesia necessary, Able to walk - pain free

Tuesday 11th Aug. Admitted from Haslar.
Wed 12th Dementia misread/ Oramorph given. Staff thought anxiousness was pain. so no fluids could be

THURSday 13 Aug.
Seen to be in pain by Grandaughter. Hrs Reed 1.30 - 2.15pm
Brought to ward staffs attention. Thought to be dementia, Mother showing with pain. Hrs Read brought to the attention of the staff that Mum had great pain in her hip. (For your info she is a qualified Nurse)

(1) AV what time did Hrs Richards fall?
(2) Who attended to her.
(3) Who moved her and how.
(4) 3.45-4pm I arrived and saw my mother was in pain. Anxious expression, weeping - calling out. I spoke to several trained and untrained staff. I was told - there is nothing wrong - its her dementia. I was then told that she had fallen from her chair. I asked had she seen a Doctor? Could she be Xrayed? At supper time while my mother was quiet and I was teaspooning her some soup I was asked "Do you think your Mother is in pain?" by RGN doing the drug round. "Not at the moment while I'm feeding her" I said "Well you said she was in pain". "Yes" I said "she has been very uncomfortable" since I got here". "Do you think she has done some damage?" "No" "she only fell on the bottom from the chair" I stayed Till 7.45pm My mother was in great distress throgout.

At 9.30pm. I received a phone call from the ward. "When we put your Mother to bed she was in great pain and she may have done something. The Doctor feels its too late to send her to Haslar and our Xray unit is closed. We will give her oramorph for the night to keep her pain free and Xray here in the morning."

(5) This was an avoidable delay. Why? Any lay person could have seen she was hurt by the angle of her leg etc.

FRIDAY 14th. I arrived as she was taken to Xray

(2)

She was deeply under with oramorph.
She was xrayed. The movement caused pain, and I stayed with her to comfort her.
We returned to the ward. I was called in to the office by Philip - ward manager and DR Barton to be told - "Your worst fears of last night appear to be true. We have rung Haslar and they have accepted her back."
We arrived at Haslar late morning - mid day. She was expected. The ambulance was bleeped. He saw Hattie in Casualty immediately. He then saw me. He showed me the Xrays and position of limb - which I had seen in G.W.H. 24 hrs from accident to admission and second emergency operation. Why? why no examination? why (6) no xray? why no transfer?
She arrived at Haslar and within 1hr had a manipulation to put the hip back in the socket. From then she was pain free.
She did not regain consciousness fm 1am (15th) on Sat 15th due to amount of analgesia required for the procedure. She was then catheterised so that there was no need to use slipper pan. She had a drip as she had had NIL BY MOUTH since before Xrays on 14th.
She remained pain free in full length leg splint. both legs level and straight - shown to me by consultant. No analgesia was required - she was able to use a commode for the toilet and weight bore for transfer. She ate and drank and the drip was removed and her fluid balance was acceptable.
She progressed on Sunday and was easily manageable. She was seen early a Monday 17th when transfer back was recommended. I rang Haslar at 8.30am to be told she would be going A.M. I asked if I should come & pack & accompany her and they said "No need

(3)

she is fine". I went to G.W.H about 10.45am and was told the ambulance was due about midday. I arrived back at 12.15 midday

On entering through the swing doors to the ward I heard my Mother screaming. On arrival to the room a care assistant said. "You try feeding her I can't do it she is screaming all the time". My Mother had a starving anxious expression She was gripping her RT thigh op site tightly. She uttered the words Do Something Do something the pain the pain - dont just stand there - I dont endestant it the pain the pain sharp sharp — this is some adventure. A SRN came into the room at all the noise. I moved the sheet and said look at the awful position she is in, she was lying awkwardly towards the left side with the full length splint not straight and the hips uneven. She cried in pain. I said to the RGN "can we please move her" We moved her together with our arms together under her lower back and the other around her thighs we placed her squarly on her buttocks and within minutes she stopped the screaming.

(7) Why when returned to bed from the ambulance was her position not checked.?

why was the source of pain not sought?

From 1pm onwards the Charge Nurse Manager frequently checked my Mother. He acknowledged our concern. He acknowledged her obvious pain. We asked for X rays We asked what had happened between leaving Haslar & arrival into her bed at G.W.H. It was acknowleged that "something" had happened

(4)

The charge nurse was concerned for his pain and analgesia was given 3 times between his admission & 6pm.

Phillip's ward manager agreed she needed Xray to establish if damage had been done as had occurred to the hip.

Xray Dept refused forms signed PP for the DR who was unavailable.

An appointment for Xray was made for 3.45pm as the DR called was expected at about 3.15pm The charge Nurse did all he could to expidite this - keeping us informed and constantly checking Mothers obvious severe pain. He administered pain relief in readiness for the Xrays. He was courteous and attentive at all times.

DR Barton arrived and we left the room as asked She examined my Mother. She stated she did not think there was further dislocation but the Xray would go ahead. A review would be held later when Xrays had been seen

We went to Xray. My mother was in pain despite her pain relief. I was not allowed in with her as I was the previous week. I could hear her wailing through the doors while the Xray plates were put in place. We returned to the ward. We were told there was no dislocation but obviously something had happened. We were told she would be given Oramorph for the pain & fully through the night for pain relief and reviewed in the morning.

On Tues 18 we arrived on the ward and were told she had had a peaceful night We were told that she had a massive haematoma causing pain at the Op sit

(5)

and the plan of management was to use a syringe driver to ensure she was pain free and she would not suffer when she was washed - moved or changed should all become inconvenient.

The outcome of the use of a syringe driver was explained to us fully. We agreed.

A little later Dr Barton appeared and informed that a Code A was present and that this was the kindest way to treat her. She also stated "and the next thing will be a chest infection". Totally insensitive to those already in the first stages of bereavement. Because the syringe driver was essential following the administration of analgesia for pain - my mother of course would not now regain consciousness, speak, open her eyes to see us, or hear anything anymore. To us Mother as we know her is already gone.

(8) How was she brought from theatre? Was there an escort? Was anyone in the back with her? (9) When did she start to show pain? What caused it? I request again to see the X-rays when decisions were made to do nothing but allow to die pain free

Answers to the numbered questions are sought in detail. 1-9 please.

Trivial things added to our trauma. Her clothing already cash's name tabs marked. - had all gone the day after Isr admission for washing - despite my agreeing to do the washing daily.

Asking continually, to insisting today that Mother be allowed to wear her own clothes has resulted in them being brought by Taxi from Sr Marys 8 days later - still unmarked and all totally unnecessary. - as was a staff Nurse yesterday asking to take her day clothes away - "because we get them up here you know". Our reply was - Just look at her - she will not be getting up anywhere.

The contents and events in this report were in the majority witnessed by my elder sister Mrs Mackenzie.

Code A

Appendix C

Letters from Portsmouth Healthcare NHS Trust answering complaints from Mrs Lack.

HAMPSHIRE CONSTABULARY - MESSAGE FORM

From/~~To~~* Code A

Address

Tel. No.

Section	GG
Date/Month	2709
Time incident Reported	
SOURCE	
Telephone 1.	✓
999 2.	
Alarm 3.	
Patrol 4.	
Station Counter 5.	
Beat	
Incident Map Ref.	
RESPONSE	
Immediate 1.	
Time Sent	
Time Resumed	
Delayed 2.	
Scheduled 3.	
Telephone 4.	
Incident Class	

RESOURCE TYPE	No. Officers attg.
Foot/Cycle 1.	
Area Car 2.	
Sub. Div. Veh. 3.	
C.I.D. 4.	
Traffic 5.	
Supervisory Officer 6.	
No Deployment 7.	

Sent by H.Q.	Yes 1. / No. 2.

RESULT	
Arrest	1.
Offence Report	2.
C.O.F.	3.
False Call	4.
Advice/Help	5.
A.S.N.T.	6.
N.F.A.	7.

Officer Dealing

Message and Action Taken: | C.O.F. (If applicable)

Ma'am, 'GG' SDO was contacted by 'phone by a Mrs Gillian McKenzie (home address refused) on tel' No' Code A stating she wished to report/allege that her mother had been unlawfully killed whilst in Gosport War Memorial Hospital recently. At that point Mrs McKenzie refused/declined all other details & insisted she spoke to The Head of Gosport CID!! As duty D.C. for the w/end I contacted her, she imparted the following :-

Her mother Gladys Mable RICHARDS Code A.

Had a fall at home in L-O-S & was admitted to Haslar Hospital where she had an operation for a dislocated hip. She stayed at Haslar for 10 days until transfer to the Gosport War Memorial Hospital. On arrival at G.W.M Hosp her mother fell again & although not treated for this until the following day she eventually went back to Haslar where her hip (which had again dislocated) was manipulated back into place.

Her mother was again transferred to the G.W.M. Hospital & given diamorphine for pain killing reasons. She subsequently had a haematoma(?) develop.

Her mother was apparently not examined on her arrival back at G.W.M. Hosp. on 18/8/98 until her death on Friday 21/8/98. The reason given for her death was pneumonia.

Mrs McKenzies sister Lesley LACK →PTO

Cross Ref. to other messages

Received by

Reply/Result *

For INFO of/ ACTION by *

Enquiry Cleared Initials/Date

INCOMPLETE Not to be removed until Enquiry cleared box completed

G4 * Delete item not applicable ☒ Tick appropriate Box

of Code A GG on Code A who is a nurse of 43 yrs. experience questioned the cause of death & was told that if she was not happy then it would lead to an inquest & P.M. for her mum. To save mother etc from this she accepted the decision reason given for her mothers death.

Subsequently Mrs McKenzie & her sister sought an investigation into their mothers treatment & the events etc leading to the eventual death. They have now received copies of the report from the Chief Executive, Max Millett, of Portsmouth Healthcare National Health Trust c/o St. James Hospital, Portsmouth. In this the Hospital apparently admit a degree of liability, but there are apparently references to conversations that Mrs McKenzie states did not take place & she feels a cover up is being done by the N.H.S.

I have advised her that on the face of what she has told me the facts etc appear if anything to fall short of unlawful killing but she may have some form of case for negligence & to that end referred her to the General Medical Council.

She appears on the 'phone to be "compus mentus" (normal) but obviously we have only her word with regards to the ins & outs of the incidents & what she claims to be in this report.

She claims her sister who lives locally has not come forward etc herself because of the fact she agreed to sign/accept what was put on the death certificate & now thinks she's in trouble for doing this.

Mrs McKenzie contacted me today 25/9 & told me she feels it necessary she be interviewed by us re: her claims & also has written to the Chief Constable etc.

I have left it that I would take advice & make some prelim. enqs. & then someone will get back to her.

Over to you.

Code A

Mrs. L. Lack,

Code A

MM/YJM

25th September, 1998

4378

Dear Mrs. Lack,

Further to your telephone conversations with my secretary I write to confirm that arrangements have been made for you and your sister, Mrs. McKenzie, to meet with Mrs. Barbara Robinson, Hospital Manager, at 2.30 p.m. on Thursday, 29th October, 1998 at Gosport War Memorial Hospital.

As also discussed I have sent a copy of my letter to you dated 22nd September, 1998 to Mrs. McKenzie.

Yours sincerely,

Code A

Max Millett
Chief Executive

Copy to: Mrs. G. McKenzie
Mrs. B. Robinson

Code A

Meeting cancelled 29th by telephone

Code A

PORTSMOUTH
HealthCare
NHS
TRUST

Mrs. G. McKenzie,

Code A

Our ref
MM/BM/YJM
Your ref

Date
22nd September, 1998
Ext
4378

Dear Mrs. McKenzie,

I understand that you have made enquiries about receiving copies of the correspondence between Portsmouth HealthCare Trust and your sister, Mrs. Lack, about your late mother's care at Gosport War Memorial Hospital.

This correspondence is personal to your sister and I am not, therefore, in a position to copy it to you. However, in my letter of today to her I have advised her of your request, and expressed the hope that she will feel able to share it with you.

Failing that, the only option would be for you to raise your own complaint directly with the Trust.

I am very sorry that your grief at this very difficult time has been compounded by these concerns.

Yours sincerely,

Code A

Max Millett
Chief Executive

PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE

St James' Hospital
Locksway Road, Portsmouth, Hants PO4 8LD
Tel: 01705 822444 Fax: 01705 293437

Mrs. L. Lack,

Code A

MM/BM/YJM

22nd September, 1998

4378

Dear Mrs. Lack,

I am writing further to my letter of 25th August, 1998 now that I have received the report from Mrs. Hutchings, who has been investigating all the matters you raised concerning the care provided for your mother, Mrs. G. Richards, prior to her death on Friday, 21st August, 1998.

I should like to reiterate how very sorry I am that your grief has been compounded by so many concerns, but that you for having taken the trouble to write, as this has resulted in a very thorough investigation, and given us the chance to explain and/or apologise for the problems you identified. It has also meant that staff have reviewed procedures and improvements are being implemented as a result.

I should like to respond to each of the points you made, using the numbering system from your notes.

1. At what time did Mrs. Richards fall?
   She fell at 1330 on Thursday, 13th August, 1998 although there was no witness to the fall.

2. Who attended her?
   She was attended by Staff Nurse Jenny Brewer and Health Care Support Worker Cook.

3. Who moved her and how?
   Both members of staff did, using a hoist.

4. After the fall
Your mother had been given medicationi presecribed by Dr. Barton, who was present on the ward just after her fall. I understand that it was not your wish for your mother to be given stronger medication because it made her drowsy.

5. Why was there such a delay in dealing with the consequences of the fall?
With the benefit of hindsight it is possible to assume that your mother's dislocation could have been identified much earlier and we can now only apologise for that delay if that was the case. It is notoriously difficult to establish degrees of pain or discomfort in dementia sufferers, but staff now recognise that more attention should have been paid to your mother's signs of discomfort, and your own expressed concerns about that.

6. Why no x-ray? Why no transfer?
These delays were a direct result of the failure to identify a problem earlier in the day - because the x-ray department at Gosport War Memorial Hospital only operates from 9 a.m. to 5 p.m. I understand that you did appreciate this when it was discussed with you on the Thursday evening, and agreed with the advice that it would be best to defer a transfer to Haslar until an x-ray based diagnosis had been made. The transfer to Haslar was organised as soon as possible after the situation had been confirmed by x-ray, on the morning of Friday, 14th August, 1998. It is a matter of great regret that this delay occurred, and we accept and apologise for the fact that the standard of care fell below that which we aim to provide.

7. Why when she was returned to bed from the ambulance was her position not checked?
When your mother arrived on the ward two health care support workers saw her into bed and then went to inform Staff Nurse Couchman that your mother had arrived. They had realised there was a problem and that professional advice was needed. Staff Nurse Couchman came and checked her position, and I believe you assisted her in straightening your mother's leg and placing a pillow between her legs.

8. (a) How was she brought from Haslar?
She was brought by an ambulance with two crew.

(b) Was there an escort/anyone in the back with her?
There was no nurse escort - this would have been arranged by Haslar had it been thought necessary.

(c) When did she start to show pain and what caused it?
The ambulance crew commented that she showed signs of being in pain as she was put into the ambulance. The cause of the pain has not been specifically identified.

(d) Why was my request to see the x-rays denied?
The x-rays were seen in the x-ray department by the doctor and the consultant radiologist. The decision to keep x-rays in the department and not to send them to the ward rests with the consultant radiologist, not the ward staff, and your request may not have been relayed to the department.

(e) Decision to do nothing but provide pain relief?
Dr,. Barton felt that the family had been involved at this stage as she discussed the situation fully with you. She made sure you were aware that the surgical intervention necessary for the haematoma would have required a general anaesthetic and clearly your mother was not well enough for such a procedure to be undertaken. Therefore, the priority, and only realistic option, was to keep her pain-free and allow her to die peacefully, with dignity.

9. Clothing sent for marking despite being named already
As a result of previous problems the ward have adopted the practice of marking all patients clothing with the ward name - a procedure designed to help, which on this occasion, did the absolute opposite. The laundry marker at Gosport War Memorial Hospital had broken down, so your mother's clothes were sent to St. Mary's Hospital and meanwhile she was given hospital clothing. In attempting to meet your completely reasonable request for her own clothes to be returned, a taxi was authorised which in the event brought the clothes back - still only bearing your mother's name. Whilst, as you say, this was a trivial problem on the scale of the real issues, it was a quite ridiculous consequence of a well-intentioned policy which served to cause unlooked for stress. The process is being reviewed as a result of your complaint.

All the staff concerned with the care of your mother were deeply saddened at her experience, and sincere apologise are proffered to you and your sister for the problems which occurred, and the failure of the service to meet your very reasonable expectations. The only constructive aspect I can identify is that lessons have been learned and the experience will benefit future patients, although I fully appreciate that such benefits have little relevance to yourselves.

You may be aware that your sister, Mrs. McKenzie, has telephoned Mrs. Hutchings as she wishes to see this correspondence. I am writing to her to confirm that it is personal to you, although, of course, I hope that you will feel able to share it with her. If you unable to do this then she will need to raise a complaint of her own.

/continued - page 4

Should you wish to pursue the matter further my secretary would be very happy to arrange a meeting with Mrs. Barbara Robinson, Hospital Manager, at your convenience and I would be grateful if you could contact her on 01705 894378 within one month should you wish this.

Thank you once again for writing so comprehensively of your concerns.

Yours sincerely,

Max Millett
Chief Executive

Silent copy to: Mrs. B. Robinson
Mr. W. Hooper