Mrs M Jackson

Code A

01 June 2002

UKCC For Nursing, Midwifery and Health Visiting
23 Portland Place
LONDON

Dear Sir / Madam

FORMAL COMPLAINT

I am writing to make a formal complaint regarding the appalling level of care given to my mother Mrs Alice Wilkie prior to her death in August 1998 at the Gosport War Memorial Hospital. I understand from Hampshire Constabulary that you have already been sent copies of the police medical files regarding this case.

To summarise briefly the events which took place, my mother was taken from Code A on 31 July 1998 to Queen Alexandra Hospital in Portsmouth as a result of a Urinary Tract Infection. My mother stayed at Queen Alexandra for five days and appeared to be making good progress. Subsequently, she was sent to the Gosport War Memorial Hospital for 'Assessment and Rehabilitation'.

At the Gosport War Memorial Hospital my mother appeared increasingly sleepy, weak and unwell, she couldn't stand or walk unaided. When I queried this with the ward sister I was simply told "yes, she was deteriorating". I was given no explanation as to why or what actions were being taken to help her. The ward sister's attitude was completely ambivalent. Incidentally there is no record on her notes that we had expressed our concern about my mother's health or of any concerns from the nursing staff. Just a few days later I was called into Phillip Beed's office and was advised that my mother was dying and there was nothing that the hospital could do to help her. I thought this was strange at the time as she had entered the Gosport War Memorial for rehabilitation and assessment, not to die. At this point I was again given no further explanation as to why this deterioration had taken place and why nothing could be done. I told Phillip Beed that I did not wish for my mother to suffer but that was the depth of our conversation at this time. There was no explanation of what actions would be taken with my mother regarding her care. I was subsequently horrified when I received my mother's medical file to see a note written by Beed suggesting that I had agreed to a syringe driver for my mother and that active treatment was not appropriate. This conversation NEVER took place and I am appalled that an outright lie has been written into my mother's medical file and I would like an explanation for Phillip Beed's actions. When I received my mother's medical file I was surprised to see the note from Phillip Beed suggesting that my mother was dying as there is no corresponding note from a doctor. I do not believe that it is the responsibility of

nursing staff to decide whether or not a patient is dying or that active treatment was not appropriate. Who made this decision?

Whilst visiting on August 20th I noticed that my mother appeared to be in pain. When I mentioned this to the nursing staff they were dismissive and said that they could see no evidence of this. I had to ask twice and waited for over an hour for Phillip Beed to come and see me. He did not examine my mother at this stage and did nothing to ascertain the level of pain she was in, but he did say that he would arrange for some pain relief that would make her sleepy. I left the hospital at 13:55 and at this point nothing had been done to alleviate my mother's discomfort despite the fact that her notes state she was placed on a syringe driver at 13:50. I had not left the hospital at this time so where does this discrepancy come from? I telephone my daughter as I was very concerned about my mother and asked her to go to the hospital to find out what was happening. When my daughter arrived, the nurse said to her in a very rude manner "your mother **SEEMS** to think that your grandmother is in pain". What sort of care is this? By the time I returned to the hospital at eight o'clock that evening my mother had been placed on a syringe driver administering Diamorphine drugs into her system. She was already unconscious and never regained it. She died the next evening. Why did the nursing staff not do any examination or summon a doctor to my mother? There is no note on the medical file to say that she had been assessed by any of the nursing staff or any doctor. How did it get from the nursing staff appearing unaware of my mother being in pain to being unconscious as a result of the Diamorphine?

I have many questions that have never been answered regarding this. Why was my mother placed on Diamorphine via a syringe driver, when only that afternoon, the nursing staff appeared unaware and unconcerned that she was in any pain? Why were other drugs not tried first to relieve her discomfort and why was the Diamorphine administered in 30mg quantities? I believe that 5 to 10 mg's would be a normal dosage and why did the nursing staff not query this level of drug?. I cannot understand why Diamorphine was used when no other drugs had been tried first. Why was no investigation done to find out where my mother's pain was and the cause of it. I suggest that it could have been a simple problem that could have been resolved with less severe pain relief.

I was persuaded to go home for some food and a change of clothes late in the afternoon of the 21st. I expressed my concern about leaving her to Phillip Beed as I did not wish for her to be alone. I was assured by Beed that should any change take place then he would contact us immediately. However, when I returned a short while later Phillip Beed entered my mother's room in front of us and told us that she had just died. However, I do not believe that she died upon our return, but I believe that she died alone and had not been monitored in our absence. Phillip Beed tried to tell us that my mother had waited until she heard our voices before passing away, however, it was quite obvious that she had died much earlier than this. My mother's records state that her daughter and granddaughter were present, but I dispute this. I would like for Phillip Beed to explain why a patient was left for that amount of time without being monitored.

I am appalled by the state of my mother's medical file. The file in itself appears to be incomplete and the details contained within it are sadly lacking to say the least. Apart

from the 'alleged' conversation where I agreed to a syringe driver, which I repeat did NOT take place, I also have a number of other concerns. There appears to be a mix up on the records of my mother and another patient Mrs Gladys Richards. A note stating that my mother was given Oromorph was crossed out with a note saying that this was written on the wrong notes. Was this drug given to my mother in error? And how did the notes come to be mixed up in the first place? Also, the time of death on my mother's files says 18:30 and 21:20. How can she die twice? After speaking with Gladys Richard's daughter she has confirmed that the 21:20 time is when her own mother passed away. The notes had obviously been mixed up yet again (days after the last time) and I would have expected a nurse such as Sylvia Roberts, who wrote the incorrect times on the file, should have known better after 25 years of experience in Nursing. This is gross incompetence on behalf of the nursing staff and the nurses concerned should be accountable for their actions. The notes themselves are incomplete and there are whole days when nothing is written on them and there is no record of what, if anything, she was given to eat or drink. I would expect that if she had a UTI, was catheterised and dehydrated then there should be a note of both her intake and her urinary output. There was a note on her file to say that her catheter bag was emptied on 21st August but no note to say that it was full of blood which both my daughter and myself had noticed. I wonder why this was not done? Just what sort of care did my mother receive when she was in the Gosport War Memorial Hospital. It was neglectful and uncaring to say the very least.

I believe that my mother died as a direct result of the drugs given to her and the abuse she received from the nursing staff in relation to their appalling lack of any sort of care. She did not even get basic care and the nursing staffs couldn't care less attitude is shocking. I will not rest until the nursing staff are held accountable for their actions and changes are made to ensure that this never happens again.

I look forward to hearing from you shortly.

Yours sincerely

Mrs M Jackson