FTPFRONTSHEET

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Code A

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<u>**Private and confidential**</u>
Emma Kelly-Dempster, Good Practice
Officer

Dear Ms Kelly-Dempster

Complaint from Ms Mackenzie about the handling of her fitness to practise case (Gosport War Memorial Hospital Case)

Thank you for you letter of 21 June 2010.

It should be noted that Gillian Mackenzie has never submitted a complaint to the Nursing and Midwifery Council (NMC) or the United Kingdom Central Council for Nursing and Midwifery (UKCC). On 18 September 2001, however, the UKCC's Preliminary Proceedings Committee (PPC) considered the care provided to Mrs Mackenzie's mother, Gladys Richards, following correspondence received from Hampshire Constabulary. The case file no longer exists, but a set of the papers from that meeting was retained.

Preliminary Proceedings Committee, 18 September 2001

No specific complaint was made by Hampshire Constabulary regarding the conduct of any registered nurse, but three nurses were named within the correspondence as having been the subject of interview.

The PPC considered the following supporting information:

- Copy correspondence from Hampshire Constabulary and a copy of Mrs Mackezie's police statement and that of her sister, Lesley Lack (now O'Brien);

- Copy correspondence and supporting documentation from Portsmouth HealthCare NHS Trust. This includes copy correspondence between Mrs Lack and the Trust; the Trust's investigation report and copy correspondence between the Trust and the police. The Trust makes the observation that Mrs Richards family did not pursue any complaint throught the NHS complaints procedure;

- A copy of Mrs Richards' notes.

dislocation of her hip she was returned to Haslar Hospital on 14 August 1998. She went back to Gosport War Memorial Hospital on 17 August 1998. A heametoma developed at the site of the manipulation and she died in hospital on 21 August 1998.

Family concerns

The family's concerns are outlined in Mrs Lack's statement to the police and also in the correspondence with Portsmouth Healthcare NHS Trust. The main ones are as follows:

1. On 12 August when first admitted to Gosport her agitation was put down to dementia when in fact it could have been simply that she wanted the toilet. She could have been treated with a milder form of pain relief.

2. When she suffered her fall a doctor should have been called before she was moved back to her chair.

3. On 13 August it took a long time for staff to identify that she had suffered a fall. Her distress was continually put down to her dementia and she was not admitted to Haslar A and E until 24 hours after the fall.

4. On 17 August when she was returned to Haslar Hospital she was obviously in extreme pain from being positioned wrongly. Why was nothing done about this until Mrs Lack arrived and assisted the nurse to move her.

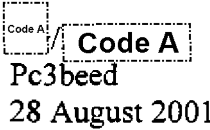
5. When Mrs Richards developed a haemetoma why was a decision made to do nothing other than to keep her pain free.

Outcome of investigations

The police have now informed the UKCC that there is no sufficient evidence to support a prosecution of any of the three practitioners. Neither are the police taking any action against Dr Barton.

The trust have provided information relating to their investigation conducted in 1998. They found no evidence of misconduct by any nurse.

The trust found that when Mrs Richards fell on 13 August 1998 there were no witnesses. A HCSW found her and called the trained nurse on duty, Staff Nurse Brewer. She checked her for injuries before transferring her to a different chair. She did not consider it necessary to call a doctor. However later in the evening Staff Nurse Brewer transferred Mrs Richards to bed she notice the angle of her hip and called the duty doctor. In the meantime Mrs Lack had advised staff that she did not consider her to be in pain. A decision was taken to wait until morning to transfer to Haslar Hospital as a transfer at night would be disturbing for the patient.



Pc3beed
28 August 2001

On 17 August when she was transferred back to Gosport War Memorial Hospital two HCSWs transferred Mrs Richard to bed. One of them noted the position of her leg and that she was in pain. As she was not qualified she went to get the qualified nurse, Margaret Code A. Nurse Code A arrived at the same time as Mrs Lack and they assisted her together.

The decisions about the quantity of pain relief and the decision not to treat Mrs Richards after she developed the haemetoma were medical ones. The Trust found that at no time had the nursing staff administered anything but the prescribed minimum of morphine.

Possible allegations

No specific allegations have been made against the three practitioners, however, a review of the documentation suggests that there could be the following concerns by the family against each nurse.

Philip Beed

1. Co-operated with inappropriate management of Mrs R's care by Dr Barton.
2. Inadequate care plan/nursing notes.
3. Failed to tell family that Mrs Richards was inappropriately transferred (no direct evidence she was)

Margaret Couchman

1. Failed to attend to Mrs Richards when she was in pain on 17 August 1998.

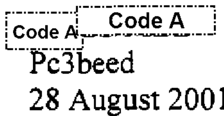
Christine Joice

1. Failed to take action when Mrs Richards appeared to be drowsy on 12 August 1998 and misinterpreted her anxiety as due to dementia.

The following documents are attached:

1. Documents provided by the Trust. D200 - 234
2. Documents provided by Police. - D1 - 51
3. Mrs Richard's notes. D52 - 199

Reasons for no action



Pc3beed
28 August 2001

- The police are not proceedings with any criminal prosecution of any practitioner.

- The Trust's findings do not support any allegations of misconduct.

- The family's complaints are mainly about the medical treatment received by Mrs Richards, although they have identified some mistakes and delays in the system their evidence does not provide proof to the required standard of professional misconduct by any practitioner.

Code A/ Code A
Pc3beed
28 August 2001

Section D, page 1

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

DIRECTOR OF PROFESSIONAL CONDUCT
RECEIVED ON
ACTION

Police Headquarters
West Hill
Romsey Road
Winchester
Hampshire
SO22 5DB

Our Ref. : Op Rochester

Your Ref. : H/Liz/I Code A

Tel. :
Direct Dial : Code A
Fax. :

18 May 2001

Liz McANULTY
Director of Professional Conduct
UKCC
23 Portland Place
London
W1N 4JT

In Confidence

Dear Liz

Your letter of 15th May 2001 is acknowledged and Mike Woodford our Force Solicitor will be responding.

In the meantime, given the fact that recent events may lead us to widen the investigation, it would be prudent to advise you now , in the strictest confidence please, that other members of the nursing staff at Gosport War Memorial Hospital have been interviewed and may be further interviewed in the future.

You will have noticed in Professor Livesley's report that he has also commented in respect of Staff Nurse Code A and Registered General Nurse Code A and has expressed his view that there may be a measure of criminal culpability.

I would be grateful if you would note the above, and indicate whether the UKCC has any record of the below-named, advising us if either of them has been the subject of complaint or investigation by yourselves in respect of any matter relevant to the issues raised in our current enquiry:

HAMPSHIRE Constabulary

- Staff Nurse Code A
- General Registered Nurse Code A

An early initial response would be appreciated by 14.00 hours on Monday 21st May 2001 if at all possible.

Yours sincerely,

Code A

Ray BURT
Detective Chief Inpector

D3 - 53

MG11(T)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of : **Lesley Frances LACK**

Age if under 18 : **Over 18yrs** (if over 18 insert 'over 18')

Occupation : **Retired**

This statement (consisting of 20 pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature : Code A **Dated the** 31. January 2000

I am the natural daughter of Gladys Mable RICHARDS (Nee BEECH) Code A Code A

My mother died on the 21st August 1998 whilst she was an admitted patient at the Gosport War Memorial Hospital.

I am a retired Registered General Nurse (RGN). I retired during 1996 after 41 years, continuously, in the nursing profession. For 25 years, prior to my retirement, I was involved in the care of elderly people. For 20 years, prior to my retirement, I held supervisory and managerial positions in this particular field of nursing.

My mother was a resident in two nursing homes from 1991 or thereabouts. The first was located in the Basingstoke area and the most recent was the 'Glen Heathers' Nursing and Residential Home, Milvil Road, Lee on Solent, Hampshire. My mother spent approximately four years at the Glen Heathers' Home. On admission to Glen Heathers my mother was ambulant - able to go up and down stairs and walk well.

She was generally well, physically, but had the onset of dementia and became increasingly forgetful. At the beginning of 1998 my mother's dementia was becoming more marked and she had become less able physically. She was inclined to wander and following a change in her medication began to have falls.

However, despite this my mother was able to stand, walk and attend the toilet. I used to take her out for trips in my car. Her last visit to my home occurred during Christmas 1997.

My mother left the 'Glen Heathers' Home on the 29th July 1998 and was admitted to the Haslar Hospital, Gosport.

Code A Code A

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

DH

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ontinuation of Statement of : **Lesley Frances LACK**

y mother had suffered a fall, at the Home, at approximately 1450 hours during the afternoon of at day. She was eventually taken to Haslar Hospital, by ambulance, at approximately 2100 urs that evening where she was diagnosed as having broken a neck of femur on her right side.

hilst it may not have a direct bearing on my main concerns surrounding my mother's death, nich I will describe later in this statement, I would like to point out that I did have serious servations as regards the standard of care which my mother was receiving whilst residing at the len Heathers' Home.

act, following my mother's admission to the Haslar Hospital on the 29th July 1998, I had ecided that, if and when my mother recovered, she would not be returning to the 'Glen Heathers' ome.

vas asked by the Social Services Department why I had made this decision and, in response, I epared and provided a hand-written account describing what I considered to be a catalogue of acceptable events which had led me to conclude that the level of care which my mother was ceiving at the 'Glen Heathers' Home was no longer acceptable to me.

ne hand-written account was prepared, by me, during August 1998 and I consider that it presented a truthful statement which dealt with various events and circumstances which I had served or had become aware of during the months which preceded my mother's admission to e Haslar Hospital.

vill not, for the purposes of this statement, refer in detail to the matters described in that account l will, by way of introducing the events which followed, make some brief references, drawing n my personal recollections and my notes, to my involvement in the events leading to my other's admission to the Haslar Hospital on Wednesday the 29th July 1998.

vas a frequent and regular visitor to the 'Glen Heathers' Home whilst my mother was residing ere and I played an active role in helping her in her daily routines. My visits were generally aily in the last 8 months of her life.

ecall that I was unable to get to the 'Glen Heathers' Home at lunchtime on Wednesday the 29th ly 1998. I telephoned the Home to inform them that I would be going there later in the ternoon.

hen I arrived, at approximately 1550 hours, I saw that my mother was lying in an armchair. She peared to have an anxious expression on her face. I asked a care assistant to help me to move y mother into a more comfortable sitting position which, together, we tried to do but, as a result, y mother screamed out in pain.

Code A | Code A

gned : L. F. LACK | Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D5

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I saw John PERKINS, an RGN and the Home's Matron/Manager, and I asked him if there was anything wrong with my mother which might account for her pain. He told me that she was fine.

I clearly knew that this could not be the case but I was not in a position to do anything more at that time. I had to leave the Home at 1615 hours in order to meet a flight at Southampton Airport. I said that I would return later.

I arrived home, from the Airport, at approximately 1810 hours. I found a message on my ,ephone answer machine, timed at 1528 hours, from a woman I knew as Margaret who was an RGN who worked at the Home. Margaret stated that my mother had experienced a fall earlier and, whilst she was alright, she was a bit noisy and upset. Margaret asked if I could attend the Home, before teatime, and sit with her, to calm her down.

I immediately telephoned the Home, at approximately 1815 hours, and spoke to John PERKINS. I told him about the message from Margaret and pointed out that I had seen him, at the Home, after the message had been left on my answer machine.

John PERKINS agreed that this was the case but stated that when he had spoken to me he was not aware of my mother's fall. He stated that he had learned about it during the 1800 hours 'hand over' process when Margaret had gone off duty.

I asked John about my mother's current condition and he said that she was OK. I told John that I would call again later. I had to go out in the meantime.

,returned home at approximately 2030 hours. I found three messages from the Home on my telephone answer machine:

1) 2008 hours - from John PERKINS - stating that my mother was quite agitated and noisy and inviting me to attend and sit with her.

2) 2029 hours - stating that my mother was calling as if she may be in pain. She had been put to bed and consideration was being given to calling a doctor.

3) 2030 hours (approximately) - from a woman named Sue, a member of the night staff - stating that she was sorry but she was sure that my mother had a fractured femur. She went on to state that when she had started work she had been told, by John, to see my mother who had been shouting for ages. Sue stated that when she did so the injury appeared obvious and, as a result, she had called an ambulance.

Code A Code A

Signed : L. F. LACK Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

D6

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ntinuation of Statement of : **Lesley Frances LACK**

elephoned the Home and advised the staff that I would meet the ambulance at the Haslar ıspital.

ı admission to the Haslar Hospital my mother was 'x' rayed and the diagnosis was confirmed. ırthermore, it was observed that the injury was consistent with my mother having been 'walked' er the fall had occurred. There was a shortening of the limb and an external rotation of the right ɔt. My mother was extremely upset and was crying and wailing in fear.
ubsequently sought a full explanation from the 'Glen Heathers' Home about the events which ırred on the 29th July 1998. As a result I saw a woman named Pauline, an RGN and ısultant/advisor to the Home.

ıuline read to me from several statements which had been obtained from members of staff at ə Home. I was not given copies.

ıring this process I was advised that my mother had fallen at 1450 hours in the dining room.

ıe statements read to me, by Pauline, indicated that my mother had been walked to the lounge, some time after the fall had occurred, and, at some time thereafter, walked to the bedroom ım the lounge.

ıe statements confirmed the following key points:

1) The fall had occurred at 1450 hours.

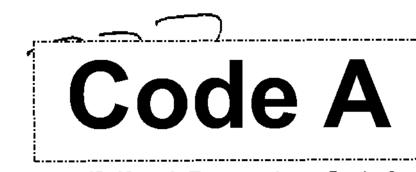
2) The serious injury which had apparently been sustained during this fall was not identified or even suspected by the staff despite my mother clearly showing signs of being in considerable and sustained pain.

3) My mother was walked on two occasions after apparently sustaining the injury which appears to have seriously aggravated her condition.

4) A doctor was not called to the Home.

5) My mother's condition was not effectively identified until a member of the night staff correctly diagnosed the likely cause of her severe discomfort and pain at or about 2030 hours when an ambulance was called to the Home and she was taken to the Haslar Hospital.

Code A



ɡned : L. F. LACK Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

D7

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I can produce a copy of the hand-written notes which I prepared. These notes have attached to them a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/1.

Following her admission to the Haslar Hospital, at approximately 2100 hours on Wednesday the 29th July 1998, my mother underwent a surgical operation. This was carried out during the following day, Thursday the 30th July 1998, following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.

My mother received a replacement hip, on her right side, and remained in the Haslar Hospital for a further eleven days until Tuesday the 11th August 1998.

I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.

Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.

She was, with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.

Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.

Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.

I will now deal with the matters which arose during the following ten days culminating in my mother's death on Friday the 21st August 1998.

In doing so I will draw upon my personal recollections and also refer to a further set of hand-written notes which I prepared, whilst sitting at my mothers bedside, while she was still alive with my sister Gillian MACKENZIE, as I was unhappy with the events that had befallen my mother.

Code A | Code A

Signed : L. F. LACK | Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D8

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ontinuation of Statement of : **Lesley Frances LACK**

elephoned the Complaints Department at Portsmouth Health Care Trust on Wednesday 19th ugust from Daedulus ward and spoke to Lesley HUMPHREY in depth. Having listened, she dvised me that everything must be in writing. I continued adding to my notes - hence the use of fferent pens. I prepared these notes on the advice of Lesley HUMPHREY, the Quality Manager r the Portsmouth Health Care Trust, to whom I expressed my serious concerns about the care nd treatment given to my mother by staff at the Gosport War Memorial Hospital.

ne hand-written notes, a copy of which I passed to Lesley HUMPHREY, are in the form of a ic chronology and I incorporated within them a series of questions which focused on particular eas of concern in respect of which I sought an explanation or clarification from the hospital uthorities. Following presentation of my notes we were visited on the ward by Mrs Sue UTCHINGS on 20.8.98.

produce the original hand-written notes which I prepared comprising of 5 numbered pages. nese notes have attached to them a Hampshire Constabulary exhibit label which I have signed nd which bears the reference LFL/2.

am in possession of a further page of notes, in my hand-writing, which I prepared at the time. I annot now recall whether this additional page was copied to Mrs HUMPHREY with the other ages. This single page has attached to it a Hampshire Constabulary Exhibit Label bearing the eference LFL/2A which I have signed.

any of the events and occasions I refer to in this statement took place in the presence of my ster Gillian Mackenzie. The addition to the notes were made when my sister and I read them r to passing them to Lesley HUMPHREY as requested. Gillian remained at the hospital with e from 18th to 21st August 1998 inclusive, either of us leaving for very short periods only.

visited my mother the day of her admission and discussed her present condition with the staff nd on the following day after her admission to the Gosport War Memorial Hospital, namely ednesday the 12th August 1998, I was rather surprised to discover that I could not rouse her. s she was unrousable she could not take nourishment or be kept hydrated.

enquired among the staff and I was told that my mother had been given the morphine based ug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the aslar Hospital, the day before, she had not required pain relief for several days.

was distressed to observe my mother's deteriorated condition which significantly contrasted with e level of recovery which had been achieved following treatment at the Haslar Hospital during e period after the surgical operation to replace her hip.

Code A

Code A

gned : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D9

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate a possible cause. I consider it likely that she was in need of the toilet.

I became concerned that perhaps the staff at the Gosport War Memorial Hospital may have misinterpreted my mother's anxious and occasionally noisy behaviour. She had been showing signs of dementia for some time, prior to her admission to the Haslar Hospital, and she was prone to becoming very anxious at times particularly when she wanted to use the toilet.

One of the consequences of being rendered unrousable, by the effects of 'Oramorph, was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.

I would like to clarify an important concern I felt at this stage.

I believed that it was possible, having regard to the level of recovery which my mother had achieved upon being discharged from the Haslar Hospital the day before, that her reported behaviour could have been wrongly attributed to the presence of pain as opposed to other possible causes, such as anxiety, which could have been addressed naturally or by the use of alternative and milder forms of medication. I believe that the possible misinterpretation of my mother's behaviour is a particularly significant factor in this case.

In the circumstances which I have just described I consider that it is possible that my mother's signs of anxiety could have been misinterpreted for pain whereas, subsequently, it appears likely that the fact that my mother, after having fallen, and was clearly showing signs of being in pain, these signs were either ignored or dismissed as being the result of her dementia.

During the following day, Thursday the 13th August 1998, I received a telephone call, at approximately 1400 hours, from my daughter, Karen READ, who is a qualified nurse. As a result I went to the Gosport War Memorial Hospital to see my mother.

I arrived at the Gosport War Memorial Hospital at approximately 1545 - 1600 hours. I immediately saw that my mother appeared to be uncomfortable and in pain. She had an anxious expression, was weeping and was calling out. She was sitting in a chair and appeared grossly uncomfortable.

I spoke to several trained and untrained members of staff expressing my concern over my mother's condition. I was told that there was nothing wrong and that her behaviour was the result of her dementia. I was not satisfied with this explanation and I was convinced that my mother was in pain.

Code A | Code A

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D10

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ontinuation of Statement of : **Lesley Frances LACK**

ater, at approximately 1630 - 1700 hours, a care assistant came into my mother's room. She told e that my mother had fallen from a chair earlier that day.

mmediately enquired if my mother had been examined by a doctor but the care assistant did not iow. I also asked if my mother could be x-rayed but I do not recall receiving a response to this quest. I was able to give my mother a fruit drink which I had brought with me and she drank it adily. The whole glass.

ittle later I saw an RGN who was doing the medicine round at approximately 1730 - 1800 urs. I was, at this time, feeding my mother by tea spooning her with some soup. My mother was uiet then.

ne RGN asked me, " Do you think your mother is in pain?" In reply I expressed the view, "Not at e moment while I'm feeding her." I was rather taken aback by the RGN's rather curt reply, "Well ou said she was in pain". I replied, "Yes, she has been very uncomfortable since I got here. Do ou think she has done some damage?" The RGN replied, "No, she only fell on her bottom from er chair". I was shocked by this seemingly casual and insensitive remark - when this accident ould very easily have caused damage and had not been checked.

emained with my mother until approximately 1945 hours that evening (Thursday the 13th August 998). After I had fed her she once again became distressed and showed signs of being in onsiderable pain. She remained in this condition, throughout, until my departure. I left very istressed as my mother was crying out and I could do nothing for her.

er I arrived home I received a telephone call from Daedalus Ward at the Gosport War emorial Hospital. The caller stated that, "When we put your mother to bed she was in great pain nd she may have 'done something'. The doctor feels it's too late to send her to Haslar and our x-ay unit is closed. We will give her 'Oramorph' for the night to keep her pain free and x-ray her in e morning".

was becoming extremely concerned about what was happening to my mother.

appeared, to me, at that time, that my mother had suffered a potentially serious fall at some me prior to my daughter's telephone call, to me, at approximately 1400 hours. I have, earlier in is account, referred to conversations which I had, during the afternoon and early evening, with vo members of staff who both knew about, and referred to, the fall.

espite the fact that my elderly mother was known to have suffered a fall, so soon after a hip peration, and then so clearly showed signs of anxiety, discomfort and pain, the reason was not roperly explored and diagnosed.

Code A | Code A

igned : L. F. LACK | Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D11

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

This, in fact, resulted in what I believe was an avoidable delay of eight hours, in the first instance, before it was acknowledged, at approximately 2130 hours, that my mother, "may have done something".

I reiterate that I was, at that time, advised that the proper facilities (x-ray unit) for diagnosing my mother's condition, at the Gosport War Memorial Hospital, "were closed" and that the doctor, "feels it is too late to send her to Haslar".

Instead, my mother was given 'Oramorph' for pain relief and remained, effectively untreated, at the Gosport War Memorial Hospital overnight.

I strongly believe that the failure, on the part of the staff at the Gosport War Memorial Hospital, to properly and promptly take steps to accurately diagnose my mother's condition, on Thursday the 13th August 1998, and immediately initiate action to effectively deal with the cause by seeking a transfer to the Haslar Hospital where treatment was available, represented an example of a pattern of omission and failure which, ultimately, contributed in her death.

The following morning, Friday the 14th August 1998, I went to the Gosport War Memorial Hospital. I arrived as my mother was being taken, on a trolley, to the x-ray department. She was still deeply under the effects of the 'Oramorph' drug. I accompanied my mother whilst she underwent the x-ray process the associated movements of which caused her great pain.

When the x-ray process was completed we returned to my mother's ward and I was called into an office by Code A the Ward Manager, where I also saw Dr BARTON. I was told, "Your worst fears of last night appear to be true, we have rung Haslar and they have accepted her back".

My mother was admitted to the Haslar Hospital, for the second time, during the late morning of Friday the 14th August 1998. I accompanied my mother and she was expected. The Consultant was called and he saw my mother in the Casualty Department immediately.

The Consultant showed me the x-rays and the position of my mother's limb, something else which I had observed, the day before, at the Gosport War Memorial Hospital.

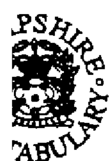
My mother's right hip, which had been the subject of a surgical 'replacement' operation 14 days previously, had become dislocated from its socket. Within one hour of being admitted my mother underwent a successful surgical operation to manipulate the hip back into the socket.

This did, indeed, confirm my fears about the care my mother had received. She had fallen, whilst at the Gosport War Memorial Hospital, and it had taken almost 24 hours to secure effective treatment.

Code A | Code A

Signed : L. F. LACK | Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

D12



MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ontinuation of Statement of : **Lesley Frances LACK**

emained at the hospital until approximately 10pm.

y mother did not regain consciousness until approximately 0100 hours on Saturday the 15th ugust 1998 due to the amount of analgesia required for the procedure. I telephoned the ward at is time as I was anxious. The night staff told me she had just regained consciousness.
ne was the catheterised so that there was no need to use a slipper pan. She had a drip as she ad been given nil by mouth since before the x-ray procedure carried out on Friday the 14th ugust 1998.

remained pain free, in a full length leg splint. The Consultant showed me that both legs were vel and straight. No analgesia was required and she was able to use a commode for the toilet th weight bare for transfer. My mother began to eat and drink and the drip was removed. Her uid balance was acceptable. I visited daily.

uch was my mother's progress that during the following day, Sunday the 16th August 1998, she ecame easily manageable.

ne issue I wish to highlight, at this point, is that when my mother's condition was correctly agnosed and treated her pain and discomfort were removed and she recovered well.

y mother was examined early on Monday the 17th August 1998 when a transfer back to the osport War Memorial Hospital was recommended. I contacted the Haslar Hospital by telephone approximately 0830 hours as requested and was told that my mother would be transferred that orning.

offered to attend the Haslar Hospital so that I could pack my mother's things and accompany her ut I was told that there was, "No need, she is fine".

arrived at the Gosport War Memorial Hospital at approximately 1045 hours with Gillian ACKENZIE and we were told that the ambulance, carrying my mother, was due at midday or ereabouts.

/e returned to the Gosport War Memorial Hospital at approximately 1215 hours.

n entering through the swing doors to the ward I heard my mother screaming. When I arrived at y mother's room a care assistant said, "You try feeding her. I can't do it. She is screaming all ie time".

y mother had a staring anxious expression. She was griping her right thigh, at the sight of the urgical operation, tigh

Code A Code A

gned : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D13

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

She uttered the words, "Do something, do something. The pain, the pain. Don't just stand there. I don't understand it. The pain, the pain, the pain. Sharp, sharp. This is some adventure". Gillian MACKENZIE was present.

An SRN came into the room because of the noise my mother was making. I removed the sheet covering my mother as she lay on her bed and pointed out the awful position she was in. She was lying awkwardly towards the left side and the hips were uneven.

My mother was crying in pain and I said to the RGN, "Can we please move her." We moved her together with our arms together under her lower back and our other arms under her thighs. We placed her squarely on her buttocks and within minutes she had stopped screaming.

I was concerned that my mother's position had not, apparently, been checked when she had been transferred from the ambulance. I was also concerned about the fact that, once again, the source of the pain had not, immediately, been sought.

I left my sister, at the Gosport War Memorial Hospital, at around this time and I went to the Haslar Hospital. This would have been about lunchtime.

I was so appalled at my mother's condition, discomfort and severe pain that I went to the ward in which she had been treated, E3, and enquired about her condition upon discharge earlier that morning.

When I had, earlier that day, telephoned E3 ward and I had been further advised that my mother was eating, drinking, using a commode and able to stand if aided. The Consultant responsible for my mother was, I was told, happy that she could be sent back to the Gosport War Memorial Hospital.

It is, perhaps, worthwhile re-emphasising that this was the level of recovery my mother had achieved on the morning of Monday the 17th August 1998 prior to being discharged from the Haslar Hospital. Whilst she was an elderly and frail lady she was not suffering with a fatal illness. Her discharge notes from Haslar refer to her care for the next 4 weeks, to ensure her progress was maintained.

Upon leaving Haslar Hospital's E3 ward, after confirming the information I had earlier been given, I met the Doctor who had been present in the Casualty Theatre at the time of my mother's second operation which took place on Friday the 14th August 1998. This Doctor had been with the Consultant when all the procedures were explained to me, upon my mother's admission, that day. The Doctor asked, "How's your mother?"

Code A | Code A

Signed : L. F. LACK | Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

D14

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ontinuation of Statement of : **Lesley Frances LACK**

explained the current position to him in detail. I told him that she was in severe pain since the ansfer which had been undertaken a short time earlier. He said, "We've had no referral. Get iem to refer her back. We'll see her."

then returned to the Gosport War Memorial Hospital where I noted that the Charge Nurse anager frequently checked my mother. He acknowledged my concern and the fact that my other was obviously in pain.
asked for my mother to be x-rayed and enquired what had happened between my mother having the Haslar Hospital and her arrival at the Gosport War Memorial Hospital.

was acknowledged that "something" had happened. The Charge Nurse was concerned for my iother's pain and analgesia was given three times between her admission and 1800 hours.

Code A the Ward Manager, agreed that my mother needed an x-ray to establish if further damage ad been done to the hip.

he x-ray department refused to act upon forms of authority prepared and signed on behalf of the octor who was unavailable.

n appointment for x-ray was made for 1545 hours as the Doctor who had been called was xpected at approximately 1515 hours.

he Charge Nurse did all he could to expedite this, keeping me informed and constantly checking iy mother's obvious severe pain. He administered pain relief in readiness for the x-ray cedure. He was courteous and attentive at all times.

r BARTON arrived and I left the room as requested whilst she examined my mother. She stated iat whilst she did not think that there was further dislocation the x-ray could go ahead. A review ould be conducted later when the result of the x-ray was known.

accompanied my mother to the x-ray department. My mother remained in pain despite the pain elief which had been administered to her. I was not allowed to accompany her as I had been the revious week . Whilst I waited outside I could hear my mother wailing, while the x-ray was taken.

i due course I returned to the ward and I was told that there was no dislocation but obviously omething' had happened. I was not given sight of the x-ray.

Code A | Code A

igned : L. F. LACK | Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D15

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I was told, by either the Ward Manager or Doctor BARTON, that my mother would be given 'Oramorph' for the pain, four hourly, through the night and she would be reviewed in the morning. I told them that Haslar would accept her back but Dr BARTON felt that was inappropriate.

I told Dr BARTON and the Ward Manager that I had been to the Haslar Hospital that morning, explained what was happening, and told them that Haslar would be prepared to re-admit my mother. I considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.

Dr BARTON said that, "It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery."

The following day, Tuesday the 18th August 1998, I returned to the Gosport War Memorial Hospital with my sister in the morning. Upon arrival we were told by, the Ward Manager Code A Code A that whilst my mother had undergone a peaceful night she had, however, developed a massive heamatoma in the vicinity of the operation site which was causing her severe pain.

The plan of management, as explained to us by the Ward Manager, was to use a syringe driver to ensure my mother was pain free at all times so that she would not suffer when washed, moved or changed in the event she should she become incontinent.

The outcome of the use of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I knew that the continuous use of morphine, as a means of relieving her pain, could result in her death. She was, at that time, unconscious from the effects of previous doses of 'Oramorph' and therefore unable to take nourishment by mouth. It was my understanding that it would not have been possible for nourishment to have been given to my mother, by way of a drip, whilst she remained at the Gosport War Memorial Hospital.

As a result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, " Are we talking about euthanasia? It's illegal in this country you know." The Ward Manager replied, "Goodness, no, of course not." I was upset and said, "Just let her be pain free".

The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998.

A little later Dr BARTON appeared and confirmed that a haemetoma was present and that this was the kindest way to treat my mother. She also stated, "And the next thing will be a chest infection."

Code A | Code A

Signed : L. F. LACK | Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D16

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ontinuation of Statement of : **Lesley Frances LACK**

considered that this was a totally insensitive remark to make to someone, such as myself, who as experiencing some of the feelings associated with the first stages of bereavement.

would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a iestion, in my mind, of 'agreement'.

wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would ctively prevent steps being taken to facilitate her recovery and would result in her death.

also wanted my mother to be transferred back to the Haslar Hospital where she had, on two ccasions, undergone operations and recovered well. My mother was not, I knew, terminally ill nd, with hindsight, perhaps I should have challenged Dr BARTON more strongly on this issue.

i my severe distress I did not but I do believe that my failure to pursue the point more vigorously iould not have prevented Dr BARTON from initiating an alternative course of action to that hich was taken, namely a referral back to the Haslar Hospital where my mother's condition ould have been treated and from where an offer had already been made to do so.

accept that my mother was unwell and that her physical reserves had been depleted. However ie had, during the preceding days and weeks, demonstrated great courage and strength. I elieve that she should have been given a further chance of recovery especially in the light of the ict that her condition had, it would seem likely, been aggravated by poor quality service and voidable delay experienced whilst in the hands of those whose responsibly it was to care for her.

ly mother's bodily strength allowed her to survive a further 4 days using her reserves. She iffered kidney failure on the 19th August and no further urine was passed. The same catheter ag remained in place until her death.

ecause the syringe driver was deemed to be essential following the night of several doses of ain relief my mother's condition gradually deteriorated during the next few days, as I knew it ievitably would, and she died on Friday the 21st August 1998.

passed, as I have previously mentioned, a copy of the notes I had prepared (LFL/2) to Mrs UMPHREY.

i reply I received a letter from Max MILLETT, the Chief Executive of the Portsmouth Health Care HS Trust, dated the 22nd September 1998.

Code A

Code A

igned : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D17

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I can produce a copy of this letter which has, attached to it, a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/3.

Whilst there are a number of issues which cause me concern I would like to make some particular comments on the contents of this letter.

In order to do this I have been provided, by DCI BURT, with a typed copy of the letter (LFL/3). This copy, to which is now attached a Hampshire Constabulary Exhibit Label bearing the reference LFL/3A and signed by me, was constructed to enable me to add hand-written comments which I have done. I feel, however, that I should point out that where I have chosen not to record such a comment this does not imply that I necessarily agree with, or accept, what has been stated.

I have been shown, by DCI BURT, a copy of an Enquiry Report which has attached to it a Hampshire Constabulary Exhibit Label bearing the reference LH/4 which I have signed.

I have been provided, by DCI BURT, with a typed copy of this Enquiry Report (LH/4). The copy, to which is now attached a Hampshire Constabulary Exhibit Label bearing the reference LFL/4 and signed by me, was constructed to enable me to add hand-written comments which I have done. I, once again, point out that where I have chosen not to comment on a particular reply or issue this does not imply that I necessarily agree with, or accept, what has been stated.

I have had sight of a Report, prepared by Dr LORD and dated the 22nd December 1998, which has attached to it a Hampshire Constabulary Exhibit Label bearing the reference LH/6 and signed by me.

If this Report is supposed to represent an independent assessment of the treatment which my mother received at the Gosport War Memorial Hospital then I find this difficult to accept.

Dr LORD was the Consultant for Daedalus Ward at the Gosport War Memorial Hospital but, in her own words, "....did not attend to Mrs RICHARDS at all....".

Dr LORD's Report appears to have been prepared by reference, some time after the event, to information, notes and documents supplied by colleagues with whom she worked on a regular basis.

I have been shown, by DCI BURT, a Portsmouth Health Care NHS Trust Risk Event Record. Attached to this document is a Hampshire Constabulary Exhibit Label bearing the reference LH/2 which I have signed.

Code A | Code A

Signed : L. F. LACK | Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D18

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ontinuation of Statement of : **Lesley Frances LACK**

ˀave examined this document, which comprises of 3 sides of paper, and I would like to make the ıllowing observations.

ņ page 1, at 12 (a) after the words 'Seen by?' there is a hand-written entry, "Dr BRIGG".

believe that this contradicts information contained in the letter from the Portsmouth Healthcare rust (LFL/3) dated 22nd September 1998 where, at point (4), it states that Dr BARTON was resent on the ward just after my mother's fall.

urthermore, at 12 (a), there is a further hand-written entry which states, "Advised by telephone - nalgesia & RV mane". This may be cross referred to an entry in my mother's Health Care ecord (LH/1/C/21) which is dated 13.8.98 and timed at 1300.

t 12 (b) it states, in reply to the question, "Has next of kin been informed? The corresponding 'es" has been positively ticked and dated 13/8/98. Furthermore it states that I had been ıformed by telephone.

was not informed and I was not telephoned. My statement shows I was on the ward and had reat difficulty in finding anyone to confirm my mother was injured.

is my opinion that the Risk Event Record is incorrect. My mother was not seen by Dr BRIGG.

art 'E' of the Risk Event Record shows that a particular question, which appears among a series ' 'tick box' questions and states, " Slipped, tripped or fell on the same level", has been positively vered. In my view this is incorrect. The normal height of the seat would be between 17 and 25 ıches so my mother's fall to the ground would have involved a considerable drop.

have been shown, by DCI Burt, a copy of a Portsmouth Health Care Trust Health Record. ttached to this Health Record is a Hampshire Constabulary Exhibit Label bearing the reference H/1/C.

his Health Record relates to my mother and I would like to make the following comments in ›spect of this document.
n the page marked LH/1/C/6, which is a copy of a Discharge Letter from the Royal Hospital aslar, I note the comment, "She can, however, mobilise fully weight bearing." I wish to highlight ıe fact that this relates to my mother's condition on the 17th August 1998.

n the page marked LH/1/C/8 there is a copy of a hand-written note, apparently signed by Philip EED, which is addressed to Haslar A & E and is dated 14th August 1998. In these notes it ates, "No change in treatment since transfer to us 11/8/98, except addition of Oramorph etc.

Code A

gned : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

Code A

D19

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I would comment that no analgesia was required until the staff at the Gosport War Memorial Hospital first used Oramorph when my mother was agitated and probably in need of the toilet on the 11th August 1998 which was the day of her admission from the Royal Hospital Haslar.

I saw that my mother was deeply unconscious when I visited her on the 12th August 1998. In my view this medication probably affected the opportunity to offer nourishment as early as the 11th August 1998.

On page LH/1/C11 I note, with some concern, an entry under the date of the 11th August 1998, in what I believe is Dr BARTON's hand-writing, the comment, "I am happy for nursing staff to confirm death."

My mother was well and enjoying a good convalescence following a major operation. She was able to eat and drink. She was able to stand whilst requiring help with all daily living events.

Perhaps this comment may be considered, by some, as being 'normal' procedure for aged admissions but not in my experience. Such a question may, perhaps, be considered if the patient was suffering from a terminal illness and death is likely or imminent. The evidence does not suggest that my mother was in this condition.

On the same page (LH/1/C/11) there is an entry under the date of the 14th August 1998 which is once again, I believe, in Dr BARTON's hand-writing. It states, "Fell out of chair last night."

Further reference to the Risk Event Record (LH/2) shows, at point (9), that the accident occurred on the 13th August 1998 at 1330 hours and it will be recalled that the Portsmouth Health Care Trust Letter (LFL/3) states that Dr BARTON was on the ward following accident.

I query whether, in fact, my mother was seen at all.

A further comment, in the same entry, states, "Daughter aware and not happy." I re-iterate that I was "not happy" because I could get nothing done for my mother who was simply given pain relief without any apparent attempt to discover the cause of her discomfort.

Finally, in the same entry, the question is raised by, I believe Dr BARTON, "Is this lady well enough for another surgical procedure?" This question was not, however, raised with me.

On the reverse side of page LH/1/C/11, under an entry dated the 17th August 1998, there are references to my mother's condition following the operation on 14.8.98 as per the nurse's notes of Haslar, not to her condition on 17.8.98.

Code A | Code A

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D20

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

:ontinuation of Statement of : **Lesley Frances LACK**

'here is a comment, I believe in Dr BARTON's hand-writing, "....now appears peaceful." I know ıat my mother screamed and cried in the period following her re-admission.

ɫy mother was only 'peaceful' being given Oramorph on 3 occasions which rendered her quiet ınd unconscious. In fact this treatment had rendered my mother incapable of taking any ourishment from this point and she did not regain consciousness again.

would like to draw attention to the fact that there are no Doctor's notes from the 18th - 21st ●ust 1998.

)n the same page, under the date of the 21st August 1998, there is an entry which, I believe, is ılso in Dr BARTON's hand-writing which I feel I must challenge. Contrary to what Dr BARTON ıas written I strongly believe that my mother did not have a rattly chest nor any other symptoms ıf Brocho-pnüemonia.

)n page LH/1/C/21, and on the following 3 pages, also so marked and headed 'Contact Record', note that no entries appear to have been made over the period of the 11th / 12th August 1998.

)n page LH/1/C/21, under an entry dated the 13th August 1998, there are comments which learly indicate that my mother was not seen by a Doctor or examined by way of X-ray following ıer fall at 1.30pm that day.

: was not until 7.30pm or 8.30pm that it was appreciated that my mother's hip was the cause of ıy mother's pain. Telephone contact, only, was made and advice sought and given by a doctor ● did not know my mother.

was present on the ward and repeatedly sought help for my mother. I was casually informed, by ı Health Care Assistant, that my mother had indeed had a fall.

ı my opinion there was a serious lack of action for a post operative patient in view of her obvious ıross "discomfort" which was brought to the attention of all grades of staff by myself. The omment included in the entry, "Daughter informed", may refer to the phone call received after I eturned home at approximately about 9pm -10pm that evening.

)n the same page, under an entry dated the 17th August 1998, there appears to be a reference to ıy mother being in pain and distress but no action was taken.

'here is an 'added' comment which refers to the fact that when my mother was transferred there ɪas, "No canvas under patient...." In my view this represented a serious breach of work ırocedures and should be questioned.

Code A

Code A

igned : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D21

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I consider that the circumstances of my mother's transfer from the Royal Hospital Haslar, to the Gosport War Memorial Hospital, should be the subject of investigation. How was she brought from Haslar? How was she lifted? How was she transferred to her bed? Was the bed moved from the wall? How was she deposited in her bed? And By whom? Who was present?

This was a woman, 2 days post operative, who was transferred on a sheet. How could this have happened? And Why?

Who was informed, and when, as regards her degree of pain which was very obvious when I arrived 30 minutes after this entry was apparently made.

On the following page there is a further entry which is also dated the 17th August 1998 and timed at 1305 hours. This entry does not refer to my mother's awful position, which I observed upon my arrival, or the fact that I asked the RGN to look at the way in which she was lying and to adjust her to be equally on both hips.

It was at this point that I told the staff that the Royal Hospital Haslar would be prepared to re-admit my mother. The Surgeon had said that she should not be in pain.

I once again point to the fact that my mother was pain free and mobilising prior to her transfer.

It should be noted there is no entry, on the 17th or 18th August 1998, regarding the fact that my sister and I were told that our mother had a massive haematoma. I can find no written evidence of this fact.
I see that no contact notes were made on the 20th August 1998.

In an entry dated the 21st August 1998 there is a reference to the fact that, "Daughters visited during morning." I would state that, in fact, we were constantly at the Gosport War Memorial Hospital, day and night, from the 17th August 1998 until the time when my mother died.

I would like to comment, in respect of the Nursing Care Plan, on the 2 pages marked LH/1/C/22, lacks information regarding the events that occurred.

With reference to the pages marked LH/1/C/22/4, headed 'Personal Hygiene' and 'Care Plan', there is, in my opinion, a gross lack of attention to the needs of daily living. Not even face and hands were washed and there are no entries at all on the 17th, 19th or 20th August 1998.

Finally, by reference to the page marked LH/1/C/22/1 and headed 'Nutrition' I comment that, in my opinion, this form is sadly lacking in information.

Code A

Code A

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D29

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

There are only 3 entries in total and no entries at all in respect of the 12th, 17th, 18th, 19th or 20th August 1998.

Furthermore there is no acknowledgement of the fact that my mother was having NIL BY MOUTH due to her induced unconscious state by the giving of pain relief only for 5 days prior to her death and during previous days of the 11th, 12th and 13th August 1998.

I have been shown, by DCI BURT, a copy of a Royal Hospital Haslar Medical Record. Attached to the document is a Hampshire Constabulary Exhibit Label bearing the reference AF/1/C which I have signed.

I would like to comment that in my opinion, when comparing it as a residual account of events with the Portsmouth Health Care Trust's Health Record (LH/1/C), it supersedes the latter in terms of quality and content.

Having examined the Medical Record (AF/1/C) I consider it to be totally accurate as regards the condition and treatment/care afforded to my mother Mrs Gladys RICHARDS. There is attention to detail and all information contained therein is as I remember.

I would particularly like to highlight a particular issue and refer to a page in the Medical Record marked (AF/1/C/11).

It should be noted that after my mother's initial admission to the Royal Hospital Haslar, when it was uncertain if she would survive, the Doctor, to his credit, has written, "She is to be kept pain free, hydrated and nourished."
To me this indicated that there was a will, and an intention, to afford to my mother total care whilst she was alive.

I wish to draw attention to the excellent standard of treatment which my mother received while at the Royal Hospital Haslar. She was nursed with care and consideration with, significantly, attention being paid to hydration and nourishment. There was an expectation, for the immediate future, on her transfer to the Gosport War Memorial Hospital.

In my view this is in direct contrast, in all aspects, to the standard of care and attention which my mother received at the Gosport War Memorial Hospital during the last 6 days of her life the most notable feature being the refusal to refer her back, once again, to the Royal Hospital Haslar when an offer had been received to accept her.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

D23

MG11T(2)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of : **Lesley Frances LACK**

Code A

Month of :							Month of :							Month of :						
1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31					29	30	31				
Month of :							Month of :							Month of :						
1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31					29	30	31				

Contact point, if different from above : N/A

Address : **N/A**

Telephone No. : **N/A**

STATEMENT TAKEN BY : **R. J. BURT DCI** Code A

Station : **Support Headquarters, Fratton Police Station, Portsmouth.**

Time statement taken : **During a period of research and consultation prior to date of signature.**

Place statement taken : **Code A**

Code A **Code A**

Signed : L. F. LACK Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

D24 - 54 / 61

MG11(T)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

atement of : **Mrs Gillian MACKENZIE**

ge if under 18 : **Over 18** (if over 18 insert 'over 18')

cupation : Housewife (previously Personnel Manager) Retired.

his statement (consisting of pages each signed by me) is true to the best of my knowledge and lief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have lfully stated in it anything which I know to be false or do not believe to be true.

gnature : Code A **Dated the** March 6 2000

m the elder daughter of the late Mrs Gladys RICHARDS and sister of Lesley LACK who currently lives Gosport, Hampshire.

y mother died at the Gosport War Memorial Hospital on Friday 21st August 1998.

llowing my father's death, in 1974, my mother either lived in close proximity to my sister or in nursing mes managed by my sister. My sister retired recently after a long career as a trained nurse. She has many ars of nursing experience especially in the care of elderly people.

mediately prior to her death my mother resided in a nursing home located at Lee-on-Solent, near Gosport, mpshire. It was called the 'Glen Heathers' Nursing Home. My sister, having retired to live in the Gosport a, was not concerned in any way with the management of these premises.

ring the time my mother was a resident at the 'Glen Heathers' Nursing Home I occasionally visited her re.

ring the last six months of her life I became unhappy with the standard of care which my mother was eiving at the 'Glen Heathers' Nursing Home and I made various complaints.

articularly recall one visit to my mother which occurred during the last six months of her life.

Code A

ned : Gillian MacKenzie Signature witnessed by : ____________

D25

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I noticed that my mother was suffering with a very bad cough. I asked the nursing staff why she wasn't being given antibiotics. I was told that it was because she was on other drugs. I was told, furthermore, that my mother was being given tranquillisers. I had not, previously, been aware of this fact.

I was very concerned and I decided to see Dr BASSETT who was my mother's GP. I asked him about the choice of drugs which were being prescribed for my mother.

He was aggressive and defensive and did nothing to alleviate my queries. As I had previously done some research, relating to another matter, I had formed the opinion that the drugs which were being administered to my mother could contribute to her confused mental state and deterioration of her physical health. One drug was Trazodone, a Tricylic, and the other was Haloperidol, a Neuroleptic drug.

Following the meeting with my mother's GP I sent him a copy of a book called 'Toxic Psychiatry'. I did so in order to draw his attention to the possible side effects of the drugs in question. I had formed the personal view that the drugs which were being administered to my mother were capable of adding, significantly, to the symptoms of her so called dementia, falls etc.

Early in the morning, on Thursday 30th of July 1998, I received a telephone call from Mrs Karen REED who is my niece. She informed me that my mother had been admitted to the Haslar Hospital, in Gosport, and was about to undergo surgery.

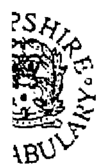
Mrs REED told me that my mother had suffered a fall at the 'Glen Heathers' Nursing Home and that she was going to have an operation to address a broken hip.

I immediately travelled from my home, in Eastbourne, to the Haslar Hospital. I arrived there shortly before my mother was brought, from the operating theatre, back onto the ward.

Code A

Signed : Gillian MacKenzie   Signature witnessed by : ____________

D26



MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ntinuation of Statement of : **Mrs Gillian MACKENZIE**

ring my mother's stay at the Haslar Hospital I remained with her, throughout, apart from two brief visits k to my home. I was with my mother until shortly before she was transferred to the Gosport War morial Hospital.

gether with my sister, Mrs Lack, I had visited the Gosport War Memorial Hospital in order to examine facilities before my mother was transferred. My sister and I were in agreement that she should be nsferred there.

ould like to clearly state, at the outset, that I have absolutely no criticism whatsoever of the Royal spital Haslar. The staff, at this hospital, handled my mother's case in a very professional way both dically and so far as the quality of nursing was concerned.

so believe that my sister and I received effective psychological support. The staff were open and honest. ey fully answered our questions and freely volunteered information.

were well aware of the situation my mother was in and the possibility that she may not survive the ration. Naturally, when my mother began to recover, we were delighted with her progress.

the Haslar Hospital my sister and I discussed with, I think, a Dr REID what would happen when she was charged. Neither my sister nor I were happy at the thought of her going back to the 'Glen Heathers' rsing Home. The Social Services Department subsequently carried out an investigation into the Nursing me care.

vas decided that our mother would be transferred to the nearby Gosport War Memorial Hospital for abilitation for about four weeks. She was, by then, using a zimmer frame. Following this period of iperation a decision would then be made as regards where she would go after that.

Code A

ned: Gillian MacKenzie Signature witnessed by :

D27

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I think another hospital was mentioned. I'm not sure but it may have been the Queen Alexandra Hospital, or similar, and she would receive care there.

Following her stay at the Haslar Hospital my mother she was certainly far more alert than she had been in the 'Glen Heathers' Nursing Home but, of course, we were under no illusions regarding her survival chances .aring in mind her age.

Whilst at the Haslar Hospital my mother was not given the Trazadone drug which had been administered to her at the 'Glen Heathers' Nursing Home. She seemed far happier, more alert, and could certainly recognise myself and my sister. Furthermore, on occasions, she could speak coherently. Not very long sentences but she was coherent. My mother was eating well and looking far better than she had done for months.

I returned home, to Eastbourne, just before my mother was transferred from the Haslar Hospital to the Gosport War Memorial Hospital. My sister rang me and said that my mother had settled in.

However, within a couple of days I received a telephone call, late one evening, from my sister Mrs LACK. She was very distressed. She told me that my mother had suffered a fall at the Gosport War Memorial Hospital. She was going to be x-rayed the following morning and would possibly be transferred back to the Haslar Hospital.

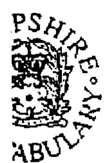
The following morning I travelled, from my home, to the Gosport War Memorial Hospital. I discovered that, in fact, my mother had already been transferred to the Haslar Hospital. I then went on to the Haslar Hospital.

On arrival I discovered that, in fact, my mother's new hip, which had been dislocated again at the Gosport War Memorial Hospital, had been manipulated back into place. She remained at Haslar Hospital for two or three days and she was then transferred back to the Gosport War Memorial Hospital.

Signed : Gillian MacKenzie Signature witnessed by :

Code A

D28



MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ntinuation of Statement of : **Mrs Gillian MACKENZIE**

ring her stay at the Haslar Hospital my mother made a good recovery and became quite alert again.

vas mentioned to me, but I can't remember who by, that my mother had been dehydrated when she was nitted to the Haslar Hospital from the Gosport War Memorial Hospital. I did not find that altogether prising in view of the fact that, at the Gosport War Memorial Hospital, my mother had been tranquillised n.

'as told by my sister, Mrs LACK, that she had made her views known to the Nursing and Medical Staff at Gosport War Memorial Hospital that such strong medication would not aid rehabilitation, eating, nking, physiotherapy or walking with a zimmer frame.

' sister and I arranged to be at the Gosport War Memorial Hospital when our mother was transferred. We nted to meet her when she arrived. In the event we were, in fact, about quarter of an hour late.

: had firstly gone there, on the morning of her transfer, at about half past ten only to be advised that she uld, in fact, be there at twelve o'clock. We arrived at about quarter past twelve.

ny sister and I went through the doors of our mother's ward we could immediately hear her moaning. I a lay person but I would say, quite confidently, that my mother was moaning in pain.

: went into our mother's room which, I think, was room number 3, to find a female care assistant, or neone of that category, attempting to feed her with lunch.

e care assistant's first words to us were, "Well thank goodness you've come because she won't eat what ı trying to make her eat and maybe you'll have more success".

nkly, I was not surprised that my mother did not want to eat the food. It was an absolute mush. She had, hort time before, been perfectly happy eating vegetables in the normal cooked state, and other food, ilst at the Haslar Hospital. This is confirmed in the Royal Hospital Haslar Medical Record (AF/1/C/63).

ned : Gillian MacKenzie Signature witnessed by : ____________

Code A

D29

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I told the care assistant that I was not surprised that my mother was unwilling to eat because it was obvious to me that she was in pain. My sister was with me on this occasion. The care assistant said, " Well no it's not, it's dementia".

Once again I expressed the view that my mother was obviously in pain and I asked a care assistant to go and get a qualified nurse.

I pulled back the sheet, which was covering my mother, and I could see that she was lying in a very awkward position with weight onto her newly replaced hip which had been, so recently, subject to yet further treatment as a result of the fall at the Gosport War Memorial Hospital. (See AF/1/C/34)

I expressed the view, to my sister, that it appeared as if our mother had been rolled off the stretcher, during the transfer process, onto her bed. The bed was beside a wall and it would have been necessary to move it out in order to effect a transfer from a stretcher onto the bed.

With that a qualified nurse came into our mother's room whose name, I believe, was Margaret. I can't recall her surname at the moment. By this time I had covered my mother up. My sister told this nurse that our mother was obviously in pain and she pulled back the sheet in order to show her the position that she was lying in.

The nurse then, with the aid of my sister, repositioned my mother so that her leg was straight. (See AF/1/C/34) This resulted in my mother assuming a more appropriate position. My sister told the nurse that our mother should have a cushion between her legs. We also told the nurse that it was obvious, to us, that our mother was in great pain. We asked her what had happened but she didn't really make any comment.

Signed : Code A   Signature witnessed by : ____________________

D30

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ntinuation of Statement of : **Mrs Gillian MACKENZIE**

wever, from that point we had a great deal of attention given to us by the nurse manager who was called Code A He acknowledged that my mother was in pain and that something should be done. He gave · mother an injection the purpose of which, I believe, was to ease her pain.

: asked Code A if a doctor could be called to examine our mother and whether she should be x-rayed. ip appeared to do everything possible then. He got the forms necessary for my mother to have an x-ray , in the first instance, they were not acceptable as they had to be signed by a doctor who was not due in il half past three that afternoon.

entually a Dr BARTON arrived and she examined our mother. Dr BARTON agreed that she should be x-ed. My sister and I accompanied our mother to the x-ray department. She was still moaning in pain pite having been given pain killers but she was able to speak coherently at times.

ıen we arrived at the Gosport War Memorial Hospital x-ray department the staff would not allow my ter to stay with our mother during the x-ray process. We could hear her moaning, through the door to x- department, throughout the time she was having the x-ray taken.

er the x-ray process had been completed my sister and I asked what had been seen on the x-rays. My ter asked, specifically, if she could see the results, whilst in the x-ray department, but this request was used. My mother was then taken back to her room in the ward.

the meantime my sister made enquiries at the Haslar Hospital in order to establish whether our mother ıld, once again, be transferred there. Whilst she was doing this I sat with my mother.

ound this time Code A came into my mother's room. He told me that I would be reassured to know t my mother has not dislocated her hip again, " but she may have suffered some bruising".

ned : Gillian MacKenzie Signature witnessed by : ____________

Code A

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

Later, after my sister had returned, Code A returned to our mother's room where we sitting with her. He said, "I'm going to make her life easier and give her an injection of Diamorphine".

I immediately reacted and said, "No, you're not giving her Diamorphine. Are we talking about a case of euthanasia here because I warn you I will not tolerate euthanasia".

. few moments later I saw Dr BARTON pass by my mother's room. My sister and I went out into the corridor to speak to her. My sister told Dr BARTON that she had spoken to the staff at the Haslar Hospital and established that they were quite happy to have our mother referred back to them.

In reply Dr BARTON said that she thought our mother had experienced quite enough trauma for that day and she didn't think it was right to send her back to Haslar then. She stated that they would keep her pain free overnight. The decision, regarding the referral back to the Royal Hospital Haslar, would be reviewed in the morning and that we should come in early when the review was going to be carried out.

I would like to highlight, for consideration, the appropriateness of an apparent 'policy' which effectively prevents patients being referred after working hours.

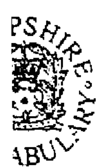
My sister and I arrived back at the Gosport War Memorial Hospital on the Tuesday morning. We were seen by Code A who took us into his office. He told us that nothing could be done for my mother. She had, according to Code A developed a massive haemetoma on the site of her hip operation and the only possible means of treating our mother was to put her on a syringe driver with Diamorphine so that she would have a pain free death.

The impression given to me, by Code A, was that my mother's death was imminent. He stated, when I asked him later that afternoon how long it would be, that it was not possible to be sure. It could be hours or longer.

Signed : Gillian MacKenzie Signature witnessed by : ____________

Code A

D32



MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ıtinuation of Statement of : **Mrs Gillian MACKENZIE**

as aware of the implications of a syringe driver and so was my sister. We had both agreed that a syringe ⁄er could be used. We went into my mother's room when Philip came in and set up the syringe driver h the Diamorphine. My sister was greatly distressed at this because my mother would not regain .sciousness or see us again and we wouldn't have a chance to speak to her.

r on during that morning, at about half past eleven, my niece Rebecca arrived with her baby. Dr RTON came to the doorway of the room and said, "Presumably things have been explained to you about syringe driver".

sister and I both said, "Yes".

BARTON then said, "Well, of course, the next thing for you to expect is a chest infection".

sister and I said, "Yes, we realise that".

ıve been present, when death has occurred, and I know that pneumonia, or a chest infection, or a 'dead ı's rattle', as the moment of death approaches, can be a normal thing. That was the only conversation we with Dr BARTON.

ːre was no mention whatsoever, by Dr BARTON, of surgery or intervention by surgery to relieve the metoma or, indeed, any reference to the fact that she didn't think my mother would stand a general esthetic.

ıuch a conversation had taken place I would have pointed out to Dr BARTON that my mother had hstood a hip replacement procedure, without a general anaesthetic, and that when it had been dislocated in, at the Gosport War Memorial Hospital, she had been transferred back to Haslar Hospital where the ⁄ hip had been manipulated back into place without a general anaesthetic.

ned : Gillian MacKenzie Signature witnessed by :

Code A

D33

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I stayed with my mother until very late that Tuesday night. It was past midnight, in fact, when my son arrived from London. As from the Wednesday night my sister also sat in with me all night long and we both remained, continuously, until twenty past nine on the following Friday evening when my mother died.

During that time Dr BARTON did not visit my mother. I am quite certain of this because our mother was t left alone, in her room, at any time apart from when she was washed by nursing staff. Either my sister, or I, was with her throughout.

I slept in a chair beside my mother's bed and at no time did I notice, in her, any signs or symptoms of pneumonia.

During the Wednesday night and Thursday morning there was a particular nurse on duty. I think her name was Sue. At about four o'clock in the morning, when she came in, she was of the opinion that our mother would probably only survive for another half hour or so. She delayed going off shift. However, my mother rallied and continued to live until the Friday.

I am of the opinion that if my mother had been near death, as we were led to believe by Code A on the previous Monday, she would not have survived until the Friday night. I believe that this is a strong indication of the actual state of her health.

It seems to me that she must have had considerable reserves of strength to enable her to survive from the Monday until the Friday, five days, when all she had was a diet of Diamorphine and no hydration whatsoever, apart from porridge, scrambled eggs and a drink, at the Royal Hospital Haslar, before transfer to the Gosport War Memorial Hospital.

As a result of what I had been told by Code A on the Tuesday morning I had been expecting our mother to die within 24 hours or so. It troubled me that she was not on a drip as the week progressed.

Signed : Gillian MacKenzie Signature witnessed by :

Code A

D34

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ntinuation of Statement of : **Mrs Gillian MACKENZIE**

iink that she was dehydrated and, with the Diamorphine, this was probably the cause of death although, of ırse, with a haemetoma, if action isn't taken very speedily, that can cause death as well. I was at a loss to derstand why action wasn't taken, promptly, as soon as a haemetoma was discovered.

s my understanding that just such a complication should have precipitated an immediate referral back to Royal Hospital Haslar (AF/1/C/75).

regards the issue of transferring our mother back to the Haslar Hospital my sister had mentioned it to Dr RTON who had told us, on the Monday evening, that a decision about that would be made on the esday morning. However, when my sister and I arrived at the Gosport War Memorial Hospital, on the esday morning, a decision had been made that, as my mother was dying, the only thing to do was to give a pain free death. I think the haemetoma would have shown up on the x-ray that was taken on the nday afternoon.

e staff at the Haslar Hospital had told my sister that they would be willing to accept our mother if she was red back to them for treatment although we didn't know she had a haemetoma at the time this was cussed.

sister clearly told Dr BARTON, in my presence, about the offer that the Haslar Hospital had made to . In the circumstances I don't think that Dr BARTON who is, I believe, a GP was qualified to make the ision to deny our mother the chance to receive treatment at the Haslar Hospital.

elieve that it is possible that my mother could have been effectively treated at the Haslar Hospital where had, only recently, twice undergone, and survived, hip treatment. Furthermore, on each occasion, her eral health had improved considerably whilst under the care of staff at the Haslar Hospital.

ned : Gillian MacKenzie Signature witnessed by :

Code A

D35

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

In my view a Consultant's opinion should have been sought when the haemetoma was discovered

It is also my view that Dr BARTON's decision not to refer our mother back to the Haslar Hospital where the causes of her condition, and not merely the symptoms, could have been addressed, effectively denied her the opportunity of having a chance to be treated, to survive and to recover even if this was for a short time.

I believe that a decision was made, for reasons which I do not accept, to reject treatment options which would have given our mother a chance to recover and, instead, a course of palliative treatment was commenced which, effectively, condemned her to death without any chance of recovery. Palliative treatment does not necessarily have to cause unconsciousness.

I have been shown, by Detective Chief Inspector BURT, some hand-written notes bearing a Hampshire Constabulary Exhibit Label, marked LFL/2, which I have signed.

I was aware of the fact that these notes were being made by my sister, Lesley LACK, because she was making them in our mother's room at the Gosport War Memorial Hospital. Frequently, I was sitting beside our mother, holding her hand and trying to reassure her, whilst my sister was sitting in the same room making her notes.

We agreed that my sister should make the notes because of the increasing concerns we had over the quality of care that was being given to our mother at the Gosport War Memorial Hospital. Obviously, therefore, my sister began to make her notes before our mother died and before we became aware of various other things since.

I was not a direct party to the writing of the notes. The comments and observations made are those of my sister. I was, however, in the company of my sister during most of the period, and during most of the incidents, she refers to in her notes. My sister and I discussed particular issues as she wrote about them.

Signed : Gillian MacKenzie   Signature witnessed by : ____________________

Code A

D36

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ntinuation of Statement of : **Mrs Gillian MACKENZIE**

ecall that a copy of my sister's notes were given to Lesley HUMPHREY, the Quality Manager of the tsmouth Health Care Trust, on Wednesday 19th August 1998 after we had complained.

ecall that I read through the notes, which my sister had made, prior to them being copied for Mrs MPHREY. It is possible that some additions were made to the notes, by my sister, at that time which ld account for the way the notes are written. The notes embody a series of questions in respect of which, part of our complaint, we sought answers from the Portsmouth Health Care Trust.

notes do not incorporate any of my handwriting. All the handwriting is that of my sister, Lesley LACK.

original notes which I have been shown (LFL/2) comprise of five numbered pages (1-5) plus an litional page which is un-numbered (LFL/2A). I note that the page numbered '5' has been signed by my er. I cannot say whether the additional, un-numbered, page was copied to Mrs HUMPHREY or not. ilst I agree with its content I do not recall seeing it before.

sister provided me with a copy of the Notes, on or about the 28th September 1998, which I produce. ched to my copy is a Hampshire Constabulary Exhibit Label bearing the reference GM/1 which I have ned.

ive, once again, read the notes (LFL/2), including the additional un-numbered page. I would like to make following general observations drawing on the contents and other recollections.

sister has commenced her notes by referring to the occasion when my mother was admitted to the sport War Memorial Hospital, from the Haslar Hospital, on Tuesday 11th August 1998.

as not in Gosport at that time but I would like to comment on, and echo the concern expressed by my er about, the fact that 'Oramorph' was almost immediately administered to our mother when she was. in probability, exhibiting signs of her dementia which were, perhaps, 'misread' as pain.

ned : Gillian MacKenzie Signature witnessed by : ____________

Code A

D37

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

Whilst at the Haslar Hospital, a matter of hours before, our mother had been pain-free and was not rendered unconscious by any form of pain relief medication except for surgery and shortly afterwards.

I have to say that I have serious concerns about the possible and inappropriate use of 'Oramorph', at this stage in my mother's treatment, as a means of suppressing the 'inconvenient' aspects of her anxiety and :mentia.

I note that there is a reference in the notes, under the date of Thursday 13th August, to my niece Mrs REED. I would like to point out that Mrs REED is not only a trained nurse but she has worked in the Orthopaedic Ward at the Haslar Hospital where my mother underwent treatment. I am appalled, given her credentials, that more attention was not paid to Mrs REED's comments and concerns by the staff at the Gosport War Memorial Hospital shortly after lunchtime on Thursday 13th August 1998.

I would like to clearly state that, having read through the notes (LFL/2), I am in complete agreement with them. This would, of course, have been my position on Wednesday 19th August 1998 when I examined them prior to a copy being made and given to Mrs HUMPHREY.

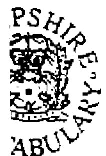
Whilst I did not write the notes (LFL/2) and whilst I did not sign them I was a party, at times, to the preparation process and where, on occasions, my sister has referred to 'I' in fact it could read 'we' as we were together when certain events occurred.

On the 19th August 1998 I wholeheartedly adopted the contents of the notes (LFL/2) as representing the basis for a joint complaint, with my sister, about the way our mother was being treated at the Gosport War Memorial Hospital.

Signed : Gillian MacKenzie Signature witnessed by :

Code A

D38



MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ntinuation of Statement of : **Mrs Gillian MACKENZIE**

due course, following my mother's death, I received a copy of the Portsmouth Health Care Trust's ponse to the copy of my sister's notes (LFL/2) which had been given to Mrs HUMPHREY on the 19th gust 1998.

e response was in the form of a letter, dated 22nd September 1998, which was addressed to my sister, sley LACK, and signed by a person named Max MILLETT designated the Chief Executive.

iave been shown, by Detective Chief Inspector BURT, the original letter which bears a Hampshire nstabulary Exhibit Label, marked LFL/3, which I have signed.

rill comment on this letter, in greater detail, later in my statement.

tially there was some reluctance, on the part of the Portsmouth Health Care Trust, for me to see the letter FL/3). Only after I made it clear that I was a joint complainant did I receive a copy.

fact, when I returned home, after my mother had died but before the funeral or just afterwards, I ephoned, I believe, Mrs HUMPHREY's office. I told her or Barbara ROBINSON, who was possibly ing with the matter in Mrs HUMPHREY's absence, that I knew about the notes which my sister had pared and asked her to address a further question.

vanted to know why a decision was made for my mother to be administered pain relief only without dration. It had taken my mother five days to die and I don't think any fit person would have been able to vive solely on a diet of Diamorphine with no hydration. This question was not answered fully by the bsequent report from Mr MILLETT (22-9-98).

ien I raised this issue with Mrs HUMPHREY she said that would have been explained at the time. I told s HUMPHREY that it certainly wasn't explained to me.

gned : Gillian MacKenzie Signature witnessed by : ______________

D39

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

When I received a copy of the letter from the Portsmouth Health Care Trust, commenting on the points raised in my sister's notes, I immediately phoned my sister because I was not happy with it. Some paragraphs seemed to be totally untrue. My sister expressed similar concerns.

As an example the notes (LFL/2), which were copied to the Portsmouth Health Care Trust, raised the stion, "At what time did Mrs RICHARDS fall?

The letter in response (LFL/3) states, in response to that question, "She fell at 13:30 on Thursday, 13th August 1998, though there was no witness to the fall". Her door was kept open and there was a glass window onto the corridor opposite the Nursing/Reception Desk.

In the Health Record (LH/1/C), to which I will refer in greater detail later in my statement, the time of my mother's fall is confirmed as being 13:30 and the venue is given as her room. However, my niece, Mrs REED, had apparently seen her, as I understood it, in the patient's sitting room but I may be wrong. If my mother had been in the patient's sitting room, by herself, this was neglectful because the staff knew she would attempt to get out of her chair if she wanted to use the toilet and she couldn't possibly do it by herself. (See AF/1/C/21)

By further reference to the letter of response (LFL/3) I note that in reply to the question, "Who attended her?" There is a response, "She was attended by a Staff Nurse Jenny BREWER and a Code A Code A This is followed by a further question, "Who moved her and how?" Which drew the response, "Both members of staff did, using a hoist".

If my mother had fallen from a chair, onto her bottom, surely the obvious thing to do, as she had only recently undergone surgery for the fitment of a new hip, was to have her thoroughly examined by a qualified doctor before moving her at all. In the letter of response (LFL/3), page 2, point 4, the comment is made.

Signed : Gillian MacKenzie Signature witnessed by : ____________________

Code A

DHO

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ıtinuation of Statement of : **Mrs Gillian MACKENZIE**

ıur mother had been given medication, prescribed by Doctor BARTON, who was present on the ward after her fall. I understand that it was not your wish for your mother to be given stronger medication ause it made her drowsy".

ny view this does not make sense at all. If someone has possibly dislocated their new hip you don't give n a medication to make them quiet you examine them and you do something about it.

Doctor BARTON examine my mother? Or, perhaps, was she just asked to look at Mrs RICHARDS, was making a noise, and give her some more tranquilliser.

Doctor BARTON did not examine my mother that, in my view, was, in the circumstances, pure ligence. The first thing any lay person would do if someone falls onto a new hip is to ensure that no nage has been done. You wouldn't simply give them a tranquilliser to keep them quiet.

ning to the question, in the notes (LFL/2), which queried the delay in dealing with the consequences of fall, page 2, point 5, in the letter of response (LFL/3), "With the benefit of hindsight it is possible to ne that your mother's dislocation could have been identified much earlier....etc". I would comment that iost certainly could. When she was later undressed they apparently discovered that she'd dislocated her That was a very long time to wait.

ıw refer to the question, re-iterated in the letter of response (LFL/3) on page 2, point 7, "Why, when she returned to bed from the ambulance was her position not checked?".

ve spoken to two health care support workers, who were working at the Gosport War Memorial Hospital ie time, one is named Jean, I think, and one is named Linda. ~~They~~ LINDA told me that when my mother returned GMH he Gosport War Memorial Hospital, from the Haslar Hospital, on Monday 17th August 1998, they were happy as she seemed to be in pain. They believed that there was a problem and they went to get

ned : Gillian MacKenzie Signature witnessed by :

Code A

D41

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

professional advice. I believe that this was at a quarter to twelve. My sister and I did not arrive until a quarter past twelve.

If, as the reply to our question suggests, Staff Nurse Code A in fact, attended to my mother at the request of the health care workers why didn't she notice the awkward position in which my mother was ...ng.

I would suggest that Staff Nurs Code A did not properly attend to my mother or did not, perhaps, come until my sister and I asked, half an hour later, and actually pointed out to her how my mother was lying.

Moving to another point, after my mother had been x-rayed at the Gosport War Memorial Hospital, on the afternoon of Monday 17th August 1998, I recall that Code A advised me that my mother had not dislocated her hip but she might have bruised herself.

I asked Code A how my mother could have been bruised. He did not provide me with an explanation .. how it could have happened.

What, I believe Code A failed to tell me at that time was that, in fact, my mother hadn't been transported on a stretcher. When I later spoke to the two care workers one of them, Linda, who didn't want me to mention to anyone that she'd told me, said that, in fact, my mother had arrived back in the ward on a sheet on a trolley. It is possible, I would assume, that she was not rolled off the stretcher, as I had thought, but she had been rolled off a sheet into the position we found her in and not checked until we raised the issue with staff. There appears to have been an avoidable delay, on the part of Staff Nurse Code A, to identify this problem.

Code A

Signed : Gillian MacKenzie Signature witnessed by : ____________________

DH2

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ıtinuation of Statement of : **Mrs Gillian MACKENZIE**

›te that in the letter of response (LFL/3) on page 2, point 8(c), it states, in reply, "The ambulance crew ımented that she showed signs of being in pain as she was put into the ambulance.....etc" I would ask y was it, then, when she arrived at the Gosport War Memorial Hospital, did they accept her? In my view y should have sent her back to the Haslar Hospital there and then. She had left the ward at Haslar pain

·esponse to the question (LFL/3) page 3, point 8(d), "Why was my request to see the x-rays denied?" The ly tendered is not satisfactory. My sister specifically asked to see the x-rays when we were in the x-ray ›artment and we were not allowed to see them.

th regard to the response to question (LFL/3) 8 (e) page 3, "Doctor BARTON felt that the family had :n involved at this stage as she discussed the situation fully with you....etc". I emphatically deny that. She nothing of the sort. It goes on to state, "She made sure you were aware that the surgical intervention :essary for the haemetoma would have required a general anaesthetic...etc". This is not true. That was r discussed. The only discussion we had about the haemetoma was with Philip who said nothing could done except give her pain relief to aid her in dying.

/ sister and I were not consulted, whatsoever. When they saw that she had a haemetoma they should have ıt her back to the Haslar Hospital there and then. We were not told that our mother had a heamatoma until : Tuesday morning.

eel, very strongly, that this reply represents an attempt to cover up the truth, by Doctor BARTON, and I ›uld go as far as to say that her gross negligence resulted in the death of my mother.

.ave been shown, by Detective Chief Inspector BURT, a copy of a Portsmouth Health Care Trust Health :cord which relates to my mother. It bears a Hampshire Constabulary Exhibit Label, marked LH/1 C.

gned : Gillian MacKenzie Signature witnessed by :

Code A

D43

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

which I have signed. I note that each page has been marked with an individual reference. Having examined this document I would like to make the following observations.

I refer to page LH/1/C/7 and I would like to comment in relation to the remark, "Deaf in both ears". This is true. My mother could hear with a hearing aid but the staff at the 'Glen Heathers' Nursing Home had lost it and it had not been replaced.

Further, "Cataract operations in both eyes". This is true but my mother could see with one eye, with her glasses, but, again, the staff at the same Nursing Home had lost my mother's glasses.

Further, "Six month history of falls". This is true. Since my mother was administered the tranquillisers Trazodone and Haloperidol.

As a result of the Social Services investigation I discovered that my mother had suffered 17 falls at the Nursing Home during the previous 6 months. My sister, who had visited our mother daily in the Nursing Home, was unaware of the extent of the falls.

Further, "Alzheimer's, worse over the last six months". I would challenge the accuracy of the diagnosis. As I understand it, it is not possible to be certain of Alzheimer's disease unless a post mortem on the brain is carried out. I would challenge the comment. "Worse over the last six months". I would suggest that my mother's condition was probably attributable to dementia and the added risk of tardive dementia due to the two drugs in question.

I now move to LH/1/C/8 which is a note made by, I think **Code A** the Charge Nurse in my mother's ward at the Gosport War Memorial Hospital. He mentions that in addition to the treatment, i.e. drugs that the staff at the Haslar Hospital had recommended, the staff at the Gosport War Memorial Hospital had added 'Oramorph'. I challenge the need for 'Oramorph'. My mother had not needed it whilst she was being

Signed: Gillian MacKenzie Signature witnessed by :

Code A

D44

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ıtinuation of Statement of : **Mrs Gillian MACKENZIE**

.ted at the Haslar Hospital except for pain. Why did she need it at the Gosport War Memorial Hospital hin 48 hours of arrival except for dislocation of new hip later on.?

ove to LH/1/C/9 which is a letter written by a Dr R I REID. In this letter Dr REID comments that my ther's mobility had deteriorated over the previous six to seven months and I have already indicated why I k that was the case. Furthermore Dr REID states that my mother's "daughters" had indicated that my ther had been 'knocked off' (out) by the prescribed medication for months and had "not spoken to them six or to seven months". Well, in truth, my mother did speak to us. Not long conversations, not always sentences, but she certainly did speak. She also recognised who I was.

REID also mentions that since the "Trazodone has been omitted" we had indicated that our mother had en much brighter mentally". In fact I would say that my mother had been more bright, mentally, than she l been during the last six months in the 'Glen Heathers' Nursing Home although I only saw her asionally, usually after a bout of ill health or a recorded fall.

ıer, Dr REID says that my mother, "....was clearly confused and unable to give any coherent history". ould suggest that when you are questioning a lady who has dementia, and cannot hear a thing without a ıring aid, she is likely to be confused plus the fact she couldn't lip read because she hadn't got her sses.

ving to LH/1/C/11, which I think contains notes made by Doctor BARTON. In an entry, dated 11th gust 1998, the date on which my mother was transferred to the Gosport War Memorial Hospital, from the slar Hospital, Dr BARTON has made a surprising statement, "I am happy for nursing staff to confirm .th".

ned : Gillian MacKenzie Signature witnessed by :

Code A

D45

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

There was no indication, from the staff at the Haslar Hospital, that my mother was anywhere near death. Why should Doctor BARTON assume that she was going to die?

The plan for my mother was that she should remain for about four to six weeks at the Gosport War Memorial Hospital before she was referred, for rehabilitation with her zimmer, to another hospital. I do not understand why Dr BARTON should feel it necessary to make this comment at the outset unless, of course, she had already had it in her mind that she had got a 91 year old patient who was, in her opinion, a damn nuisance and that this was going to be the outcome.

Further, in respect of LH/1/C/11, under date of the 14th August 1998, "Is this lady well enough for another surgical procedure?". I would point out that this was prior to the successful referral back to the Haslar Hospital. Perhaps it is fortunate that Dr BARTON relented, on that occasion, otherwise my mother could, perhaps, have been placed on a syringe driver earlier than, in fact, she was and I make the point that Dr BARTON was making decisions which, I suggest, she was not qualified to make.

Further, in an entry dated the 18th August 1998 Dr BARTON states that, "I will see daughters today". Well she might have said she was going to but she certainly didn't except for brief reference to syringe driver at approximately 1130 am.

I have to say that I suspect that these notes (LH/1/C/11) were not made as per the dates. I believe that they could, in fact, have been made retrospectively.

I must say that the notes in the Portsmouth Health Care Trust Health Record are very scant. I notice that there is a gap between the 18th and 21st August 1998.

Moving to LH/1/C/14 I note an entry, dated 11th August 1998, which states, "Admitted from E6 ward Royal Hospital Haslar, into a continuing care bed". For me the issue is 'continuing care' and not 'terminal care'.

Signed : Gillian MacKenzie Signature witnessed by : ____________

Code A

D46

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

ıtinuation of Statement of : **Mrs Gillian MACKENZIE**

ving to LH/1/C/15 there is a comment, "Patient has no apparent understanding of her circumstances due ıer impaired mental condition". My mother knew she was in pain. She couldn't hear what anybody said ıer. It is no good asking somebody a question when they cannot hear a thing and then say it is due to ıentia.

ving to LH/1/C/21. There is an entry dated the 13th August 1998 which is timed at 1300 hours. It states, ıund on floor at 13.30hrs checked for injury none apparent". I would ask who it was who checked for ıry. It should have been a qualified doctor.

ıte that a recorded time, later in the same entry, has apparently been changed from 2000 hrs to 1930 hrs. ıre is a reference to the fact that a Dr BRIGG was contacted, presumably he or she did not attend in son, but this does not, apparently, correlate with the time my sister was contacted. Dr BRIGG is recorded ıaving advised, "X-ray AM (and) analgesia during the night. Inappropriate to transfer for x-ray this PM. ıghter informed."

ıld strongly query whether it was, in fact, inappropriate or simply contrary to 'policy'.

ish to draw attention to the fact that Dr BARTON was apparently in my mother's ward shortly after she . She therefore had the opportunity to, and should have, put in hand steps to properly diagnose and ify the 'cause' of my mother's pain and distress immediately. She did not. This resulted in my mother ing to endure hours of unnecessary suffering. There is no reference, in the clinical notes, to the fact that BARTON attended to my mother after her fall. I question what, in fact, Dr BARTON actually bothered .o at that stage apart from, perhaps, advocating painkillers or tranquilisers.

Code A

Signature witnessed by : ____________________

D47

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

Further, on LH/1/C/21, under the date 17th August 1998 and timed 1148 hrs, there is an entry which states, "Returned from R.N. Haslar, patient very distressed and appears to be in pain". However, when we arrived we were told that our mother was not in pain, it was her dementia.

I would like to draw attention to the fact that there is an addition to this entry as follows, "No canvas under tient - patient transferred on sheet by crew". I would suggest that it is possible that this has been added later and after, perhaps, I had spoken to the two care support workers who told me what had really happened. There is a further entry, under the same date, which states, "To remain in straight knee splint for 4/52....pillow between legs at night". There was no pillow put between my mother's legs, when we arrived half an hour after she had been admitted, and her leg was certainly not straight. There is a further entry, "No follow up unless complications." Surely a haemetoma is a serious complication.

Further, on LH/1/C/21, under the date 18th August 1998 and timed 'a.m.', "Reviewed by Doctor BARTON. For pain control via syringe driver". It appears, to me, that Dr BARTON had not given any serious consideration to the option of surgical intervention. The entry goes on, timed at 1115, "Treatment discussed with both daughters". That is not correct. We were there at 9 o'clock in the morning and we had the conversation with Philip BEED who told us nothing could be done and discussed the use of the syringe driver and Diamorphine.

He said that my mother had developed a massive haemetoma and that the kindest way to treat her was to put her on Diamorphine, to ease her pain, until she died.

The entry goes on, "They agree to use of syringe driver to control pain and allow nursing care to be given". Yes, we did agree the syringe driver because we were under the impression she was going to die within 24 hours or very soon.

Signed : Gillian MacKenzie Signature witnessed by : ____________

Code A

D48

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

:tinuation of Statement of : **Mrs Gillian MACKENZIE**

:her, on LH/1/C/21, under the date 21st August 1998, ..."Daughters visited during morning". In truth we e there the whole time. We were virtually living there.

ve been shown, by Detective Chief Inspector BURT, a copy of a Portsmouth Health Care NHS Trust :k Event Record' attached to which is a Hampshire Constabulary Exhibit Label , marked LH/2, which I e signed.

ould like to comment on an entry on page 1 under section 7, "Patient sat in chair in room 3 found on r by the nursing staff". I have already queried where she fell.

ould like to comment about the fact that, after the 18th August 1998, staff members continually expressed r surprise at the length of time our mother continued to live. I believe that this was indicative of her ngth and, as a critical factor worth mentioning, her ability to potentially cope with a further referral to Haslar Hospital for surgical intervention, had she been granted this opportunity by Dr BARTON.

ve been shown, by DCI BURT, a copy of a Royal Hospital Haslar Medical Record. Attached to this ment is a Hampshire Constabulary Exhibit Label bearing the reference AF/1/C which I have signed.

ould like to make the observation that, as a lay person, this Record appears to me to be far superior to the lth record (LH/1/C) in terms of content and detail.

ould also like to observe that each time my mother was discharged from the Royal Hospital Haslar the ook, in terms of her health, seemed positive but, upon admission and re-admission to the Gosport War norial Hospital, it seemed to me that her condition quickly deteriorated.

ive been shown a copy of a Report, made by Dr LORD, which has attached to it a Hampshire stabulary Exhibit Label bearing the reference LH/4, which I have signed.

ied : Gillian MacKenzie Signature witnessed by : ____________

Code A

D49

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

If this Report purports to be an objective assessment of the medical and nursing care and attention given to my mother at the Gosport War Memorial Hospital then I would challenge its value as such. Dr LORD did not, apparently, have any dealings with my mother and she prepared her Report on the basis of reading other documents and contact with colleagues.

I have been shown a copy of an Enquiry Report to which is attached a Hampshire Constabulary Exhibit Label bearing the reference LH/4 which I have signed.

I have been provided, by DCI BURT, with a typed copy of the Enquiry Report (LH/4). The copy, to which is now attached a Hampshire Constabulary Exhibit Label bearing the reference GM/2 and signed by me, was constructed to enable me to add hand-written comments which I have done.

I would like to point out that where I have chosen not to comment on a particular reply or issue this does not imply that I necessarily agree with, or accept, what has been stated.

I would like to raise an issue regarding the cause of my mother's death as recorded on the Death Certificate. At the time of her death and, so far as I am concerned, for 2 or 3 days before hand, my mother was not seen by a doctor.

On the 18th August 1998 Dr BARTON had commented that, "The next thing will be a chest infection", suggesting to me that, so far as this doctor was concerned, there was no chest infection present on that day, the 18th August 1998. Furthermore, from my own observations, there was no indication of a chest infection up until the time of my mother's death.

A doctor did not attend my mother upon her death. My sister and my niece laid my mother out, in my presence, and then we waited while she was prepared to go to the mortuary.

Signed : Gillian MacKenzie Signature witnessed by : ______________

Code A

NMC100090-0060

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

tinuation of Statement of : **Mrs Gillian MACKENZIE**

ıd it hard to understand how a doctor could have certified death as being attributable to bronco-ımonia in these circumstances and with no reference to the heamatoma.

ɔuld like to draw attention to the fact that no reference to the alleged onset of bronco-pneumonia appears ıe Health Record (LH/1/C) prior to my mother's death.

hermore there is no reference to the presence of a heamatoma on the 17th August 1998 or, indeed. rwards.

onclusion I would ask the question, "Was the cause of my mother's death Diamorphine poisoning and ydration?

Code A

ned : Gillian MacKenzie Signature witnessed by : ____________________

D51

MG11T(2)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of : **Mrs Gillian MACKENZIE**

Code A

Month of : April							Month of : May							Month of : June						
1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31					29	30	31				
Month of :							Month of :							Month of :						
1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31					29	30	31				

Contact point, if different from above : **N/A**

Address : **N/A**

Telephone No. : **N/A**

STATEMENT TAKEN BY : **Detective Chief Inspector R J BURT**

Station : **Major Crime Complex, Support HQ, FRATTON, PORTSMOUTH.**

Time statement taken : **During a period of research and consultation prior to signature.**

Place statement taken : **Code A**

Signed : Gillian MacKenzie Signature witnessed by : ____________

NMC100090-0062

D52 HF...2

PORTSMOUTH
HealthCare
NHS
TRUST

DR R I REID, FRCP
CONSULTANT GERIATRICIAN

Elderly Medicine
Queen Alexandra Hospital
Cosham
Portsmouth PO6 3LY

Tel: 01705 822444
Extension: 6920
Direct Line: Code A
Fax: 01705 200381

RIR/BJG/WVTQ130407

5th August 1998

Surgeon Commander M Scott
The Royal Hospital Haslar
Gosport
Hants

H00302284

Dear Surgeon Commander Scott

Code A

contd.......

please file in notes
1873

D53

Gladys RICHARDS

Code A

DR R I REID, FRCP
Consultant Physician in Geriatrics

cc. Dr J H Bassett
Lee-on-Solent Health Centre
Manor Way
Lee-on-Solent
Hampshire

D54

H HASLAR

cident & Emergency Department

A&E No: 012080/98

Priority: 03.

ame: RICHARDS

st Name: GLADYS

Code A

rvice No:

k/Title:

ress/Unit:

Code A

t Code:

one No:

).B:

e:

Code A

g :

ient Categor

e of Inciden

.A.: No

cription of Complaint:

ful right hip

GP Name: GP not registered

Health Centre:

Phone No:

Date of Arrival: 29/07/98

Time of Arrival: 21:20

Mode of Arrival: Ambulance

Time of Triage: 2122.

Time Seen: 2200.

Time Left: 0010

Disposal: → E6.

Code A

ge Notes:

Code A

D55

octor's Report (continued)

Code A

ME OF PARTURE: | TRANSPORT HOME Y / N RETURN Y / N | SIGNATURE: | NAME:

/ESTIGATIONS:
X Ray 5 Biochemistry 9 Scan 98 Other
ECG 6 Urine 10 Ultrasound 99 Unknown
Haematology 7 Bacteriology 11 Pregnancy
X Match 8 Histology 12 None

SPECIAL CASES:
1 Asthma 5 Hepatitis Risk
2 Haematological 6 Pacemaker
3 Diabetic 7 S/C
4 Fits 8 S/C

gnosis: | Referred To: | Time Referred:

ne Seen by cialist: | Specialist's Diagnosis: | Time Decision to Admit / Discharge:

DING:	Patient Group	Diagnostic Category	Anatomical Site	Side		
AGNOSIS 1:					ARG Code	
AGNOSIS 2:					Alcohol Related	

EATMENT:
Dress / Bandage / Sling 6 Incision & Drainage 11 IV Cannula 16 Urinary Catheter 21 Monitoring 26 Splint
Sutures/Steristrips 7 Minor Surgery 12 Central Line 17 Peritoneal Lavage 22 Advice Only
Prescription 8 Manipulation 13 Lavage / Emesis 18 Defib / Pacing 23 Nebuliser
Written Instructions 9 POP / Splint 14 Intubation 19 Other 24 Stat Drugs
Removal Foreign Body 10 Physiotherapy 15 Chest Drain 20 None 25 Wound Closure

ESCRIPTION: | COMMENT:

AESTHESIA:
L.A.
G.A.
Regional Block
Entonox
Sedation

TETANUS:
1 Immune
2 Tet Tox Course
3 Tet Tox Booster
4 Immunoglobulin

METHOD OF DEPARTURE:
1 Home / A&E PRN 6 Fracture Clinic 11 Left before Treatment
2 GP 7 Other OPD 12 Left Refused Treatment
3 District Nurse / HV 8 Admit A&E Ward 13 Died
4 Social Services 9 Admit own Unit 14 Transfer Other provider
5 A&E Clinic 10 Transfer outside DHA 15 this District
98 Other 99 Unknown

TTERS:
Removal of Sutures No... Days ... 2 Discharge No Follow Up 3 Discharge GP Follow Up 4 Admission
Return to A&E 6 OPD (GP to Refer) 7 OPD (A&E Referral)
Discharge frm Short Stay Ward 9 Discharge from A&E Clinic 10 Minor Operation 11 Notification of Death

D56

Code A

To: Casualty Officer

Code A

/over

D57

Barthel:	Date:	Waterlow:	Date:

Code A

Medica' in - Confidence

D58

Date	**Clinical notes:** To be signed by Medical Officers, giving Rank and appointment.
	Code A

NMC100090-0069

D59

Medic - in - Confidence

Clinical Continuation Sheet

F Med 11
(Rev. 12/90)

ORTHOPAEDIC

To be used to continue the clinical notes from forms in the F Med series (ie Fs Med 1, 10, 19).
This form is to be securely attached to the original.

Continued from F Med	dated	Name including forenames: Richards, G		
		Service No.	Rank/Rating	Regt./Corps

Code A

D60

Medic - in - Confidence

nical Continuation Sheet

F Med 11
(Rev. 12/90)

used to continue the clinical notes from forms in the F Med series (ie Fs Med 1, 10, 19).
orm is to be securely attached to the original.

ORTHOPAEDIC

Code A

D61

Medica' in - Confidence

Date	Clinical notes: To be signed by Medical Officers, giving Rank and appointment.
31/7/98	
2/8/98	

Code A

ROYAL HOSPITAL HASLAR D69

OPERATION RECORD

Code A

D63

patients notes

Anaesthetist(s) Scott / Bateman | Surgeon(s) Mc Hinton | Date 30 07 9

Code A

D64

Code A

D65

AFI/1/C/15

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LONDON
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104-112 M
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TEL 071-

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Code A

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POSTOPERATIVE INSTRUCTIONS

onsent Form

D66 AF1 1c/16

' medical or dental investigation, treatment or operation

Code A

D67 AE1/C117

Medical - in - Confidence

Clinical Continuation Sheet

F Med 11
(Rev. 12/90)

ORTHOPAEDIC

To be used to continue the clinical notes from forms in the F Med series (ie Fs Med 1, 10, 19).
This form is to be securely attached to the original.

Name including forenames

D68

Medical - in - Confidence

Date	Clinical notes: To be signed by Medical Officers, giving Rank and appointment.

Code A

D64

Medical - in - Confidence

Clinical Continuation Sheet

F Med 11
(Rev. 12/90)

Code A

DAEDALUS WARD
Gosport War Memorial Hospital
Bury Road, Gosport
Visiting 2pm-8pm
(other times by arrangement)
Tel. 01705 603218

Code A

D71

MR 200

Gum HOSPITAL

UNIT NO

S.M.W. M.F.

Nan G099198

(Sui RICHARDS... ADYS QD2

Add S

Code A

Da 1

DR BASSETT

Code A

Family Dr. ....

HISTORY SHEET

Code A

D42 AF1 1 0 23

DATE

CLINICAL NOTES
(Each entry must be signed)

Code A

NMC100090-0083

RH HASLAR

D73

A&E No: 013070/98

Code A

Blood Sugar:

Other:

D74

HF...

or's Report (continued)

OF RTURE:	TRANSPORT HOME Y / N RETURN Y / N	SIGNATURE:	NAME:

TIGATIONS:

ay	5 Biochemistry	9 Scan	98 Other
i	6 Urine	10 Ultrasound	99 Unknown
natology	7 Bacteriology	11 Pregnancy	
arch	8 Histology	12 None	

SPECIAL CASES:

1 Asthma	5 Hepatitis Risk
2 Haematological	6 Pacemaker
3 Diabetic	7 S/C
4 Fits	8 S/C

Referred To: **Time Referred:**

een by ist: **Specialist's Diagnosis:** **Time Decision to Admit / Discharge:**

G:	Patient Group	Diagnostic Category	Anatomical Site	Side		
OSIS 1:	______	______	______	______	ARG Code	______
OSIS 2:	______	______	______	______	Alcohol Related	______

MENT:

s / Bandage / Sling	6 Incision & Drainage	11 IV Cannula	16 Urinary Catheter	21 Monitoring	26 Splint
es/Steristrips	7 Minor Surgery	12 Central Line	17 Peritoneal Lavage	22 Advice Only	
ription	8 Manipulation	13 Lavage / Emesis	18 Defib / Pacing	23 Nebuliser	
en Instructions	9 POP / Splint	14 Intubation	19 Other	24 Stat Drugs	
oval Foreign Body	10 Physiotherapy	15 Chest Drain	20 None	25 Wound Closure	

RIPTION: **COMMENT:**

THESIA:

onal Block	
iox	
ion	

TETANUS:

1 Immune
2 Tet Tox Course
3 Tet Tox Booster
4 Immunoglobulin

METHOD OF DEPARTURE:

1 Home / A&E PRN	6 Fracture Clinic	11 Left before Treatment
2 GP	7 Other OPD	12 Left Refused Treatment
3 District Nurse / HV	8 Admit A&E Ward	13 Died
4 Social Services	9 Admit own Unit	14 Transfer Other provider
5 A&E Clinic	10 Transfer outside DHA	15 this District
		98 Other 99 Unknown

RS;

val of Sutures No..... Days.....	2 Discharge No Follow Up	3 Discharge GP Follow Up	4 Admission
n to A&E	6 OPD (GP to Refer)	7 OPD (A&E Referral)	
arge frm Short Stay Ward	9 Discharge from A&E Clinic	10 Minor Operation	11 Notification of Death

D75

Medical - - - Confidence

Clinical Continuation Sheet

F Med 11
(Rev. 12/90)

ORTHOPAEDIC

To be used to continue the clinical notes from forms in the F Med series (ie Fs Med 1, 10, 19).
This form is to be securely attached to the original.

Code A

D76

Med'cal - in - Confidence

Da

Code A

Code A

NMC100090-0088

D78 AF110430

Code A

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Consent Form D79

for medical or dental investigation, treatment or operation

Code A

D80 [illegible]

NH 72
(Revised Mar 97)

AFFIX THIS FORM SECURELY TO THE FRONT OF THE F MED 9

LOCAL COMMUNITY TRANSFER FORM

This form is to be used

a. **In ALL cases of civilian patients being transferred to Elderly Medical bed placements in Gosport Community Hospitals** - Complete details below and ensure that the patient takes their hospital notes with them

b. **When a patient has been discharged/referred to Dolphin Day Hospital** - Complete details below and forward notes immediately to CMR Manager.

H 302284
RICHARDS GLADYS

Code A

Or Details ....

From: Royal Hospital Haslar .....E6.......ward

Name of Consultant ......SGN CDR SCOTT..........

To: DAEDALUS WARD G.W MEMORIAL .... Hospital

Name of Consultant..

Date: 11-8-98....................

NOTE: HOSPITAL NOTES AND X-RAYS ARE TO BE RETURNED TO RH HASLAR FOR DISCHARGE SUMMARY WITHIN THREE WEEKS OF THIS DATE

FROM: .... Hospital

Notes/X-RAYS are returned herewith. Date: ....

AFFIX THIS FORM SECURELY TO THE FRONT OF THE F MED 9

NMC100090-0091

ted in the UK - The Stationery Office J28713 10/97 C1000 38636

D81

DISTRICT J21 RH HASLAR SITE 39

Code A

Code A

HAEMATOLOGY REPORTS D83 MEDICAL IN CONFIDENCE

Remove lowest numbered strip and apply report.

12 →	← 12
11 →	← 11
10 →	← 10
9 →	← 9
8 →	← 8
7 →	← 7
6 →	← 6
5 →	← 5
4 →	← 4
3 →	← 3
2 →	← 2

Code A

Code A

Pathologist/Authorised by	Report Date	Report Status	Lab No
Mrs Jane L. Newman	31/07/98 10:53		H,98.0022256.R
Specimen	**Investigation**		**Date Taken**
VENOUS BLOOD	FBC MDIFF		31/07/98

Code A

3 →

← 3

Code A

Code A

D87 AF[illegible]37

ROY[illegible] HASLAR
PRE-OPERATIVE CHECK LIST

P8 H00302284
RICHARDS GLADYS
13041907 F NHS MRS
GLENHEATHERS NURSING HOME
LEE ON SOLENT
HANTS
DR. JH BASSETT

This check list is to be completed by ward staff prior to the administration of any premedication and again prior to the patient leaving the ward, in accordance with hospital protocols.

All items are to be ticked YES, NO or N/A (not applicable), with comment as necessary.

In the event that [illegible]

Code A

Hampshire
COUNTY COUNCIL

D88 AE [illegible]

Screening For Community Care Services (Older People) Ref No:

Code A

D89

ooo

The BARTHEL ADL Index

DA

BO

BL

GI

TO

FE

M

Code A

D90,

F Med 152

Code A

General Instructions for use

1. This record is valid for fourteen days from commencement. On expiry the patient's medication is to be reviewed by the doctor and a new record commenced if appropriate.
2. Only one prescription record is to be used at any time.
3. Only GENERIC names of drugs are to be used.
4. Prescriptions are to be clearly written in BLOCK CAPITALS.
5. Any alteration in drug therapy must be written as a new entry on the record.
6. Discontinue a drug as follows: ~~PENICILLIN~~ and a similar line through the remaining administration days.
7. Discontinuations of drugs must be signed and dated by the doctor.
8. REGULAR PRESCRIPTION times of administration must be inserted by a doctor.
9. The nurse (or doctor) must complete the record after administering the medication.
10. Special circumstances which cause a drug to be omitted or postponed require to be recorded as follows:
    a. Mark the appropriate box with an x .
    b. Enter the details in the section provided.
11. All Pre-Op and Post-Op medication must be prescribed on this record.
12. This record must accompany the patient to theatre.

D91

Regular Prescriptions

Code A

Dose	Frequency	Route														
Signature and Date																

Code A

D93

Regular Prescriptions

Code A

Drug	Date / Time													
Dose / Frequency / Route														
Signature and Date														

As required Prescriptions

Code A

Dose	Route	Freq.												
Signature/Date														
DIRECTIONS														

Intravenous Fluid Prescription and Administration Record

Patient Label

Code A

WARD E8 EVALUATION FORM

D96

Code A

WARD E8 EVALUATION FORM

Code A

N

Code A

Peri Operative Care Plan

D99

-AF 1/4/50

Code A

D100

NEUROVASCULAR OBSERVATION CHART

Code A

7/98

18

Daily Fluid Balance Chart D101

Code A

Number

✓ box if form to be retained

Special Instructions

D102

Daily Fluid Balance Chart

Code A

Special Instructions

D103

Daily Fluid Balance Chart

Code A

Special Instructions

D104

Daily Fluid Balance Chart

Code A

Special Instructions

Code A

Code A

Hospital Number		✓ box if form to be retained	

Special Instructions

Daily Fluid Balance Chart

D107

AF/IC/59

Code A

Hospital Number

✓ box if form to be retained

Special Instructions

NMC100090-0118

D108

Daily Fluid Balance Chart

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Code A

Special Instructions

Daily Fluid Balance Chart

Code A

Special Instructions

Daily Fluid Balance Chart

D11o

Code A

Hospital Number

✓ box if form to be retained

Special Instructions

D111

FOOD RECORD CHART

Code A

DAILY FOOD INTAKE		Kcals Protein (g)

D112

FOOD RECORD CHART

Code A

DAILY FOOD INTAKE		Kcals Protein (g)

FOOD RECORD CHART

D113

Code A

DAILY FOOD INTAKE		Kcals Protein (g)

D114 AF/1/c/35

FOOD RECORD CHART

Code A

AILY FOOD INTAKE		Kcals Protein (g)

Code A

TPR and BP Chart

D116 AF-C/69 F/Med 13

Pulse

Respiratio

Special Checks

Code A

Observation Chart

D117 AF/1/2/68

Code A

Code A

Code A

Code A

Code A

D131

Code A

D193

Code A

Code A

Code A

NAME :

HOSPITAL NUMBER :

WARD E1 EVALUATION FORM

Code A

NAME :_______________

HOSPITAL NUMBER :_____________

Med/909A
(Introduced 9/92)

For short stay pts. score through the unnecessary boxes

Nursing history/assessment form (adult) Long stay/Short stay

Code A

NMC100090-0138

Code A

D129

Code A

General Instructions for use

1. This record is valid for fourteen days from commencement. On expiry the patient's medication is to be reviewed by the doctor and a new record commenced if appropriate.
2. Only one prescription record is to be used at any time.
3. Only GENERIC names of drugs are to be used.
4. Prescriptions are to be clearly written in BLOCK CAPITALS.
5. Any alteration in drug therapy must be written as a new entry on the record.
6. Discontinue a drug as follows: ~~PENICILLIN~~ and a similar line through the remaining administration days.
7. Discontinuations of drugs must be signed and dated by the doctor.
8. REGULAR PRESCRIPTION times of administration must be inserted by a doctor.
9. The nurse (or doctor) must complete the record after administering the medication.
10. Special circumstances which cause a drug to be omitted or postponed require to be recorded as follows:
    a. Mark the appropriate box with an x .
    b. Enter the details in the section provided.
11. All Pre-Op and Post-Op medication must be prescribed on this record.
12. This record must accompany the patient to theatre.

D130

Regular Prescriptions

Code A

Dose	Frequency	Route												
Signature and Date														

D131

As required Prescriptions

Code A

Dose	Route	Freq.
Signature/Date		
DIRECTIONS		

Code A

TPR and BP Chart

D133

F/Med 13

Code A

Blood Pressure (IN RED)

(Black Ink)

Rank

Number

Hospital Number

Code A

HOSPITAL NUMBER :

Code A

NAME :

Code A

D137 AF[illegible]

Daily Fluid Balance Chart

F/Med 100

Code A

D138

Daily Fluid Balance Chart

Code A

D139 AF [illegible]

Daily Fluid Balance Chart

F/Med 100

Code A

D140

Daily Fluid Balance Chart

Code A

Code A

Code A

Code A

Code A

Code A

Code A

92

Code A

Code A

Code A

Code A

Code A

PROVIDER SPELL SUMMARY D152 HOSPITAL SITE CODE: GWM

Code A

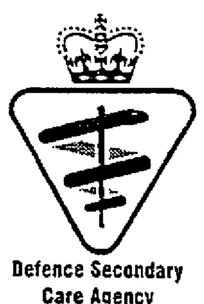
D153 HOSPITAL SITE CODE: GWM

CASENOTE NO: G099198 DISTRICT NO: 1304072V HOSPITAL: GOSPORT WAR MEMOR

Code A

NMC100090-0164

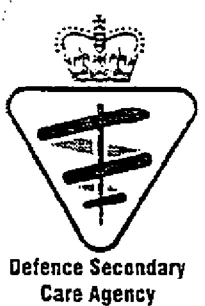
Royal Hospital Haslar
Gosport • Hants • PO12 2AA
Telephone 01705 584255 Ext. 2127 Fax. 01705 762403



Code A

D155

Royal Hospital Haslar
Gosport • Hants • PO12 2AA
Telephone 01705 584255 Ext. 2739 Fax. 01705 762403



The Sister in Charge
Ward Memorial Hospital
Bury Road
GOSPORT
Hants

Date: 10th August 1998

Your ref:

Our ref: H 302284

Code A

N J Curran
Sergeant
Staff Nurse

D156

Code A

Code A

D158

MR 200

Gum HOSPITAL

HISTORY SHEET

UNIT NO

S.M.W. M.F.

Nam G099198
(Sur

QD2

Add

Code A

Da

DR JH BASSETT

PO13 9LU
13040707

Code A

Code A

Code A

D161

LH/1/C/13

General Information

Code A

Code A

D163

Code A

Code A

PORTSMOUTH HealthCare NHS TRUST

Patient Name ....

Assessment Sheet

Code A

Code A

D167

Code A

D168

Code A

NR4

D168

lental Study

Study No:	
m Optional	Disch

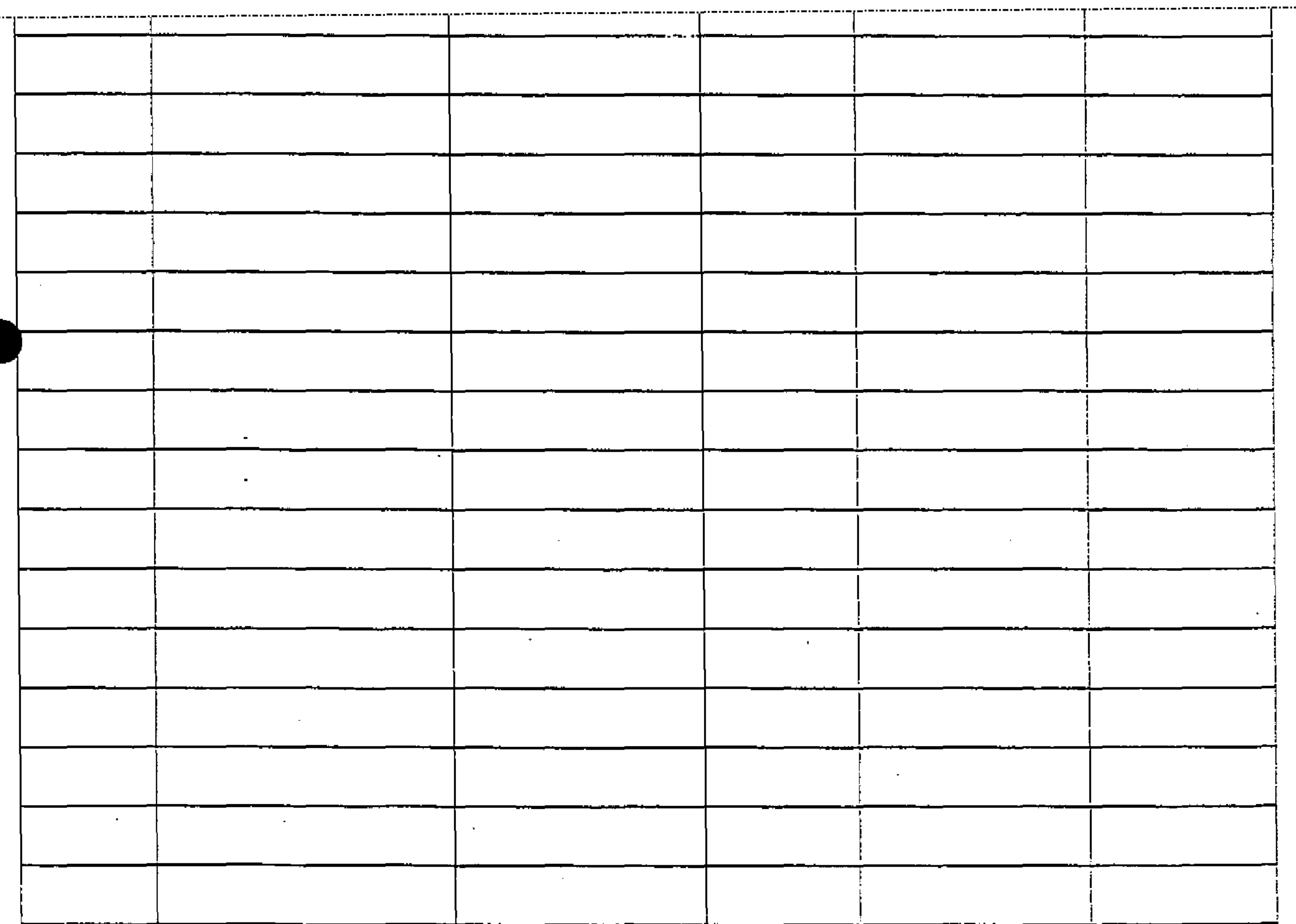
D170

Code A

Code A

D172 [illegible]

Code A



Code A

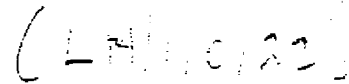
Code A

Code A

Code A

Code A

D178



PORTSMOUTH HealthCare NHS TRUST

Patient Name ....

Nursing Care Plan

Named Nurse ....

Date

Code A

D179

Daedalus Ward GWMH

NUTRITION

Code A

Code A

Code A

D182

Daedalus Ward GWMH
Nursing Care Plan

PERSONAL HYGIENE

Code A

Code A

Code A

Code A

Code A

TAKES MEDICINE OFF & ... D187 (L141/10/20)

Code A

Code A

Code A

Code A

D191

INVESTIGATIONS

REPORTS TO BE FILED IN STRICT CHRONOLOGICAL ORDER ON APPROPRIATE MOUNT SHEET.

FILING ORDER:

BIOCHEMISTRY	(Green)
HAEMATOLOGY	(Red)
MICROBIOLOGY	(Yellow)
CYTOLOGY	(Yellow)
RADIOLOGY	(Blue)

IRREGULAR SIZED SHEETS TO BE FILED IN FRONT OF THE APPROPRIATE MOUNT SHEETS

D199

PORTSMOUTH PATHOLOGY SERVICE

Microbiology Report

Telephone (01705) 866206 for Enquiries

Forename(s) Sex Date of Birth Hosp. No.

Code A

y number	Pathologist
:6078L	Dr R J Brindle x3204

	Date Collected	Date Received	Date Reported
screen	11/08/1998	11/08/1998	14/08/1998

D193

LH...

RADIOLOGY

STANDARD MOUNT SHEET

RADI

PORTSMOUTH HOSPITALS N.H.S. TRUST
DIAGNOSTIC IMAGING

FINAL
Report.

RICHARDS GLADYS 91Y F 13/04/1907

Code A

G98-5899
Dr. J. M. Domjan FRCR
Exam Date : 17/08/98

Beasley,PA-FORT
Dictated : 17/08/98 Typist :JR

D194

2

PORTSMOUTH HOSPITALS N.H.S. TRUST FINAL

Code A

398-5848
Dr. J. M. Domjan FRCR
Exam Date : 14/08/98

Barton,JA-FORT
Dictated : 17/08/98 Typist :JR

Code A

Code A

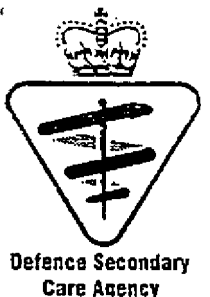
Code A

NMC100090-0208

Royal Hospital Haslar

Gosport • Hants • PO12 2AA

Telephone 01705 584255 Ext. 2739 Fax. 01705 762403



ıe Sister in Charge
'ard Memorial Hospital
ıry Road
OSPORT
ants

Date: 10th August 1998

Your ref:

Our ref: H 302284

ır Sister

Code A

: J Curran
ergeant
taff Nurse

D199 LH/1/C/8

DAEDALUS WARD
Gosport War Memorial Hospital
Bury Road, Gosport
Visiting 2pm-8pm
(other times by arrangement)
Tel. 01705 603218

14/8/98

Haslar A&E

Patient to A&E for reduction of dislocated (R) Hip.
No change in treatment since transfer to us 11/8/98,
except ~~discontinuation~~ addition of Oramorph PRN.
10mg Oramorph given at 1150.
We will be happy to take her back following
reduction of the dislocation.

Code A

Code A C. Nurse.

D260

Portsmouth HealthCare
NHS Trust

DIRECTOR OF PROFESSIONAL CONDUCT
RECEIVED ON:
ACTION:

Trust Central Office
St James' Hospital
Locksway Road
Portsmouth
Hants
PO4 8LD

Tel 023 9282 2444
Fax 023 9229 3437

Mrs Liz McAnulty
Director of Professional Conduct
UKCC
23 Portland Place
LONDON
W1B 1PZ

Our ref: ET/DB
Your ref:
Date: 21 June, 2001
Ext: 4353

Dear Mrs McAnulty

Gosport War Memorial Hospital

Ray Greenwood passed on to me your letter regarding a Police investigation which has taken place at Gosport War Memorial Hospital. I hope the following information is helpful.

The investigation is centred around a 91 year old woman who was admitted to Gosport War Memorial Hospital from Haslar Hospital. She had fallen in a nursing home sustaining a fractured neck of femur which was repaired with a hemi-arthroplasty. She was transferred to Gosport for trial of slow rehabilitation, where unfortunately she slipped from a chair and dislocated her hip prosthesis. She was transferred back to Haslar for manipulation under intravenous sedation. She was initially unresponsive following the sedation, but gradually improved and was transferred back to Gosport.

On arrival back at Gosport War Memorial Hospital, by ambulance, she was screaming in pain. A large haematoma had developed at the surgery site. She had multiple pathologies, and a decision was made that she was not fit for transfer back to Haslar again for further treatment. A palliative care approach was adopted and she was basically receiving end of life care.

There was family conflict before she died and this increased considerably in the period after her death, primarily regarding property.

The family raised a formal complaint with the Trust, after the second transfer from Haslar, and this was progressed through the local resolution procedures. However, the family withdrew before local resolution was completed. A full Trust investigation was carried out, which identified weakness in our systems relating to pain assessment and in relation to protocols for prescribing.

D201

The family then complained to the Police along the grounds that Mrs R was unlawfully killed. The initial Police investigation could find no evidence for this. The family subsequently complained about the Police investigation process.

Anomalies were found in this first Police investigation, consequently, a much more thorough investigation of hospital processes was undertaken which led to the newspaper article.

Part of the complaint to the Police centres around a prescription for diamorphine written up by the clinical assistant for elderly medicine, a local General Practitioner. The ward concerned provides NHS continuing care and slow rehabilitation

In an attempt to ensure that her patient's pain was adequately controlled, the clinical assistant had written up diamorphine "40-200 mgs in 24 hours". This was to permit the nurses to increase the medication as required - because Gosport being a community hospital, doctors are not on site 24 hours per day. The nurses at Gosport responded responsibly to this and no dose above the lowest "40 mgs" was every administered before Mrs R died.

Our response to this complaint/prescribing practice has been rigorous, with training of all staff undertaken, together with the implementation of pain charts, clear protocols and a detailed Trust policy for all staff.

The practice of wide prescribing is no longer undertaken and the GP concerned is no longer employed by the Trust. I am confident that the nursing staff acted appropriately and responsibly at the time, and that valuable lessons have been learnt and changes implemented. I will be very happy to provide you with any further details you require.

Yours sincerely

Code A

Dr Eileen Thomas
Nursing Director

Copies to: Dr Ian Reid
Mrs Barbara Melrose
Mrs Fiona Cameron
Mr Ray Greenwood

NMC100090-0212

D209

Portsmouth HealthCare NHS
NHS Trust

Trust Central Office
St James' Hospital
Locksway Road
Portsmouth
Hants
PO4 8LD

Tel 023 9282 2444
Fax 023 9229 3437

30 JUL 2001

PRIVATE AND CONFIDENTIAL

Code A
UKCC
23 Portland Terrace
LONDON
W1B 1PZ

Our ref: ET/DB
Your ref: PPC/Code A 10347
Date: 27 July, 2001
Ext: 4353

Dear Code A

Gosport War Memorial Hospital

Further to your letter and our recent discussion regarding a Police investigation into the events surrounding the death of Mrs Gladys Richards, I am enclosing the following information:

1. Paperwork associated with the original complaint. This commences with a copy of a letter from Lesley Lack, Mrs Richards' daughter, (Appendix A), the Trust's investigation report (Appendix B), and a letter from the Chief Executive to Mrs Lack. Mrs Richards' family did not pursue this complaint further within the NHS complaints procedure.

2. Some time after this initial complaint, the Trust received a telephone call from the Police, requesting a written report about the death of Mrs Richards. The Police would not inform us what specific aspects they were investigating, a situation that applied until a short time ago. At no stage were individual nurses mentioned but it became clear from the line of questioning that the Police were interested in the morphine prescription. We provided the information shown in Appendix B.

3. Gosport War Memorial is a Community Hospital in which medical care is shared between GPs and Consultants. In order to help control the pain of patients, a practice had existed that led to broad prescribing of analgesics. The nurses only administered the lowest dose to Mrs Richards and did not, in our view, contravene Trust policies. However, in order to protect nurses and patients more fully, the Trust has implemented new policies and practice guidelines (Appendix C).

D203

Continued / page 2

The Police investigation is now complete and the three nurses you refer to in your letter have received letters from the Police informing them that they are no longer part of any Police investigation. The Trust has been informed by the Police that the C.P.S. have decided that there is insufficient evidence to proceed with a charge of unlawful killing. The nurses concerned have experienced an extremely traumatic three year period and have all suffered personally. I am anxious to stress that the Trust has never received a complaint in relation to the three nurses mentioned in your letter (in all 19 nurses were interviewed as part of this process) and I am concerned about the consequences of another investigation, as they are the kind of committed nurses we want to try to retain in the health service. In consequence, I truly hope that the UKCC is able to offer an early decision in respect of further steps or required information.

Yours sincerely

Dr Eileen Thomas
Nursing Director

204

APPENDIX B

CONFIDENTIAL

MM/LH/YJM

Detective Constable Madeson,
Gosport Police Station,
South Street,
GOSPORT. PO12 1ES

19th January, 1999

4378

Dear Detective Constable Madeson,

Mrs. Gladys Richards (deceased)

Further to your telephone conversation with Mrs. Lesley Humphrey, Quality Manager, please find enclosed a written report from Dr. A. Lord, Consultant Geriatrician, explaining the care provided to Mrs. Richards prior to her death. You will see from Dr. Lord's report that the use of a syringe-driver was discussed with Mrs. Richards' daughters, Mrs. Lack and Mrs. McKenzie. The administration of intravenous fluids was not raised by either daughter prior to Mrs. Richards' death, or in the subsequent formal complaint. The care provided was appropriate for Mrs. Richards' needs.

Strictly speaking the complaint was never formally concluded. Our offer to meet with both daughters to discuss their concerns was accepted and arrangements were made for this to take place on 29th October, 1998. Mrs. McKenzie then advised us that this date was not convenient and volunteered to agree a suitable date with her sister and inform us accordingly. This action was agreed on 30th September, 1998; we heard nothing further until your call to Mrs. Humphrey on 11th December, 1998.

I hope these details help with your investigation. Please contact Mrs. Humphrey if we can be of any further assistance.

Yours sincerely,

Max Millett
Chief Executive

Silent copy to: Mrs. N. Pendleton (to share with Dr. A. Lord), Dr. J. Barton, and Mr. W. Hooper

205

Re- late Gladys Richards - Code A

I am writing this in response to Lesley Humphrey's written request on 17th December 1998. I am the Consultant of Daedalus ward to which Mrs. Richards was admitted as a patient for NHS Continuing Care. She had been assessed at Haslar by Dr. Ian Reid who had also spoken to her 2 daughters. (Letter attached - *Note 1*). My wards rounds for the Continuing Care patients in Gosport are fortnightly on Mondays as I cover both Daedalus and Dryad wards. I was on Study leave on the 17th and 18th August 98. During her 2 short stays on Daedalus Ward (11/8 to 14./8 and 17/8 to 21/8) I did not attend to Mrs. Richards at all, nor did I have any contact with her daughters and hence the comments made are from what I have gathered from her medical, psychiatry and nursing notes, Sue Hutchings report, the sequence of events as documented by Mrs. Lesley Lack (Mrs. Richards' daughter) and from discussions with Code A (Charge Nurse, Daedalus) and Dr. Jane Barton (Clinical Assistant). I have not had access to the Haslar records. The written complaint from Mrs. Lesley Lack, the documentation of the investigations and Sue Hutchings report of 11/9/98 were first made available to me on the 17th December 98.

In brief the sequence of events that affected Mrs. Gladys Richards -
30/7/98 - fall in Nursing Home, admitted to Halsar where she underwent a right hemiarthroplasty
11/8/98 - admitted to NHS Continuing Care Daedalus ward, GWMH - able to mobilise with frame and 2 persons
13/8/98 - fall on ward
14/8/98 - right hip x-rayed and subsequent transfer back to Haslar arranged. The same day s Closed hip relocation of right hip hemiarthroplasty was carried out under IV sedation. Nursing transfer letter states "rather unresponsive following the sedation"
17/8/98 - returned to Daedalus ward. On admission in pain and distress and was screaming loudly. She was given 5mg of Oramorph at 1 p.m. after discussion with a daughter who was present. A further Xray was arranged the same day and a dislocation excluded. This is also confirmed in the Radiologist's report.
18/8/98 - decision made following discussion with both daughters to commence a syringe driver containing Diamorphine. Mrs. Richards had required 45 mg Oramorph in a 24 hour period but seemed to be in considerable pain, discomfort and distress. This was reviewed and renewed daily till Mrs. Richards passed away on 21/8.

I have itemised my comments as follows:

1) **Use of Diamorphine via a Syringe Driver**
All the documentation available supports the fact that Mrs. Richards was in very severe pain and distress, screaming loudly on return to Daedalus ward on 17/8. An X-Ray that same day excluded a 2nd dislocation (confirmed by Radiologist's report) and it was decided by the medical and nursing staff that good pain control would be the aim of management.

As Mrs. Richards was demented, her pain control was discussed with one of her daughters who agreed that Oramorph (the oral liquid preparation of Morphine) was

given. This has a short action and needs to be administered 4 hourly for adequate pain control. Inspite of a substantial dose a day later, pain and distress was still a problem. Adequate nursing care was difficult to provide.

If someone is in considerable pain after having received regular Oramorph then the next step up the anaelgesic ladder is Diamorphine. The syringe driver was chosen as it delivers a continuous dose of Diamorphine over a 24 hour period, and hence 4 hourly injections are not required. It was also possible to add in Haloperidol 5 mg/24hours into the syringe driver. Mrs. Richards had been on this prior to her initial admission to Haslar. This was to treat agitation which had been a problem in the Nursing Home and occasionally at night on Daedalus Ward. Due to her underlying dementia, and inability to communicate fully, her distress could have been due to an element of anxiety and hence Midazolam was added to the syringe driver as an anxiolytic.

The above anaelgesia and sedation was considered necessary for Mrs. Richards to keep her comfortable and aimed at addressing pain, anxiety and agitation.

2) **Decision not to start intravenous fluids.**

Having established with Mrs. Richards daughters that she required opiates for pain control, we were now in the situation of providing palliative care. Basic nursing care, including mouth care was not possible as Mrs. Richards could not understand and comply with requests and was also in considerable distress. In this instance parenteral fluids are often not used as they do not siginificantly alter the outcome. If this is necessary in order to keep the mouth dry and skin hydrated, it is done by the subcutaneous route only on NHS continuing care wards. Patients requiring intravenous fluids would need to be transferred to an acute bed at Haslar or QA. Mrs. Richards was 91 years of age, frail, confused and had been twice to Halsar for surgical procedures and hence a 3rd transfer back for intravenous fluids only would not have been appropriate. I do not feel that the lack of intravenous fluids for the 4 days that Mrs. Richards was on a syringe driver significantly altered the outcome.

The concern about the lack of intravenous fluids was not raised by either daughter on Daedalus ward prior to her death and isn't included in Mrs. Lacks' written comments/questions.

3) **What was agreed with Mrs. Lack and Mrs. McKenzie**

The administration of the 1st dose of Oramorph on 17/8 was discussed and agreed with a daughter prior to it being administered. Consent was obtained for the doses to be repeated to ensure adequate anaelgesia.. The administration of subcutaneous morphine via a syringe driver was discussed on 18/8 and agreed by both daughters. Both these discussions were carried out by C/N Philip Beed.

Code A

Dr.A.Lord, Consultant Geriatrician
22/12/98

22nd December 98.

Dear Lesley,

In addition to the 2 pages of the requested report on the late Gladys Richards I have 2 further comments to make, and would value a written reply to these from yourself, Barbara Robinson and Bill Hooper.

1)"Review agreed 'policy' of medical consultant team not to transfer patients to Accident and Emergency, Haslar outside of working hours (i.e. G.W.M.H. X-Ray Department)" This statement is taken from Sue Hutchings signed CONCLUSION of 11/9/98. Copy attached - *Note 2.*

This statement is false. I am the sole member of the medical consultant team for NHS Continuing Care at GWMH at present. Neither I or any of my predecessors have recommended such a policy. There is no written policy regarding transfer of patients to A & E at Haslar. If there is one as mentioned I would be grateful for a copy as I have not been able to find one either at QAH or Gosport. It is expected that anyone suspected of a fracture or dislocation is sent to the nearest A & E department and if there is a reason for not doing so this is documented in the notes.

Further I was not consulted about this complaint in August or September. Inspite of a statement that is an insult to my professional integrity I find out by chance on the 18th December - more than 3 months after it was written. Why?

At no point was either myself or the duty Consultant Geriatrician involved in making the decision not to transfer Mrs. Richards to Haslar on the night of 13/8. I attach a Memo (*Note 3*) that has gone out to Daedalus and Dryad wards, Dr. Jane Barton, Dr. A. Knapman so that appropriate action can be taken if similar events occur over the Christmas and New Year weekends. This memo contains temporary guidelines of what should be done in the event of a suspected fracture or dislocation and hasn't been agreed by the medical or nursing staff on Deadalus and Dryad wards yet. I will discuss this further with Mrs. N. Pendleton and Consultant Colleagues so that a suitable policy could be circulated to all NHS Continuing Care Wards of the department.

2) There seems to be discrepancy in the way in which complaints are handled at QAH and GWMH. If there is a compliant on the acute ward at QAH, Nicky Pendleton sends me a copy as soon as it arrives requesting a response and then sends me a copy of the final statement <u>before</u> it is sent out to the complainant. This is not the case in Gosport and I'm writing to request that the system that is and always has been operational in QAH is carried out in Gosport and hope that this will happen with immediate effect.

Sincerely,

Code A

Althea Lord
Consultant Geriatrician

copies:
Barbara Robinson
Bill Hooper
Nicky Pendleton

NOTE 2

CONCLUSION

Mrs. Richards did fall from her chair on 13.08.98 but this was not witnessed by anyone. The trained nurse on duty at the time did check her for injuries and there did not appear to be any. Therefore, Mrs. Richards was put into another chair with a table to help prevent reoccurrence. Unfortunately, on that day the Ward was exceptionally busy and low in numbers of trained staff, although patient care did not suffer - only the stress level of the one trained nurse. Mrs. Lack stayed with her mother until early evening and was asked if she felt her mother to be in pain. Mrs. Lack did not feel her mother was. Mrs. Lack was then asked if she would like her mother to be put to bed. She replied "No rush".

Once S/N Brewer put Mrs. Richards on the bed, using a hoist, she noticed the angle of the hip and immediately phoned the Duty Doctor. Medical opinion was not to transfer to x-ray until the following day.

When did dislocation occur, i.e. when she fell? or when hoist was used?- unable to define.

Once x-rays confirmed dislocation, transfer to Accident and Emergency at Haslar was arranged - as appropriate.

In view of Mrs. Richards' previous fracture I feel she should have been transferred to Haslar the night before and that S/N Brewer should have insisted on this when contacting the Duty Doctor. S/N Brewer did agree with the Doctor that transferring Mrs. Richards at that time, i.e. 8.30 p.m. - 9.00 p.m. would have been too traumatic for Mrs. Richards. You could argue, due to Mrs. Richards's dementia, would she have been aware of the time?

Haslar Hospital were responsible for organising transport to transfer Mrs. Richards back to Daedalus Ward. It appears they booked Main Line Ambulance Services who were not happy about transferring Mrs. Richards without a canvas to lie her on. Haslar apologised and gave them two sheets instead. The Ambulance Crew confirmed to the nursing staff that Mrs. Richards began crying/screaming immediately they put her into the ambulance. They were given instructions to keep her flat. This may have been the cause of Mrs. Richards' distress or pain due to the transfer from bed to trolley to bed at Daedalus.

A nurse escort did not accompany Mrs. Richards. Unable to confirm the position Mrs. Richards was in in the ambulance, but once in bed it was noted her leg was not straight but at an angle. This would have caused some considerable discomfort. Once her (right) leg was straightened, within a few minutes of arrival she stopped crying out.

Once further x-rays confirmed no further dislocation, medical, nursing and family were involved in making the decision of how to treat Mrs. Richards - in view of Mrs. Richards age of 91 years. Agreement was made that she must be kept free of pain, therefore syringe driver was put in situ to ensure continual pain relief, the outcome of which was explained fully to both daughters.

Sadly, Mrs. Richards last few days and her death were not how her daughters had hoped her end would be, i.e. she did not regain consciousness and they felt they could not say "goodbye". The nursing staff were very aware of this and tried to involve the family as much as possible. Regarding the "trivia" part of the complaint, i.e. clothing being sent away for marking. It is policy on Daedalus Ward for all patient's clothing to be marked with the Ward name. This decision has been made in the light of complaints from relatives whose clothing has disappeared. This includes clothing of patients whose relatives agree to their laundry. It is a safeguard in case an article of clothing is put into the Hospital Laundry Bag by mistake. Unfortunately, at the time Mrs. Richards was admitted the marking machine at G.W.M.H. was broken so the laundry lady sent it to St. Mary's for marking but failed to inform the Ward of this. Steps have now been taken to ensure Wards are kept informed.

The nursing staff are sorry that this added to the stress the family were already suffering. As a result of this investigation an action plan will be recommended by myself to ensure we reduce the risk of further complaints of this nature.

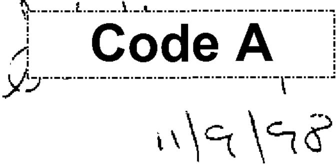
RECOMMENDED ACTION PLAN (to be agreed with Service Manager)

1. Review agreed "policy" of medical consultant team not to transfer patients to Accident and Emergency, Haslar outside of working hours (i.e. G.W.M.H. X-Ray Dept.).

2. Review nursing records and documentation.

3. Further training on records and documentation for all staff.

4. Review marking of clothing "policy".



11/9/98

210 -NOTE 3

URGENT - FOR THE NOTICE OF ALL MEDICAL AND NURSING STAFF

DAEDALUS AND DRYAD WARDS
GOSPORT WAR MEMORIAL HOSPITAL

In the event of a **suspected fracture and/or dislocation** in a patient on the ward the following must be adhered to:

1) Ensure the patient is comfortable and pain free.
2) Call out Dr. Jane Barton or the duty doctor.
3) If after a medical examination a fracture and/or dislocation cannot be confidently excluded an urgent X-Ray must be arranged as soon as is possible. If this is not possible at GWMH, the patient must be transferred to the nearest A&E Department irrespective of the time of day.
4) If for any reason this is not done (eg: in someone who is for palliative care) this must be discussed with the next-of-kin and documented in the medical and nursing notes.
5) If there is any concern about making the right decision the duty Geriatrician should be contacted via QA switchboard.

If there is any problem with carrying this out please let me know.

Code A

Dr. Althea Lord
Consultant Geriatrician
20.12.98.

Circulation:

- Dr. Jane Barton, Clinical Assitant
- Dr. A.Knapman and partners
- Code A
- Lesley Humphrey, Quality Manager, Portsmouth HealthCare Trust

211

1. on 12 August when first admitted to Gosport her agitation was put down to dementia when in fact it could have been simply that she wanted the toilet. She could have been treated with a milder form of pain relief.

2. When she suffered her fall a doctor should have been called before she was moved back to her chair.

3. on 13 August it took a long time for staff to identify that she had suffered a fall. Her distress was continually put down to her dementia and she was not admitted to Haslar A and E until 24 hours after the fall.

4. On 17 August when she was returned to Haslar Hospital she was obviously in extreme pain from being positioned wrongly. Why was nothing done about this until Mrs Lack arrived and assisted the nurse to move her.

5. When Mrs Richards developed a haemotoma why was a decision made to do nothing other than to keep her pain free.

212

APPENDIX A

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 Code A.

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

/continued - page 2

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 Code A that your mother had arrived. They had realised there was a problem and that professional advice was needed. Staff Nurse Code A 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.

/continued - page 3

(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.

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/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

(1) 216 1

Ref Gladys Richards **Code A**

Died 21.8.98

No Analgesia necessary

Tuesday 11th Aug. Admitted from Haslar. Able to walk - painf

Wednesday 12. Dementia mis-read. Diamorphine given - (knocked off) so no food etc would be given. Thought her anxiousness was pain!

THURSday 13 Aug.

Seen to be in pain by Grandaughter Mrs Reed 1.30 - 2.15

Brought to ward staffs attention. Thought to be dementia, Mother showing with pain, great pain in her hip (For your info she is a qualified Nurse) LL. Mrs Reed brought to the attention of the staff that Mum h

(1) At what time did Mrs Richards fall?

(2) Who attended to her.

(3) who moved her and how.

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 - it's her dementia. I was then told 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 you 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 her bottom from the chair" I stayed till 7.45pm My mother was in distress throughout.

At 9.30pm. I received a phone call from the ward. "When we put you're 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 & thigh LL

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 Code A ward manager and Dr Barton to be told - "You're 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 consultant was bleeped. He saw Mother 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 till 1am (ish) 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 bare for transfer. She ate and drank and the drip was removed and her fluid balance was acceptable.
She progressed on Sunday and was easily managable She was seen early on 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

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 mid day.
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 - don't just stand there - I don't understand 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 her 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 under her thighs we placed her squarely 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 acknowledged that "something" had happened

(FW)

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

Phillips ward manager agreed she needed Xray to establish if damage had been done or had occured to the hip.

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

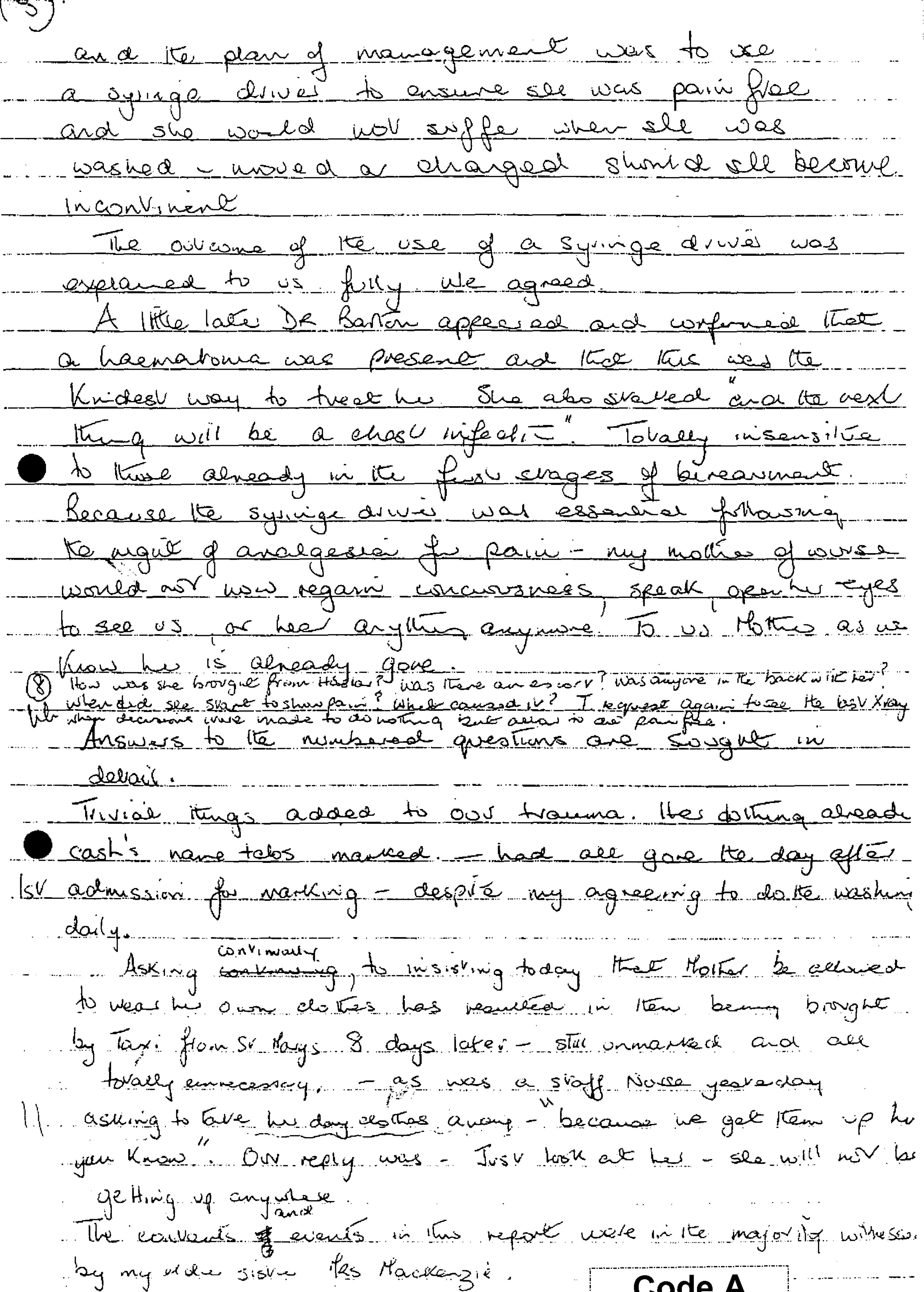
An appointment for Xray was made for 3.45pm as the DR called was expected at about 3.15pm

The charge Nurse did all he could to expedite this - keeping us informed and constantly check[ing] 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 ask[ed]. 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 de[spite] 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 4 hrly 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



(3)

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 she become incontinent

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

A little later Dr Barton appeared and confirmed that a haematoma 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 regime 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 Haslar? Was there an escort? Was anyone in the back with her? When did she start to show pain? What caused it? I request again to see the last X-ray

(9) When decisions were made to do nothing but allow her to die pain free.

Answers to the numbered questions are sought in detail.

Trivial things added to our trauma. Her clothing already cash's name tabs marked – had all gone the day after 1st admission for marking – despite my agreeing to do the washing daily.

Asking ~~continuing~~ continually, to insisting today that Mother be allowed to wear her own clothes has resulted in them being brought by Taxi from St Marys 8 days later – still unmarked and all totally unnecessary. – as was a staff Nurse yesterday

11. 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 ~~of~~ and events in this report were in the majority witnessed by my elder sister Mrs Mackenzie.

Code A

COMPLAINT MADE BY MRS. L. LOCK RE STANDARDS OF CARE FOR HER LATE MOTHER MRS. GLADYS RICHARDS WHILST A PATIENT ON DAEDALUS WARD - G.W.M.H. FROM 11.08.98 TO 14.08.98 AND 17.08.98 TO 21.08.98

1. At what time did Mrs. Richards fall?
   Answer - 1330 hours on 13.08.98.

2. Who attended to her?
   Answer - S/N Jenny Brewer and Code A

3. Who moved her and how?
   Answer - S/N Jenny Brewer and Code A using a hoist.

4. No direct questions asked. Statement only. There is some question regarding accuracy of this statement:-

   Response (a) There was only one trained nurse on duty after 3.30 p.m.and prior to this the second Staff Nurse was completing consultant round. There fore would not have been available to speak to Mrs.Lack (she states several trained nurses). Trained staff confirmed they would not have said it was Mrs. Richards dementia causing her to cry out; she had been given medication prescribed by Dr. Barton who was present on the Ward just after Mrs. Richards' fall. She was not given the stronger medication because Mrs. Lack had previously requested that it was not to be administered as it made her Mother very drowsy.

   S/N Brewer did see Mrs. Lack and gave her full details of the fall and the following actions that had been taken (statement by S/N Brewer attached).

5. Why the delay in x-raying Mrs. Richards?
   Answer - Mrs. Lack was telephoned and informed once dislocation was suspected and informed of the Doctor's advise, to which she agreed. This included not transferring her Mother immediately to Haslar.

6. Why no medical examination? Why no x-ray? Why no transfer?
   Answer - Duty Doctor was given the full facts of the situation including Mrs. Richards' diagnosis and her age. He stated he felt it would be too traumatic to transfer to Haslar for x-ray at that time of the evening and the journey could cause considerable distress. He advised medication, i.e. Oramorphine (strong pain relief) and to arrange for x-ray the following morning. S/N Brewer agreed with this as did Mrs. Lack when she was informed.

   Why no x-ray?
   X-ray at G.W.M.H only operational up to 5.00 p.m. Monday to Friday.

   Why no transfer?
   As above.

7. When returned from Haslar from the ambulance, was Mrs. Richards' position not checked?
   Answer - Her position was checked by an H.C.S.W. who immediately went to find a trained nurse and asked her to look at the position of Mrs. Richards' leg. Due to the considerable noise Mrs. Richards was making and, being untrained, she decided not to attempt to move Mrs. Richards herself.

8 (a) How was Mrs. Richards brought from Haslar Hospital?
Answer - By ambulance and two crew. She was not escorted by a Nurse, this would have been the responsibility of Haslar Hospital to arrange.

(b) When did she start to show pain? What caused it?
Answer - Ambulance Crew commented to nursing staff she began screaming as soon as she was put into the ambulance and continued throughout the journey and on Daedalus Ward. The cause of the pain cannot be confirmed, but we do know Haslar Hospital were unable to provide an appropriate canvas to transport Mrs. Richards on. Two sheets were used instead. This did mean Mrs. Richards' limb was not supported as well as it would have been on a canvas when moved from bed to trolley to ambulance to trolley to bed on Daedalus Ward. This may have caused the pain.

8 (c) Request to see x-rays denied?
Answer - This was a decision made by individual radiologist. The Ward Staff are unable to influence their decisions. The x-rays Mrs. Lack refers to did not come back to the Ward, they were seen in the Department by the Doctor and Consultant Radiologist.

8 (d) Decision made to do nothing but allow Mrs. Richards to die pain-free?
Answer - Dr. Barton did see Mrs.Lack and involve her in the decision making process. Due to Mrs. Richards' age she would not be able to have surgical intervention for the Haematoma as this would involve general anaesthetic. Therefore, the priority was to keep her pain-free and allow a peaceful death with dignity.

TRIVIAL CONCERNS RE CLOTHING/LAUNDRY

1. Clothing sent for marking despite Cash's name on all items of clothing?
   Answer - All patients/relatives are informed on admission that to safeguard their belongings, clothing is marked with the name of the Ward. This includes clothing of patients whose relatives agree to do the laundry. This decision has been made on Daedalus Ward following several complaints from patients/relatives whose clothing was sent off to the Hospital Laundry by mistake and often never seen again.

Obviously, while Mrs. Richards' clothing had been sent for marking she was given hospital clothing to wear. This should have only been for a day or two. Unfortunately, unbeknown to Ward Staff, G.W.M.H.'s Laundry Marker had broken down so Mrs. Richards' clothing was sent to St. Mary's Hospital for marking. The Ward were not informed of this and, due to Mrs.Lack's stress at this time, a taxi was authorised to goand collect the clothing and return it to Daedalus Ward.

2. I have not been able to confirm if any Staff Nurse made any comment regarding getting Mrs. Richards up when she was so obviously near to death. I would find difficulty in believing any member of staff, either trained or untrained, would make such a comment.

Investigation of Complaint made by Mrs Lesley Lack
Re: Standard of Care Received by her late Mother - Mrs Gladys Richards
whilst Patient on Daedalus Ward Gosport War Memorial Hospital

Complaint made verbally to Lesley Humphrey - Director of Quality followed by written notes of events forwarded to myself on 21st August 1998.

Following discussion with Mr Bill Hooper - I was asked to commence investigation on 24th August 1998.

Commissioning Officer - Mr W Hooper
Investigating Officer - Mrs Sue Hutchings

Investigation commenced: 24th August 1998
Investigation completed: 11th September 1998

1. Background
2. Analysis of Events
3. Conclusion
4. Recommendations
5. Statements taken during the investigation
   - 5.1 Code A n - September 3rd 1998
   - 5.2 tember 3rd 1998
   - 5.3 Beed - September 8th 1998
   - 5.4 eptember 8th 1998
   - 5.5 ptember 9th 1998
   - 5.6 tember 10th 1998 (telephone statement) – withdrawn

Other Documents

6. Accident Report Form
7. Riddor Form
8. Mrs Lack's Notes

1. Background

Mrs Gladys Richards
Code A
Died 21.8.98

Mrs Richards was admitted to Daedalus Ward Gosport War Memorial Hospital from Haslar Hospital on Tuesday 11th August 1998 following hemi-anthroplasty for fracture Rt neck of femur; this had been sustained as a result of a fall while Mrs Richards was a resident at Glen Heather's Nursing Home. Mrs Richards did suffer from degree of dementia but was walking with the aid of a zimmer frame and 2 nurses pain free; not requiring any analgesia when she was discharged from Haslar.

Wednesday 12th August 1998. Mrs Lack felt her Mother's dementia was mis-read by nursing staff - although Mrs Lack stated her Mother was able to communicate when she needed to go to the toilet, or when she was in pain. For some reason (not made clear to Mrs Lack) her Mother was given oramorphine - which caused Mrs Richards to become very drowsy and unable to take any fluids. At this point Mrs Lack suggested to nursing staff, she thought her Mother was in pain - but was told it was her dementia that was causing her Mother to cry and scream. On 13th August 1998 about 5 pm Mrs Lack was informed by Staff Nurse - her Mother had fallen earlier in the day.

It was a further 24 hours before diagnosis of dislocation of Rt hip was confirmed.

Mrs Lack has raised the following questions, which the investigation will focus on:-

1. At what time did Mrs Richards fall?

2. Who attended to her?

3. Who moved her and how?

4. Mrs Richards in pain, anxious, crying - calling out - told by trained and untrained staff "nothing wrong" - why?

5. Avoidable delay in being seen by Doctor and X-Ray ordered - why?

6. Why not transferred sooner?

7. Transfer back from Haslar to Gosport War Memorial Hospital? - leg not positioned correctly - not checked by trained nurse - source of pain not identified?

8a. Was there a nurse escort from Haslar - was anyone accompanying Mrs Richards in the back of the ambulance.

8b. When did Mrs Richards begin to show signs of being in pain and what caused it?

9. Why was Mrs Lack not allowed to see X-Rays and not involved in making decision "to do nothing" - allowed to die pain-free.

10a. Mrs Richards personal clothing - identified by cash's name tags all sent for "marking" day after 1st admission - despite Mrs Lack agreeing to do the washing daily - why?

10b. No clothes sent with Mrs Richards to Haslar.

10c. Following Mrs Lacks insistence on her Mother wearing her own clothes and asking where they were, discovered they were at Laundry at St Mary's Hospital - returned to Daedalus - once taxi was ordered by nursing staff - still unmarked - why?

ANALYSIS OF EVENTS

Mrs. Gladys Richards was a frail, 91 year old with dementia who had sustained a fracture of her right neck of femur whilst resident in a Nursing Home. She had surgical repair at Haslar Hospital. Despite her age and confused mental state Mrs. Richards made a good recovery and the medical team at G.W.M.H. agreed to accept Mrs. Richards to give her the opportunity for mobilisation. The transfer to Daedalus Ward was arranged and took place on **11.08.98.**

On arrival to Daedalus Ward, Mrs. Richards was quiet and accompanied by her daughter, Mrs. Lack. She was admitted by Enrolled Nurse Pulford and Mrs. Lack was seen and told of the plan for managing her mother whilst on Daedalus. Mrs. Richards was also seen by Dr. Barton and medication was prescribed.

Wednesday 12th August, 1998.

S/N Code A was on a late shift. She went into Mrs. Richards room and became concerned because Mrs. Richards looked poorly. She was very drowsy and pale in colour although sitting in a chair. When Mrs. Lack visited later that afternoon she also became very concerned about her mother's drowsy condition. She was informed of the medication her mother had been given. Mrs. Richards was transferred back to bed by use of a hoist. This did cause Mrs. Richards to wake up and cry out. She settled and was fed her supper by Mrs. Lack

Thursday a.m. 13th August, 1998.

The Ward was very busy with general activities plus two admissions expected and two discharges. Staffing levels were low although the Clinical Manager had taken some steps to ensure adequate level. There was only one trained nurse on until 12.15 p.m. and after 3.30 p.m. with Consultants round due at 2.00 p.m.

Mrs. Richards had been got up earlier in the morning and sat in a chair in her room. After lunch, approximately 13.30 hours, an H.C.S.W. found Mrs. Richards on the floor by her chair. S/N Brewer was informed and she immediately attended to Mrs. Richards. She checked for any injuries. At this point she did not feel any had been sustained so authorised Mrs. Richrds to be put back into a safer chair using a hoist.

Mrs. Lack was due to visit that afternoon so S/N Brewer made the decision to see her rather than telephone her regarding her mother's fall, particularly as she did not appear to be suffering from any injuries. It was 6.30 p.m. when S/N Brewer spoke to Mrs. Lack and informed her of the fall, explaining she did not know how she fell but reassured Mrs. Lack she had checked her mother before moving her. At this point S/N Brewer asked Mrs. Lack if she thought her mother to be in pain. Mrs. Lack did not feel she was as she was eating her tea.

At 7.45 p.m. S/N Brewer commenced putting Mrs. Richards to bed. Once in a lying position she could see Mrs. Richards (right) hip was internally rotated. The Duty Doctor was called immediately and informed of the problem, patients age and dementia. The Duty Doctor felt it would be too traumatic to transfer Mrs. Richards overnight, but to give pain relief and arrange x-ray at G.W.M.H. the following morning and to contact him if any further problems arose.

Mrs. Lack was telephoned as soon as the pain relief had been administered (approximately 8.30 p.m.) and informed of the current situation and Doctor's advice. S/N Brewer asked if she was satisfied with this to which Mrs. Lack replied "Yes" and thanked S/N Brewer. Mrs. Richards slept well that night.

Friday 8.00 a.m. 14th August, 1998

Dr. Barton visited the Ward and completed X-Ray Request Form. Mrs. Richards was taken to X-ray Department about 10.45 a.m. accompanied by Mrs. Lack. X-ray confirmed dislocation of (right) hip. Mrs. Lack was seen by Dr. Barton and Code A d, Clinical Manager, and informed. Arrangements made for transfer to Accident and Emergency, Haslar. Mrs. Richards was given pain relief prior to transfer and was accompanied by H.C.S.W. in the ambulance (Mrs. Lack followed in her car). Mrs. Richards remained at Haslar for 48 hours and arrangements were made to transfer back to Daedalus Ward on 17.08.98.

Monday 11.45 a.m. 17th August, 1998

Mrs. Richards arrived on Daedalus Ward. Mainline Ambulance Crew, but no nurse escort. Transport was arranged by Haslar who telephoned Daedalus and apologised they could not find a canvas to put Mrs. Richards on, i.e. canvas would have two poles inserted to lift patient. Instead they used two sheets to lift Mrs. Richards who was crying and screaming, which apparently had started in the ambulance and continued for some time after her arrival.

Two H.C.S.W.'s supervised Mrs. Richards being put into bed. The ambulance man stated he had been given strict instructions from Haslar that Mrs. Richards was to be kept flat - in bed she was given two pillows only and a pillow between her leg. Code A was very concerned regarding the position of (right) leg. She was afraid to straighten it because of the noise Mrs.Richards was making so went to find a trained nurse and seek her advice. At that point Mrs. Lack arrived. S/N Code A walked into the room and pulled back the covers and realised the leg was not positioned correctly. Mrs. Lack offered to assist S/N Couchman and between them re-positioned Mrs. Richards who then stopped screaming.

Mrs. Richards became agitated again a little later. Mrs. Lack requested her mother be x-rayed again. Dr. Barton was contacted and agreed . S/N Code A was asked to complete X-ray Request Form and p.p. it. Unfortunately, X-ray Department refused to accept the form and insisted a Doctor's signature had to be on the form. Surgery was contacted and Duty Doctor signed the form and faxed to G.W.M.H. All of this did cause delay.

Mrs. Richards was x-rayed at 15.45 hours. Films were seen by Consultant Radiologist who confirmed no further dislocation. Dr. Barton was informed and discussion took place with Clinical Manager and both Mrs. Richards's daughters who were informed a haematoma had developed at the site of manipulation, i.e. (right) hip and, in medical opinion, the best treatment would be to keep her pain free. The use of a syringe driver was discussed fully. Both daughters agreed to this course of action. From 18th August - 21st August Mrs. Richards condition deteriorated and she died at 8.20 p.m. on the 21st August. Both daughters were present.

All trained staff interviewed were very aware that Mrs. Lack and her sister, Mrs. McKenzie, did not agree between themselves regarding their mother's care, particularly about pain control. This did make the nursing of Mrs. Richards difficult at times, i.e. she was not returned to bed following her fall on 13.08.98 as Mrs. Lack had complained previously she felt her mother was on her bed too much and this would not help with rehabilitation.

During her last day of life Nursing Staff were prevented from removing Mrs. Richards dentures as part of mouth care as the daughters said they were not to remove them.

Nursing staff reluctantly accepted this, although in hindsight agree they should have tried harder to persuade the daughters it was in their Mother's best interest to remove the teeth for cleaning.

Sadly, Mrs. Richards's death was not as Mrs. Lack had hoped it would be. She felt the use of the syringe driver made her mother become unconscious and she did not say her "goodbye", although both she and her sister were with their mother almost continuously day and night during Mrs. Richards last few days. Nursing staff tried not to be obtrusive.

CONCLUSION

Mrs. Richards did fall from her chair on 13.08.98 but this was not witnessed by anyone. The trained nurse on duty at the time did check her for injuries and there did not appear to be any. Therefore, Mrs. Richards was put into another chair with a table to help prevent reoccurrence. Unfortunately, on that day the Ward was exceptionally busy and low in numbers of trained staff, although patient care did not suffer - only the stress level of the one trained nurse. Mrs. Lack stayed with her mother until early evening and was asked if she felt her mother to be in pain. Mrs. Lack did not feel her mother was. Mrs. Lack was then asked if she would like her mother to be put to bed. She replied "No rush".

Once S/N Brewer put Mrs. Richards on the bed, using a hoist, she noticed the angle of the hip and immediately phoned the Duty Doctor. Medical opinion was not to transfer to x-ray until the following day.

When did dislocation occur, i.e. when she fell? or when hoist was used?- unable to define.

Once x-rays confirmed dislocation, transfer to Accident and Emergency at Haslar was arranged - as appropriate.

In view of Mrs. Richards' previous fracture I feel she should have been transferred to Haslar the night before and that S/N Brewer should have insisted on this when contacting the Duty Doctor. S/N Brewer did agree with the Doctor that transferring Mrs. Richards at that time, i.e. 8.30 p.m. - 9.00 p.m. would have been too traumatic for Mrs. Richards. You could argue, due to Mrs. Richards's dementia, would she have been aware of the time?

Haslar Hospital were responsible for organising transport to transfer Mrs. Richards back to Daedalus Ward. It appears they booked Main Line Ambulance Services who were not happy about transferring Mrs. Richards without a canvas to lie her on. Haslar apologised and gave them two sheets instead. The Ambulance Crew confirmed to the nursing staff that Mrs. Richards began crying/screaming immediately they put her into the ambulance. They were given instructions to keep her flat. This may have been the cause of Mrs. Richards' distress or pain due to the transfer from bed to trolley to bed at Daedalus.

A nurse escort did not accompany Mrs. Richards. Unable to confirm the position Mrs. Richards was in in the ambulance, but once in bed it was noted her leg was not straight but at an angle. This would have caused some considerable discomfort. Once her (right) leg was straightened, within a few minutes of arrival she stopped crying out.

Once further x-rays confirmed no further dislocation, medical, nursing and family were involved in making the decision of how to treat Mrs. Richards - in view of Mrs. Richards age of 91 years. Agreement was made that she must be kept free of pain, therefore syringe driver was put in situ to ensure continual pain relief, the outcome of which was explained fully to both daughters.

Sadly, Mrs. Richards last few days and her death were not how her daughters had hoped her end would be, i.e. she did not regain consciousness and they felt they could not say "goodbye". The nursing staff were very aware of this and tried to involve the family as much as possible. Regarding the "trivia" part of the complaint, i.e. clothing being sent away for marking. It is policy on Daedalus Ward for all patient's clothing to be marked with the Ward name. This decision has been made in the light of complaints from relatives whose clothing has disappeared. This includes clothing of patients whose relatives agree to their laundry. It is a safeguard in case an article of clothing is put into the Hospital Laundry Bag by mistake. Unfortunately, at the time Mrs. Richards was admitted the marking machine at G.W.M.H. was broken so the laundry lady sent it to St. Mary's for marking but failed to inform the Ward of this. Steps have now been taken to ensure Wards are kept informed.

The nursing staff are sorry that this added to the stress the family were already suffering. As a result of this investigation an action plan will be recommended by myself to ensure we reduce the risk of further complaints of this nature.

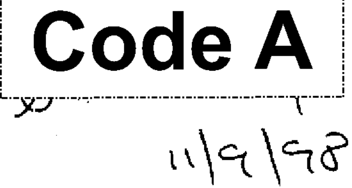
RECOMMENDED ACTION PLAN (to be agreed with Service Manager)

1. Review agreed "policy" of medical consultant team not to transfer patients to Accident and Emergency, Haslar outside of working hours (i.e. G.W.M.H. X-Ray Dept.).

2. Review nursing records and documentation.

3. Further training on records and documentation for all staff.

4. Review marking of clothing "policy".



11/9/98

232

Daedalus Ward Action Plan
(in response to investigation re. Mrs. G. Richards)

1. Transfer of patients

Existing ward policy on transfer of patients allows a degree of discretion as to whether or not to transfer a patient if their condition changes. The purpose of this is to save patients and relatives the distress of transfer to a busy acute facility if contra-indicated by their overall condition and prognosis.

The following guidelines will now form part of the policy:

Where it is clearly evident, or highly probable, that an injury has been sustained, for which acute treatment is required and applicable, the patient will be transferred.

The patient and/or relatives are to be involved in deciding whether or not transfer is applicable, ensuring they are aware of the options and their consequences, with the aim of having their informed agreement for whatever decision is taken.

2. Marking of Clothing

Losses of personal clothing are inevitable when clothing is not marked, is upsetting for relatives, and takes up valuable nursing time (inevitably detracting from patient care).

An insistence that all personal clothing is marked has significantly reduced incidence of loss, but still poses some difficulty owing to the time lag required for initial marking.

An information leaflet (copy attached) advises patients and relatives of our personal clothing policy. Included in this is the option for relatives to mark clothing themselves if they wish to do so, which may be quicker than our own marking facilities.

Individual laundry bags are to be purchased for laundry being taken home (as soon as a suitable supplier can be found). These will be hung on patients wardrobes, making it easier for staff to identify when clothing is being washed at home, and allowing relatives to easily locate patients dirty laundry.

A lost laundry book will be used as a central reference of missing clothing. This will save time and effort in handling lost clothing complaints and be a more efficient means of trying to trace the items.

3. Nursing Records & Documentation

A programme of education on nursing documentation will take place on the ward involving all qualified and non qualified staff, relevant to their specific needs.

Internal audit of nursing documentation will take place at regular intervals, and involve all qualified staff, to identify areas of weakness, and consider developments and improvements.

4. Availability & Use of Bank Staff

Activity levels, combined with vacancies, long term sick leave and annual leave, made the period in question busy and stressful for qualified staff. Using qualified bank staff was not an option, as the reality is that contacting those on the bank list invariably draws a negative response.

This is a great pity as it is an option that the ward would and could have used, particularly as the budget existed to do so.

The recommendation is that the hospital seeks to recruit qualified nurses to the bank, who are available to work, and inducts them appropriately.

234

Daedalus Ward

Patient Information

Clothing

Patients on Daedalus Ward are encouraged to wear their own clothing if they wish to do so. Nursing staff will be happy to advise you on what type of clothing is most appropriate, this is particularly relevant if you intend buying any new items of clothing.

As an alternative to your own clothing the ward has a good stock of clean presentable clothing which patients may use.

If you are wearing your own clothing you may wish to send it home for laundering, in which case it will be left in the bottom of your wardrobe, or you may wish to use the hospitals laundry facilities.

Whether your laundry is being done at home or in the hospital, it is **absolutely essential** that it is properly marked. This can be done by the hospital laundry, and usually takes 3-4 working days (sometimes a little longer), or you can arrange for a relative to mark it.

Marking needs to be on a secure label, with a proper laundry marker, and must contain the following information:

Surname Daedalus 05 GWMH

You should be aware that due to the high volume of laundry handled by the ward and hospital, clothing does periodically go missing. Provided it is properly marked it will usually reappear.

If you think some clothing has gone missing please inform a member of staff, who will record the details in our laundry book, and ask the laundry room staff to look out for the item.