Information Pack

Complainants: Mrs Lack, Mrs McKenzie

Patient: Gladys Richards

Ward: Daedalus

Admitted: 11.8.98 – 14.8.98
17.8.98

Died: 21.8.98

1.	Original telephone complaint from Mrs Lack and handwritten report Mrs Lack.	**19.8.98**
2.	Copy of investigation report – Sue Hutchings	**24.8.98 – 11.9.98**
3.	MM Response to complaint	**22.9.98**
4.	Letter from MM to Mrs McKenzie	**22.9.98**
5.	Subsequent letters from MM to Mrs Lack re meeting	**25.9.98** **8.10.98**
6.	LH file note Mrs McKenzie telephone conversation	**28.9.98**
7.	LH file note DC Madeson telephone conversation	**11.12.98**
8.	Letter to Mrs McKenzie to release records to police	**14.12.98**
9.	LH file note Mrs McKenzie telephone conversation	**15.12.98**
10	Dr A Lord Statement	**22.12.98**
11.	Letter from DCI Burt to PHCT	**10.8.99**
12.	LH file note DCI Burt telephone conversation	**19.10.99**
13.	LH E-Mail folllowing meeting with DCI Burt	**27.10.99**
14.	LH file note DCI Burt telephone conversation	**20.1.00**
15.	LH letter to DCI Burt requesting clarification	**6.12.99**
16.	DCI Burt response to above	**14.12.99**
17.	DCI Burt letter to PHCT	**8.2.00**
18.	E-Mail LH re telephone conversation with DCI Burt	**15.5.00**
19.	LH file note & E-Mail re meeting DC Simon Poulter	**26.5.00**
20.	LH E-Mail telephone conversation police	**12.6.00**
21.	LH E-Mail telephone conversation DCI Burt	**1.9.00**

Comm/Host (6)

1

Mrs. L. Lack,

Code A

LH/YJM

25th August, 1998

4026

Dear Mrs. Lack,

Thank you for telephoning me last Wednesday, 19th August, 1998, to explain your concerns about the care provided for your mother, Mrs. Gladys Richards, on Daedalus Ward at Gosport War Memorial Hospital. I understand that she died on Friday. This will be a very sad time for you and your family, made worse by the traumatic events of last week. I would like to offer our condolences to you and your family.

I understand that following our telephone conversation, Mrs. Sue Hutchings visited you on Daedalus Ward (covering for Mrs. Barbara Robinson, Service Manager, who is currently on leave). I had intended to capture the details of our telephone conversation in this letter. Events, however, overtook me and I now have a copy of your hand-written report, describing what happened and asking some very logical questions. There seems little point in repeating these in detail here.

An investigation has already begun within our formal complaints procedure. The enclosed leaflets explain how the NHS complaints procedure works, and the future options open to you.

Mr. Max Millett, Chief Executive, will write to you in more detail when our investigation is complete, in about three to four weeks time. In the meantime please let me know if I can be of any further help.

Yours sincerely,

Code A

Lesley Humphrey
Quality Manager

Silent copy to: Mrs. S. Hutchings
Mr. W. Hooper

Portsmouth HealthCare NHS Trust
26 AUG 1998
General Manager, Fareham/Gos

Friday 20th August.

Mrs Hutchings.

Please find herewith some notes I have written and added to over the past 24hrs. I have retained the original.

If you feel you need any clarification please do not hesitate to contact me. or my daughter Karen Read

I have included all matters relevant as I see it.

Code A RGN

LESLEY LACK

Code A

Karen Read

Code A

(1)

Ref Gladys Richards DOB 13 4 98
Died 21.8.98 HTH.

Tuesday 11th Aug. Admitted from Haslar. Able to walk - painful
Wednesday 12. Dementia mis-read. Diamorphine given - (knocked off) so no further
etc could be given. Thought her anxiousness was pain!
No Analgesia necessary

THURSday 13 Aug.

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

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

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

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

(2)

She was deeply under with oramorph.
She was xrayed. The movement caused pain and I stayed with her to comfort her.
We returned to the ward. I was called in to the office by Philip - ward manager and DR Barton to be told - "Your worst fears of last night appear to be true. We have rung Haslar and they have accepted her back."
We arrived at Haslar late morning - mid day. She was expected. The ambulance was bleeped. He saw Hayley in Casualty immediately. He then saw me. He showed me the Xrays and position of limb - which I had seen in [illegible] 24 hrs from accident to admission and second emergency operation. Why? why no examination? why no xray? why no transfer?

(6) She arrived at Haslar and within 1hr had a manipulation to put the hip back in the socket. From then she was pain free.

She did not regain consciousness fm 1am (15th) on Sat 15th due to amount of analgesia required for the procedure. She was then catheterised so that there was no need to use slippa pa. She had a drip as she had had NIL BY MOUTH since before Xrays on 14th.

She remained pain free in full length leg splint. both legs level and straight - shown to me by consultant. No analgesia was required - she was able to use a commode for the toilet and weight bore for transfer. She ate and drank and the drip was removed and her fluid balance was acceptable.

She progressed on Sunday and was easily manageable. She was seen early 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

(3)

She is fine". I went to G.W.H about 10.45am and was told the ambulance was due about midday. I arrived back at 12.15 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 staring anxious expression She was gripping her Rt thigh op site tightly. She uttered the words Do Something Do something the pain the pain - dont just stand there - I dont endurstand 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 around 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 acknowleged that "Something" had happened

(4)

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

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

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

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

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

We went to Xray. My mother was in pain despite her pain relief. I was not allowed in with her as I was the previous week. I could hear her wailing through the doors while the Xray plates were put in place. We returned to the ward. We were told there was no dislocation but obviously something had happened. We were told she would be given Oramorph for the pain 4 hrly through the night for pain relief and reviewed in the morning.

On Thurs 18 we arrived on the ward and were told she had had a peaceful night. We were told that she had a mass we haemotoma causing pain at the Op sit

(5)

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

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

A little later Dr Barton appeared and 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 for having the right 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 rays who decisions were made to do nothing but allow to die painfree.

Answers to the numbered questions are sought in detail.

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

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

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

Code A
Code A Code A

2

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:

1. Background
2. Analysis of Events
3. Conclusion
4. Recommendations
5. Statements taken during the investigation
   - 5.1 S.N Margaret Couchman - September 3rd 1998
   - 5.2 S.N Jenny Brewer - September 3rd 1998
   - 5.3 Clinical Manager Philip Beed - September 8th 1998
   - 5.4 E.N Monica Pulford - September 8th 1998
   - 5.5 S.N Christine Joice - September 9th 1998
   - 5.6 HCSW Jean Moss - September 10th 1998 (telephone statement)

Other Documents

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

1. Background

Mrs Gladys Richards
D.O.B. 13.4.07
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 Joice 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 Philip Beed, 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. H.C.S.W. Baldacchino 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 Couchman 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 Couchman 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.

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".

Code A

11/9/98

Witness Statement: Mrs Margaret Couchman - Staff Nurse Daedalus Ward.

The following statement was taken by Mrs S Hutchings - Investigating Officer on 3rd September 1998.

Q1. Can you confirm you were the named nurse for Mrs Gladys Richards?

A. Yes

Q2. Did you complete the admission documentation on 11th August 1998.

A. No - not on duty - EN Pulford was responsible for completing the admission documentation.

Q3:1 Can you explain why Mental Test Sheet was not completed as Mrs Richards was diagnosed with dementia?

Q3:2 Can you explain why Lifting/Handling Risk Calculator Form was not completed?

A3:1) No
A3:2) No - I did not complete the admission documentation - but agree this should have been completed.

Q4. Were you on duty at the time Mrs Richards was found on the floor?

A. No.

Q5. Were you on duty when Mrs Richards was transferred back from Haslar Hospital?

A. Yes.

Q6. On arrival on the Ward, did Mrs Richards appear to be in any discomfort?

A. I was at coffee break at time of her arrival, but on my return I went into Mrs Richards room and introduced myself - I noticed Mrs Richards was in some distress and not positioned correctly - Mrs Lack offered to help me move her Mother - informing me she was a retired nurse, we straightened her, placed a pillow in between her legs - she immediately appeared more comfortable. I cannot be certain if she had a splint - I think she probably did.

Q7. When moving Mrs Richards with her daughter - did you notice any swelling around the hip?

A. No - Mrs Richards held her hand on her hip and said "it hurt".

Q8. Was she accompanied by a nurse from Haslar.

A. I cannot answer, I was not on the Ward at the time of Mrs Richards arrival.

Q9. How was Mrs Richards pain controlled?

A. Oramorph 10 mgs 4 hourly - given orally.

Q10. Was her daughter involved in making this decision?

A. After Mrs Richards was settled, the daughter tried to feed her Mother (HCSW took meal away to "mince") as Mrs Richards could not cope with "lumps". Mrs Lack felt her Mother was still in pain and she told me that the Surgeon at Haslar had said if the hip dislocated again - it was to be replaced. Pain controlled discussed with Mrs Lack - who was reluctant for her Mother to be given medication, but did eventually agree. Dr Barton contacted and advice sought - X-Ray form written and signed by me i.e. pp. By Dr Barton, but this was not acceptable to X-Ray Dept. - who insisted form must be signed by Doctor new form was faxed to Surgery and signed by Duty Doctor. Mrs Richards was X-Rayed at 15.45 hours.

Q11. Why would her clothing be sent for marking at the Hospital when her family had agreed to do her washing?

A. Not necessary, but I am aware Gosport War Memorial Hospital had run out of labels i.e. "Dacdalus Ward", therefore it was sent to St. Mary's to be labelled.

Q12. Were you aware of the family's concerns regarding the standard of care their Mother was receiving?

A. Yes - the family told me in no uncertain terms.

Q13. It there anything else you would like to say?

A. After the syringe driver was commenced and Mrs Richards appeared more peaceful - the family's attitude appeared to change towards the staff.

Witness Statement: Mrs Jenny Brewer - Staff Nurse Daedalus Ward

The following statement was taken by Mrs S Hutchings Investigating Officer on 3rd September 1998.

Q1. How long have you worked on Daedalus Ward as 'D' grade Staff Nurse?

A. Since December 1996.

Q2. Did you have any involvement in the care of the late Mrs Gladys Richards?

A. Yes on Wednesday 13th August 1998 I was on late shift and after 15.30 hrs - the only trained nurse on duty. I was not the named nurse for Mrs Richards.

Q3. Where you on duty when Mrs Richards had a fall?

A. Yes.

Q4.1 Can you describe what happened and the action you took.

A. See attached statement.

Q4.2 Can you explain why you did not fully complete the Accident Form?

A. As I was busy with Dr Lord - a colleague completed some of the details for me and I signed it - I admit I did not complete all the details and Philip filled in parts that had not been completed.

Q5. Did you ask the Duty Doctor to visit Mrs Richards?

A. Dr Barton was on the Ward and was aware; as Mrs Richards did not appear to have suffered any injuries - I did not ask her to examine Mrs Richards. The Duty Doctor was contacted by telephone after 19.45 hrs when I noticed the internal rotation of Mrs Richards Rt hip.

Q6. How would you describe Mrs Richards mental state while she was on Daedalus Ward?

A. I am aware she suffered from dementia - but she was not my patient.

Q7. Did you speak to Mrs Lack (Mrs Richards daughter) on the day of the fall?

A. Yes - when she visited tea-time approximately I was completing the medicine round. I did not telephone her immediately after the fall as I felt it better to see her face to face.

Q8. What did you say to her?

A. I informed her that her Mother had fallen from the chair earlier, but she did not have any apparent injuries.

Q9. Were you on duty for the evening drug round?

A. Yes.

Q10. Did you ask Mrs Lack if she thought her Mother was in pain?

A. Yes. Mrs Lack's reply was "not at the moment I am feeding her" - it was at this point I informed her of her Mothers fall. After this Mrs Lack did say her Mother was in pain (see Question 19).

Q.11 Who put Mrs Richards to bed that evening?

A. Myself and HCSW put Mrs Richards to bed at 19.45 hrs using hoist. At this time - I noticed the Rt hip to be internally rotated and painful. At 2000 hrs contacted Duty Doctor Dr Brigg and informed him I thought the hip to be dislocated - see statement.

Q12. Did you have any further involvement with Mrs Richards after the day of the fall?

A. Yes - only very little - she was not my patient.

Q13. Were you on duty when Mrs Richards was transferred back from Haslar?

A. No - I was a day off. I next saw Mrs Richards on Tuesday 18th August 1998 - I was on a late duty i.e. 12.15 pm - 9 pm (see attached).

Mrs Lack spoke to me whilst I was in the sluice, she was angry - telling me that her Mother "was walking yesterday at Haslar - she is here today and dying". My response was sympathetic - said I was sorry and maybe the journey from Haslar had upset her.

Q14. Were you aware of the disappearance of Mrs Richards clothing?

A. No.

Q15. Were you aware that the family agreed to do her washing?

A. Not aware - as Mrs Richards was not my patient.

Q16. Were you on duty on 19th August 1998?

A. Yes.

Q17. Did you ask the family to take Mrs Richards clothes away?

A. No.

Q18. Were you aware of the family's concerns regarding the standard of care their Mother received?

A. Yes.

Q19. Do you have anything else to say?

A. Yes - concerning Mrs Lacks account of events, page 1 Mrs Lack refers to speaking to trained and untrained staff - there was only 2 trained staff on duty - S.N Joice and myself - I was completing the Consultants Round and I would not have blamed the dementia as a cause for Mrs Richards distress.

I did ask Mrs Lack if she thought her Mother to be in pain, she responded by saying "no - I am feeding her". At this point I did inform Mrs Lack that her Mother had had a fall - I had not previously phoned her as I wanted to see her face to face. After I informed her of her Mother's fall - she sought me out (I was still doing the medicine round) and informed me her Mother was in great pain. I told Mrs Lack I would come back and make an assessment with Mrs Richards on the bed - Mrs Lack asked me not to put her on the bed.

At this point - an emergency occurred with another patient and as the only trained nurse on - I had to attend. I did not want HCSW putting Mrs Richards to bed, so it was not until 19.45 hrs that I was able to put Mrs Richards to bed and that was when I noticed the internal rotation of the Rt leg.

Witness Statement: Mr Philip Beed - Clinical Manager Daedalus Ward

The following statement was taken by Mrs S Hutchings, Investigating Officer on 8th September 1998.

Q1. How long have you been Clinical Manager on Daedalus Ward?

A. 18 months.

Q2. Were you on duty when Mrs Richards was admitted from Haslar Hospital on 11th August 1998?

A. Yes - I spoke to Mrs Lack at some length and explained Plan of Care. For 30-60 mins. Mrs Richards was very calm/relaxed - 15 mins. after being seen by Dr she began to cry out. I was unable to differentiate between pain/dementia - I gave her dose of Oramorph - which settled her. I informed daughter of my actions, who appeared pleased with what I did. I did find difficulty in Mrs Lacks approach to pain control, at times she appeared in agreement - other times she didn't

Q3. Were you on duty day of Mrs Richards fall 13th August 1998?

A. No - but the day before - I realised the Ward was going to be busy due to overall activity, admissions, discharges (a) I booked an additional HCSW for a.m. shift (b) Identified 3 patients that could remain in bed (c) Made everyone (all staff) aware it was going to be a busy day.

Q4. On the following day what did you do?

A. I assessed Mrs Richards for myself - she appeared to be pain free (having Oramorph the night before). Dr Barton was present - decision made to X-Ray, we also informed Dr Lord and sought her advice - she agreed with our action plan. I organised the X-Ray after Dr Barton had signed the form. I booked the X-Ray as soon as department opened. Mrs Richards was X-Rayed mid-morning.

Q5. Can you explain why there was a delay in Mrs Richards being seen by a Doctor following her fall - particularly as she had previously had # neck of femur?

A. I believe Mrs Lack is referring to the delay the night before. It is agreed between medical and nursing team, that if accident occurs outside of X-Ray Dept. hours - we would ensure patient is free of pain and referred ASAP the following day - obviously each patient is assessed individually and agreement reached with patients and relatives.

Q7. Would you agree/disagree, that a trained nurse should have observed the angle of her leg to have been abnormal especially as she was in so much pain/distress.

A. Yes.

Q8. Can you please describe what happened when Mrs Lack was called into the office to be seen by yourself and Dr Barton following X-Ray of Mrs Richards.

A. Dr Barton had spoken to Consultant at Haslar who agreed to take Mrs Richards back for manipulation rather than surgery. This was explained to Mrs Lack, booked Paramedic Ambulance, notified A & E and said we would take Mrs Richards back when ready. I asked Mrs Lack if she would like to accompany her Mother to Haslar. Mrs Richards given dose of Oramorph. There was approximately 1 hr delay for Ambulance. I did not feel this delay would cause any adverse effect to Mrs Richard's condition. A HCSW accompanied Mrs Richards.

Q9.1 Why was Mrs Richards not examined following her fall?

9.2 Why a 24 hr delay from fall to admission to Haslar?

9.3 Why was an X-Ray not arranged sooner?

A.9.1 Injury not apparent at time - I found it difficult to distinguish Mrs Richards cries from wanting the toilet or in pain.

9.2 See answer to Q6. (5)

9.3 See answer to Q6.

Q10. Were you on duty on the 18th August 1998 when Mrs Richards returned from Haslar?

A. I was on a late duty that day.

Q11. When were you made aware of the apparent pain and discomfort Mrs Richards was in?

A. At the same time that Mrs Lack became aware. Sequence of events not as Mrs Lack written. S.N Couchman received Mrs Richards and put her into bed. HCSW Jean Moss attempted to feed Mrs Richards lunch - which she didn't appear to want - S.N Couchman advised her to mince the meat. Mrs Lack arrived while Mrs Richards being fed - but Mrs Richards was not screaming at this time. Mrs Richards began to become distressed at the time of Mrs Lacks arrival. Mrs Richards had not been in any distress/pain - if she had - we would have given her some analgesia. The whole situation became very "tense" - Mrs Richards screaming very loudly, both daughters very agitated and worried about another dislocation, this made the situation difficult to handle.

Q12. Can you confirm the family asked for further X-Rays of Mrs Richards hip?

A. Yes - they felt Mrs Richards hip had dislocated again.

Q13. Can you explain the problems with X-Ray Department?

A. Dr Barton contacted and she requested X-Ray Form to be completed. Form was pp - but would not be accepted. Dr Beasley was Duty Doctor who agreed to fax form - booked X-Ray - daughters informed at all times.

Q14. Are family relatives usually allowed to see X-Rays?

A. This would be dependent upon Radiographer in X-Ray dept. - the X-Rays were not forwarded to the Ward - seen by Radiologist in dept.

Q15. Can you recall how long from admission to examination by Dr Barton.

A. 3 hrs. approx.

Q16. Were the family involved in the decision making for pain control and use of syringe driver?

A. The decision to use syringe driver was made after a course of time, discussed with both daughters, this was one option offered - oral analgesia could be continued on 18th August. Medical opinion - by Dr Barton, was that a syringe driver would be the best way of controlling the pain - I explained fully the purpose of using a syringe driver and they both agreed.

Q17. Were you aware that following Mrs Richards first admission to Daedalus, her clothes - already with Cash's name tags, had been sent for marking?

A. Policy for all patients clothing to go for marking at Gosport War Memorial Hospital - unfortunately on this occasion the machine was not working, so they were sent to St Mary's but laundry lady - did not inform us of this.

Q18. Were you aware of the family's agreement to do their Mothers laundry?

A. Yes - but I would still want clothing to be marked - I did explain this to Mrs Lack.

Q19. Can you give any explanation why their request for their Mother to wear her own clothes - was not carried out?

A. They had been sent for marking.

Q20. Were you aware of the family's concerns regarding standard of care for their Mother?

A. Yes.

Q21. Did you or Dr Barton have any discussion with the family regarding "feeding" Mrs Richards during her last four days of life (to include I/V fluids)?

A. I do not remember specially talking about feeding/fluids apart from giving a drink if Mrs Richards woke up. The family did not raise this as a concern at the time.

Q22. Do you have anything else to add?

A. We did find nursing Mrs Richards difficult at times - due to the difference of opinion between both daughters regarding management and pain relief of their Mother.

Witness Statement taken from Monica Pulford Enrolled Nurse Daedalus Ward

The following statement was taken by Mrs S Hutchings - Investigation Officer on 8th September 1998.

Q1. Please state your role/grade and how long you have worked on Daedalus Ward.

A. Enrolled Nurse - 'D' grade - many years.

Q2. Were you involved in looking after Mrs Gladys Richards?

A. Yes. On day of admission spoke to Mrs Lack - checked her surname generally chatted - Mrs Richards was quiet. During supper she (Mrs Richards) asked to pass urine, so we helped her use commode - she was "weight bearing".

The following day I was on early shift - I feed Mrs Richards her breakfast (in dining room) she became "fidgety" - a sign she needed to pass urine - along with another member of staff, we took Mrs Richards to the toilet - I do not recall any further problems during my shift.

Q3. You admitted Mrs Richards on 11th August 1998 and completed the documentation?

A. Yes - most of it.

Q4. Can you explain why the section for "Pain" was not completed?

A. No - negligent of me not to have done so.

Q5. Can you explain why the section for Mental Study was not completed?

A. I was advised by Clinical Manager to leave, it would be addressed later.

Q6. Can you explain why the section for Lifting/Handling Risk Calculator was not completed?

A. I was advised by Clinical Manager to leave, it would be addressed later.

Q7. Were you on duty when Mrs Richards had her fall?

A No - I was a day off.

Q8. Were you on duty on 17th August 1998 when Mrs Richards returned from Haslar?

A. No - I came on duty later at 3.30 pm Mrs Lack was not there - Mrs MacKenzie was with her Mother who had been given oramorph. Philip and I made Mrs Richards comfortable about 2.15 pm she became quiet and settled. Mrs Lack came back into room and kissed her Mother and woke her up again - she became very noisy and distressed. Mrs Richards had been crying/screaming for most of the afternoon.

Q9. Did you have any further involvement with Mrs Richards?

A. No.

Q10. Were you aware the family had agreed to do Mrs Richards laundry?

A. I am not sure.

Q11. Do you have anything else you wish to say?

A. No - as I only work part-time - I did not have much involvement with the family.

Witness Statement of S.N Christine Joice - Staff Nurse Daedalus Ward

The following statement was taken by Mrs S Hutchings Investigating Officer on 9th September 1998.

Q1. Please state your grade/role and length of service on Daedalus Ward.

A. RGN 'E' - 5 years on Daedalus.

Q2. Did you have any involvement with Mrs Gladys Richards?

A. Yes - giving her medication - not involved in any personal care - I work primarily on the Stroke Team - I do not have much involvement in continuing care patients - see statement attached.

Q3. On Mrs Richards return from Haslar on 17th August 1998 did you admit her?

A. No - I saw her arrive on stretcher with ambulance crew - I was at Nurses Station.

Q4. Can you recall which Ambulance Service brought Mrs Richards in and was there a nurse escort?

A. It was Mainline Ambulance - and there was not a nurse escort.

Q5. How was Mrs Richards transferred from stretcher to bed?

A. I do not know - I was not involved - two HCSW assisted.

Q6. Did you attend Mrs Richards during this time at all?

A. No - S.N Couchman returned from coffee break and went into Mrs Richards.

Q7. Did you have any further involvement with Mrs Richards that day?

A. No.

Q8. Please describe Mrs Richards condition on the 18th August 1998?

A. I was on late shift - I saw Mrs Lack leave Mrs Richards room crying and walking towards Activities Room - I followed her - she was very angry and upset and implied I was not telling her everything - I tried to reassured her this was not true.

Q9. Did you give Mrs Richards any fluids whilst you were on duty during 18th August or 21st August 1998?

A. No.

Q10. Did the family ask any questions regarding feeding or giving fluids.

A. No.

Q11. Were you aware the family wished to do the laundry for Mrs. Richards?

A. No.

Q12. Do you remember making any comment to daughters regarding the need for clothes "as we get patients up here" when Mrs Richards was obviously so poorly?

A. No - I couldn't imagine any of the staff making any comment about getting patient up when they were so obviously very poorly.

Q13. Do you have anything further to say?

A. No.

Statement: S.N. C Joice - S.N Daedalus Ward

On the 12th August 1998 - late duty - not met Mrs Richards before - but concerned about her because she looked drowsy: she was pale in colour. I checked her drug chart - she had been given Oramorph at 6 am and Haloperidol.

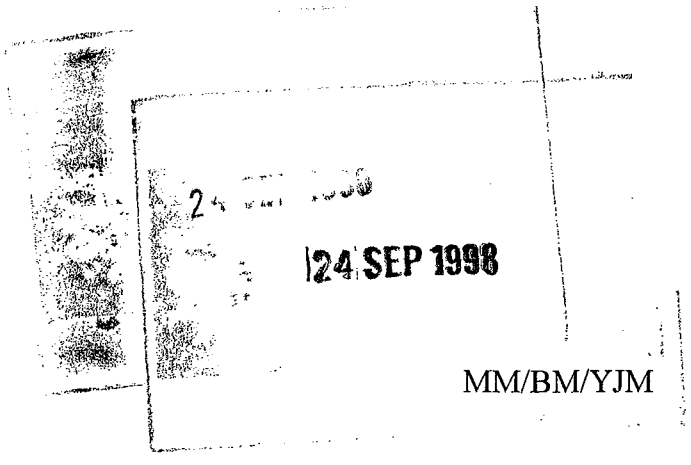
About 5 pm Mrs Lack visited Mrs Richards - she expressed her concerns regarding her Mothers condition/drowsiness. I informed her of the medication she had been given - reassured Mrs Lack I would inform Doctor if she deteriorated. I asked HCSW to put Mrs Richards into bed - a hoist was used - she woke up and began to cry out. Mrs Lack assisted her Mother with her supper (soup). Mrs Richards continued to be very noisy - but I was very reluctant to give any further medication due to Mrs Lacks concerns; eventually she settled and went to sleep - no further problems for the remainder of shift.

On 13th August 1998 - I was on early shift - Night Staff reported Mrs Richards had been noisy all night - I commenced the Drug Round - I attempted to give her the Haloperidol - she screamed and pushed it away - so it was not given. I asked the HCSW to let me know when they had got her up. I would give her medication then - this time she took the medicine. I was the only trained nurse until 12.15 pm - when S.N Jenny Brewer came on duty - I gave her a report on all patients. I then completed admission process on new patient and Jenny commenced medicine round.

I cannot remember who told me that Mrs Richards had slipped out of her chair - or what time. I did not follow up the report of the fall - as I understood S.N Brewer had dealt with her. I now realise I should have checked her.

I do not recall going into Mrs Richards room during the afternoon up to 3.30 pm when I went off duty; I cannot remember if she was making any noise.

3



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

/continued - page 4

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

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

Yours sincerely,

Code A

Max Millett
Chief Executive

Silent copy to: Mrs. B. Robinson
[redacted]

4

Mrs. G. McKenzie,
[redacted]

Code A

MM/BM/YJM

22nd September, 1998

4378

Dear Mrs. McKenzie,

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

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

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

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

Yours sincerely,

Max Millett
Chief Executive

Silent copy to: Mrs. B. Robinson

5

Mrs L Lack

Code A

MM/BM/dab

8 October, 1998

4378

Dear Mrs Lack,

I am writing further to my letters of 22nd and 28th September 1998 and the various phone calls which have also taken place.

In summary the situation now seems to be that both you and your sister Mrs McKenzie, would like to take up the suggested meeting with Mrs B Robinson, but that your sister is unable to make the proposed time - which was 2.30pm on 29th October 1998.

I understand that you will be away from 14th to 24th October, and that we will receive a call from either you or your sister when you have agreed some dates that suit you both. I understand that you will also be providing a note of the points which you would like to raise at that meeting, in advance - so that further investigations can be made if required.

I look forward to hearing from either of you at your convenience.

Yours sincerely,

Max Millett
Chief Executive

Mrs. L. Lack,

Code A

MM/YJM

25th September, 1998

4378

Dear Mrs. Lack,

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

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

Yours sincerely,

Max Millett
Chief Executive

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

Post Complaint — File Note 28/9/92

6

Mrs Mackenzie phoned.

She is not happy with some of our responses in my letter & neither is her sister (Mrs Post). Has she had a copy — Yes now? See letter of 25/9/92. (LH. knows.

They would both like to attend meeting with Barbara Robinson but Mrs M cannot make suggested date — they will contact us to reschedule.

She took great pains to explain this was a family complaint — not just Mrs Peck's. I explained this was fine by us (if Mrs Post agrees) but they need to speak to us with one voice — it will confuse & confound if they both have different agendas. Mrs Post made complaint — she is in driving seat.

I said it would be helpful if they listed the point they were not happy with before the meeting to give us a chance to collect any extra info / or chase facts again.

It was not an easy conversation — she began by saying she was an old "Aberdeen" girl — High IQ & tenacious — & would not give up until she was happy all t's X'd & i's ...!!

P.D.H.

File Note 11-12-98. 7

12.30. Re: Peak/Mackenzie B981042

Telephone call from DC Madeson Gosport Police Station

Code A

South Street
Gosport
PO12 1ES

Mrs Mckenzie has asked the police bring a charge of unlawful killing against the doctor in charge of Mrs Richards (Peaks) care. Says doctor failed to "give nourishment via a drip whilst a syringe driver was being used — ∴ causing Mrs Richards death.

D.C. Madeson has already (taken statement from) visit Macmillan Nurse - Barbara Penis. Who said drip probably not used as would cause added discomfort.

D.C. Madeson needs to decide what action to take (as none!) He feels the matter is about a clinical decision & therefore

not a police matter. He would like a statement from us +/- ~~copies~~ a copy of the redacted notes Re: use of oxygen during IV Fluids (decisions made & why) and details of information shared with family at the time.

DC Hodson has been in contact with the GMC who have asked him to write to them, explaining that charge comes from Ms Mackenzie, not Police.

I said we would do our best to help — be consulting our solicitor — get back to him next week.

action

(1) get Notes from GWMH to check details.

(2) check with Solicitor about K-o-K consent etc

(3) ? seek consent from Ms Mackenzie + Ms Hart (? N.O.K.) to give info to police. — copy to police.

(4) alert Ds Concerned (Dr Barton Jane)

(5) check info to be given to police and Solicitor Sutton ward. GWMH.

NB could find no mention in original complaint about IV fluids not being given. No response to date to my letter to Ms H+ Ms Mc offering meeting.

(3)

Discussed with Bill Hooper - he agrees to above action - suggests we copy letter to Mrs Lt Mc to police.

* Dr Jane Barton will be on Sultan Ward on Monday 4 Hts please to alert.

•

Code A

•

8

Mrs. G. McKenzie,

Code A

LH/YJM

14th December, 1998

4378

Dear Mrs. McKenzie,

We have been approached by Detective Constable Madeson of Gosport police station. He is investigating a complaint that your late mother, Mrs. G. Richards, was unlawfully killed because she was not given intravenous fluids whilst she was being given pain-relieving medication via a syringe driver.

Detective Constable Madeson has requested that we supply him with a statement explaining the decisions made regarding the use of the syringe driver and associated care and/or a copy of the relevant health records.

I am writing to ask your permission for us to release this information. You can contact me at the address and telephone number shown.

Yours sincerely,

Lesley Humphrey
Quality Manager

Copy to: D.C. Madeson, Gosport Police Station

Post/Richards/Mackenzie 15-12-98 **9**

File Note:

Mrs Mackenzie rang to give her permission for information to be shared with the police.

* She was aware of Police interest
* She was still waiting for us to set up a meeting — she & Mrs Mck. have fallen out &
* Mrs Mck had not told her SHE was arranging date for meeting.
* She is unhappy that sister bringing the police actions.
* But whilst accepting mother's death & terminal care — still feels she has not had an explanation as to how haematoma happened.
* Whatever happened killed her — up & about one minute — the next we are all consigning her to death!

Although upset & unhappy she was not blaming GWMH — our conversation was very friendly.

Code A

* Mrs Mck advised by Police not to discuss case — we agreed the proposed meeting cannot happen now — Police's & the future depends on outcome

22/12/98.

10

Re- late Gladys Richards - DOB 13/04/07

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 Philip Beed (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

HAMPSHIRE Constabulary

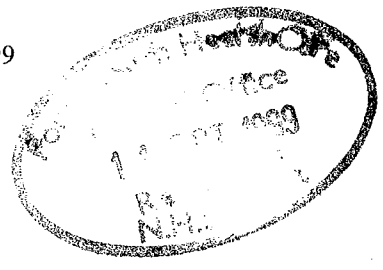
Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

11

Major Crime Complex
Fratton Police Station
Kingston Crescent
North End
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/E/CID/DCI/99

Your Ref.



Tel. 023 92839333
Direct Dial 02392 899043
Fax. 023 92891504

10/08/99

Mr M. MILLETT
Chief Executive
Portsmouth Health Care Trust
Central Office,
St. James' Hospital,
Locksway Road,
PORTSMOUTH, Hampshire.
PO4 8LD

Dear Sir,

Gladys Mable RICHARDS

You may recall that police officers from Gosport Police Station sought your assistance regarding enquiries which were being made following the death, on the 21st August 1998, of Gladys RICHARDS who had been receiving treatment at the Gosport War Memorial Hospital.

I would like to advise you that, following a review of the police investigation which was carried out, I have been appointed to re-examine the case and, where appropriate, gather further evidence to enable the matter to be subjected to further consideration.

There is one particular matter that I would like to seek your assistance with at the outset. I would like to take possession of the medical notes relating to Gladys RICHARDS. At this stage I am particularly interested in the period which embraces her fall at the Nursing Home in Lee on Solent on the 29th July 1998 and culminates in her death on the 21st August 1998.

I am not familiar with the conventions and practices governing the compilation of such notes but I imagine that details of observations made and treatment given, together with the rationale for taking such action, would be recorded.

HAMPSHIRE Constabulary

I understand the underlying sensitivity associated with the release of this documentation and I would welcome your advice on who to approach and what steps I must take to properly seek and obtain the information which I require.

Yours faithfully,

Code A

Ray BURT
Detective Chief Inspector

Richards File Note 19-10-99.

12

Tel. call from DCI Burt. He has been asked to review previous investigation because a complaint was made that it was inadequate.

Prior complaint – Unlawful killing.

He will need to review the medical records & probably get an independent opinion on the care provided.

agreed he would meet me at 2pm on 27/10 (my office) to discuss the case & review the late – copies to be provided.

Contact details [redacted] Code A

or ext [redacted] Code A (Margaret or Di to take a message)

[redacted] Code A

P.S. From Burt asked to send late to me by internal post.

Lesley Humphrey-Quality Manage 27-10-99 **13**

To: Ian Reid-Medical Director; Max Millett - Chief Executive
Cc: Code A
Subject: Richards Complaint - file note

LH meeting with DCI Ray Burt - Weds 27 Oct 1999

In March 1999 the CPS (on second submission) decided that there was not case of unlawfull killing to be answered, on the basis is the evidence presented.

Following this a complaint was made that the police investigation and thus evidence presented was not through enough. On cursory examination there seemed to be some justification for this complaint, therefore DCI Burt asked to review case. His role is to gather and make sense of the evidence, not to decide if there is a case - CPS will do this.

RECORDS
CSI provided with a full copy of Mrs Richard's record - the originals are to stay in LH secure possession until the police outcome clear. LH to make a police statement re; records - confirming what they are, who made etc - not comment on content. LH confirmed OK to share content of records with Mrs Lack and Mrs Mackenzie. The police are likely to ask for an independent clinical opinion on this case (decisions made etc) and the notes woukld need to be shared for this purpose.

STATEMENTS
Statements are to be taken first from Mrs Lack and Mrs Mackenzie; then medical staff as seems appropriate, certainly Dr Barton, ? Dr Lord. Nursing statements might be needed, depending on issues raised by daughters/investigation, but medical might suffice.

* ALL arrangemetns for interviews/statements from staff will be made via LH (DCI informed Dr Lord on sick leave - return unknown)

ACTION
LH - check if records complete (no observation charts present)
- identify signatures in records

IR - (please) inform David J/Althea of current situation

IR/BH - (please) inform Jane Barton of current situation

POTENITAL ISSUES
Medical records state that OK for nurse to certify death + nurse did certify. Might need to demonstrate that this is acceptable practice in given circumstances - ? does not feature in our current CPR policy, ? in local Gosport policy/procedure. Records do not seem to state rescus. status.

Lesley

14

File Note. Reload Case 20-1-200

Telephone conversation with Ray Burke

Investigation progressing slowly still gathering information. Seeing clinical Advisor next week.

There is no new evidence to suggest that a criminal act was performed.

Jane Barton's interview with police will be part of information gathering process once info from relatives & clinical advisor collated. He has no reason to believe that Jane would be held in custody after her interview except in the unlikely event that SHE offered information to suggest she should be held.

Jane will get about 2 weeks notice of interview. 3 tapes will be made 1) for Jane (TO4; 2) DCI Burt report 3) C.P.S - in sealed envelope.

Jane's representative, Code A Ian Barker has contacted DCI Burt asking for copies of redacted records. I promised to check with Jane that this O.K.

Code A

15

DCI R. Burt,
Major Crime Complex,
Fratton Police Station,
Kingston Crescent,
North End,
PORTSMOUTH. PO2 8BU

LH/YJM

6th December, 1999

4378

Dear Ray,

Mrs. Gladys Richards

Very sensibly our medical staff are in contact with their medical defence union (MDU) with regard to the claim of unlawful killing of Mrs. Gladys Richards. The MDU have asked for written confirmation of the details of the allegation being explored by the police.

Could you please either send me a copy of any written communication/statement which details the complaint (obviously we appreciate that some documents are confidential) or a letter from you which specifies the exact complaint. The original police investigation seemed to focus on the giving of fluids - is this still the case or has the focus broadened?

I look forward to hearing from you in the near future.

Yours sincerely,

Lesley Humphrey
Quality Manager

Copy to: Dr. A. Lord
Dr. J. Barton
Mr. W. Hooper

HAMPSHIRE Constabulary

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

Major Crime Complex
Fratton Police Station
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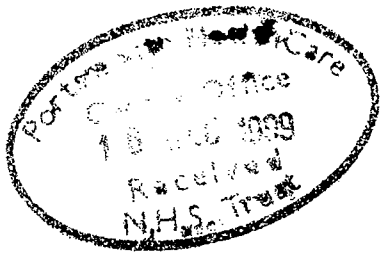
Hampshire
PO2 8BU

16

Our Ref. HQ/E/CID/DCI/99

Your Ref.



Code A

14/12/99

Mrs L. HUMPHREY
Quality Manager
Portsmouth Health Care NHS Trust
Central Office
St James' Hospital
Locksway Road
PORTSMOUTH,
Hampshire. PO4 8LD

Dear Lesley,

I am writing to you in reply to your letter of the 6th December 1999.

I quite understand the involvement of the MDU. When serious allegations are made all parties would be well advised to reflect on the issues and seek the best possible advice. I hope you will understand that I am not in a position, at this stage in my investigation, to provide you with copies of any documentation relating to the allegations which are being made.

I can confirm that both Mrs Lack and Mrs Mackenzie, who are the daughters of the late Mrs Richards, have expressed wide ranging concerns about the standard of care which their mother received at the Gosport War Memorial Hospital. It is possible that these concerns, when taken as a whole, may well have a bearing on the case. However, I think it would be appropriate, at this stage, to suggest that it is the decision which was taken on the 17th-18th August 1998, to retain Mrs Richards at the Gosport War Memorial Hospital as opposed to referring her, once again, for treatment at the Royal Hospital Haslar, which represents a key feature of the allegations.

Yours sincerely,

Code A

Ray Burt
Detective Chief Inspector

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HAMPSHIRE Constabulary

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

Major Crime Complex
Fratton Police Station
Kingston Crescent
North End
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/E/CID/DCI/2000

Your Ref.

Code A

8th February 2000

Mrs L. HUMPHREY
Quality Manager
Portsmouth Health Care NHS Trust
Central Office, St James' Hospital,
Locksway Road, PORTSMOUTH,
Hampshire. PO4 8LD

Dear Lesley,

I hope you received the x-ray images and papers that I left for you at the Reception Desk at St James' Hospital on the 29th January 2000. A young lady called Sarah MARKS kindly signed for them. Did you understand my scribbled notes about the small alteration to page 6 of your statement? I would be grateful if you would make the alteration, initial it, and send it back to me. I apologise for putting you to this trouble, I should have spotted it first time around.

I wonder if I could now, as touched upon in my letter of the 29th January 2000, raise a few issues associated with obtaining additional information and seek your help/advice as regards how I can best deal with them.

Some of the matters may, already, have been referred to but it would be helpful if I could review and consider them again.

Perhaps it would be beneficial if, once you have had an opportunity to consider the points, we met and discussed these matters.

1. Mrs RICHARDS was conveyed from the Royal Hospital Haslar to the Gosport War Memorial Hospital on Monday 17th August 1998. It has been reported that she was transported by a 'Mainline' Ambulance Crew. It was further reported that 'Haslar' arranged this transport and telephoned 'Daedalus' to inform them that a canvas (with two poles inserted) could not be found to put Mrs RICHARDS on. Instead, it was reported, two sheets were used to lift the patient who began crying and screaming in the ambulance and continued for some time after her arrival at the Gosport War Memorial Hospital. Having regard to this patient's condition,

and the fact that the method of carriage may have aggravated her condition, can you please advise me.

(a) Were any reports regarding this incident prepared by any employee of the Portsmouth Health Care (NHS) Trust?

I am, of course, aware of the Report which was prepared by S.M. HUTCHINGS after Mrs LACK's letter of complaint and prior to Mr MILLETT's letter in reply which was dated the 22nd September 1998.

(b) Were the circumstances formally drawn to the attention of the Royal Hospital Haslar?

(c) What is a 'Mainline' Ambulance and who is responsible for this service and the staff?

(d) Does the Portsmouth Health Care (NHS) Trust have rules or guidelines which deal with the carriage and transportation of a patient in Mrs RICHARDS condition?

(e) Would it have been appropriate to carry a patient in Mrs RICHARDS' condition in the manner which was apparently employed?

(f) Are you aware of any disciplinary action following this incident?

Presumably, if any such disciplinary action had been taken, evidence would have been required from staff at the Gosport War Memorial Hospital.

2. You have advised me that medical care is provided for patients at the Gosport War Memorial Hospital on a 'visiting' or 'on call' basis.

(a) Whilst Mrs RICHARDS was admitted to the Gosport War Memorial Hospital were there any medical staff, apart from Dr BARTON, with responsibility for her care?

(b) Could you please provide me with details of the 'on call' Rota in force during the time that Mrs RICHARDS was admitted to the Gosport War Memorial Hospital?

(c) Having regard to the content of Dr LORD's Report, can you please tell me who was providing Consultant cover, for the Gosport War Memorial Hospital, during the period that Mrs RICHARDS was admitted?

(d) **Can you please provide me with details of the contractual arrangements which govern the employment of medical staff at the Gosport War Memorial Hospital?**

(e) **Could you tell me if there is was a policy in place, during the time that Mrs RICHARDS was admitted to the Gosport War Memorial Hospital, which dealt with the circumstances in which a patient could be referred to the Royal Hospital Haslar after 'office hours'?**

3. A Syringe Driver was used in Mrs RICHARDS case.

(a) **Can you tell me how often Syringe Drivers are used at the Gosport War Memorial Hospital?**

(b) **Can you comment on the level of skill of the Nursing Staff, responsible for Mrs RICHARDS care whilst she was admitted to the Gosport War Memorial Hospital, in monitoring Syringe Drivers in the absence of the Clinical Assistant?**

(c) **What was the nature and dose of the drug administered in the Syringe Driver?**

(d) **Who checked the dose of the drug being administered by the Syringe Driver?**

4. In terms of other complaints about the clinical management of patients at the Gosport War Memorial Hospital by Clinical Assistants.

(a) **Have any such complaints been made?**

and, if so,

(b) **What was the nature of these complaints?**

(c) **Have any other complaints been made about the terminal care of elderly people, generally, at the Gosport War Memorial Hospital?**

and, if so,

(d) **What was the nature of these complaints?**

HAMPSHIRE Constabulary

I appreciate that this will cause you some extra work and I fear that I may, as time goes on, require yet more information.

I appreciate your support.

Yours sincerely, Code A

Code A

Ray Burt
Detective Chief Inspector

18

Lesley Humphrey-Quality Manage

From: Peter King - Personnel Director
To: Lesley Humphrey-Quality Manage; Max Millett - Chief Executive; Tony Horne - Operational Director; Code A
Cc: Code A Business Mgr (HQ); Ian Reid-Medical Director; Code A Personal Assistant to Chairman & Chief Executive
Subject: RE: POlice interest - Gladys Richards case
Date: 16 May 2000 10:15

I think we should very actively support our staff involved - possibly providing legal support and counselling support to them . The support needs to be project managed in partnership with TUs. Jane Parvin has agreed to assess the situation and we will meet on Fri to formulate a plan

-----Original Message-----
From: Lesley Humphrey-Quality Manage
Sent: 15 May 2000 14:01
To: Max Millett - Chief Executive; Tony Horne - Operational Director
Cc: Code A r; Fiona Cameron-General Manager; Lorna Green Business Mgr (HQ); Ian Reid-Medical Director; Peter King - Personnel Director; Code A - Personal Assistant to Chairman & Chief Executive
Subject: POlice interest - Gladys Richards case

I've just had DCI Ray Burt on the phone; as a result of his preliminary screening they have decided to take a higher profile with this case. I asked the 6 million dollar question of why/what found - not surprisingly I got a very bland answer - simply that Ray has seen enough to suggest a higher profile warranted [he has to justify increased use of resources etc]. He seemed to agree that this means the local police feel there may be a case for procecution [where as before they were responding to a complaint] - however, the decision still lies with the CPS as to whether criminal action is taken.

From 22 May additional officers will be joining the team and the investigation will move into a higher gear in gathering information - formal interviews will be held with potential witnesses [staff who had direct contact with Mrs Richards + staff who can explain policies/procedures etc]. Where appropriate, people like Jane Barton will be afforded some protection with regard to these interviews; presumably to help them avoid incriminating themselves.

I will still act as the main contact for the police, in arranging staff interviews; but will need support from Yvonne. I told Ray we would be advising staff to be accompanied when interviewed - MDU/Union/Solicitor etc [LORNA/PETER any comments on this?].

BILL can you please let Althea know
FIONA can you please let Jane and ward staff know
Max - I guess you will want to do a board briefing paper

There is of course a higher potential now for a press leak - the police are getting thier media people to put together a statement just in case - I've given them David/Rob as contacts as joint strategy seems sensible and I'll let David/Rob know.

Lesley

File Note.

19

Richards Police Case

Meeting 26-5-00 – LH and D.S. Simon Poulton.

See attached ~~letter~~ E-mail for further information.

action agreed.

* SC – contact PHT Pharmacy Jeff Watling re supply / likelihood use of Midazolam.

* Done LH – prepare list of all nursing staff (name/address/phone) contracted to Daedalus in July/August 98 + agency staff working on ward when Mrs R a patient + contact details of all doctors attending Mrs R.

* LH – Get copy of Jane Barton's contract of employment. (check with Personnel first) (written to Jane for permission)

* LH – check + confirm if J. Barton clinical assistant at GWM Hat time – B. Robinson says yes.

Lesley Humphrey-Quality Manage

From: Code A
To: Max Millett - Chief Executive; Tony Horne - Operational Direc; Eileen Thomas - Nursing Direct; Ian Reid-Medical Director; Code A Code A General Manager
Cc: Code A Business Mgr (HQ); Peter King - Personnel Directo; Jane Parvin Snr. Personnel Mgr; Code A - Personnel Mgr.
Subject: GWMH police case
Date: 26 May 2000 17:11

I spent 3 and a half hours with DC Code A new to the case this am; he was at pains to stress that this was not a "hard hitting" investigation. They were simply collecting information and they had no knowledge or axe to grind - they are painting the picture for CPS to decide if there is an issue that needs addressing. The investigaiton includes Haslar and a separate team of officers have been assigned to the two organisations. we have DC Code A and DC Code A

From DC Code A questions of me, interest lies in the prescription for S/C diamorphine; 40 - 200 mgs in 24 hours - I was asked how/which nurses would decided how much to give. An academic question as only 40 mgs in 24 hours was ever given - and this is borne out by the controlled drug register. Interest also in midazolam and the police will be exploring with pharmacy what pharmacuitical company manufactured and supplied and what this drug was registered for in August 1998.

The investigaiton will begin with interviews of all nursing staff who were on the estblishment for Daedelus in July/Aug 1998 -trained and untrained. If there were agency/bank staff working on the ward during the period Mrs R was a patient then they would be interviewed two. Second stage will be interviews with Philip Beed - as ward manager, and probaly Barbara Robinson as Service Manager. Third stage will be interviews with doctors; Lord/reid/Barton/Peters/Briggs.

Staff will be contacted by police at home and offered interview in own home, at GWMH or in police station if they wish. Fiona and I have agreed that staff should be given time off/time in lieu to attend these interviews.

Thats about it. I will be in touch with some off you to confirm some specific details.

Lesley

Sister D.S.

not hand written

DC Colvin & Poulter — PHCT.
— Haslar.

Station — issues — action

Every staff re Jos involved in care
+

Check that all Dad staff exited
Sing Browns still working
— 3 B. Address
— S J Ltd — will be interviewed

1st Round — S/N HCSW.
2 " — Child Board — 2nd Manager
+ other manager.

LH Check records of ages / BAR used

LH – Nan / address / Tel all staff
Either at their home or station
if staff prefer. — or GWH.

Meeting visit.

action

July / August 98.

Nursing Staff — Name / address / Tel no.

check for Bank / agency staff

Ward Shifts

~~FB~~ 11 aug 98 — 14 aug 98.

17 august-98 — 21 august.

Jane Content Employment.

Chris Dowdeswell.

Dr Peters — Jan P.

Pharmacy — ? Who

Medagoda — Drug Supplying
— Manufacturing

Complain JB on GP working
for ER at times

Code A

Code A

Code A

Code A

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Lesley Humphrey-Quality Manage

From:
To: Code A

Cc: Max Millett - Chief Executive; Tony Horne - Operational Direc; Ian Reid-Medical Director; Yvonne Mills - Personal Assist; Peter King - Personnel Directo
Subject: GWMH - investigation
Date: 12 June 2000 12:15

I have today checked out progress with the police team - they have changed their approach to this investigation. They will now only be interviewing specific memebers of staff [i.e. those who were directly involved in caring for GR or on duty during her stay on Daedelus], but these people will be interviewed under caution. These interviews will be voluntary, be held in a police station, caution given and interview taped. Presumably if some-one refused to be interviewed, and their statement was felt to be crucial, they might be arrested?

Our guidance for staff should be that they have a solicitor help them prepare and attend interview with them. Lorna Green will arrange this for those who do not want to use/have access to the services of their union, or solicitor of their own.

The police are still stressing that this in still information gathering, they are not trying to prove a known crime.

Whilst this approach will be more stressful for some, it prevents other staff being involved needlessly and should lead to a swifter conclusion.

Lesley

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Lesley Humphrey - Quality Manager

From: Code A Quality Manager
Sent: 01 September 2000 15:16
To: Max Millett - Chief Executive; Fiona Cameron-General Manager; Bill Hooper General Manager; Lorna Green - Business Manager
Cc: Ian Reid-Medical Director; Ian Piper - Finance Director; Steve King - Nurse Recruitment Adviser/Clinical Risk Adviser; Tony Horne - Operational Director; Eileen Thomas - Nursing Director; Barbara Melrose - Project Mgr.
Subject: Gladys Richards - update

I've spoken this PM to DCI Ray Burt, in charge of this case. All the paper work, interviews etc are currently with their clinical expert, Professor Livesey. DCI Burt is going to see him on Friday 8 Sept. After this the we may be asked for further information, or the file may be passed straight to the CPS - which ever, that's where it will end up. He will emphasise need for speed to CPS, but it could be 3 months or more before we know if they think there is any basis for criminal action. I am on A/L from 8-25 Sept, if need be DCI Burt will contact Code A in my absence.

Bill/Fiona, can you keep the staff up to date with this please. Fiona, are you still in contact with Jane Barton, or should I write to her?

DCI Burt stressed that they did not think there was any "individual" with criminal intent. What they are exploring is whether institutional practices might constitute a breach of criminal law.

He said this is not the only case in the country being explored in this way. Some cases have been taken out of the hands of the local CPS and passed on to London.

If it is thought, either by Professor Livesey, or by the CPS that there might be a basis for proceeding with a criminal case, they may want to consider if we had any other cases where death occurred in similar circumstances. We would obviously want to co-operate, but I suggest that Lorna checks out the situation with Wansboroughs, with regard to confidentiality etc.

Sorry, but my gut feeling is that if there is the slightest whiff of a case, that this will go the distance as a test case.

Lesley

COMPLAINTS ~ JAN – MAR 2002