Gillian Mackenzie

From: Gillian Mackenzie [Code A]
Sent: 24 September 2012 09:22
To: 'White, John'
Subject: Ferner cont. Page 15

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Item 87
At last I absolutely agree !

Item 88
There was no reassessment. The same situation happened with another patient – Mike Wilson's mother – He kicked up such a fuss Reid was called in and a hydration drip was set up. Mike had a heart attack and was not there when his mother died. He gave up dealing with the hospital and the police – his case was not heard by the GMC. None of the patients had a hydration drip – it was said there were no facilities !!. It is more than likely that all Gosport patients died of dehydration. Thank goodness I was not denied one when I was having blood transfusions in one arm and hydration in the other. Who is Beed or Barton to decide on end of life decisions – another decision maker should have been called in and a proper assessment made of the situation.

Item 89
At last – a glimmer of light. In view of the fact that my mother did not have 45 mg of oramorph, the administration of 40 mg of diamorphine was more than double.

Item 90
See Livesley's notes on the administration of the drugs in the syringe driver.

Page 16

Item 91
Mr. Round doubly objects to this remark. There was no sign of pain - she could not take liquid by mouth when unconscious. Had she not been rendered unconscious she could swallow.

Item 92
A non evidential haematoma – not written up on file – not mentioned on the death certificate – her treatment was criminal.

Item 93
The penny has struck. The first bit of sense. I would agree to renal failure – hastened by dehydration and overdose of sedatives caused death. My mother has now been given the cause of death as haematoma by Beed, pneumonia by Barton– absolutely no evidence, Alzheimer's - informed by John James – and now renal failure. But the true cause is unlawful killing – and in view of the policy adopted by Barton for years – "overlooked" by the Hospital Authorities and Dr. Reid despite the 1990 Report I do not think this can be categorised as "negligent ",. This was Barton's adopted policy and in researching her background from a psychological point of view from childhood quite explainable. Her father Dr. Bulstrode – the first consultant radiologist in Guernsey dealing with cancer and patients dying in pain – there is still a Bulstrode House hospital in St. Martins, Guernsey. Barton's brother a Consultant orthopaedic surgeon at Radcliffe Hospital, (Barton in his shadow) her sister a physiotherapist. Her mother I believe died of cancer and possibly her father. She was brought up surrounded by patients dying in pain. Do not tell me her father did not bring his thoughts home and discuss some patients in front of his children. Barton born in Uckfield and went to Guernsey circa 4 years of age. Dr. Christopher Bulstrode (brother) joined the Council of the GMC in 2008 just before my case was to come up for the second time.
NOTA BENE My mother was not "drowsy" – she was out for the count.

Opinion

Item 95
"Occasionally can have fatal consequences". I am well aware of that – in fact on travelling down to Haslar on 30 July I did not expect my mother to come out of theatre alive. She loathed doctors and kept away until an "emergency" developed . I expected her to give up due to trauma and age.

Item 96
That is obvious – but it is also obvious that Haslar did not consider she should be "put out" with the advice of co-codomol.

Page 16 and 17

Item 97
It is not right to administer un-necessary drugs which hasten death to such a degree. I was well aware of the situation when my husband went from injection to syringe driver and so was he – I did not demur .

Item 98 -99
Did Ferner ever ask the police if eye-witness statements had been taken – was he aware of the background of my relationship with the police since 2 October 1998 or did he think the investigations all began in 2003. Was he aware of Readhead's remarks in September 2002 11 September at Fareham police station in front of 15 families that no investigations were to take place which would take up a minute of police time or a penny of budget. What is the position of the police - no action taken from October 2 1998 until after official complaints a further investigation 1999 – 2000 into my case and the extraordinary circumstance s around that.

Item 100
Policy

Item 101
At last sense.

Item 102
See Livesley's – and Ford's reports

Item 103
There was no sign of nausea or agitation

104
Likewise diamorphine and hyoscine.

Item 105
What is he saying – she was not sedated before this ? Has he noticed "very sensitive to oramorph " I am not aware of methotrimeprazine written up on Gosport file – is this another paper not given to me ? Is this the drug recommended by Reid – if so he was well aware that my mother was to be at Gosport for 2-4 weeks and at a stretch 6 weeks to give me time to find an alternative Nursing home to Glen Heathers.

Item 106
There is no evidence that Mrs. Richards was given any fluids at all in sedated state or otherwise. No records.

Item 108
Very likely !!

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Report unsigned - Suggest he signs it before he sees the Report of Ford and Livesley.