Appendix B

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

(1)

Ref Gladys Richards DOB 13 4 07

No Analgesia necessary, Able to walk - pain free

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

THURSday 13 Aug.
Seen to be in pain by Grandaughter. Mrs Reed 1.30-2.35pm
Brought to ward staffs attention. Thought to be dementia, Mother showing with pain. Mrs Read brought to the attention of the staff that Mum had great pain in her hip. (For your info she is a qualified Nurse)

(1) At what time did Mrs Richards fall?
(2) Who attended to her.
(3) Who moved her and how.

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

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

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

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

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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 consultant was bleeped. He saw Hollie in Casualty immediately. He then saw me. He showed me the Xrays and position of limb - which I had seen - G.W.H -
24 hrs from accident to admission and second emergency operation. Why? why no examination? why
(6) no xray? why no transfer?
She arrived at Haslar and within 1hr had a manipulation to put the hip back in the socket. From then she was pain free.
She did not regain consciousness fm 1am (15th) on Sat 15th due to amount of analgesia required for the procedure. She was then catheterised so that there was no need to move slippi pan. She had a drip as she had had NIL BY MOUTH since before Xrays on 14th.
She remained pain free in full length leg splint. both legs level and straight - shown to me by consultant. No analgesia was required - she was able to use a commode for the toilet and might have 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 midday
On entering through the swing doors to the ward I heard my Mother screaming. On arrival to the room a care assistant said. "You try feeding her I can't do it she is screaming all the time". My Mother had a shaving 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 understand it the pain the pain sharp sharp — this is some adventure. A SRN came into the room at all the noise. I moved the sheet and said look at the awful position she is in, she was lying awkwardly towards the left side with the full length splint not straight and the hips uneven. She cried in pain. I said to the RGN "can we please move her" We moved her together with our arms together under her lower back and the other around her thighs we placed her 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

14)

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

Phillips ward manager agreed she needed Xray to establish if damage had been done & 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 & help through the night for pain relief and reviewed in the morning.

On Wed 18 we arrived on the ward and were told she had had a peaceful night We were told that she had a massive 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 informed that a haematoma was present and that this was the kindest way to treat her. She also stated "and the next thing will be a chest infection". Totally insensitive to those already in the first stages of bereavement. Because the syringe driver was essential following the night of analgesia for pain - my mother of course would not now regain consciousness, speak, open her eyes to see us, or hear anything anymore. To us Mother as we know her is already gone.

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

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

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

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

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

Code A