Mrs Code A 22.11.01

Very concerned about husband's care and circumstances around his death. He was transferred from Queen Alexandra. Mrs Code A rang local journalist when story first broke, who put her in touch with police.

He had Parkinson's disease and had something similar to Alzheimer's. Admitted to Queen Alexandra with kidney infection in August 2000. All his medication was stopped. He developed pneumonia and he was transferred to War Memorial. I was quite impressed with all their decor - told they had much more time to help patients. Went on to pureed food at Queen Alexandra before he left for War Memorial Daedalus Ward.

Consultant did ward round the day Mrs Code A arrived. I was quite horrified by lack of care. Only saw him helping patients eat twice. Bedside trolleys mixed up between neighbouring trolleys. Even if patients want to stand they're not allowed to due to fear of prosecution.

Two lounges and dining areas, one of which seemed to be reserved for patients who are improving. Patients put in very uncomfortable chairs in lounge and just left. They would wheel patients to dining tables, just put the dinner in front of them and then leave. There did not appear to be any shortage of staff and they were gathered around nurses station laughing and chatting. At no time, did I see any staff in the dining room to help patients to eat. Nurses would then clean plates away and patients would have nothing to eat. Nobody told me that I could come and take him outside

On another occasion left alone in lounge for hours. Mrs Code A asked if he could come home or go into care home. He wasn't an invalid before. Consultant told her it would take a long time to arrange care package and he would die anyway. Seemed they wanted her out of the way. Suggested she go on holiday.

During the week he died patients all had colds - relatives handing out tissues to everyone. Day he died, daughter suggested he should be put to bed - nurses promised he would in a few minutes. Hours later he was still in lounge. Set aside special toilets for patients with MRSA but saw staff moving in and out without washing hands. Saw Ward Sister on two occasions - told her no question of his ever coming home but advised her to go on holiday and build up strength for when he came home.

Two days before he died, took Mr Code A off all antibiotics, said his condition was all clear. Speech therapist rang Mrs C Code A and suggested Mrs Code A go home, saying it could be quickly arranged. Night before Mrs Code A died charge nurse said only two nurses on. There never seemed any shortage of staff. Rarely saw ward sister.

They were never in their own clothes. They seemed to catheterise everyone - my husband was not incontinent - heard lots of patients ask to go to the toilet. Nurse said it was done mostly to save time.

Charge nurse gave Mr Code A an injection shortly before he died. Mr Code A had reported pain in groin after catheter procedure within 10 - 15 minutes he had died. At no time did Consultant come onto ward when husband near to death. When Mrs Code A queried cause of death 'Louis Body Dementia' - Mrs Code A queried as unlikely. Coroner did post-mortem found that cause of death was pneumonia. Post mortem found organs normal but Post Mortem certificate found that he had recovered from pneumonia.

As far as she knows, the day of his death was the first time he had been given diamorphine. Charge nurse definitely knew he was going to die as suggested calling rest of family. Did not explain DNR policy at War Memorial. Staff seemed to concentrate on room where patients who were recovering were and ignored sicker patients. Mostly spoke to charge nurse / clinical manager.

I definitely was not happy about lack of care in hospital. I was often the only relative there at mealtimes and had seen patients left with meals but with no nurses help to eat. Did not complain to hospital until after he died. I don't know why they gave him diamorphine - he seemed not to be suffering htat much pain after catheter procedure. Consultant was nearby but had no part in giving injection. Nor did SHO who felt that his blood pressure was normal.

Had considered transfer to Queen Mary's in Fareham but no vacancy came up. Mr **Code A** had no physio-therapy at War Memorial. Complained about lack of cooperation between different hospitals. Mr **Code A** was going to four different hospitals for different things with no link between them. No Parkinson's nurse in area. I would never even go into that hospital. Its never out of my mind - these patients just left.

Very concerned re mixed ward clothes and bed trolleys because of risk of infection. Agency nurses always blamed for mix-up.