Mrs Mackenie, 10 December, 2001

April 2001: Police Complaints Authority upheld all her complaints against Gosport police after an investigation lasting over a year

Until recently, thought her mother's death an isolated instance, then learned that many more relatives had had similar experiences with GWM

Chronology:
1. 29 July, 1998: mother fell in nursing home & taken by ambulance to Haslar

2. 30 July 98: surgery (arthoplasty? for FNOF); mother making good recovery after

3. seen by consultant geriatrician from QA who said that despite her age and dementia, Mrs R would benefit from and should be given the opportunity to rehabilitate; at that stage she was eating normally and was mobile using a zimmer frame

4. Mrs R put on hyperadin and trazinidol(?) ; consultant recommended that she be moved to GWM for 3 weeks until an alternative nursing home found for her

5. 11 August, 2001: Mrs R admitted to GWM with note from consultant saying that she was fully mobile; She was placed in a room on her own in Daedalus ward facing onto corridor and in sight of nursing staff

6. Shortly after arrival at GWM, put on heavy sedation; became groggy; nurse said that she wasn't lucid

7. Neice came to visit soon after and told that 'she'd had a little fall'; neice asked why no X-ray; seen by a Dr Briggs who worked at same surgery as Dr Barton who recommended morning Xray; family confused as fall apparently happened at 1:30 pm and GWM Xray dept open at that time

8. After Xray at GWM which found dislocation but no fracture Mrs R taken back to Haslar where doctors queried fact that she was de-hydrated; after eating full breakfast she went back to GWM; family happy with decision for her to return there

9. Family arrived at GWM on 13/08 to visit; found her in considerable pain; complained to health care assistant who said that 'it was just dementia'; however found that she had been placed in very unwieldy position on her side; had to shift her themselves to ease the pain

10. Family requested another Xray; charge nurse agreed that something was wrong; long delay as he was not authorized to order one; family refused sight of Xrays when finally taken and they asked to see them

11. When family objected to administration of diamorphine, Dr Barton reacted angrily saying that Mrs R was her patient and that it was her decision to make; there was no reference to fact that mother had haematoma at that stage; family wanted to get her back to Haslar

12. Charge nurse Philip Bede told them that nothing could be done for Mrs R and that she would have to put on a syringe driver for administration of pain relief

13. Mrs R dies on 15/08. Cause of death reported as pneumonia.

Breaking of the news of their mother's imminent death by GWM staff was abrupt and terribly amateur...there was no empathy, no compassion; shied away from discussing death or dying directly (Mrs M asked how long her mother had left, Philip from the whole thing. She said that the 'next thing will be a chest infection'; first time any such thing had been mentioned

Particularly upsetting when a health care assistant came in to mother's room, asked for a dress, and suggested that her mother get up and dressed; family had just been told that their mother was dying

'We were facing facts...we knew that she was getting older and didn't have much longer but still thought she had a chance of recovery and getting back to normal with appropriate support

Mrs. R.s daughters stayed at hospital constantly until she died so had a good opportunity to see nursing care which Mrs M describes as 'very poor'',' they were having real difficulties and didn't know how to handle the situation'
Dealt mostly with Philip Bede and an agency nursed called Sue, for whom Mrs M has very high praise

Wonders why she wasn't put on a drip for nutrition and fluids; contacted Lesley Humphreys to find out; Mrs H told them that Dr Barton would have explained reasons to them (she had not)

Max Millett's letter to Mrs. M's sister claims that Dr Barton had spoken to family and had advised against surgery for haematoma because of risk to Mrs R from general anaesthetic

Cause of death recorded on death certificate as pneumonia; no reference to any of the other things affecting Mrs R and never mentioned to family. Dr Barton signed it and sister queried it but would not agree to a post mortem and their mother was cremated

Obtained mother's medical notes from both Haslar and GWM; Halar's a 'very high standard; with lots of detail' whereas GWM's 'absolutely abysmal' - nothing seemed to be in order; concerned about discrepancies in recording time of her mother's fall at GWM and in the administration of drugs; dates don't tally; some notes appear to have been written after her death; recorded that she had eaten porridge for breakfast on the day of her death when that would have been physically impossible

Mrs R had not been treated as a patient for remobilization as she should have been according to advice from consultant geriatrician at Haslar, 3 days after her hip operation

When she arrived at GWM she was mobile (with aid of nurses or zimmer), continent (wanted to go to toilet and asked nurses) and could make herself understood

Day of second admission to GWM, Dr Barton said that she was happy for staff to confirm death; started administering olimorph (form of diamorphine) at four-hourly intervals ; Mrs M and sister very surprised and distressed by this news as her mother was put in continuing care rather than a palliative care bed

Also upset about the arrangements for her second transfer from Haslar to GWM when she was carried on nothing more than a sheet; there was also nothing on her notes on arrival at GWM to indicate that she had pneumonia

Mrs M asked at public meeting with GWM in Sept 2001 for reassurance that trust had implemented action plan in which staff were to go on training course for dealing with relatives; would not give it

Mrs M recommends that
Staff need traqining in dealing with next of kin; need for sensitivity about treating families and patients with dignity eg right to wear own clothes (eg Health care assistant insisted that Mrs M eat a dinner she'd ordered from the canteen despite the fact that Mrs M upset as her mother was dying)

'The attitude was that these are old people who've had their life, they're taking up beds, so what does it matter any more what happens to them?'

Totally uncaring atmosphere, totally cold

'They had no intention to re-mobilise her...I don't think this hospital has a system to rehabilitate older people'.