Code A

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Max Millett
Chief Executive
Portsmouth Healthcare Trust
St James Hospital
Locksway Road
Milton, Portsmouth
Hants, PO4 8LD

18 April, 2002

Dear Sir,

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Thank you for your letter JP/svn dated 20 March 02 which included the medical records, for which I am most grateful. After reading those records and in conjunction with the observations my wife and I made during our various visits and contacts with the Gosport War Memorial Hospital; I am now in a position to lodge a formal complaint over the treatment received by my late father.

Specialty History Sheet

The entry for 25 January 02 (on admission) shows 4 falls in 48 hours. There appears to have been no examination of my father for injuries as a result of these falls. Nor is there any assessment as to why these falls were occuring and how they could be prevented in the future.

The report of 28 January 02 shows that my father's condition was deteriorating, including not passing urine, irregular pulse and jaundice. It was a Healthcall doctor that constructed a Liver Disease Plan. We support these observations, during Monday 28th and Tuesday 29th we felt my father had moved in to a new phase of his illness, and that he had become very unwell. We passed these concerns on to the nursing staff and it is interesting to note that these concerns were not recorded by the nursing staff and yet our earlier comments that he had improved on Sunday 27th were recorded.

We note that despite the Liver Disease Plan etc on 28 January 02 report there was no Specialty History Sheet entries for the 29th or 30th and the entry for 31st shows no sign of medical urgency in respect of my father. Likewise the Contact Record shows little urgency by Dr Grocott following the 28 January 02 report.

On 1 February 02 Dr Grocott wrote 'because of dehydration and the family's lack of confidence in care at War Memorial transfer to QAH'. Dr Grocott recorded this following a telephone call from myself on the morning of 1 February 02 because I was concerned about the deterioration in my father's condition and the fact that it appeared little was being done. It also followed the day where my father was virtually left dehydrated (more about this extremely serious incident under the 'Contact Record' heading later in my complaint). Dr Grocott's comments here are interesting because they are superficial and appear to make light of my father's condition, as if his transfer is not necessary. He states that Liver Scan Result was normal (although the Ultrasound Report reports – 'Very difficult scan), and he continues to report bronchitis. He reports my father uncomplaining. The very same day that Dr Grocott wrote these remarks, the medical staff of Anne Ward, Queen Alexandra Hospital recorded/made the following remarks in respect of my father:

a. He had abdominal ascites.
b. He had pneumonia
c. He was septic
d. He had limited responses to questions.
e. A Registrar informed my wife and I that my father's condition was so serious he may not make it.
f. Dr Tandy (my father's consultant) informed us (after my father had died) that she considered my father's condition so serious on admission, she wondered what she or her team could do to save him.
g. He was placed on diamorphine.
h. We were being prepared by the medical and nursing staff for the loss of my father.

I can therefore only conclude from Dr Grocott's comments show how little understanding of how ill my father was and how inappropriate my father's retention in the Gosport War Memorial Hospital had been.

Contact Record - 31 January 02

The entry for 31 January 02 at 2100 explains a possible complaint coming from me. However it fails to report the reason for my complaint which was as follows:

My wife and I arrived at 2005 and proceeded to my father's bed, which was located in a side room down a short corridor from the nursing station. He was presumably placed in this location from his original location in an open ward so that he could be better observed. We found a scene of abandonment, the bed was a mess, my father lying on his side naked from the waist down. The urine container had become detached from its stand and was lying on the floor. The urine was extremely concentrated (dark sherry colour). It was so dark that my wife an RGN for over 30 years had never seen urine this colour. The weight of the sheath/catheter was pulling my father's penis at a very uncomfortable angle.

My father had defecated, urine had escaped and he had vomited. My father was in a very uncomfortable and agitated state. Above his bed was a large 'Nil by mouth sign'. The sight that greeted my wife and I that evening will never be forgotten. My father has now passed away and is at peace, but the

vision of my father on this evening is still with my wife and I and I do not believe we will ever forget it. Without overstating the incident I believe the only way to describe it was 'horrific'.

I went to the nurse station to report what I had found. A nurse followed me in to the room and said 'oh I think we should have taken the sign down this afternoon, he had been 'nil by mouth' for his ultrasound. Let me find out if he is still 'nil by mouth'.' We were then asked to leave the room whilst two nurses took 10 minutes to 'clean' my father up and restore some dignity to him and his family.

I informed the nurses that I was very unhappy with how we had found my father. I was asked to discuss the matter in the short corridor outside my father's room. I informed the senior nurse that this was not an appropriate place to discuss the matter and my wife and I, were then invited to go to the nurses' office. We told her what we had found. She apologised several times and informed us that my father was too ill for the Gosport War Memorial Hospital. We asked what communication had taken place between the nursing staff and the GP to communicate this very important point and we received no answer.

Do I therefore assume that a request had been made by the nursing staff to the GP to move my father to a more appropriate hospital? If this is not the case then I can only assume that the nursing staff failed to provide this information to the GP?

Fluids

It was clear before admission to Gosport War Memorial Hospital that my father had a problem with fluid intake. At home he was not capable of taking a drink himself. The notes for 25 January 02 clearly state my concerns in this area. The Fluid intake and output records show the following:

Intake		**Output**
26 Jan	1550 Mls	Toilet x 2
27 Jan	700 Mls	No record
28 Jan	650 Mls	Nil
29 Jan	400 Mls	Nil
30 Jan	1300 Mls	1400 Vomited
31 Jan	325 Mls	Nil
1 Feb	990 Mls	600 Mls
Total	**5915 Mls**	

This amounts to an average intake of 845 Mls per day. This is an extremely small amount of fluids for a dehydrated patient to consume over a 7 day period. I understand that it is normal nursing practice to aim for the intake of fluids for a non dehydrated patient to be around 2000 Mls per day, let alone a dehydrated patient.

Regularly throughout my father's stay we asked why a drip was not being put up and we were told that it was hospital policy not to. We could not

understand how an organisation that calls itself a 'hospital' could have such a policy. It takes only a basic medical skill to put up a drip and maintain it. The nursing staff assured us that they would ensure sufficient fluid intake for my father. We were sure at the time that they were not keeping their promise, and this is now confirmed from the records.

With this policy, was it not inappropriate for my father to have been admitted to Gosport War Memorial Hospital? If he had been admitted to a more appropriate hospital he would have had a better outcome.

It is also interesting that the his fluid intake shows 6 cups of tea consumed amounting to 1200 Mls, or one fifth of his total intake (a significant amount in my father's case). We believe my father did not consume this tea. The ladies who brought the beverage trolley around, were less than impressive in their patient care. They would ask him if he wanted a tea from their trolley. Because my father was hard of hearing and becoming more ill, he would not reply to them. They would then move away quickly when he did not answer them.

We were present with him on many occasions and we would try to get him to have a drink but he would decline it. When ever we visited him on the open ward we would ask fellow patients what he had drunk. In fact his fluid intake would have been much lower still if it were not for my wife and myself continually helping him to drink. This is basic nursing care and all staff need to be instructed on the importance of fluid intake and appropriate methods of encouragement.

The consumption on 31 Jan shows 325 Mls, but 275 Mls was consumed after our discovery that my father was still 'Nil by Mouth' at 8 p.m., 5 hours after the ultrasound. My father had therefore consumed 50 Mlles of fluid in a period of 14 hours. I believe this lapse in basic nursing care deprived an already dehydrated patient essential fluid, which had the effect of seriously harming his condition to such an effect that his organs started to fail him.

The output record speaks for itself. Again this is basic nursing and It clearly indicates a patient who is very unwell. Both the nursing staff and GP should have reacted to what this record was telling them, particularly given the other indicators.

Nursing Care 30 January 02

My wife visited my dad just after lunch on this day and found him sitting in a chair by his bed next to a hot radiator. He was slumped over, very agitated and extremely tired having not slept all night. He begged my wife many times to help him to get into bed. The bed had been elevated to its highest point and the cot sides were up. My wife enquired of the nursing staff why this had been done. The reply was that it was to prevent him from getting in to bed because the nursing staff wanted him to sleep at night. How can this be done in the interest of the patient? Presumably it was done to aid the night staff have a quieter time. It was certainly not done to make my father feel comfortable.

Does it really matter when a patient sleeps when someone is so ill? My father had actually managed to get into bed despite these preventative

measures and he had been removed and sat out again. I consider this a very cruel action to have been taken on a very weak and sick and gentle man. My father's kidney condition was making him feel very uncomfortable when he was in the sitting position. The nursing staff was well aware that he preferred to lie as flat as possible and they were well aware of the severe bruising on his back and yet they still sat him in the chair.

My father was eventually put back to bed when he almost immediately vomited violently. My wife was standing at the end of the bed and it reached her. The Ward Sister was present and she remarked that this was a virus and that my wife would be getting it now. She then said we have no where to wash his clothes you will have to take them with you. Later a nurse working with the Sister said she would rinse the clothes and these would be available for collection to wash them at home that evening. We wonder about the infection control policy that allows possible infected clothes to leave the hospital? In addition there appears to be no entry of this incident being recorded in my father's notes.

My Complaints are therefore as follows:

1. Was my father admitted on 25 January 2002 to the most appropriate hospital for his needs?

2. What examination/investigations took place on admission re the injuries that my father suffered as a result of his falls prior to admission?

3. Why the Specialty History Report of 28 January 02 was not acted upon?

4. Why there was a lack of medical/nursing action for 29th, 30th and 31st.

5. Why my father was left so many hours without fluids on 31 January 02?

6. How my father came to be left un-cared for on the evening of 31 January 02?

7. Why my father was allowed to have such a small fluid intake during his stay at Gosport War Memorial Hospital?

8. Why my father was not transferred earlier to a hospital able to rehydrate him when it was apparent that the facilities at the War Memorial Hospital were not able to.

9. Why my father was allowed to remain at Gosport War Memorial Hospital when he was clearly in need of medical and nursing care from an Acute Hospital?

10. How my father's fluid records came to be so inaccurate?

11. Why the nursing records for 31 January 02 failed to report the serious 'Nil by Mouth' incident?

12. Why the nursing records fail to record our concerns that we feel my father's condition was deteriorating?

13. How the practice of raising a patient's bed to prevent them getting in to it can occur in a modern NHS Hospital in year 2002?

14. Why the nursing record fails to record the vomiting incident of 30 January 02 and his move to a side room?

15. How patient relatives can be given possibly infected patient clothing to wash at home?

16. Why Gosport War Memorial Hospital has no personal patient laundry system when many of the patients may not have able bodied partners or family to undertake this task?

17. Why is was necessary for my father's family to fight for his dignity and care that he so rightly deserved?

Yours sincerely,

Code A

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