The outcome of the use of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I knew that the continuous use of morphine, as a means of relieving her pain, could result in her death. She was, at that time, unconscious from the effects of previous doses of 'Oramorph' and therefore unable to take nourishment by mouth. It was my understanding that it would not have been possible for nourishment to have been given to my mother, by way of a drip, whilst she remained at the Gosport War Memorial Hospital.

As a result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, 'Are we talking about euthanasia? It's illegal in this country you know'. The Ward Manager replied 'Goodness, no, of course not'. I was upset and said, 'Just let her be pain free'.

The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998 (17/08/1998).

A little later Dr BARTON appeared and confirmed that a haematoma was present and that this was the kindest way to treat my mother. She also stated, 'And the next thing will be a chest infection'.

I considered that this was a totally insensitive remark to make to someone, such as myself, who was experiencing some of the feelings associated with the first stages of bereavement.

I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'.

I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death.

I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON more strongly on this issue.

In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have prevented Dr BARTON from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and from where an offer had already been made to do so.

I accept that my mother was unwell and that her physical reserves had been depleted. However she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely, been aggravated by poor quality service and avoidable delay

experienced whilst in the hands of those whose responsibly it was to care for her.

My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure o the 19th August and no further urine was passed. The same catheter bag remained in place until her death.

Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would and she died on Friday the 21st August 1998 (21/08/1998).

I passed, as I have previously mentioned, a copy of the notes I had prepared (LFL/2) to Mrs HUMPHREY.

In reply I received a letter from Max MILLETT , the Chief Executive of the Portsmouth Health Care NHS Trust, dated the 22nd September 1998 (22/09/1998).

I can produce a copy of this letter which has, attached to it, a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/3.

Whilst there are a number issues which cause me concern I would like to make some particular comments on the contents of this letter.

In order to do this I have been provided, by DCI BURT, with a typed copy of the letter (LFL/3). This copy, to which is now attached a Hampshire Constabulary exhibit label bearing the reference LFL/3A and signed by me, was constructed to enable me to add handwritten comments which I have done. I feel, however, that I should point out that where I have chosen not to record such a comment this does not imply that I necessary agree with, or accept, what has been stated.

I have been shown, by DCI BURT, a copy of an Enquiry Report which has attached to it a Hampshire Constabulary exhibit label bearing the reference LH/4 which I have signed.

I have been provided, by DCI BURT, with a typed copy of this Enquiry Report (LH/4). The copy, to which is now attached a Hampshire Constabulary exhibit label bearing the reference LFL/4 and signed by me, was constructed to enable me to add handwritten comments which I have done. I, once again, point out that where I have chosen not to comment on a particular reply or issue this does not imply that I necessarily agree with, or accept, what has been stated.

I have had sight of a report, prepared by Dr LORD and dated the 22nd December 1998 (22/12/1998), which has attached to it a Hampshire Constabulary exhibit label bearing the reference LH/6 and signed by me.

If this report is supposed to represent an independent assessment of the treatment which my mother received at the Gosport War Memorial Hospital then I find this difficult to accept.

Dr LORD was the consultant for Daedalus Ward at the Gosport War Memorial Hospital but, in her own words '... did not attend to Mrs RICHARDS at all ...'.

Dr LORD's report appears to have been prepared by reference, some time after the event, to information, notes and documents supplied by colleagues with whom she worked on a regular basis.

I have been shown, by DCI BURT, a Portsmouth Health Care NHS Trust Risk Event Record. Attached to this document is a Hampshire Constabulary exhibit label bearing the reference LH/2 which I have signed.

I have examined this document, which comprises of 3 sides of paper and I would like to make the following observations.

On page 1, at 12(a) after the words 'seen by?' there is a handwritten entry, 'Dr BRIGG '.

I believe that this contradicts information contained in the letter from the Portsmouth Health Care Trust (LFL/3) dated 22nd September 1998 (22/09/1998) where, at point (4), it states that Dr BARTON was present on the ward just after my mother's fall.

Furthermore, at 12 (a), there is a further handwritten entry which states 'Advised by telephone – analgesia & RV mane'. This may be cross referred to an entry in my mother's Health Care Record (LH/1/C/21) which is dated 13.8.98 (13/08/1998) and timed at 1300.

At 12(b) it states, in reply to the question, 'Has next of kin been informed? The corresponding 'Yes' has been positively ticked and dated 13/8/98 (13/08/1998). Furthermore it states that I had been informed by telephoned.

I was not informed and I was not telephoned. My statement shows I was on the ward and had great difficulty in finding anyone to confirm my mother was injured.

It is my opinion that the Risk Event Record is incorrect. My mother was not seen by Dr BRIGG.

Part 'E' of the Risk Event Record shows that a particular question, which appears among a series of 'tick box' questions and states, 'Slipped, tripped or fell on the same level', has been positively answered. In my view this is incorrect. The normal height of the seat would be between 17 and 25 inches so my mother's fall to the ground would have involved a considerable drop.

I have been shown, by DCI BURT, a copy of the Portsmouth Health Care Trust Health Record. Attached to this Health Record is a Hampshire Constabulary exhibit label bearing the reference LH/1/C.

This health Record relates to my mother and I would like to make the following comments in respect of this document.

On the page marked LH/1/C/6, which is a copy of a Discharge Letter from the Royal Hospital Haslar

, I note the comment, 'She can, however, mobilise fully weight bearing'. I wish to highlight the fact that this relates to my mother's condition on the 17th August 1998 (17/08/1998).

On the page marked LH/1/C/8 there is a copy of a handwritten note, apparently signed by Philip BEED, which is addressed to Haslar A&E and is dated 14th August 1998 (14/08/1998). In these notes it states, 'No change in treatment since transfer to us 11/8/98 (11/08/1998), except addition of Oramorph etc.

I would comment that no analgesia was required until the staff at the Gosport War Memorial Hospital first used Oramorph when my mother was agitated and probably in need of the toilet on the 11th August 1998 (11/08/1998) which was the day of her admission from the Royal Hospital Haslar.

I saw the my mother was deeply unconscious when I visited her on the 12th August 1998 (12/08/1998). In my view this medication probably affected the opportunity to offer nourishment as early as the 11th August 1998 (11/08/1998).

On page LH/1/C11 I note, with some concern, an entry under the date of the 11th August 1998 (11/08/1998) in what I believe is Dr BARTON's handwriting, the comment, 'I am happy for nursing staff to confirm death'.

My mother was well and enjoying a good convalescence following a major operation. She was able to eat and drink. She was able to stand whilst requiring help with all daily living events.

Perhaps this comment may be considered, by some, as being 'normal' procedure for aged admissions but not in my experience. Such a question may, perhaps, be considered if the patient was suffering from a terminal illness and death is likely or imminent. The evidence does not suggest that my mother was in this condition.

On the same page (LH/1/C/11) there is an entry under the date of the 14th August 1998 (14/08/1998) which is once again, I believe, in Dr BARTON's handwriting. It states 'Fell out of chair last night'.

Further reference to the Risk Event Record (LH/2) shows, at point (9), that the accident occurred on the 13th August 1998 (13/08/1998) at 1330 hours and it will be recalled that the Portsmouth Health Care Trust letter (LFL/3) states that Dr BARTON was on the ward following accident.

I query whether, in fact my mother was seen at all.

A further comment, in the same entry, states, 'Daughter aware and not happy'. I reiterate that I was 'not happy' because I could get nothing done for my mother who was simply given pain relief without any apparent attempt to discover the cause of her discomfort.

Finally, in the same entry, the question is raised by, I believe Dr BARTON, 'Is this lady well enough

for another surgical procedure?' This question was not, however, raised with me.

On the reverse side of page LH/1/C/11, under an entry dated the 17th August 1998 (17/08/1998), there are references to my mother's condition following the operation on 14.8.98 (14/80/1998) as per the nurse's notes of Haslar, not to her condition on 17.8.98 (17/08/1998).

There is a comment, I believe in Dr BARTON's handwriting, '... now appears peaceful'. I know that my mother screamed and cried in the period following her re-admission.

My mother was only 'peaceful' being given Oramorph on 3 occasions which rendered her quiet and unconscious. In fact this treatment had rendered my mother incapable of taking any nourishment from this point and she did not regain consciousness again.

I would like to draw attention to the fact that there are no Doctor's notes from the 18th – 21st August 1998 (18/08/1998), (21/08/1998).

On the same page, under the date of the 21st August 1998 (21/08/1998) there is an entry which, I believe, is also in Dr BARTON's handwriting which I feel I must challenge. Contrary to what Dr BARTON has written I strongly believe that my mother did not have a rattly chest nor any other symptoms of Brocho-pnuemonia.

On page LH/1/C/21 and on the following 3 pages, also so marked and headed 'Contact Record', I note that no entries appear to have been made over the period of the 11th/12th August 1998 (11/08/1998) (12/08/1998).

On page LH/1/C/21, under an entry dated the 13th August 1998 (13/08/1998) there are comments which clearly indicate that my mother was not seen by a doctor or examined by way of x-ray following her fall at 1.30pm (1330) that day.

It was not until 7.30pm (1930) or 8.30pm (2030) that it was appreciated that my mother's hip was the cause of my mother's pain. Telephone contact, only, was made and advice sought and given by a doctor who did not know my mother.

I was present on the ward and repeatedly sought help for my mother. I was casually informed by a Health Care Assistant, that my mother had indeed had a fall.

In my opinion there was a serious lack of action for a post operative patient in view of her obvious gross 'discomfort' which was brought to the attention of all grades of staff by myself. The comment included in the entry, 'daughter informed' may refer to the phone call received after I returned home at approximately about 9pm (2100) – 10pm (2200) that evening.

On the same page, under an entry dated the 17th August 1998 (17/08/1998) there appears to be a

reference to my mother being in pain and distress but no action was taken.

There is an 'added' comment which refers to the fact that when my mother was transferred there was, 'no canvas under patient ...' In my view this represented a serious breach of work procedures and should be questioned.

I consider that the circumstances of my mother's transfer from the Royal Hospital Haslar, to the Gosport War Memorial Hospital, should be the subject of investigation. How was she brought from Haslar? How was she lifted? How was she transferred to her bed? Was the bed moved from the wall? How was she deposited in her bed? And by whom? Who was present?

This was a woman, 2 days post operative, who was transferred on a sheet. How could this have happened? And why?

Who was informed, and when, as regards her degree of pain which was very obvious when I arrived 30 minutes after this entry was apparently made.

On the following page there is a further entry which is also dated the 17th August 1998 (17/08/1998) and time at 1305 hours. This entry does not refer to my mother's awful position, which I observed upon my arrival, or the fact that I asked the RGN to look at the way in which she was lying and to adjust her to be equally on both hips.

It was at this point that I told the staff that the Royal Hospital Haslar would be prepared to re-admit my mother. The surgeon had said that she should not be in pain.

I once again point to the fact that my mother was pain free and mobilising prior to her transfer.

It should be noted there is no entry, on the 17th or 18th August 1998 (17/08/1998) (18/08/1998), regarding the fact that my sister and I were told that our mother had a massive haematoma. I can find no written evidence of this fact.

I see that no contact notes were made on the 20th August 1998 (20/08/1998).

In an entry dated the 21st August 1998 (21/08/1998) there is a reference to the fact that, 'daughters visited during morning'. I would state that, in fact, we were constantly at the Gosport War Memorial Hospital, day and night, from the 17th August 1998 (17/08/1998) until the time when my mother died.

I would like to comment, in respect of the Nursing Care Plan on the 2 pages marked LH/1/C/22, lacks information regarding the events that occurred.

With reference to the pages marked LH/1/C/22/4, headed 'Personal Hygiene' and 'Care Plan', there is, in my opinion, a gross lack of attention to the needs of daily living. Not even face and hands were washed and there are no entries at all on the 17th, 19th, or 20th August 1998 (20/08/1998).

Finally, by reference to the page marked LH/1/C/22/1 and headed 'Nutrition' I comment that, in my opinion, this form is sadly lacking in information.

There are only 3 entries in total and no entries at all in respect of the 12th, 17th, 18th, 19th or 20th August 1998 (20/08/1998).

Furthermore there is no acknowledgement of the fact that my mother was having NIL BY MOUTH due to her induced unconscious state by the giving of pain relief only for 5 days prior to her death and during previous days of the 11th, 12th and 13th August 1998 (13/08/1998).

I have been shown, by DCI BURT, a copy of a Royal Hospital Haslar Medical Record. Attached to this document is a Hampshire Constabulary exhibit label bearing the reference AF/1/C which I have signed.

I would like to comment that in my opinion, when comparing it as a residual account of events with the Portsmouth Health Care Trust's Health Record (LH/1/C), it supersedes the latter in terms of quality and content.

Having examined the Medical Record (AF/1/C) I consider it to be totally accurate as regards the condition and treatment/care afforded to my mother Mrs Gladys RICHARDS. There is attention to detail and all information contained therein is as I remember.

I would particularly like to highlight a particular issue and refer to a page in the Medical record marked (AF/1/C/11).

It should be noted that after my mother's initial admission to the Royal Hospital Haslar, when it was uncertain if she would survive, the doctor, to his credit, has written, 'she is to be kept pain free, hydrated and nourished'.

To me this indicated that there was a will, and an intention, to afford to my mother total care whilst she was alive.

I wish to draw attention to the excellent standard of treatment which my mother received while at the Royal Hospital Haslar. She was nursed with care and consideration with, significantly, attention being paid to hydration and nourishment. There was an expectation, for the immediate future, on her transfer to the Gosport War Memorial Hospital.

In my view this is in direct contrast, in all aspects, to the standard of care and attention which my mother received at the Gosport War Memorial Hospital during the last 6 days of her life the most notable feature being the refusal to refer her back, once again, to the Royal Hospital Haslar when an offer had been received to accept her.

DOCUMENT RECORD PRINT

Statement number: S3

Signed: Lesley Lack

Signature witnessed by: R J BURT