Draft Statement - Lesley Frances LACK

I am the natural daughter of Gladys Mable RICHARDS (Nee BEECH) who was born on the Code A

My mother died on the 21st August 1998 whilst she was an admitted patient at the Gosport War Memorial Hospital.

I am a retired Registered General Nurse (RGN). I retired during 1996 after 41 years, continuously, in the nursing profession. For 25 years, prior to my retirement, I was involved in the care of elderly people. For 20 years, prior to my retirement, I held supervisory and managerial positions in this particular field of nursing.

My mother was a resident in two nursing homes from I991 or thereabouts. The first was located in the Basingstoke area and the most recent was the 'Glen Heathers' Nursing and Residential Home, Milvil Road, Lee on Solent, Hampshire. My mother spent approximately four years at the 'Glen Heathers' Home. On admission to Glen Heathers my mother was ambulant - able to go up and down stairs and walk well.

She was generally well, physically, but had the onset of dementia and became increasingly forgetful. At the beginning of 1998 my mother's dementia was becoming more marked and she had become less able physically. She was inclined to wander and following a change in her medication began to have falls.

However, despite this my mother was able to stand, walk and attend the toilet. I used to take her out for trips in my car. Her last visit to my home occurred during Christmas 1997.

My mother left the 'Glen Heathers' Home on the 29th July 1998 and was admitted to the Haslar Hospital, Gosport.

My mother had suffered a fall, at the Home, at approximately 1450 hours during the afternoon of that day. She was eventually taken to Haslar Hospital, by ambulance, at approximately 2100 hours that evening where she was diagnosed as having broken a neck of femur on her right side.

Whilst it may not have a direct bearing on my main concerns surrounding my mother's death, which I will describe later in this statement, I would like to point out that I did have serious reservations as regards the standard of care which my mother was receiving whilst residing at the 'Glen Heathers' Home.

In fact, following my mother's admission to the Haslar Hospital on the 29th July 1998, I had decided that, if and when my mother recovered, she would not be returning to the 'Glen Heathers' Home.

I was asked by the Social Services Department why I had made this decision and, in response, I prepared and provided a hand-written account describing what I considered to be a catalogue of unacceptable events which had led me to conclude that the level of care which my mother was receiving at the 'Glen Heathers' Home was no longer acceptable to me.

The hand-written account was prepared, by me, during August 1998 and I consider that it represented a truthful statement which dealt with various events and circumstances which I had observed or had become aware of during the months which preceded my mother's admission to the Haslar Hospital.

I will not, for the purposes of this statement, refer in detail to the matters described in that account but I will, by way of introducing the events which followed, make some brief references, drawing on my personal recollections and my notes, to my involvement in the events leading to my mother's admission to the Haslar Hospital on Wednesday the 29th July 1998.

I was a frequent and regular visitor to the 'Glen Heathers' Home whilst my mother was residing there and I played an active role in helping her in her daily routines. My visits were generally daily in the last 8 months of her life.

I recall that I was unable to get to the 'Glen Heathers' Home at lunchtime on Wednesday the 29th July 1998. I telephoned the Home to inform them that I would be going there later in the afternoon.

When I arrived, at approximately 1550 hours, I saw that my mother was lying in an armchair. She appeared to have an anxious expression on her face. I asked a care assistant to help me to move my mother into a more comfortable sitting position which, together, we tried to do but, as a result, my mother screamed out in pain.

I saw John PERKINS, an RGN and the Home's Matron/Manager, and I asked him if there was anything wrong with my mother which might account for her pain. He told me that she was fine.

I clearly knew that this could not be the case but I was not in a position to do anything more at that time. I had to leave the Home at 1615 hours in order to meet a flight at Southampton Airport. I said that I would return later.

I arrived home, from the Airport, at approximately 1810 hours. I found a message on my telephone answer machine, timed at 1528 hours, from a woman I knew as Margaret who was an RGN who worked at the Home. Margaret stated that my mother had experienced a fall earlier and, whilst she was alright, she was a bit noisy and upset. Margaret asked if I could attend the Home, before teatime, and sit with her, to calm her down.

I immediately telephoned the Home, at approximately 1815 hours, and spoke to John PERKINS. I told him about the message from Margaret and pointed out that I had seen him, at the Home, after the message had been left on my answer machine.

John PERKINS agreed that this was the case but stated that when he had spoken to me he was not aware of my mother's fall. He stated that he had learned about it during the 1800 hours 'hand over' process when Margaret had gone off duty.

I asked John about my mother's current condition and he said that she was OK. I told John that I would call again later. I had to go out in the meantime.

I returned home at approximately 2030 hours. I found three messages from the Home on my telephone answer machine:

1) 2008 hours - from John PERKINS - stating that my mother was quite agitated and noisy and inviting me to attend and sit with her.

2) 2029 hours - stating that my mother was calling as if she may be in pain. She had been put to bed and consideration was being given to calling a doctor.

3) 2030 hours (approximately) - from a woman named Sue, a member of the night staff - stating that she was sorry but she was sure that my mother had a fractured femur. She went on to state that when she had started work she had been told, by John, to see my mother who had been shouting for ages. Sue stated that when she did so the injury appeared obvious and, as a result, she had called an ambulance.

I telephoned the Home and advised the staff that I would meet the ambulance at the Haslar Hospital.

On admission to the Haslar Hospital my mother was 'x' rayed and the diagnosis was confirmed. Furthermore, it was observed that the injury was consistent with my mother having been 'walked' after the fall had occurred. There was a shortening of the limb and an external rotation of the right foot. My mother was extremely upset and was crying and wailing in fear.

I subsequently sought a full explanation from the 'Glen Heathers' Home about the events which occurred on the 29th July 1998. As a result I saw a woman named Pauline, an RGN and consultant/advisor to the Home.

Pauline read to me from several statements which had been obtained from members of staff at the Home. I was not given copies.

During this process I was advised that my mother had fallen at 1450 hours in the dining room.

The statements read to me, by Pauline, indicated that my mother had been walked to the lounge, at some time after the fall had occurred, and, at some time thereafter, walked to the bedroom from the lounge.

The statements confirmed the following key points:

1) The fall had occurred at 1450 hours.

2) The serious injury which had apparently been sustained during this fall was not identified or even suspected by the staff despite my mother clearly showing signs of being in considerable and sustained pain.

3) My mother was walked on two occasions after apparently sustaining the injury which appears to have seriously aggravated her condition.

4) A doctor was not called to the Home.

5) My mother's condition was not effectively identified until a member of the night staff correctly diagnosed the likely cause of her severe discomfort and pain at or about 2030 hours when an ambulance was called to the Home and she was taken to the Haslar Hospital.

I can produce a copy of the hand-written notes which I prepared. These notes have attached to them a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/1.

Following her admission to the Haslar Hospital, at approximately 2100 hours on Wednesday the 29th July 1998, my mother underwent a surgical operation. This was carried out during the following day, Thursday the 30th July 1998, following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.

My mother received a replacement hip, on her right side, and remained in the Haslar Hospital for a further eleven days until Tuesday the 11th August 1998.

I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.

Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.

She was, with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.

Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.

Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.

I will now deal with the matters which arose during the following ten days culminating in my mother's death on Friday the 21st August 1998.

In doing so I will draw upon my personal recollections and also refer to a further set of hand-written notes which I prepared, whilst sitting at my mothers bedside, while she was still alive with my sister Gillian MACKENZIE, as I was unhappy with the events that had befallen my mother.

I telephoned the Complaints Department at Portsmouth Health Care Trust on Wednesday 19th August from Daedulus ward and spoke to Lesley HUMPHREY in depth. Having listened, she advised me that everything must be in writing. I continued adding to my notes - hence the use of different pens. I prepared these notes on the advice of Lesley HUMPHREY, the Quality Manager for the Portsmouth Health Care Trust, to whom I expressed my serious concerns about the care and treatment given to my mother by staff at the Gosport War Memorial Hospital.

The hand-written notes, a copy of which I passed to Lesley HUMPHREY, are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Mrs Sue HUTCHINGS on 20.8.98.

I produce the original hand-written notes which I prepared comprising of 5 numbered pages. These notes have attached to them a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/2.

I am in possession of a further page of notes, in my hand-writing, which I prepared at the time. I cannot now recall whether this additional page was copied to Mrs HUMPHREY with the other pages. This single page has attached to it a Hampshire Constabulary Exhibit Label bearing the reference LFL/2A which I have signed.

Many of the events and occasions I refer to in this statement took place in the presence of my sister Gillian Mackenzie. The addition to the notes were made when my sister and I read them prior to passing them to Lesley HUMPHREY as requested. Gillian remained at the hospital with me from 18th to 21st August 1998 inclusive, either of us leaving for very short periods only.

I visited my mother the day of her admission and discussed her present condition with the staff and on the following day after her admission to the Gosport War Memorial Hospital, namely Wednesday the 12th August 1998, I was rather surprised to discover that I could not rouse her. As she was unrousable she could not take nourishment or be kept hydrated.

I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days.

I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar Hospital during the period after the surgical operation to replace her hip.

I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate a possible cause. I consider it likely that she was in need of the toilet.

I became concerned that perhaps the staff at the Gosport War Memorial Hospital may have misinterpreted my mother's anxious and occasionally noisy behaviour. She had been showing signs of dementia for some time, prior to her admission to the Haslar Hospital, and she was prone to becoming very anxious at times particularly when she wanted to use the toilet.

One of the consequences of being rendered unrousable, by the effects of 'Oramorph, was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.

I would like to clarify an important concern I felt at this stage.

I believed that it was possible, having regard to the level of recovery which my mother had achieved upon being discharged from the Haslar Hospital the day before, that her reported behaviour could have been wrongly attributed to the presence of pain as opposed to other possible causes, such as anxiety, which could have been addressed naturally or by the use of alternative and milder forms of medication. I believe that the possible misinterpretation of my mother's behaviour is a particularly significant factor in this case.

In the circumstances which I have just described I consider that it is possible that my mother's signs of anxiety could have been misinterpreted for pain whereas, subsequently, it appears likely that the fact that my mother, after having fallen, and was clearly showing signs of being in pain, these signs were either ignored or dismissed as being the result of her dementia.

During the following day, Thursday the 13th August 1998, I received a telephone call, at approximately 1400 hours, from my daughter, Karen READ, who is a qualified nurse. As a result I went to the Gosport War Memorial Hospital to see my mother.

I arrived at the Gosport War Memorial Hospital at approximately 1545 - 1600 hours. I immediately saw that my mother appeared to be uncomfortable and in pain. She had an anxious expression, was weeping and was calling out. She was sitting in a chair and appeared grossly uncomfortable.

I spoke to several trained and untrained members of staff expressing my concern over my mother's condition. I was told that there was nothing wrong and that her behaviour was the result of her dementia. I was not satisfied with this explanation and I was convinced that my mother was in pain.

Later, at approximately 1630 -1700 hours, a care assistant came into my mother's room. She told me that my mother had fallen from a chair earlier that day.

I immediately enquired if my mother had been examined by a doctor but the care assistant did not know. I also asked if my mother could be x-rayed but I do not recall receiving a response to this request. I was able to give my mother a fruit drink which I had brought with me and she drank it readily. The whole glass.

A little later I saw an RGN who was doing the medicine round at approximately 1730 - 1800 hours. I was, at this time, feeding my mother by tea spooning her with some soup. My mother was quiet then.

The RGN asked me, " Do you think your mother is in pain?" In reply I expressed the view, "Not at the moment while I'm feeding her." I was rather taken aback by the RGN's rather curt reply, "Well you said she was in pain". I replied, "Yes, she has been very uncomfortable since I got here. Do you think she has done some damage?" The RGN replied, "No, she only fell on her bottom from her chair". I was shocked by this seemingly casual and insensitive remark - when this accident could very easily have caused damage and had not been checked.

I remained with my mother until approximately 1945 hours that evening (Thursday the 13th August 1998). After I had fed her she once again became distressed and showed signs of being in considerable pain. She remained in this condition, throughout, until my departure. I left very distressed as my mother was crying out and I could do nothing for her.

After I arrived home I received a telephone call from Daedalus Ward at the Gosport War Memorial Hospital. The caller stated that, "When we put your mother to bed she was in great pain and she may have 'done something'. The doctor feels it's too late to send her to Haslar and our x-ray unit is closed. We will give her 'Oramorph' for the night to keep her pain free and x-ray her in the morning".

I was becoming extremely concerned about what was happening to my mother.

It appeared, to me, at that time, that my mother had suffered a potentially serious fall at some time prior to my daughter's telephone call, to me, at approximately 1400 hours. I have, earlier in this account, referred to conversations which I had, during the afternoon and early evening, with two members of staff who both knew about, and referred to, the fall.

Despite the fact that my elderly mother was known to have suffered a fall, so soon after a hip operation, and then so clearly showed signs of anxiety, discomfort and pain, the reason was not properly explored and diagnosed.

This, in fact, resulted in what I believe was an avoidable delay of eight hours, in the first instance, before it was acknowledged, at approximately 2130 hours, that my mother, "may have done something".

I reiterate that I was, at that time, advised that the proper facilities (x-ray unit) for diagnosing my mother's condition, at the Gosport War Memorial Hospital, "were closed" and that the doctor, "feels it is too late to send her to Haslar".

Instead, my mother was given 'Oramorph' for pain relief and remained, effectively untreated, at the Gosport War Memorial Hospital overnight.

I strongly believe that the failure, on the part of the staff at the Gosport War Memorial Hospital, to properly and promptly take steps to accurately diagnose my mother's condition, on Thursday the 13th August 1998, and immediately initiate action to effectively deal with the cause by seeking a transfer to the Haslar Hospital where treatment was available, represented an example of a pattern of omission and failure which, ultimately, contributed in her death.

The following morning, Friday the 14th August 1998, I went to the Gosport War Memorial Hospital. I arrived as my mother was being taken, on a trolley, to the x-ray department. She was still deeply under the effects of the 'Oramorph' drug. I accompanied my mother whilst she underwent the x-ray process the associated movements of which caused her great pain.

When the x-ray process was completed we returned to my mother's ward and I was called into an office by Philip, the Ward Manager, where I also saw Dr BARTON. I was told, "Your worst fears of last night appear to be true, we have rung Haslar and they have accepted her back".

My mother was admitted to the Haslar Hospital, for the second time, during the late morning of Friday the 14th August 1998. I accompanied my mother and she was expected. The Consultant was called and he saw my mother in the Casualty Department immediately.

The Consultant showed me the x-rays and the position of my mother's limb, something else which I had observed, the day before, at the Gosport War Memorial Hospital.

My mother's right hip, which had been the subject of a surgical 'replacement' operation 14 days previously, had become dislocated from its socket. Within one hour of being admitted my mother underwent a successful surgical operation to manipulate the hip back into the socket.

This did, indeed, confirm my fears about the care my mother had received. She had fallen, whilst at the Gosport War Memorial Hospital, and it had taken almost 24 hours to secure effective treatment.

I remained at the hospital until approximately 10pm.

My mother did not regain consciousness until approximately 0100 hours on Saturday the 15th August 1998 due to the amount of analgesia required for the procedure. I telephoned the ward at this time as I was anxious. The night staff told me she had just regained consciousness.
She was the catheterised so that there was no need to use a slipper pan. She had a drip as she had been given nil by mouth since before the x-ray procedure carried out on Friday the 14th August 1998.

She remained pain free, in a full length leg splint. The Consultant showed me that both legs were level and straight. No analgesia was required and she was able to use a commode for the toilet with weight bare for transfer. My mother began to eat and drink and the drip was removed. Her fluid balance was acceptable. I visited daily.

Such was my mother's progress that during the following day, Sunday the 16th August 1998, she became easily manageable.

The issue I wish to highlight, at this point, is that when my mother's condition was correctly diagnosed and treated her pain and discomfort were removed and she recovered well.

My mother was examined early on Monday the 17th August 1998 when a transfer back to the Gosport War Memorial Hospital was recommended. I contacted the Haslar Hospital by telephone at approximately 0830 hours as requested and was told that my mother would be transferred that morning.

I offered to attend the Haslar Hospital so that I could pack my mother's things and accompany her but I was told that there was, "No need, she is fine".

I arrived at the Gosport War Memorial Hospital at approximately 1045 hours with Gillian MACKENZIE and we were told that the ambulance, carrying my mother, was due at midday or thereabouts.

We returned to the Gosport War Memorial Hospital at approximately 1215 hours.

On entering through the swing doors to the ward I heard my mother screaming. When I arrived at my mother's room a care assistant said, "You try feeding her. I can't do it. She is screaming all the time".

My mother had a staring anxious expression. She was griping her right thigh, at the sight of the surgical operation, tightly.

She uttered the words, "Do something, do something. The pain, the pain. Don't just stand there. I don't understand it. The pain, the pain, the pain. Sharp, sharp. This is some adventure". Gillian MACKENZIE was present.

An SRN came into the room because of the noise my mother was making. I removed the sheet covering my mother as she lay on her bed and pointed out the awful position she was in. She was lying awkwardly towards the left side with the full length splint not straight and the hips uneven.

My mother was crying in pain and I said to the RGN, "Can we please move her." We moved her together with our arms together under her lower back and our other arms under her thighs. We placed her squarely on her buttocks and within minutes she had stopped screaming.

I was concerned that my mother's position had not, apparently, been checked when she had been transferred from the ambulance. I was also concerned about the fact that, once again, the source of the pain had not, immediately, been sought.

I left my sister, at the Gosport War Memorial Hospital, at around this time and I went to the Haslar Hospital. This would have been about lunchtime.

I was so appalled at my mother's condition, discomfort and severe pain that I went to the ward in which she had been treated, E3, and enquired about her condition upon discharge earlier that morning.

When I had, earlier that day, telephoned E3 ward and I had been further advised that my mother was eating, drinking, using a commode and able to stand if aided. The Consultant responsible for my mother was, I was told, happy that she could be sent back to the Gosport War Memorial Hospital.

It is, perhaps, worthwhile re-emphasising that this was the level of recovery my mother had achieved on the morning of Monday the 17th August 1998 prior to being discharged from the Haslar Hospital. Whilst she was an elderly and frail lady she was not suffering with a fatal illness. Her discharge notes from Haslar refer to her care for the next 4 weeks, to ensure her progress was maintained.

Upon leaving Haslar Hospital's E3 ward, after confirming the information I had earlier been given, I met the Doctor who had been present in the Casualty Theatre at the time of my mother's second operation which took place on Friday the 14th August 1998. This Doctor had been with the Consultant when all the procedures were explained to me, upon my mother's admission, that day.

The Doctor asked, "How's your mother?" I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said, "We've had no referral. Get them to refer her back. We'll see her."

I then returned to the Gosport War Memorial Hospital where I noted that the Charge Nurse Manager frequently checked my mother. He acknowledged my concern and the fact that my mother was obviously in pain.
I asked for my mother to be x-rayed and enquired what had happened between my mother having left the Haslar Hospital and her arrival at the Gosport War Memorial Hospital.

It was acknowledged that "something" had happened. The Charge Nurse was concerned for my mother's pain and analgesia was given three times between her admission and 1800 hours.

Philip, the Ward Manager, agreed that my mother needed an x-ray to establish if further damage had been done to the hip.

The x-ray department refused to act upon forms of authority prepared and signed on behalf of the doctor who was unavailable.

An appointment for x-ray was made for 1545 hours as the Doctor who had been called was expected at approximately 1515 hours.

The Charge Nurse did all he could to expedite this, keeping me informed and constantly checking my mother's obvious severe pain. He administered pain relief in readiness for the x-ray procedure. He was courteous and attentive at all times.

Dr BARTON arrived and I left the room as requested whilst she examined my mother. She stated that whilst she did not think that there was further dislocation the x-ray could go ahead. A review would be conducted later when the result of the x-ray was known.

I accompanied my mother to the x-ray department. My mother remained in pain despite the pain relief which had been administered to her. I was not allowed to accompany her as I had been the previous week . Whilst I waited outside I could hear my mother wailing, while the x-ray was taken.

In due course I returned to the ward and I was told that there was no dislocation but obviously 'something' had happened. I was not given sight of the x-ray.

I was told, by either the Ward Manager or Doctor BARTON, that my mother would be given 'Oramorph' for the pain, four hourly, through the night and she would be reviewed in the morning. I told them that Haslar would accept her back but Dr BARTON felt that was inappropriate.

The following day, Tuesday the 18th August 1998, I returned to the Gosport War Memorial Hospital with my sister in the morning. Upon arrival we were told by, the Ward Manager Mr Philip BEED, that whilst my mother had undergone a peaceful night she had, however, developed a massive haemetoma in the vicinity of the operation site which was causing her severe pain.
The plan of management, as explained to us by the Ward Manager, was to use a syringe driver to ensure my mother was pain free at all times so that she would not suffer when washed, moved or changed in the event she should she become incontinent.

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 17.8.98. A little later Dr BARTON appeared and confirmed that a haemetoma was present and that this was the kindest way to treat my mother.

I told Dr BARTON and the Ward Manager that I had been to the Haslar Hospital that morning, explained what was happening, and told them that Haslar would be prepared to re-admit my mother. I considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.

Dr BARTON said that, "It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery." 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. Because the syringe driver was essential following the night of several doses of pain relief - my mother etc. Etc.

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'.

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Dr BARTON more strongly on this

See notes

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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 on the 19th August and no further urine was passed. The same catheter bag remained in place until her death.

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.

After my mother's death 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.

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 of 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 hand-written 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 necessarily 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 hand-written 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, 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 hand-written entry, "Dr BRIGG".

I believe that this contradicts information contained in the letter from the Portsmouth Healthcare Trust (LFL/3) dated 22nd September 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 hand-written 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 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. Furthermore it states that I had been informed by telephone.

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 a 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.

On the page marked LH/1/C/8 there is a copy of a hand-written note, apparently signed by Philip BEED, which is addressed to Haslar A & E and is dated 14th August 1998. In these notes it states, "No change in treatment since transfer to us 11/8/98, 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 which was the day of her admission from the Royal Hospital Haslar.

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

On page LH/1/C11 I note, with some concern, an entry under the date of the 11th August 1998, in what I believe is Dr BARTON's hand-writing, 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 which is once again, I believe, in Dr BARTON's hand-writing. 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 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 re-iterate 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, there are references to my mother's condition following the operation on 14.8.98 as per the nurse's notes of Haslar, not to her condition on 17.8.98.

There is a comment, I believe in Dr BARTON's hand-writing, "....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.

On the same page, under the date of the 21st August 1998, there is an entry which, I believe, is also in Br BARTON's hand-writing 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.

On page LH/1/C/21, under an entry dated the 13th August 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 that day.

It was not until 7.30pm or 8.30pm 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 -10pm that evening.

On the same page, under an entry dated the 17th August 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 worked procedure 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 and timed 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, 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.

In an entry dated the 21st August 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 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.

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.

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.

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.