Subject: FW: Prof. Ferner

From: Gillian Mackenzie Code A

To: Code A

Date: Thursday, 16 May 2013, 14:43

Peta for info. Gillian

From: Gillian Mackenzie Code A
Sent: 16 May 2013 14:28
To: 'joanne.lane Code A
Subject: Prof. Ferner

Joanne, with reference to our telephone conversation, I would be grateful if you would pass on the following letter to Prof. Ferner.

Dear Professor Ferner,

I was very surprised when you appeared to be surprised not knowing about my eye witness and my sister's account regarding the administration of two diamorphine injections given by Philip Beed . As far as we were concerned that evidence was the core of the case. My sister Mrs. O'Brien was a nurse of 40 years standing dealing with the care of the elderly and dying and has also had experience of working in a hospice. Neither of us were so stupid not to know the chances of a 91 year old were slim recovering from the operation at Haslar Hospital let alone another fall (under sedation) on the 13th. August 1998. I have also had experience as a volunteer go-for in a hospice and two years at the Royal Marsden on the ward accompanying my husband for cancer treatment at the Royal Marsden Hospital – experience of the drugs and syringe drivers.

When you expressed surprise I was shocked and I understood Mr. White was going to discuss the matter with you when driving you to Southampton Airport. I was further surprised to discover that he did not write to you until 9 May. The so called allegation was that when my mother was transferred back to Gosport on the 17th. August she was accompanied by a discharge letter from Haslar stating that she had been given a splint to be in situ for 4 weeks , which when we saw her had been removed 15 – 20 minutes after arrival, had been transferred on a sheet to her bed without a canvas or patslide – was then in pain . I was informed of this by the care worker Code A There has been discrepancy from the ambulance crew evidence . In addition the care worker's statement has not been produced by the police (according to Code A) or in the disclosures by the Coroner. It took until 3.30 pm (having arrived at noon) for Dr. Barton to examine my

mother for an X ray carried out at 3.45 pm. During that period we agreed that my mother should be given oramorph – and my sister went to Haslar for advice which was that my mother should be referred back to them.

Philip Beed came into the room with a syringe and when I asked him what it was he said "diamorphine" I told him as she had had a dose of oramorph you do not give diamorphine so soon after that dose – my mother was quite comfortable. He went out of the room and with that my sister came back from Haslar. She had obviously been spoken to by Philip Beed regarding my questioning of his proposed action. Beed having been given the go –ahead to keep my mother pain free by Mrs. Obrien then came in with another injection – I assumed it was not diamorphine given my previous protest – he injected her in front of myself and my sister. After Dr. Barton examined my mother he came back stating as my mother was going to be man-handled in X ray he was going to give her a booster injection for possible pain. My mother was still conscious, speaking coherently as we went down to X ray. She lost consciousness in X ray and I never saw her conscious again. Neither of those injections are written up on the drug chart. Diamorphine was written up on the chart by Dr. Barton on the 11th. August and as we know from the CHI Report 2002 it was the policy – not only for my mother – that drugs were written up in anticipation with full agreement that the Nurses could administer them as and when they considered it applicable.

Beed's defence is that as he did not initial the drug chart he did not give those two injections. I did not leave my mother until at least 11m that evening. My sister claims my mother had another dose of oramorph at 8pm. I cannot imagine how it was I was not aware of that.

According to the drug chart my mother continued to have oramorph during the night until 4 am. obviously she could swallow but nothing more until 11.15 am when Philip Beed put my mother on the continuous syringe driver – she was not showing any sign of consciousness when we arrived at 9 am. and were seen by Beed only stating my mother had suffered a massive haematoma and was dying - I queried and stated I wanted her back at Haslar - Beed disagreed – and I queried whether my mother was so close to dying she would die in the ambulance and Beed said it was possible – I therefore agreed to the syringe driver . I assumed it would be a few hours – as in the case at the Royal Marsden , not only with my husband in 1986 at the age of48 but with numerous other patients. Both my sister nor I needed explanations about syringe drivers – and we certainly never had "explanations" or "conversations " with Barton about them. There are no details on the medical file that my mother had a haematoma and presumable at the time of death – 4 days later there would have been some sign of one – there was not –my sister and my niece laid my mother out after death at 9.20 pm. We had no nursing care offered during those 4 days and as noted on the file there is only one recorded incident as other statements from Nurses " did not intrude on the family. I slept beside my mother's bed from the 18th. – 21st. August.

No doubt you have seen the charts re. diamorphine on Daedelus Ward in the Commission of Health Improvement Report 2002

Covering 1998/1999 when Beed was taken on by the Health Authority ,and the drop in dosages when Dr. Barton left Gosport when the Police commenced interviews. There had been a considerable delay by the

Police whom I approached in 1998 , who had dismissed my concerns. The PCA upheld all my complaints for investigative failures against the Hampshire Constabulary in 2001 – the Chief Constable et al having sat on my complaint made in writing in November 1998 having had my interview with them in October 1998. Further complaints were upheld in 2004 by 7 other families for the same thing. I assume also that your have seen the report by Prof. Brian Livesley in 2000 and heard of then alleged action towards Acting Supt. Ray Burt and Prof. Livesley just as the papers were being sent up to the CPS.

The Inquest raises more questions than it answered. I am amazed that Code A 's statement was not allowed nor were the discharge letters discussed during the inquest and it seems you were not "completely in the picture"

So far I have not had answers from Mr. White although he informs me by e mail he is behind with his e mails. In addition I am now aware that he is not on the AvMa panel of recommended solicitors at Blake Lapthorn

Sincerely

Gillian M Mackenzie