PORTSMOUTH
HealthCare
NHS
TRUST

Mrs. L. Lack,

Code A

Our ref
MM/BM/YJM
Your ref

Date
22nd September, 1998
Ext
4378

Dear Mrs. Lack,

I am writing further to my letter of 25th August, 1998 now that I have received the report from Mrs. Hutchings, who has been investigating all the matters you raised concerning the care provided for your mother, Mrs. G. Richards, prior to her death on Friday, 21st August, 1998.

I should like to reiterate how very sorry I am that your grief has been compounded by so many concerns, but that you for having taken the trouble to write, as this has resulted in a very thorough investigation, and given us the chance to explain and/or apologise for the problems you identified. It has also meant that staff have reviewed procedures and improvements are being implemented as a result.

I should like to respond to each of the points you made, using the numbering system from your notes.

1. At what time did Mrs. Richards fall?
   She fell at 1330 on Thursday, 13th August, 1998 although there was no witness to the fall.

2. Who attended her?
   She was attended by Staff Nurse Code A and Health Care Support Worker Code A

3. Who moved her and how?
   Both members of staff did, using a hoist.

PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE

St James' Hospital
Locksway Road, Portsmouth, Hants PO4 8LD
Tel: 01705 822444 Fax: 01705 293437

4. After the fall
Your mother had been given medicationi presecribed by Dr. Barton, who was present on the ward just after her fall. I understand that it was not your wish for your mother to be given stronger medication because it made her drowsy.

5. Why was there such a delay in dealing with the consequences of the fall?
With the benefit of hindsight it is possible to assume that your mother's dislocation could have been identified much earlier and we can now only apologise for that delay if that was the case. It is notoriously difficult to establish degrees of pain or discomfort in dementia sufferers, but staff now recognise that more attention should have been paid to your mother's signs of discomfort, and your own expressed concerns about that.

6. Why no x-ray? Why no transfer?
These delays were a direct result of the failure to identify a problem earlier in the day - because the x-ray department at Gosport War Memorial Hospital only operates from 9 a.m. to 5 p.m. I understand that you did appreciate this when it was discussed with you on the Thursday evening, and agreed with the advice that it would be best to defer a transfer to Haslar until an x-ray based diagnosis had been made. The transfer to Haslar was organised as soon as possible after the situation had been confirmed by x-ray, on the morning of Friday, 14th August, 1998. It is a matter of great regret that this delay occurred, and we accept and apologise for the fact that the standard of care fell below that which we aim to provide.

7. Why when she was returned to bed from the ambulance was her position not checked?
When your mother arrived on the ward two health care support workers saw her into bed and then went to inform Staff Nurse Couchman that your mother had arrived. They had realised there was a problem and that professional advice was needed. Staff Nurse Couchman came and checked her position, and I believe you assisted her in straightening your mother's leg and placing a pillow between her legs.

8. (a) How was she brought from Haslar?
She was brought by an ambulance with two crew.

(b) Was there an escort/anyone in the back with her?
There was no nurse escort - this would have been arranged by Haslar had it been thought necessary.

(c) When did she start to show pain and what caused it?
The ambulance crew commented that she showed signs of being in pain as she was put into the ambulance. The cause of the pain has not been specifically identified.

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(d) Why was my request to see the x-rays denied?
The x-rays were seen in the x-ray department by the doctor and the consultant radiologist. The decision to keep x-rays in the department and not to send them to the ward rests with the consultant radiologist, not the ward staff, and your request may not have been relayed to the department.

(e) Decision to do nothing but provide pain relief?
Dr,. Barton felt that the family had been involved at this stage as she discussed the situation fully with you. She made sure you were aware that the surgical intervention necessary for the haematoma would have required a general anaesthetic and clearly your mother was not well enough for such a procedure to be undertaken. Therefore, the priority, and only realistic option, was to keep her pain-free and allow her to die peacefully, with dignity.

9. Clothing sent for marking despite being named already
As a result of previous problems the ward have adopted the practice of marking all patients clothing with the ward name - a procedure designed to help, which on this occasion, did the absolute opposite. The laundry marker at Gosport War Memorial Hospital had broken down, so your mother's clothes were sent to St. Mary's Hospital and meanwhile she was given hospital clothing. In attempting to meet your completely reasonable request for her own clothes to be returned, a taxi was authorised which in the event brought the clothes back - still only bearing your mother's name. Whilst, as you say, this was a trivial problem on the scale of the real issues, it was a quite ridiculous consequence of a well-intentioned policy which served to cause unlooked for stress. The process is being reviewed as a result of your complaint.

All the staff concerned with the care of your mother were deeply saddened at her experience, and sincere apologise are proffered to you and your sister for the problems which occurred, and the failure of the service to meet your very reasonable expectations. The only constructive aspect I can identify is that lessons have been learned and the experience will benefit future patients, although I fully appreciate that such benefits have little relevance to yourselves.

You may be aware that your sister, Mrs. McKenzie, has telephoned Mrs. Hutchings as she wishes to see this correspondence. I am writing to her to confirm that it is personal to you, although, of course, I hope that you will feel able to share it with her. If you unable to do this then she will need to raise a complaint of her own.

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Should you wish to pursue the matter further my secretary would be very happy to arrange a meeting with Mrs. Barbara Robinson, Hospital Manager, at your convenience and I would be grateful if you could contact her on 01705 894378 within one month should you wish this.

Thank you once again for writing so comprehensively of your concerns.

Yours sincerely,

Code A

Max Millett
Chief Executive

Mrs. L. LACK,
3 Hunter Close,
Grange Road,
GOSPORT.
PO13 9XY

MM/BM/YJM

22nd September, 1998.

4378

Dear Mrs. LACK,

I am writing further to my letter of 25th August, 1998, now that I have received the report from Mrs. HUTCHINGS, who has been investigating all the matters you raised concerning the care provided for your mother, Mrs. G RICHARDS, prior to her death on Friday, 21st August, 1998.

I should like to reiterate how very sorry I am that your grief has been compounded by so many concerns, but that you for having taken the trouble to write, as this has resulted in a very thorough investigation, and given us the chance to explain and/or apologise for the problems you identified. It has also meant that staff have reviewed procedures and improvements are being implemented as a result.

I should like to respond to each of the points you made, using the numbering system from your notes.

1. <u>At what time did Mrs. RICHARDS fall?</u>
She fell at 1330 on Thursday, 13th August, 1998, although there was no witness to the fall.

2. <u>Who attended her?</u>
She was attended by Staff Nurse Code A and Health Care Support Worker Code A

3. Who moved her and how?
Both members of staff did, using a hoist.

4. After the fall
Your mother had been given medicationi presecribed by Dr. BARTON, who was present on the ward just after her fall. I understand that it was not your wish for your mother to be given stronger medication because it made her drowsy.
Why didnt Dr Barton examine my Mother who was in pain. The dislocation would have been obvious to the eye. I did not object to the medication in principle - but its misuse on 11. & 12 8 98 when my Mother was not in pain. and therefore it knocked her out so she could not take anything to eat or drink.

5. Why was there such a delay in dealing with the consequences of the fall?
With the benefit of hindsight it is possible to assume that your mother's dislocation could have been identified much earlier and we can now only apologise for that delay if that was the case. It is notoriously difficult to establish degrees of pain or discomfort in dementia sufferers, but the staff now recognise that more attention should have been paid to your mother's signs of discomfort, and your own expressed concerns about that.

It is not an assumption that the dislocation could have been identified It is a fact. The dislocation had occured and examination would have found it, with confirmation by Xray. No attention was paid to my fears or anyone trying to discover the cause of pain. It would not have been a difficult thing to determine.

6. Why no x-ray? Why no transfer?
These delays were a direct result of the failure to identify a problem earlier in the day - because the x-ray department at Gosport War Memorial Hospital only operates from 9 a.m. to 5 p.m. I understand that you did appreciate this when it was discussed with you on the Thursday evening, and agreed with the advice that it would be best to defer a transfer to Haslar until an x-ray based diagnosis had been made. The transfer to Haslar was organised as soon as possible after the situation had been confirmed by x-ray, on the morning of Friday, 14th August, 1998. It is a matter of great regret that this delay occurred, and we accept and apologise for the fact that the standard of care fell below that which we aim to provide.

7. Why when she was returned to bed from the ambulance was her position not checked?
When your mother arrived on the ward two health care support workers saw her into bed and then went to inform Staff Nurse COUCHMAN that your mother had arrived. They had realised there was a problem and that professional advice was needed. Staff Nurse COUCHMAN came and checked her position, and I believe you assisted her in straightening your mother's leg and placing a pillow between her legs.

8. (a) How was she brought from Haslar?
She was brought by an ambulance with two crew.

(b) Was there an escort/anyone in the back with her?
There was no nurse escort - this would have been arranged by Haslar had it been thought necessary.
As she screamed as soon as she was put in the ambulance why was she left alone in the back. She must have been very frightened and unable to communicate properly.

(c) When did she start to show pain and what caused it?
The ambulance crew commented that she showed signs of being in pain as she was put into the ambulance. The cause of the pain has not been specifically identified.
Why not? She left hospital pain free. She screamed in the ambulance and noone did anything.

(d) Why was my request to see the x-rays denied?
The x-rays were seen in the x-ray department by the doctor and the consultant radiologist. The decision to keep x-rays in the department and not to send them to the ward rests with the consultant radiologist, not the ward staff, and your request may not have been relayed to the department.

(e) Decision to do nothing but provide pain relief?
Dr. BARTON felt that the family had been involved at this stage as she discussed the situation fully with you. She made sure you were aware that the surgical intervention necessary for the haematoma would have required a general anaesthetic and clearly your mother was not well enough for such a procedure to be undertaken. Therefore, the priority, and only realistic option, was to keep her pain-free and allow her to die peacefully, with dignity
This was not the only realistic option when Haslar had offered to see Mrs Richards again

Being denied any form of nourishment and therefor inducing kidney failure does not come under to die peacefully with dignity. There is no dignity in the refusal to remove a catheter bag which had about 200mls of stagnant fluid on the 19.8.99 and remained in place until the time of death with no further urine passed. If peacefully means she was unconscious throughout and so did not speak or call out then that was indeed achieved. It was an induced death due to lack of basic needs of the living.

9. Clothing sent for marking despite being named already

As a result of previous problems the ward have adopted the practice of marking all patients clothing with the ward name - a procedure designed to help, which on this occasion, did the absolute opposite. The laundry marker at Gosport War Memorial Hospital had broken down, so your mother's clothes were sent to St. Mary's Hospital and meanwhile she was given hospital clothing. In attempting to meet your completely reasonable request for her own clothes to be returned, a taxi was authorised which in the event brought the clothes back - still only bearing your mother's name. Whilst, as you say, this was a trivial problem on the scale of the real issues, it was a quite ridiculous consequence of a well-intentioned policy which served to cause unlooked for stress. The process is being reviewed as a result of your complaint.

My Mother had no clothing items of her own from 12.8.98 until the day before her death when I was anguished at seeing her dying in borrowed nightwear - when she had plenty of nice things of her own.

All the staff concerned with the care of your mother were deeply saddened at her experience, and sincere apologise are proffered to you and your sister for the problems which occurred, and the failure of the service to meet your very reasonable expectations. The only constructive aspect I can identify is that lessons have been learned and the experience will benefit future patients, although I fully appreciate that such benefits have little relevance to yourselves.

Please specify what lessons have been learned.

You may be aware that your sister, Mrs. McKENZIE, has telephoned Mrs. HUTCHINGS as she wishes to see this correspondence. I am writing to her to confirm that it is personal to you, although, of course, I hope that you will feel able to share it with her. If you unable to do this then she will need to raise a complaint of her own.

I had informed you that Mrs Mackenzie should have copies of all correspondence regarding my Mother.

Should you wish to pursue the matter further my secretary would be very happy to arrange a meeting with Mrs. Barbara ROBINSON, Hospital Manager, at your convenience and I would be grateful if you could contact her on 01705 894378 within one month should you wish this.

Thank you once again for writing so comprehensively of your concerns.

Yours sincerely,

Max Millett
Chief Executive

Silent copy to **Code A**