RESTRICTED

Statement number: S4

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STATEMENT PRINT

Surname: MACKENZIE

Forenames: GILLIAN

Age: 68 Date of Birth: Code A

Address: Code A Postcode: Code A

Occupation: RETIRED PERSONNEL MANAGER

Telephone No.: Code A

Statement Date: 06/03/2000

Appearance Code: 1 Height: 1.68 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages: 27

I am the elder daughter of the late Mrs Gladys RICHARDS and sister of Lesley LACK who currently lives at Gosport, Hampshire.

My mother died at the Gosport War Memorial Hospital on Friday 21st August 1998 (21/08/1998).

Following my father's death, in 1974, my mother either lived in close proximity to my sister or in nursing homes managed by my sister. My sister retired recently after a long career as a trained nurse. She has many years of nursing experience especially in the care of elderly people.

Immediately prior to her death my mother resided in a nursing home located at Lee-on-Solent, near Gosport, Hampshire. It was called the 'Glen Heathers' Nursing Home . My sister, having retired to live in the Gosport area, was not concerned in any way with the management of these premises.

During the time my mother was a resident at the 'Glen Heathers' Nursing Home I occasionally visited her there.

During the last six months of her life I became unhappy with the standard of care which my mother

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This is important because Gillian arrived when Mother came back to the ward.

On the notes by Commander Scott. reference to "not to be resussivated" was a meeting between him + me and my daughter Karen at 08.30 am

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I point this out as Gillian was very vocal about D.N.R for Mother and she wasn't there.

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Solicitors File

was receiving at the 'Glen Heathers' Nursing Home and I made various complaints.

I particularly recall one visit to my mother which occurred during the last six months of her life.

I noticed that my mother was suffering with a very bad cough. I asked the nursing staff why she wasn't being given antibiotics. I was told that it was because she was on other drugs. I was told, furthermore, that my mother was being given tranquillisers. I had not, previously, been aware of this fact.

I was very concerned and I decided to see Dr BASSETT who was my mother's GP. I asked him about the choice of drugs which were being prescribed for my mother.

He was aggressive and defensive and did nothing to alleviate my queries. As I had previously done some research, relating to another matter, I had formed the opinion that the drugs which were being administered to my mother could contribute to her confused mental state and deterioration of her physical health. One drug was Trazodone, a Tricylic and the other was Haloperidol, a Neuroleptic drug.

Following the meeting with my mother's GP I sent him a copy of a book called 'Toxic Psychiatry'. I did so in order to draw his attention to the possible side effects of the drugs in question. I had formed the personal view that the drugs which were being administered to my mother were capable of adding, significantly, to the symptoms of her so called dementia, falls etc.

Early in the morning, on Thursday 30th of July 1998 (30/07/1998) I received a telephone call from Mrs Karen REED who is my niece. She informed me that my mother had been admitted to the Haslar Hospital , in Gosport, and was about to undergo surgery.

Mrs REED told me that my mother had suffered a fall at the 'Glen Heathers' Nursing Home and that she was going to have an operation to address a broken hip.

I immediately travelled from my home, in Eastbourne, to the Haslar Hospital. I arrived there shortly before my mother was brought, from the operating theatre, back onto the ward.

During my mother's stay at the Haslar Hospital I remained with her, throughout, apart from two brief visits back to my home. I was with my mother until shortly before she was transferred to the Gosport War Memorial Hospital.

Together with my sister, Mrs LACK, I had visited the Gosport War Memorial Hospital in order to examine the facilities before my mother was transferred. My sister and I were in agreement that she should be transferred there.

I would like to clearly state, at the outset, that I have absolutely no criticism whatsoever of the Royal Hospital Haslar . The staff, at this hospital, handled my mother's case in a very professional way

both medically and so far as the quality of nursing was concerned.

I also believe that my sister and I received effective psychological support. The staff were open and honest. They fully answered our questions and freely volunteered information.

We were well aware of the situation my mother was in and the possibility that she may not survive the operation. Naturally, when my mother began to recover, we were delighted with her progress.

At the Haslar Hospital my sister and I discussed with, I think, a Dr REID what would happen when she was discharged. Neither my sister nor I were happy at the thought of her going back to the 'Glen Heathers' Nursing Home. The Social Services Department subsequently carried out an investigation into the Nursing Home care.

It was decided that our mother would be transferred to the nearby Gosport War Memorial Hospital for rehabilitation for about four weeks. She was, by then, using a zimmer frame. Following this period of recuperation a decision would then be made as regards where she would go after that.

I think another hospital was mentioned. I'm not sure but it may have been the Queen Alexandra Hospital , or similar, and she would receive care there.

Following her stay at the Haslar Hospital my mother she was certainly far more alert than she had been in the 'Glen Heathers' Nursing Home but, of course, we were under no illusions regarding her survival chances bearing in mind her age.

Whilst at the Haslar Hospital my mother was not given the Trazadone drug which had been administered to her at the 'Glen Heathers' Nursing Home. She seemed far happier, more alert and could certainly recognise myself and my sister. Furthermore, on occasions, she could speak coherently. Not very long sentences but she was coherent. My mother was eating well and looking far better than she had done for months.

I returned home, to Eastbourne, just before my mother was transferred from the Haslar Hospital to the Gosport War Memorial Hospital. My sister rang me and said that my mother had settled in.

However, within a couple of days I received a telephone call, late one evening, from sister Mrs LACK. She was very distressed. She told me that my mother had suffered a fall at the Gosport War Memorial Hospital. She was going to be x-rayed the following morning and would possibly be transferred back to the Haslar Hospital.

The following morning I travelled, from my home, to the Gosport War Memorial Hospital. I discovered that, in fact, my mother had already been transferred to the Haslar Hospital. I then went on to the Haslar Hospital.

On arrival I discovered that, in fact, my mother's new hip, which had been dislocated again at the

Gosport War Memorial Hospital, had been manipulated back into place. She remained at Haslar Hospital for two or three days and she was then transferred back to the Gosport War Memorial Hospital.

During her stay at the Haslar Hospital my mother made a good recovery and became quite alert again. It was mentioned to me, but I can't remember who by, that my mother had been dehydrated when she was admitted to the Haslar Hospital from the Gosport War Memorial Hospital. I did not find that altogether surprising in view of the fact that, at the Gosport War Memorial Hospital, my mother had been tranquillised again.

I was told by my sister, Mrs LACK, that she had made her views known to the nursing and medical staff at the Gosport War Memorial Hospital that such strong medication would not aid rehabilitation, eating, drinking, physiotherapy or walking with a zimmer frame.

My sister and I arranged to be at the Gosport War Memorial Hospital when our mother was transferred. We wanted to meet her when she arrived. In the event we were, in fact, about quarter of an hour later.

We had firstly gone there, on the morning of her transfer, at about half past ten (1030) only to be advised that she would, in fact, be there at twelve o'clock (1200). We arrived at about quarter past twelve (1215).

As my sister and I went through the doors of our mother's ward we could immediately hear her moaning. I am a lay person but I would say, quite confidently, that my mother was moaning in pain.

We went into our mother's room which, I think, was room number 3, to find a female care assistant, or someone of that category, attempting to feed her with lunch.

The care assistant's first words to us were, 'Well thank goodness you've come because she won't eat what I'm trying to make her eat and maybe you'll have more success'.

Frankly, I was not surprised that my mother did not want to eat the food. It was an absolute mush. She had, a short time before, been perfectly happy eating vegetables in the normal cooked state and other food, whilst at the Haslar Hospital. This is confirmed in the Royal Hospital Haslar Medical Record (AF/1/C/63).

I told the care assistant that I was not surprised that my mother was unwilling to eat because it was obvious to me that she was in pain. My sister was with me on this occasion. The care assistant said 'Well no it's not, it's dementia'.

Once again I expressed the view that my mother was obviously in pain and I asked a care assistant to go and get a qualified nurse.

I pulled back the sheet, which was covering my mother, and I could see that she was lying in a very awkward position with weight onto her newly replaced hip which had been, so recently, subject to yet further treatment as a result of the fall at the Gosport War Memorial Hospital (see AF/1/C/34).

I expressed the view, to my sister, that it appeared as if our mother had been rolled off the stretcher, during the transfer process, onto her bed. The bed was beside a wall and it would have been necessary to move it out in order to effect a transfer from a stretcher onto the bed.

With that a qualified nurse came into our mother's room whose name, I believe, was Margaret. I can't recall her surname at the moment. By this time I had covered my mother up. My sister told this nurse that our mother was obviously in pain and she pulled back the sheet in order to shown her the position that she was lying in.

The nurse then, with the aid of my sister, repositioned my mother so that her leg was straight (see AF/1/C/34). This resulted in my mother assuming a more appropriate position. My sister told the nurse that our mother should have a cushion between her legs. We also told the nurse that it was obvious, to us, that our mother was in great pain. We asked her what had happened but she didn't really make any comment.

However, from that point we had a great deal of attention given to us by the nurse manager who was called Philip BEED . He acknowledged that my mother was in pain and that something should be done. He gave our mother an injection the purpose of which, I believe, was to ease her pain.

We asked Philip if a doctor could be called to examine our mother and whether she should be x-rayed. Philip appeared to do everything possible then. He got the forms necessary for my mother to have an x-ray but, in the first instance, they were not acceptable as they had to be signed by a doctor who was not due in until half past three (1530) that afternoon.

Eventually a Dr BARTON arrived and she examined our mother. Dr BARTON agreed that she should be x-rayed. My sister and I accompanied our mother to the x-ray department. She was still moaning in pain despite having been given pain killers but she was able to speak coherently at times.

When we arrived at the Gosport War Memorial Hospital x-ray department the staff would not allow my sister to stay with our mother during the x-ray process. We could hear her moaning, through the door to x-ray department, throughout the time she was having the x-ray taken.

After the x-ray process had been completed my sister and I asked what had been seen on the x-rays. My sister asked, specifically, if she could see the results, whilst in the x-ray department, but this request was refused. My mother was then taken back to her room in the ward.

In the meantime my sister made enquiries at the Haslar Hospital in order to establish whether our

mother could, once again, be transferred there. Whilst she was doing this I sat with my mother.
Around this time Philip BEED came into my mother's room. He told me that I would be reassured to know that my mother has not dislocated her hip again, 'but she may have suffered some bruising'.
Later, after my sister had returned, Philip returned to our mother's room where we sitting with her. He said, 'I'm going to make her life easier and give her an injection of Diamorphine '. 17TH
I immediately reacted and said 'No you're not giving her Diamorphine. Are we talking about a case of euthanasia here because I warn you I will not tolerate euthanasia'.
A few moments later I saw Dr BARTON pass my mother's room. My sister and I went out into the corridor to speak to her. My sister told Dr BARTON that she had spoken to the staff at the Haslar Hospital and established that they were quite happy to have our mother referred back to them.
In reply Dr BARTON said that she thought our mother had experienced quite enough trauma for that day and she didn't think it was right to send her back to Haslar then. She stated that they would keep her pain free overnight. The decision, regarding the referral back to the Royal Hospital Haslar, would be reviewed in the morning and that we should come in early when the review was going to be carried out. 18TH
I would like to highlight, for consideration, the appropriateness of an apparent 'policy' which effectively prevents patients being referred after working hours.
My sister and I arrived back at the Gosport War Memorial Hospital on the Tuesday morning. We were seen by Philip BEED who took us into his office. He told us that nothing could be done for my mother. She had, according to Philip, developed a massive haematoma on the site on the site of her hip operation and the only possible means of treating our mother was to put her on a syringe driver with Diamorphine so that she would have a pain free death.
The impression given to me, by Philip BEED, was that my mother's death was imminent. He stated, when I asked him later that afternoon how long it would be, that it was not possible to be sure. It could be hours or longer.
I was aware of the implications of a syringe driver and so was my sister. We had both agreed that a syringe driver could be used. We went into my mother's room when Philip came in and set up the syringe driver with the Diamorphine. My sister was greatly distressed at this because my mother would not regain consciousness or see us again and we wouldn't have a chance to speak to her.
Later on during that morning, at about half past eleven, my niece Rebecca arrived with her baby. Dr BARTON came to the doorway of the room and said 'Presumably things have been explained to you about the syringe driver'.

My sister and I both said 'Yes'.

Dr BARTON then said 'Well, of course, the next thing for you to expect is a chest infection'.

My sister and I said 'Yes, we realise that'.

I have been present, when death has occurred and I know that pneumonia, or a chest infection, or a 'dead man's rattle', as the moment of death approaches, can be a normal thing. That was the only conversation we had with Dr BARTON.

There was no mention whatsoever, by Dr BARTON, of surgery or intervention by surgery to relieve the haematoma or, indeed, any reference to the fact that she didn't think my mother would stand a general anaesthetic.

If such a conversation had taken place I would have pointed out to Dr BARTON that my mother had withstood a hip replacement procedure, without a general anaesthetic and that when it had been dislocated again, at the Gosport War Memorial Hospital, she had been transferred back to Haslar Hospital where the new hip had been manipulated back into place without a general anaesthetic.

I stayed with my mother until very late that Tuesday night. It was past midnight, in fact, when my son arrived from London. As from Wednesday night my sister also sat in with me all night long and we both remained, continuously, until twenty past nine (2120) on the following Friday evening when my mother died.

During that time Dr BARTON did not visit my mother. I am quite certain of this because our mother was not left alone, in her room, at any time apart from when she was washed by nursing staff. Either my sister, or I, was with her throughout.

I slept in a chair beside my mother's bed and at no time did I notice, in her, any signs or symptoms of pneumonia.

During the Wednesday night and Thursday morning there was a particular nurse on duty. I think her name was Sue. At about four o'clock (0400) in the morning, when she came in, she was of the opinion that our mother would probably only survive for another half hour or so. She delayed going off shift. However, my mother rallied and continued to live until the Friday.

I am of the opinion that if my mother had been near death, as we were led to believe by Philip BEED on the previous Monday, she would not have survived until the Friday night. I believe that this is a strong indication of the actual state of her health.

It seems to me that she must have had considerable reserves of strength to enable her to survive from the Monday until the Friday, five days, when all she had was a diet of Diamorphine and no hydration whatsoever, apart from porridge, scrambled eggs and a drink, at the Royal Hospital Haslar, before

transfer to the Gosport War Memorial Hospital.

As a result of what I had been told by Philip BEED on the Tuesday morning I had been expecting our mother to die within 24 hours or so. It troubled me that she was not on a drip as the week progressed. I think that she was dehydrated and with the Diamorphine this was probably the cause of death although, of course, with a haematoma, if action isn't taken very speedily, that can cause death as well. I was at a loss to understand why action wasn't taken, promptly, as soon as a haematoma was discovered.

It is my understanding that just such a complication should have precipitated an immediate referral back to the Royal Hospital Haslar (AF/1/C/75).

As regards the issue of transferring our mother back to the Haslar Hospital my sister had mentioned it to Dr BARTON who had told us, on the Monday evening, that a decision about that would be made on the Tuesday morning. However, when my sister and I arrived at the Gosport War Memorial Hospital, on the Tuesday morning, a decision had been made that, as my mother was dying, the only thing to do was to give her a pain free death. I think the haematoma would have shown up on the x-ray that was taken on the Monday afternoon.

The staff at the Haslar Hospital had told my sister that they would be willing to accept our mother if she was referred back to them for treatment although we didn't know she had a haematoma at the time this was discussed.

My sister clearly told Dr BARTON, in my presence, about the offer that the Haslar Hospital had made to her. In the circumstances I don't think that Dr BARTON who is, I believe, a GP was qualified to make the decision to deny our mother the chance to receive treatment at the Haslar Hospital.

I believe that it is possible that my mother could have been effectively treated at the Haslar Hospital where she had, only recently, twice undergone, and survived, hip treatment. Furthermore, on each occasion, her general health had improved considerably whilst under the care of staff at the Haslar Hospital.

In my view a consultant's opinion should have been sought when the haematoma was discovered. It is also my view that Dr BARTON's decision not to refer our mother back to Haslar Hospital where the causes of her condition, and not merely the symptoms, could have been addressed, effectively denied her the opportunity of having a chance to be treated, to survive and to recover even if this was for a short time. I believe that a decision was made, for reasons which I do not accept, to reject treatment options which would have given our mother a chance to recover and, instead, a course of

palliative treatment was commenced, which effectively, condemned her to death without any chance of recovery. Palliative treatment does not necessarily have to cause unconsciousness.

I have been shown by Detective Chief Inspector BURT , some handwritten notes bearing the Hampshire Constabulary exhibit label, marked LFL/2, which I have signed.

I was aware of the fact that these notes were being made by my sister, Lesley LACK, because she was making them in our mother's room at the Gosport War Memorial Hospital. Frequently, I was sitting beside our mother, holding her hand and trying to reassure her, whilst my sister was sitting in the same room making her notes.

We agreed that my sister should make the notes because of the increasing concerns we had over the quality of care that was being given to our mother at the Gosport War Memorial Hospital. Obviously, therefore, my sister began to make her notes before our mother died ad before we became aware of various other things since.

I was not a direct party to the writing of the notes. The comments and observations made are those of my sister. I was, however, in the company of my sister during most of the period, and during most of the incidents, she refers to in her notes. My sister and I discussed particular issues as she wrote about them.

I recall that a copy of my sister's notes were given to Lesley HUMPHREY , the Quality Manager of the Portsmouth Health Care Trust, on Wednesday 19th August 1998 (19/08/1998) after we had complained.

I recall that I read through the notes, which my sister had made, prior to them being copied for Mrs HUMPHREY. It is possible that some additions were made to the notes, by my sister, at that time which would account for the way the notes are written. The notes embody a series of questions in respect of which, as part of our complaint, we sought answers from the Portsmouth Health Care Trust.

The notes do not incorporate any of my handwriting. All the handwriting is that of my sister, Lesley LACK. The original notes which I have been shown (LFL/2) comprise of five numbered pages (1-5) plus an additional page which is un-numbered (LFL/2A). I note that the page numbered '5' has been signed by my sister. I cannot say whether the additional, un-numbered, page was copied to Mrs HUMPHREY or not. Whilst I agree with its content I do not recall seeing it before.

My sister provided me with a copy of the notes, on or about the 28th September 1998 (28/09/1998) which I produce. Attached to my copy is a Hampshire Constabulary exhibit label bearing the reference GM/1 which I have signed.

I have, once again, read the notes (LFL/2), including the additional un-numbered page. I would like to make the following general observations drawing on the contents and other recollections.

My sister has commenced her notes by referring to the occasion when my mother was admitted to the Gosport War Memorial Hospital, from the Haslar Hospital, on Tuesday 11th August 1998 (11/08/1998).

I was not in Gosport at that time but I would like to comment on and echo the concern expressed by my sister about, the fact that 'Oramorph' was almost immediately administered to our mother when she was, in all probability, exhibiting signs of her dementia which were, perhaps, 'misread' as pain.

Whilst at the Haslar Hospital, a matter of hours before, our mother had been pain-free and was not rendered unconscious by any form of pain relief medication except for surgery and shortly afterwards.

I have to say that I have serious concerns about the possible and inappropriate use of 'Oramorph', at this stage in my mother's treatment, as a means of suppressing the 'inconvenient' aspects of her anxiety and dementia.

I note that there is a reference in the notes, under the date of Thursday 13th August, to my niece Mrs REED. I would like to point out that Mrs REED is not only a trained nurse but she has worked I the Orthopaedic Ward at the Haslar Hospital where my mother underwent treatment. I am appalled, given her credentials, that more attention was not paid to Mrs REED's comments and concerns by the staff at the Gosport War Memorial Hospital shortly after lunchtime on Thursday 13th August 1998 (13/08/1998).

I would like to clearly state that, having read through the notes (LFL/2), I am in complete agreement with them. This would, of course, have been my position on Wednesday 19th August 1998 (19/08/1998) when I examined them prior to a copy being made and given to Mrs HUMPHREY.

Whilst I did not write the notes (LFL/2) and whilst I did not sign them I was a party, at times, to the preparation process and where, on occasions, my sister has referred to 'I' in fact it could read 'we' as we were together when certain events occurred.

On the 19th August 1998 (19/08/1998) I wholeheartedly adopted the contents of the notes (LFL/2) as representing the basis for a joint complaint, with my sister, about the way our mother was being treated at the Gosport War Memorial Hospital.

In due course, following my mother's death, I received a copy of the Portsmouth Health Care Trust's response to the copy of my sister's notes (LFL/2) which had been given to Mrs HUMPHREY on the

19th August 1998 (19/08/1998).

The response was in the form of a letter, dated 22nd September 1998 (22/09/1998) which was addressed to my sister, Lesley LACK, and signed by a person named Max MILLETT designated the Chief Executive.

I have been shown, by Detective Chief Inspector BURT, the original letter which bears a Hampshire Constabulary exhibit label, marked LFL/3, which I have signed.

I will comment on this letter, in greater detail, later in my statement.

Initially there was some reluctance, on the part of the Portsmouth Health Care Trust, for me to see the letter (LFL/3). Only after I made it clear that I was joint complainant did I receive a copy.

In fact, when I returned home, after my mother had died but before the funeral or just afterwards, I telephoned, I believe, Mrs HUMPHREY's office. I told her or Barbara ROBINSON , who was possibly dealing with the matter in Mrs HUMPHREY's absence, that I knew about the notes which my sister had prepared and asked her to address a further question.

I wanted to know why a decision was made for my mother to be administered pain relief only without hydration. It had taken my mother five days to die and I don't think any fit person would have been able to survive solely on a diet of Diamorphine with no hydration. This question was not answered fully by the subsequent report from Mr MILLETT (22-9-98) (22/09/1998).

When I raised this issue with Mrs HUMPHREY she said that would have been explained at the time. I told Mrs HUMPHREY that it certainly wasn't explained to me.

When I received a copy of the letter from the Portsmouth Health Care Trust, commenting on the points raised I my sister's notes, I immediately phoned my sister because I was not happy with it. Some paragraphs seemed to be totally untrue. My sister expressed similar concerns.

As an example the notes (LFL/2), which were copied to the Portsmouth Health Care Trust, raised the question, 'At what time did Mrs RICHARDS fall?'

The letter in response (LFL/3), states, in response to that question, 'She fell at 1330 on Thursday 13th August 1998 (13/08/1998), though there was not witness to the fall'. Her door was kept open and there was a glass window onto the corridor opposite the nursing/reception desk.

In the Health Record (LH/1/C), to which I will refer in greater detail later in my statement, the time of my mother's fall is confirmed as being 1330 and the venue is given as her room. However, my niece, Mrs REED, had apparently seen her, as I understood it, in the patient's sitting room but I may be wrong. If my mother had been in the patient's sitting room, by herself, this was neglectful because the staff knew she would attempt to get out of her chair if she wanted to use the toilet and she

couldn't possibly do it by herself (see AF/1/C/21).

By further reference to the letter of response (LFL/3) I noted that in reply to the question, 'Who attended her?'. There is a response, 'She was attended by a staff nurse Code A and a health support worker Code A '. This is followed by a further question, 'Who moved her and how?', which drew the response, 'Both members of staff did, using a hoist'.

If my mother had fallen from a chair, onto her bottom, surely the obvious thing to do, as she had only recently undergone surgery for the fitment of a new hip, was to have her thoroughly examined by a qualified doctor before moving her at all. In the letter of response (LFL/3), page 2, point 4, the comment is made, 'Your mother had been given medication, prescribed 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'.

In my view this does not make sense at all. If someone has possibly dislocated their new hip you don't give them a medication to make them quiet you examine them and you do something about it.

Did Dr BARTON examine my mother? Or, perhaps, was she just asked to look at Mrs RICHARDS, who was making a noise, and give her some more tranquilliser.

If Dr BARTON did not examine my mother that, in my view, was, in the circumstances, pure negligence. The first thing any lay person would do if someone falls onto a new hip is to ensure that no damage has been done. You wouldn't simply give them a tranquilliser to keep them quiet.

Turning to the question, in the notes (LFL/2), which queried the delay in dealing with the consequences of the fall, page 2, point 5, in the letter of response (LFL/3), 'With the benefit of hindsight it is possible to assume that your mother's dislocation could have been identified much earlier ... etc'. I would comment that it most certainly could. When she was later undressed they apparently discovered that she'd dislocated her hip. That was a very long time to wait.

I now refer to the question, reiterated in the letter of response (LFL/3) on page 2, point 7, 'why, when she was returned to bed from the ambulance was her position not checked?

I have spoken to two health care support workers, who were working at the Gosport War Memorial Hospital at the time, one is named Code A, I think and one is named Code A. Code A told me that when my mother returned to the Gosport War Memorial Hospital, from the Haslar Hospital, on Monday 17th August 1998 (17/08/1998), they were not happy as she seemed to be in pain. They believed that there was a problem and they went to get professional advice. I believe that this was at a quarter to twelve. My sister and I did not arrive until a quarter past twelve (1215).

If, as the reply to our question suggests, Staff Nurse COUCHMAN, in fact, attended to my mother at

Oramorph
first given at
16.15 on 11.8.98
about 4 hours
following admission
NOT 48HRS.

the request of the health care workers why didn't she notice the awkward position in which my mother was lying.

I would suggest that Staff Nurse COUCHMAN did not properly attend to my mother or did not, perhaps, come until my sister and I asked, half an hour later and actually pointed out to her how my mother was lying.

Moving to another point, after my mother had been x-rayed at the Gosport War Memorial Hospital, on the afternoon of Monday 17th August 1998 (17/08/1998), I recall that Philip BEED advised me that my mother had not dislocated her hip but she might have bruised herself.

I asked Philip BEED how my mother could have been bruised. He did not provide me with any explanation of how it could have happened.

What, I believe, Philip failed to tell me at that time was that, in fact, my mother hadn't bee transported on a stretcher. When I later spoke to the two care workers one of them, Code A who didn't want me to mention to anyone that she'd told me, said that, in fact, my mother had arrived back in the ward on a sheet on a trolley. It is possible, I would assume, that she was not rolled off the stretcher, as I had thought, but she had been rolled off a sheet into the position we found her in and not checked until we raised the issue with staff. There appears to have been an avoidable delay, on the part of Staff Nurse COUCHMAN, to identify this problem.

I note that in the letter of response (LFL/3) on page 2, point 8(c), it states, in reply, 'The ambulance crew commented that she showed signs of being in pain as she was put into the ambulance ... etc' I would ask why was it then, when she arrived at the Gosport War Memorial Hospital, did they accept her? In my view they should have sent her back to the Haslar Hospital there and then. She had left the ward at Haslar pain free.

In response to the question (LFL/3) page 3, point 8(d), 'Why was my request to see the x-rays denied?' The reply tendered is not satisfactory. My sister specifically asked to see the x-rays when we were in the x-ray department and we were not allowed to see them.

With regard to the response to question (LFL/3) 8 (e) page 3, 'Dr BARTON felt that the family had been involved at this stage as she discussed the situation fully with you ... etc'. I emphatically deny that. She did nothing of the sort. It goes on to state, 'she made sure you were aware that the surgical intervention necessary for the haematoma would have required a general anaesthetic ... etc'. This is not true. That was never discussed. The only discussion we had about the haematoma was with Philip who said nothing could be done except to give her pain relief to aid her in dying.

My sister and I were not consulted, whatsoever. When they saw that she had a haematoma they

should have sent her back to the Haslar Hospital there and then. We were not told that our mother had a haematoma until the Tuesday morning.

I feel, very strongly, that this reply represents an attempt to cover up the truth, by Dr BARTON, and I would go as far as to say that her gross negligence resulted in the death of my mother.

I have been shown, by Detective Chief Inspector BURT, a copy of the Portsmouth Health Care Trust Health Record which relates to my mother. It bears a Hampshire Constabulary exhibit label, marked LH/1/C, which I have signed. I note that each page has been marked with an individual reference. Having examined this document I would like to make the following observations.

I refer to page LH/1/C/7 and I would like to comment in relation to the remark 'Deaf in both ears'. This is true. My mother could hear with a hearing aid but the staff at the 'Glen Heathers' Nursing Home had lost it and it had not been replaced.

Further, 'Cataract operations in both eyes'. This is true but my mother could see with one eye, with her glasses, but again, the staff at the same Nursing Home had lost my mother's glasses.

Further, 'Six month his history of falls'. This is true. Since my mother was administered the tranquillisers Trazodone and Haloperidol.

As a result of the Social Services investigation I discovered that my mother had suffered 17 falls at the nursing home during the previous 6 months. My sister, who had visited our mother daily in the nursing home, was unaware of the extent of the falls.

Further, 'Alzheimer's worse over the last six months'. I would challenge the accuracy of the diagnosis. As I understand it, it is not possible to be certain of Alzheimer's disease unless a post mortem on the brain is carried out. I would challenge the comment 'Worse over the last six months'. I would suggest that my mother's condition was probably attributable to dementia and the added risk of tardive dementia due to the two drugs in question.

I now move to LH/1/C/8 which is a note made by, I think, Philip BEED, the charge nurse in my mother's ward at the Gosport War Memorial Hospital. He mentions that in addition to the treatment, ie, drugs that the staff at the Haslar Hospital had recommended, the staff at the Gosport War Memorial Hospital had added 'Oramorph'. I challenge the need for 'Oramorph'. My mother had not needed it whilst she was being treated at the Haslar Hospital except for pain. Why did she need it at the Gosport War Memorial Hospital within 48 hours of arrival except for dislocation of new hip later on?

See note

I move to LH/1/C/9 which is a letter written by Dr R I REID . In this letter Dr REID comments that my mother's mobility had deteriorated over the previous six to seven months and I have already

indicated why I think that was the case. Furthermore Dr REID states that my mother's 'daughters' had indicated that my mother had been 'knocked off' (out) by the prescribed medication for months and had 'not spoken to them for six or to seven months'. Well, in truth, my mother did speak to us. Not long conversations, not always full sentences, but she certainly did speak. She also recognised who I was.

Dr REID also mentions that since the 'Trazodone has been omitted' we had indicated that our mother had 'been much brighter mentally'. In fact I would say that my mother had been more bright, mentally, than she had been during the last six months in the 'Glen Heathers' Nursing Home although I only saw her occasionally, usually after a bout of ill health or a recorded fall.

Further, Dr REID says that my mother, '... was clearly confused and unable to give any coherent history'. I would suggest that when you are questioning a lady who has dementia, and cannot hear a thing without a hearing aid, she is likely to be confused plus the fact she couldn't lip read because she hadn't got her glasses.

Moving to LH/1/C/11, which I think contains notes made by Dr BARTON. In an entry, dated 11th August 1998 (11/08/1998), the date on which my mother was transferred to the Gosport War Memorial Hospital, from the Haslar Hospital, Dr BARTON has made a surprising statement, 'I am happy for nursing staff to confirm death'.

There was no indication, from the staff at the Haslar Hospital, that my mother was anywhere near death. Why should Dr BARTON assume that she was going to die?

The plan for my mother was that she should remain for about four to six weeks at the Gosport War Memorial Hospital before she was referred, for rehabilitation with her zimmer, to another hospital. I do not understand why Dr BARTON should feel it necessary to make this comment at the outset unless, of course, she had already had it in her mind that she had got a 91 year old patient who was, in her opinion, a damn nuisance and that this was going to be the outcome.

Further, in respect of LH/1/C/11, under date of the 14th August 1998 (14/08/1998), 'is this lady well enough for another surgical procedure?' I would point out that this was prior to the successful referral back to the Haslar Hospital. Perhaps it is fortunate that Dr BARTON relented, on that occasion, otherwise my mother could, perhaps, have been placed on a syringe driver earlier than, in fact, she was and I make the point that Dr BARTON was making decisions which, I suggest, she was not qualified to make.

Further, in an entry dated the 18th August 1998 (18/08/1998) Dr BARTON states that 'I will see daughters today'. Well she might have said she was going to but she certainly didn't except for brief

reference to syringe driver at approximately 1130 am.

I have to say that I suspect that these notes (LH/1/C/11) were not made as per the dates. I believe that they could, in fact, have been made retrospectively.

I must say that the notes in the Portsmouth Health Care Trust Health Record are very scant. I notice that there is a gap between the 18th and 21st August 1998 (21/08/1998).

Moving to LH/1/C/14 I note an entry, dated 11th August 1998 (11/08/1998) which states 'Admitted from E6 ward, Royal Hospital Haslar, into a continuing care bed'. For me the issue is 'continuing care' and not 'terminal care'.

Moving to LH/1/C/15 there is a comment 'Patient has no apparent understanding of her circumstances due to her impaired mental condition'. My mother knew she was in pain. She couldn't hear what anybody said to her. It is no good asking somebody a question when they cannot hear a thing and then say it is due to dementia.

Moving to LH/1/C/21. There is an entry dated the 13th August 1998 (13/08/1998) which is timed at 1300 hours. It states, 'Found on floor at 1330 hrs, checked for injury none apparent'. I would ask who it was who checked for injury. It should have been a qualified doctor.

I note that a recorded time, later in the same entry, has apparently been changed from 2000 hrs to 1930 hrs. There is a reference to the fact that a Dr BRIGG was contacted, presumably he or she did not attend in person, but this does not, apparently, correlate with the time my sister was contacted. Dr BRIGG is recorded as having advised, 'X-ray am (and) analgesia during the night. Inappropriate to transfer for x-ray this pm. Daughter informed'.

I would strongly query whether it was, in fact, inappropriate or simply contrary to 'policy'.

I wish to draw attention to the fact that Dr BARTON was apparently in my mother's ward shortly after she fell. She therefore had the opportunity to, and should have, put in hand steps to properly diagnose and rectify the 'cause' of my mother's pain and distress immediately. She did not. This resulted in my mother having to endure hours of unnecessary suffering. There is no reference, in the clinical notes, to the fact that Dr BARTON attended to my mother after her fall. I question what, in fact Dr BARTON actually bothered to do at that stage apart from, perhaps, advocating painkillers or tranquillisers.

Further, on LH/1/C/21, under the date 17th August 1998 (17/08/1998) and timed at 1148 hrs, there is an entry which states, 'Returned from RN Haslar, patient very distressed and appears to be in pain'. However, when we arrived we were told that our mother was not in pain, it was her dementia.

I would like to draw attention to the fact that there is an addition to this entry as follows, 'No canvas

under patient - patient transferred on sheet by crew'. I would suggest that it is possible that this has been added later and after, perhaps, I had spoken to the two care support workers who told me what had really happened. There is a further entry, under the same date, which states, 'To remain in straight knee splint for 4/52 ... pillow between legs at night'. There was no pillow put between my mother's legs, when we arrived half an hour after she had bee admitted, and her left was certainly not straight. There is a further entry, 'No follow up unless complications'. Surely a haematoma is a serious complication.

Further, on LH/1/C/21, under the date 18th August 1998 (18/08/1998) and timed 'am', 'Reviewed by Dr BARTON. For pain control via syringe driver'. It appears, to me, that Dr BARTON had not given any serious consideration to the option of surgical intervention. The entry goes on, timed at 1115, 'Treatment discussed with both daughters'. That is not correct. We were there at 9 o'clock (0900) in the morning and we had the conversation with Philip BEED who told us nothing could be done and discussed the use of the syringe driver and Diamorphine.

He said that my mother had developed a massive haematoma and that the kindest way to treat her was to put her on Diamorphine, to ease her pain, until she died.

The entry goes on, 'They agree to use of syringe driver to control pain and allow nursing care to be given'. Yes, we did agree the syringe driver because we were under the impression she was going to die within 24 hours or very soon.

Further, on LH/1/C/21, under the date 21st August 1998 (21/08/1998), ... 'Daughters visited during morning'. In truth we were there the whole time. We were virtually living there.

I have been shown by Detective Chief Inspector BURT, a copy of a Portsmouth Health Care NHS Trust ' Risk Event Record' attached to which is a Hampshire Constabulary exhibit label, marked LH/2 which I have signed.

I would like to comment on an entry on page 1 under section 7, 'Patient sat in chair in room 3 found on floor by the nursing staff'. I have already queried where she fell.

I would like to comment about the fact that, after the 18th August 1998 (18/08/1998), staff members continually expressed their surprise at the length of time our mother continued to live. I believe that this was indicative of her strength and, as a critical factor worth mentioning, her ability to potentially cope with a further referral to the Haslar Hospital for surgical intervention, had she been granted this opportunity by Dr BARTON.

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 make the observation that, as a lay person, this record appears to me to be far superior to the health record (LH/1/C) in terms of content and detail.

I would also like to observe that each time my mother was discharged from the Royal Hospital Haslar the outlook, in terms of her health, seemed positive but, upon admission and re-admission to the Gosport War Memorial Hospital, it seemed to me that her condition quickly deteriorated.

I have been shown a copy of a report, made by Dr LORD , which has attached it to a Hampshire Constabulary exhibit label bearing the reference LH/4, which I have signed.

If this report purports to be an objective assessment of the medical and nursing care and attention given to my mother at Gosport War Memorial Hospital then I would challenge its value as such. Dr LORD did not, apparently have any dealings with my mother and she prepared her report on the basis of reading other documents and contact with colleagues.

I have been shown a copy of an enquiry report to which is attached 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 the enquiry report (LH/4). The copy, to which is now attached to a Hampshire Constabulary exhibit label bearing the reference GM/2 and signed by me, was constructed to enable me to add handwritten comments which I have done.

I would like to 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 would like to raise an issue regarding the cause of my mother's death as recorded on the Death Certificate. At the time of her death and, so far as I am concerned, for 2 or 3 days beforehand, my mother was not seen by a doctor.

On the 18th August 1998 (18/08/1998) Dr BARTON had commented that, 'The next thing will be a chest infection', suggesting to me that, so far as this doctor was concerned, there was no chest infection present on that day, the 18th August 1998 (18/08/1998). Furthermore, from my own observations, there was no indication of a chest infection up until the time of my mother's death.

A doctor did not attend my mother upon her death. My sister and my niece laid my mother out, in my presence and then we waited while she was prepared to go to the mortuary.

I find it hard to understand how a doctor could have certified death as being attributable to bronco-pneumonia in these circumstances and with no reference to the haematoma.

I would like to draw attention to the fact that no reference to the alleged onset of bronco-pneumonia appears in the Health Record (LH/1/C) prior to my mother's death.

Furthermore there is no reference to the presence of a haematoma on the 17th August 1998 (17/08/1998) or indeed, afterwards.

In conclusion I would ask the question 'Was the cause of my mother's death Diamorphine poisoning and dehydration?'

Signed: Gillian MacKENZIE Signature witnessed by: