TRIVIAL CONCERNS RE CLOTHING/LAUNDRY

1 Clothing sent for marking despite CASH's name on all items of clothing?

Answer - All patients/relatives are informed on admission that to safeguard their belongings, clothing is marked with the name of the Ward. This includes clothing of patients whose relatives agree to do the laundry. This decision has been made on Daedalus Ward following several complaints from patients/relatives whose clothing was sent off to the Hospital Laundry by mistake and often never seen again.

I particularly raised on admission that all items were marked, that I would take anything for washing and I wanted her to wear items that were familiar to her. I accepted responsibility that items may have got lost but as I was visiting every day and had brought a good supply of everything needed I thought this to be unlikely.

Obviously, while Mrs. RICHARDS' clothing had been sent for marking she was given hospital clothing to wear. This should have only been for a day or two. Unfortunately, unbeknown to Ward Staff, G.W.M.H.'s Laundry Marker had broken down so Mrs. RICHARDS' clothing was sent to St. Mary's Hospital for marking. The Ward were not informed of this and, due to Mrs. LACK'S stress at this time, a taxi was authorised to go and collect the clothing and return it to Daedalus Ward.

My Mothers clothing was returned a day or two before she died. In the meantime I had to see her lay in Hospital clothing that was ill fitting and nor as my Mother was used to. Everything was gone including bedjacks and towels. Totally unnessary.

2. I have not been able to confirm if any Staff Nurse made any comment regarding getting Mrs. RICHARDS' up when she was so obviously near to death. I would find difficulty in believing any member of staff, either trained or untrained, would make such a comment.

I can assure you the comment was made in front of my Sister & myself. The words used were "We get them up here you know". We raised our eyes to Heaven. My Mother was unconscious on a syringe driver. We said. My Mother won't be getting up anywhere.

4. No direct questions asked. Statement only. There is some question regarding accuracy of this statement:-

Response (a) There was only one trained nurse on duty after 3.30 pm and prior to this the second Staff Nurse was completing consultant round. Therefore would not have been available to speak to Mrs. LACK (she states several trained nurses). Trained staff confirmed they would not have said it was Mrs. RICHARDS' dementia causing her to cry out; she had been given medication prescribed by Dr. BARTON who was present on the Ward just after Mrs. RICHARDS' fall. She was not given the stronger medication because Mrs. LACK had previously requested that it was not to be administered as it made her Mother very drowsy.

There were several nursing staff on duty, before 3.30pm. Nobody spoke to me till 6.30pm. Accident was 1.30pm. If Dr Barton was on the ward why was Mrs Richards not seen and not just given medication. The cause of pain should have been investigated and not just alleviated. It is ridulous to state I had previously requested medication not to be given as it made Mother drowsy. This is out of context. This refers to oramorph. 11th & 12th 8.99 regarding My Mother [illegible] – unable to have nourishment – when she was agitated I would not deny My Mother pain relief.

S/N Code A did see Mrs. LACK and gave her full details of the fall and the following actions that had been taken (statement by S/N Code A attached)

S/N Code A only gave me a brief detail of the fall. My question of Is there any damage done. was greeted with she only fell on her bottom. This is exactly how damage would occur to a hip replacement newly done. Why did she not realise the indications – thirst – pain – that something was amiss

5. Why the delay in x-raying Mrs. RICHARDS?

Answer - Mrs. LACK was telephoned and informed once dislocation was suspected and informed of the Doctor's advice, to which she agreed. This included not transferring her Mother immediately to Haslar.

Mrs Lack was telephoned at 9pm or there abouts. I did not agree. I listened and was thankful that someone had at last investigated the cause of pain and that a chain of events had commenced.

6. Why no medical examination? Why no x-ray? Why no transfer?

Answer - Duty Doctor was given the full facts of the situation including Mrs. RICHARDS' diagnosis and her age. He stated he felt it would be too traumatic to transfer to Haslar for x-ray at that time of the evening and the journey could cause considerable distress. He advised medication, i.e. Oramorphine (strong pain relief) and to arrange for x-ray the following morning. S/N Code A agreed with this as did Mrs. LACK when she was informed.

The delay between decision making and then deciding to wait Till next day is unacceptable.
There was no choice offered just a statement from S/N Code A that this was what would be done. I was thankful for the administration of pain relief - having seen My Mothers condition

Why no x-ray?
X-ray at G.W.M.H. only operational up to 5.00 pm Monday to Friday.

Up to 5pm! Accident was stated to be 13.30pm. Three & a half hours for an Xray to be arranged — but this was not even discussed except requested by me, more than once.

Why no transfer?
As above.

Any accident should be transferred to ensure that all care is offered in case there is damage done. Following Xray if the results were negative there would be no harm done but action should have been taken.

7. When returned from Haslar from the ambulance, was Mrs. RICHARDS' position not checked?

Answer - Her position was checked by an H.C.S.W. who immediately went to find a trained nurse and asked her to look at the position of Mrs. RICHARDS' leg. Due to the considerable noise Mrs. RICHARDS was making and, being untrained, she decided not to attempt to move Mrs. RICHARDS herself.

The HCSW did go to find a trained nurse correctly so. A trained Nurse did not see my mother or investigate her pain until after I arrived with my sister. Did the staff know she had just had a second operation? Did the staff know the site would be a likely cause of pain? If not why not?

8 (a) How was Mrs. RICHARDS brought from Haslar Hospital?

Answer - By ambulance and two crew. She was not escorted by a Nurse, this would have been the responsibility of Haslar Hospital to arrange.

If Mrs Richards was screaming loudly for the whole journey why did not one of the crew remain with her instead of leaving her alone to scream all the way. Why was her screaming not seen as something was wrong?

(b) When did she start to show pain? What caused it?

Answer - Ambulance Crew commented to nursing staff she began screaming as soon as she was put into the ambulance and continued throughout the journey and on Daedalus Ward. The cause of the pain cannot be confirmed but we do know Haslar Hospital were unable to provide an appropriate canvas to transport Mrs. RICHARDS on. Two sheets were used instead. This did mean Mrs. RICHARDS' limb was not supported as well as it would have been on a canvas when moved from bed to trolley to ambulance to trolley to bed on Daedalus Ward. This **may** have caused the pain.

b). There is no "may" have caused pain. The Fact is she was in pain - she screamed as soon as she was put in the ambulance. This from a lady who had been pain free up Till now. She should have been seen straight away.

(c) Request to see x-rays denied?

Answer - This was a decision made by individual radiologist. The Ward Staff are unable to influence their decisions. The x-rays Mrs. LACK refers to did not come back to the Ward, they were seen in the Department by the Doctor and Consultant Radiologist.

I wished to see them wherever they were. This was denied.

(d) Decision made to do nothing but allow Mrs. RICHARDS to die pain-free?

Answer - Dr. BARTON did see Mrs. LACK and involve her in the decision making process. Due to Mrs. RICHARDS' age she would not be able to have surgical intervention for the Haematoma as this would involve general anaesthetic. Therefore, the priority was to keep her pain-free and allow a peaceful death with dignity.

Dr Barton did not see Mrs Lack and involve her in the decision making. The assumption that she would not be able to have surgical intervention for the Haematoma is not for Dr Barton's to decide. The Registrar at Hasler offered to see My Mother again. Her discharge letter says they will see again if there are complications. My Mother had not had a general anaesthetic for previous procedures. She should have been given the chance to be seen by the orthopaedic team who had dealt with her so well.

Did all the staff realize on readmission on 17.8.98 and the days following that my Mother had had a second operation? If not why not. On the Contact record it just says "Returned from Haslar". It does not say following a second operation 48hrs ago. Why not?

ANALYSIS OF EVENTS

Mrs. Gladys RICHARDS was a frail, 91 year old with dementia who had sustained a fracture of her right neck of femur whilst resident in a Nursing Home. She had surgical repair at Haslar Hospital. Despite her age and confused mental state Mrs. RICHARDS made a good recovery and the medical team at G.W.M.H. agreed to accept Mrs. RICHARDS to give her the opportunity for mobilisation. The transfer to Daedalus Ward was arranged and took place on **11.08.98.**

My Mother was in good condition on transfer to Daedalus Ward. She was transferred from Haslar - by ambulance - as a "sitting" case. I awaited her arrival in reception at G.W.M.H, arriving a little before her and watched as she was transferred to a wheelchair and accompanied her to the ward. Her ~~Doctors~~ notes at Haslar stated "to be kept pain free, hydrated and nourished - a total contrast to that which was experienced for my Mother at GWMH.

Ref * AF/1/C/11 Haslar Hosp Notes.

On arrival to Daedalus Ward, Mrs. RICHARDS was quiet and accompanied by her daughter, Mrs. LACK. She was admitted by Enrolled Nurse Code A and Mrs. LACK was seen and told of the plan for managing her mother whilst on Daedalus. Mrs. RICHARDS was also seen by Dr. BARTON and medication was prescribed.

I was able to give the admitting Nurse my Mothers medical history and progress since her operation. I spoke about her difficulties in making her needs known but explained if she was agitated she would probably be in need of assistance with the toilet. She may attempt to get up on her own if her toilet needs were not foreseen, suggested or met. She could not manage without help. Although not requiring analgesia, except her prescribed Co-codamol when and if necessary - it should be noted that her medication chart was written up on day of admission for ORAMORPH, and indeed was given to her twice on 11.8.98 and again at 06.00hrs on 12.8.98. This was not discussed with

Wednesday 12th August, 1998

S/N JOICE was on a late shift. She went into Mrs. RICHARDS room and became concerned because Mrs. RICHARDS looked poorly. She was very drowsy and pale in colour although sitting in a chair. When Mrs. LACK visited later that afternoon she also became very concerned about her mother's drowsy condition. She was informed of the medication her mother had been given. Mrs. RICHARDS was transferred back to bed by use of a hoist. This did cause Mrs. RICHARDS to wake up and cry out. She settled and was fed her supper by Mrs. LACK.

I enquired reasonably as to why my Mother was unrousable when I arrived. I was told it was her medication. I asked what she had been given and was told ORAMORPH. I did express my concern and did ask that she was not given something so strong that she was unrousable and unable to take any nourishment. I felt the use of ORAMORPH was inappropriate at this time and would certainly inhibit her progress, if she was confined to bed or chair, sleeping soundly - not exercising or eating. My Mother was so sleepy she only took a drink. Tea was on the locker, out of reach, not drunk when I arrived.

Thursday, a.m. 13th August, 1998

The Ward was very busy with general activities plus two admissions expected and two discharges. Staffing levels were low although the Clinical Manager had taken some steps to ensure adequate level. There was only one trained nurse on until 12.15 p.m. and after 3.30 p.m. with Consultants round due at 2.00 p.m.

My Mother was visited by her youngest granddaughter, Rebecca Pennicott and new great granddaughter in the morning. She appeared to be OK. She was sitting in the day-room.

Mrs RICHARDS had been got up earlier in the morning and sat in a chair in her room. After lunch, approximately 13.30 hours, an H.C.S.W. found Mrs. RICHARDS on the floor by her chair. S/N Code A was informed and she immediately attended to Mrs. RICHARDS. She checked for any injuries. At this point she did not feel any had been sustained so authorised Mrs. RICHARDS to be put back into a safer chair using a hoist.

My Mother was visited by her eldest grandchild Karen Read. during late morning and lunch time period. My Mother was shaking and in distress and was in the toilet area with three members of staff. My daughter Mrs Read offered to help. She is also a trained Nurse. My Mother was crying and staff had raised voices enquiring what is it Gladys - whats the matter. Words to that effect. A mention of her dementia was made and Mrs Read said that is not her dementia — Grandma is in pain. At that moment another patient a male - had fallen and the Nurses needed to help him. Mrs Read said she would help my Mother and the Nurses left to help the gentleman on the floor.

Mrs. LACK was due to visit that afternoon so S/N Code A made the decision to see her rather than telephone her regarding her mother's fall, particularly as she did not appear to be suffering from any injuries. It was 6.30 p.m. when S/N Code A spoke to Mrs. LACK and informed her of the fall, explaining she did not know how she fell but reassured Mrs. LACK she had checked her mother before moving her. At this point S/N Code A asked Mrs. LACK if she thought her mother to be in pain. Mrs. LACK did not feel she was as she was eating her tea.

I arrived to see my Mother at about 2.45 or thereabouts. She was in her room at this time. She was in great distress at this time - sitting awkwardly in her chair which had a tray across the front of her. I spoke to several Nursing staff. — the changeover for 3.30 had not been done - so there were several staff about. I was in the ward for over 3 hours before S/N Code A told me my Mother had had a fall. It is not clear who moved my Mother to her bedroom. I had told several staff my Mother was in pain. At medicine round as I was spoonfeeding her I said at that moment she appeared calmer, while I was there.

At 7.45 p.m. S/N Code A commenced putting Mrs. RICHARDS to bed. Once in a lying position she could see Mrs. RICHARDS' (right) hip was internally rotated. The Duty Doctor was called immediately and informed of the problem, patient's age and dementia. The Duty Doctor felt it would be too traumatic to transfer Mrs. RICHARD'S overnight, but to give pain relief and arrange x-ray at G.W.M.H. the following morning and to contact him if any further problems arose.

If Mrs Richards had been in the Nursing Home or her own Home she would have been sent for Xray at any time of night if it was thought there was an injury.

HAND WRITTEN NOTE ATTACHED TO PAGE 9

Mrs Read attended my Mother and pushed her in her wheel chair towards her bedroom - but the Nurses indicated they wanted her left in the day room. Mrs Read left when my Mother dropped off to sleep and knocked on the door of the office to say she was leaving and that Mrs Reynolds appeared to be in some considerable pain. ~~She~~ Mrs Read telephoned me about 2pm to tell me that Grandma was in pain and I ought to go to the Hosp. I arrived about 2.45pm.

Mrs. LACK was telephoned as soon as the pain relief had been administered (approximately 8.30 p.m.) and informed of the current situation and Doctor's advice. S/N Code A asked if she was satisfied with this to which Mrs. LACK replied, "Yes," and thanked S/N Code A Mrs. RICHARDS slept well that night.

I did thank the Nurse for the information because I was thankful that the problem was acknowledged. I was also thankful for him to administer pain relief to my Mother who suffered greatly while I visited for 5-6 hours that evening.

Friday 8.00 a.m. 14th August, 1998

Dr. BARTON visited the Ward and completed X-ray Request Form. Mrs. RICHARDS was taken to X-ray Department about 10.45 a.m. accompanied by Mrs. LACK. X-ray confirmed dislocation of (right) hip. Mrs. LACK was seen by Dr. BARTON and Philip BEED, Clinical Manager, and informed. Arrangements made for transfer to Accident and Emergency, Haslar. Mrs. RICHARDS was given pain relief prior to transfer and was accompanied by H.C.S.W. in the ambulance (Mrs. LACK followed in her car). Mrs. RICHARDS remained at Haslar for 48 hours and arrangements were made to transfer back to Daedalus Ward on 17.08.98.

The above information is correct and I was pleased My Mother had pain relief. My distress was compounded by the amount of doses needed which rendered my Mother unable to have any nourishment.

Monday 11.45 a.m. 17th August, 1998

Mrs. RICHARDS arrived on Daedalus Ward. Mainline Ambulance Crew, but no nurse escort. Transport was arranged by Haslar who telephoned Daedalus and apologised they could not find a canvas to put Mrs. RICHARDS on, i.e. canvas would have two poles inserted to lift patient. Instead they used two sheets to lift Mrs. RICHARDS who was crying and screaming, which apparently had started in the ambulance and continued for some time after her arrival.

Were the staff advised that this lady had had a second operation 48 hrs earlier? What about her full splint that the Haslar staff said was essential. How could a lady be transported with sheets without causing further damage. Mrs Richards left the hospital at Haslar in good condition. Why didnt anyone query her obvious pain? - if necessary turn the ambulance back.

Two H.C.S.W.'s supervised Mrs. RICHARDS being put into bed. The ambulance man stated he had been given strict instructions from Haslar that Mrs. RICHARDS was to be kept flat - in bed she was given two pillows only and a pillow between her leg. H.C.S.W. Code A was very concerned regarding the position of (right)leg. She was afraid to straighten it because of the noise Mrs. RICHARDS was making so went to find a trained nurse and seek her advice. At that point Mrs. LACK arrived. S/N COUCHMAN walked into the room and pulled back the covers and realised the leg was not positioned correctly. Mrs. LACK offered to assist S/N COUCHMAN and between them re-positioned Mrs. RICHARDS who then stopped screaming.

How was she put to bed? Was the bed pulled over from the wall to get each side. Was she dumped from the sheet? Was she rolled over? Where was the essential splint. Did staff know she was post-operative? The H.C.S.W was concerned about my Mother. I could hear her screaming as I arrived. S/N Couchman entered the room and stood at the end of the bed. I pulled back the sheet and brought her attention to the terrible position she was in. I asked her to help me move my Mother. My Mother screamed and held her thigh prior to that.

Mrs. RICHARDS became agitated again a little later. Mrs. LACK requested her mother be x-rayed again. Dr. BARTON was contacted and agreed. S/N COUCHMAN was asked to complete X-ray Request Form and p.p. it. Unfortunately, X-ray Department refused to accept the form and insisted a Doctor's signature had to be on the form. Surgery was contacted and Duty Doctor signed the form and faxed to G.W.M.H. All of this did cause delay.

Mrs Richards was in great distres throughout and was attended by Philip Beed Ward Manager, who recognised her pain and gave diamorph to help her. He continually came in and out to reassure us that he was trying to get X/rays arranged and he administered further pain relief over the next few hours. As per my statement, I visited Hastie, and returned and made it clear that Hastie would accept her back if she was reffered. Nothing was done.

Mrs. RICHARDS was x-rayed at 15.45 hours. Films were seen by Consultant Radiologist who confirmed no further dislocation. Dr. BARTON was informed and discussion took place with Clinical Manager * and both Mrs. RICHARDS' daughters who were informed a haematoma had developed at the site of manipulation, i.e. (right) hip and, in medical opinion, the best treatment would be to keep her pain free. The use of a syringe driver was discussed fully. Both daughters agreed to this course of action. From 18th August - 21st August Mrs. RICHARDS condition deteriorated and she died at 8.20 p.m. on the 21st August. Both daughters were present. My Mother died at 9.20pm

* The discussion mentioned above did not take place until the next day Tuesday 18th My sister and I were seen by Philip Beed. on his own. It was late in the morning that Dr Barton enquired that Philip had indeed told us about the haematoma.

All trained staff interviewed were very aware that Mrs. LACK and her sister, Mrs. McKENZIE did not agree between themselves regarding their mother's care, particularly about pain control. This did make the nursing of Mrs. RICHARDS difficult at times, i.e. she was not returned to bed following her fall on 13.08.98. as Mrs. LACK had complained previously

POST-IT NOTE
ATTACHED TO
PAGE 12

I find it amazing that an X-ray Dept can refuse a RGN request for an X-ray and yet it is policy to write on admission notes that the DR is happy for Nurses to confirm death. The attention should be to the needs of the living.

she felt her mother was on her bed too much and this would not help with rehabilitation.

During her last day of life Nursing Staff were prevented from removing Mrs. RICHARDS' dentures as part of mouth care as the daughters said they were not to remove them.

I totally refute that Nursing Care was made difficult by the family. The example of Mrs Richards not being returned to bed on 13.08.99 is totally out of context. I did not complain but brought to the staff attention, that my Mother had not stood or walked with her frame since admission, had been given a urinal when catheterised and that her convalescence was duly being hindered by these events and not having any nourishment. There is no excuse for my Mother not being returned to bed during the afternoon and not left till the evening in such discomfort.

Nursing staff reluctantly accepted this, although in hindsight agree they should have tried harder to persuade the daughters it was in their Mother's best interest to remove the teeth for cleaning.

As to her teeth. During her last day of life staff attempted for the first time to remove her dentures. As she had had nil by mouth for six days they were adhered to the roof of her mouth and I asked them to please leave her alone. My Mother was close to death and it was obscene to pull her about. I had removed my Mothers teeth and cleaned them in the last few days and it was not in the best interest of my Mother to insist they were taken off for an emergency patient. My Mother always slept with her teeth in all her life as on her admission notes.

Sadly, Mrs. RICHARDS' death was not as Mrs. LACK had hoped it would be. She felt the use of the syringe driver made her mother become unconscious and she did not say her "goodbye", although both she and her sister were with their mother almost continuously day and night, during Mrs. RICHARDS last few days. Nursing staff tried not to be obtrusive.

We were with Mrs Richards continuously and I am able to state that as a family we did all we could for her in the circumstances except to challenge the lack of attention to the needs of daily living, her dehydration and the consequences of this including her kidney failure.

CONCLUSION

Mrs. RICHARDS did fall from her chair on 13.08.98. but this was not witnessed by anyone. The trained nurse on duty at the time did check her for injuries and there did not appear to be any. Therefore, Mrs. RICHARDS was put into another chair with a table to help prevent re-occurrence. Unfortunately, on that day the Ward was exceptionally busy and low in numbers of trained staff, although patient care did not suffer - only the stress level of the one trained nurse. Mrs. LACK stayed with her mother until early evening and was asked if she felt her mother to be in pain. Mrs. LACK did not feel her mother was. Mrs. LACK was then asked if she would like her mother to be put to bed. She replied, "No rush."

Because I was very aware of the staff shortages I did all I could personally. My Mother was reasonably quiet when I was asked if I would like mother to be put to bed. I probably did say there is 'No rush'. That comment was meant to be helpful to staff who were working full out against the clock. I did not refuse the staff to carry on with any task they needed to do. And I stayed till late evening to speak and calm my mother as much as I was able.

Once S/N Code A put Mrs. RICHARDS on the bed, using a hoist, she noticed the angle of the hip and immediately phoned the Duty Doctor. Medical opinion was not to transfer to x-ray until the following day.

My Mother was not seen by a Doctor. Why not? The accident form shows a verbal message and instructions.

If in her own Home she would have gone to Hospital no matter what time of night. She was known at Haslar and they would have diagnosed her immediately.

When did dislocation occur, i.e. when she fell? Or when hoist was used? - unable to define.

Once x-rays confirmed dislocation, transfer to Accident and Emergency at Haslar was arranged - as appropriate.

In view of Mrs. RICHARDS' previous fracture I feel she should have been transferred to Haslar the night before and that S/N Code A should have insisted on this when contacting the Duty Doctor. S/N Code A did agree with the Doctor that transferring Mrs. RICHARDS at that time, i.e. 8.30 p.m. - 9.00 p.m. would have been too traumatic for Mrs. RICHARDS. You could argue, due to Mrs. RICHARDS' dementia, would she have been aware of the time?

Mrs Richards diagnosis confirmation should have been the first concern. Not the time of day. Find the cause of pain and plan the treatment. This was denied for 24HRS. It was 24HRS until she was seen in A+E at Haslar. This must, and indeed did, add to her pain and gross discomfort.

Haslar Hospital were responsible for organising transport to transfer Mrs. RICHARDS back to Daedalus Ward. It appears they booked Main Line Ambulance Services who were not happy about transferring Mrs. RICHARDS without a canvas to lie her on. Haslar apologised and gave them two sheets instead. The Ambulance Crew confirmed to the nursing staff that Mrs. RICHARDS began crying/screaming immediately they put her into the ambulance. They were given instructions to keep her flat. This may have been the cause of Mrs. RICHARDS' distress or pain due to the transfer from bed to trolley to bed at Daedalus.

If the Ambulance service were not happy to transfer her without a canvas why did they go ahead? Somebody is responsible for this decision? You cannot transport/transfer using a sheet and keep the legs straight. That manoeuvre would not be possible: As she screamed damage must have occurred at this point.

A nurse escort did not accompany Mrs. RICHARDS. Unable to confirm the position Mrs. RICHARDS was in in the ambulance, but once in bed it was noted her leg was not straight but at an angle. This would have caused some considerable discomfort. Once her (right) leg was straightened, within a few minutes of arrival she stopped crying out.

What about the splint? Was it on during transfer. This indeed would have needed her to be on a trolley.

Once further x-rays confirmed no further dislocation, medical,. Nursing and family were involved in making the decision of how to treat Mrs. RICHARDS - in view of Mrs. RICHARDS age of 91 years. Agreement was made that she must be kept free of pain, therefore syringe driver was put in situ to ensure continual pain relief, the outcome of which was explained fully to both daughters.

I am aware of the use of syringe drivers for continual pain relief. I am also aware that pain relief via a syringe driver can be controlled so that a patient may have varying levels of consciousness & awareness during this time allowing nourishment to be given. My Mother was unconscious from 17.8.99 until the time of her death. Her own bodily strength allowed her to survive this time when she's her heart & lungs were strong, despite her age, and she died eventual Daily, the staff were surprised each day that Mother had survived another day

Sadly, Mrs. RICHARDS' last few days and her death were not how her daughters had hoped her end would be, i.e. she did not regain consciousness and they felt they could not say "goodbye". The nursing staff were very aware of this and tried to involve the family as much as possible. Regarding the "trivia" part of the complaint, i.e. clothing being sent away for marking. It is policy on Daedalus Ward for all patient's clothing to be marked with the Ward name. This decision has been made in the light of complaints from relatives whose clothing has disappeared. This includes clothing of patients whose relatives agree to their laundry. It is a safeguard in case an article of clothing is put into the Hospital Laundry Bag by mistake. Unfortunately, at the time Mrs. RICHARDS was

admitted the marking machine at G.W.M.H. was broken so the laundry lady sent it to St. Mary's for marking but failed to inform the Ward of this. Steps have now been taken to ensure Wards are kept informed.
The nursing staff are sorry that this added to the stress the family were already suffering. As a result of this investigation an action plan will be recommended by myself to ensure we reduce the risk of further complaints of this nature.

RECOMMENDED ACTION PLAN (to be agreed with Service Manager)

1. Review agreed "policy" of medical consultant team not to transfer patients to Accident and Emergency, Haslar outside of working hours (i.e. G.W.M.H. X-Ray Dept.).

2. Review nursing records and documentation.

3. Further training on records and documentation for all staff.

4. Review marking of clothing "policy".

26th January 2000
7:40pm

Dear Mrs LACK,

Here is the latest draft of your statement, prepared following our discussion yesterday. Would you please read it through and let me know if you are happy with it.

I have included the last draft (with notes), for you to refer to, as well as some other notes which you provided for me.

I would like to retain these notes, with my file, once you have completed the examination of the latest draft.

I have also enclosed, for your retention, the original copy of the letter from the Trust dated 22/9/98.

I know we discussed this yesterday but would you kindly check through your file of papers, once again, to see if by chance you have the original copy of the Notes you prepared for the Social Services Department. I have a copy of these Notes but I cannot trace the original among my papers.

If you are not at home when I call, shortly, I will telephone you in the morning.

Code A

Ray Burt
Detective Chief Inspector

Received: (1) Original Death Certificate IAN Code A

(2) Original letter from Soc Services Home (1/2/99)

(Plus other docs. re. Social Services Complaint.

Code A 1/c/8 28/1/2000