21 NOV 2001

Dear Nina,

RE: GWMH – Eva Isabel Page
DOB: Code A - Deceased: 3 March 1998

The following is a transcript of a letter sent to CHI, prior to a meeting with them. It outlines the key points of my mother's case.

Head of Commission for Health Improvement (CHI)
Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Date: Wednesday 21st November 20, 2001

RE: INVESTIGATION (CARE AT GOSPORT WAR MEMORIAL) – MRS E.I.PAGE

Prior to our meeting today I would like to put in writing to you the events relating to the death of my mother.

Before I present my comments relating to this case there are some minor discrepancies that I found when I eventually retrieved my mother's documents, which you should know of:

1. Correct DOB on Death Certificate should read Code A
   Place of Birth should be Hackney, London.

On the (Date Unknown) my mother was residing at a Residential home:
Chesterholme Lodge, (CHL)
Britten Road
Lee on the Solent
Tel: 023 92 550169
Contact: Kay (Owner)

When she was admitted to Queen Alexandra Hospital (QAH) with Tachycardia (Fast pulse) associated with a known heart condition. She was mobile and not in pain. During her stay in QAH further investigations were carried out that:

a. Confirmed that the cause for her being admitted had been her failure to take her prescribed medication relating to her heart condition as prescribed. This had not been the first time she had been admitted for a similar incident, she had been admitted to QAH during July 1995 and May 1997.

b. Following a chest X-ray, a shadow was identified around the bronchus area, which could possibly be a tumour.

At a meeting at QAH accompanied by my daughter, Samantha, the ward's Consultant explained my mother's condition and her prognosis was discussed:

> **A shadow had been found on X-Ray and that to confirm any diagnosis a Brochcoscopy would have to be performed. This would require a general unaesthetic. It was the consultant's view that the risks of a GA combined with my mother's age and heart condition an operation would be unwise. It was discussed and agreed that my mother's best treatment would be to control her heart condition and move her to GWMH, which was nearer to us and to convalescence and let matters take their natural course. This we agreed.**
>
> **The impression that Samantha recalls of this meeting was that my mother was suffering from a controllable heart problem with an additional problem of an undiagnosed shadow on her lung, which was too invasive to investigate further. Her condition at this time showed no signs of pain or discomfort and as a terminal illness was not death imminent.**

Samantha, at that time, understood the implications of this move would result in the following prognosis:

1. She would recover sufficiently to return to her home (CHL)
2. She would require more intensive nursing that (CHL) could provide and therefore require a move to another Nursing Home.
3. Her condition would slowly deteriorate whilst at GWM and that Palliative treatment would be required until she died.

It is important to note at this stage that during her stay at QAH there had been two separate incidents that had caused extensive bruising to her face. The first was explained that she had attempted to go to the toilet during the night and fallen. Unfortunately this happened again and at both times I was phoned by the ward staff to inform me. I complained to the Sister, and was told that putting her in a bed with "constraint" bars would require permission. Why had permission not been sought?
It is of note that following these incidents my mother although looking like Mike Tyson's sparring partner was still alert, talkative, and able to communicate.

Samantha's last visit to my mother whilst she was at QAH confirms that she was "perky, talkative, eating and drinking" and most important ….not in pain or discomfort. My mother was never told of her condition and knowing her as a determined person she was would have continued to live. She had not given up.

I visited my mother on the morning of her discharge from QAH (27th Feb 1998). During that visit although I found her to be weak, she was still communicative, perky and not in pain. She was transferred to GWM by ambulance around midday on 27th Feb 1998.

I made my first visit to my mother during the early afternoon that day (1400). At that time it was my opinion that my mother was definitely under sedative medication, she was unable to communicate, focus, talk, and was falling in and out of consciousness. During that early part of that afternoon I spoke to the ward Sister who stated that on arrival my mother had been in pain,

and was, quote "a very poorly lady". It was her opinion that she would not last too much longer. I did mention that I had seen her at QAH that morning and although very weak was not in pain.

My wife arrived in the ward soon after I had arrived and her recollection of my mother confirms my last previous paragraph.

There was a meeting between myself, my wife, the Ward Sister and Dr Barton. (Date Not Known). The Sister stated that on admission my mother was in pain and had been put on strong pain relief medication, I stated that in the morning she had not been in pain, but was certainly weak. My wife remembers that someone had mentioned that the journey was the cause of her pain, but I remember the sister stating that my mother was showing signs of pain, and that she was severely ill and that it was likely she would pass away very shortly.

At this point I can confirm that my mother was receiving Diamorphine Sulphate by Intravenous Pump Injection/ or some other powerful analgesic.

I visited every day at which time my mother was always in a deep unconscious state. I eventually received a call on the 2nd March 1998 to say that she had developed Steyne Stokes Breathing and that death was close.

3rd March 1998 - I visited most of the day, leaving late afternoon, at which time Samantha stayed. I returned at around 2200, to be informed that Eva had passed away ay 2100hours. I did not view the body.

During the administrative handover of effects it was found that my mother's wedding ring was missing. My wife confirms that whilst at QAH it had been taped to her finger.

In conclusion: After conversation with my daughter, I emphasize her qualified concern in that she was very surprised that my mother had deteriorated so soon after arriving at GWMH.
In her words: " She had been discharged from QAH having been treated from her initial Cardiac problem with a related sign (Shadow on Chest X-Ray) but with no other signs or symptoms of cancer."

It was not until other cases similar to my mother, were reported in the press that I made an official police complaint concerning the treatment of my mother.

It is my firm belief that certain members of staff at Gosport War memorial were operating a euthanasia policy on patients being admitted to the hospital. This certainly falls within the realms of murder or manslaughter.

The following questions we feel are important in this case:

1. What medication for **pain relief** was being prescribed by QAH prior to her transfer?
2. What was the QAH Consultant's reason for transferring her to GWM apart from my close proximity?
3. What was the QAH Consultant's prognosis of this case, would she have considered death within 7 days, as was the case?
4. What drug was administered within 6 hours of admission and why?
5. What drug / medication was prescribed/administered at GWMH and why?
6. What nutritional nourishment was provided to sustain my mother's life whilst at GWM?

We intend to pursue this case, and demand to know why other members of the nursing staff were not accused under the Dangerous Drugs Act relating to use and issue of such drugs.

Yours Sincerely
Bernard Page